

**A PROVIDER'S HANDBOOK
ON
CULTURALLY
COMPETENT
CARE**



**LESBIAN, GAY, BISEXUAL AND TRANSGENDER POPULATION
2ND EDITION**

Kaiser Permanente National Diversity Council
and Kaiser Permanente National Diversity



KAISER PERMANENTE.

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INTRODUCTION

Kaiser Permanente faces serious challenges and opportunities. The challenges are centered around continuously maintaining and improving the quality of care we deliver to our members in an environment in which cost has become an obstacle to our ability to grow and flourish in a predominantly for-profit health care marketplace. Also, the health care consumer market is demanding hard evidence of our ability to provide high quality, cost-effective care. At the same time the U.S. population and labor force is becoming more diverse than at any other time in history.

This handbook is the second edition of the Provider's Handbook on Culturally Competent Care: Lesbian, Gay, Bisexual and Transgender Population. This edition contains updated information and presents a new section on Intersexuality. The term "culturally competent care" describes the delivery of health care services that acknowledges and understands cultural diversity in the clinical setting, respects members' health beliefs and practices, and values cross-cultural communication. Increasingly, consumers are evaluating health care organizations for their ability to provide such care. Additionally, studies now indicate that sexual orientation and gender identity are as important as age or race in understanding health care utilization patterns and cost of care.

Incorporating cultural competence in meeting our current and potential members' needs is an important strategy in:

- Enhancing quality of care
- Expanding our markets
- Maximizing retention rates
- Delivering on the KP Promise of customized care
- Containing costs

This handbook is just one aspect of Kaiser Permanente's overall strategy to address diversity as a business imperative and maintain a competitive quality advantage. Our goal in creating this handbook for Kaiser Permanente's health care professionals is to provide an overview of the cultural and epidemiological differences that characterize the LGBT populations included in our membership. The handbook focuses on the characteristics of each group that impact health care utilization. It does not, by any means, suggest that we stereotype our members by groups. Rather, the handbook presents the general background information and scientific findings that can assist us in becoming more sensitive and knowledgeable about our diverse membership.

The data reported in this handbook come primarily from two sources: (i) articles published in medical and other health-related journals and (ii) state and federal health publications. In addition, national efforts to improve the quality and timely availability of vital research have resulted in access to information via the Internet. Most of the data were gathered or reported in the last decade. An editorial board composed of Kaiser Permanente physicians, nurses, psychologists and health care professionals reviewed all materials. To aid readability, all data sources have been placed in a reference section by subheading at the end of the handbook.

Kaiser Permanente National Diversity Council 2004

DEMOGRAPHICS

The diverse lesbian, gay, bisexual and transgender (LGBT) population includes individuals who are open about their sexual identity as well as those who are not visible to us and many of those around them. Due to the secrecy with which many feel they must lead their lives, we face the challenge of encouraging individuals to self-identify through a relationship based on trust and respect. In parts of the U.S., aspects of some individuals' private lives were until recently illegal and may still be socially stigmatized. Special challenges may be presented for providers who treat these individuals. Some individuals in this population are also often subject to legally permitted discrimination in places where the unintentional "outing" of an individual could have significant impact on their family relationships, livelihood and social status, as well as their personal safety. The issue of confidentiality is an important aspect of care to all in the health care setting, but especially to vulnerable LGBT individuals. The "invisibility" of large segments of this population is a major challenge in gathering sufficient data to accurately reflect their needs and expectations. The constructive dialogue generated by this handbook can facilitate not only increased clinical research and interest, but also a better understanding of our LGBT member population.

LGBT persons can face discrimination upon disclosure of their sexual orientation or behavior, making it especially difficult to assess the demographics of this population. To complicate matters, definitions of sexual orientation and sexual behavior are not standardized in the scientific literature, resulting in a fairly wide range of population estimates. Prevalence rate estimates of same sex sexual behavior among adult men and women vary from 5.5% to 10.7%. However, one large sample study in the U.S., United Kingdom and France reported that the combined variable of sexual behavior and sexual attraction yields a prevalence rate of 20.8% among men and 17.8% among women. The transgender population is estimated to be between less than 1% and 10% of the general population.

Like any large population, the LGBT population is heterogeneous with numerous sub-populations that reflect a wide range of dimensions such as age, socioeconomic status, gender, religion and race/ethnicity, to name a few.

Definitions and Terminology

For purposes of this handbook, we refer to the term "LGBT" to describe the lesbian, gay, bisexual, transgender and intersex communities. Also, we may refer to only "lesbians" or "gays" since the majority of studies employ samples from these populations. LGBT individuals are also referred to as "queer," a term that has both prideful and negative connotations depending on the social environment. For many LGBT youth in the U.S., the term "queer" is an empowering word. In some states, however, use of the term "queer" in a crime setting will be deemed as a hate crime.

It is also important to note that as sexual behavior can be fluid throughout one's life, so can self-identification. For example, a woman may self-identify as bisexual in her adolescence and then as an older adult self-identify as lesbian.

Heterosexual

Heterosexuals are individuals who have primary emotional and physical attraction to the opposite sex. Self-identified heterosexuals may occasionally engage in sexual contact with the same sex, but do not identify as being homosexual or bisexual. Heterosexuals are generally referred to as "straight." This term must be used with care. The term "straight" can be offensive to LGBT persons as it implies that anything other than "straight" is "crooked" or "twisted."

Lesbian

A lesbian is a woman who has primary emotional and physical attraction to other women. In the scientific literature, lesbian sex is usually abbreviated as “WSW,” or women having sex with women. Sometimes lesbian women engage in sexual behaviors with men although they self-identify as lesbian.

Gay

Gay individuals are men who have primary emotional and physical attraction to men. In the scientific literature, gay sex is commonly abbreviated as “MSM,” or men having sex with men. A self-identified gay man doesn’t necessarily limit sexual behavior to men. Occasionally, gay men may engage in sex with a woman. The term “gay” is sometimes used to refer to the larger LGBT population or an individual within it. For example, some lesbians identify as “gay.”

Bisexual

Bisexual men and women have physical and emotional attraction to both genders. Bisexuals are also referred to as being “bi.” Both the heterosexual population and the homosexual community frequently shun bisexuals. The reasons for this are complex. Bisexuality is frequently seen as a nonentity — a transitional stage from heterosexuality to homosexuality or vice-versa and/or as denial of one’s homosexuality. Bisexuality tends to be more problematic for men than women, partly because of the more rigid male sex role expectations regarding intimacy between males in many cultures.

Transgender

The transgender individual has a strong sense of incongruity between their birth sex and their self-identified gender (“gender identity”). Transgender persons may be receiving hormonal treatment without a plan for sex reassignment surgery or may actively seek surgical therapies to become genitally congruent with their gender identity. Transgender individuals may also identify as being heterosexual, homosexual or bisexual and therefore can experience discrimination based on their sexual orientation as well as their gender identity.

Female to male transsexuals are sometimes referred to as “FTMs” (or transsexual men) and male to female transsexuals as “MTFs” or (transsexual women). Pre-operative or “pre-op” transsexuals are preparing for sex reassignment surgery and usually participate in individual counseling and hormonal therapy for approximately one year. Non-operative or “non-op” transsexuals either do not elect or cannot afford to obtain sex reassignment surgery and may or may not receive hormone treatment and mental health services. Post-operative or “post-op” transsexuals have undergone sex reassignment surgery, hormone therapy, and most likely, counseling services. Usage of the terms “pre-op,” “non-op” and “post-op” is decreasing with the transgender community.

Intersex

Intersexuality features congenital variations of the reproductive and sexual system. Intersex people are born with “sex chromosomes,” external genitalia, and/or internal reproductive systems that are not considered exclusively male or female. It is also referred to as “ambiguous genitalia” and, in the past, “hermaphrodite,” a term whose use is discouraged because it is seen as stigmatizing. Conservative estimates suggest that one in 2,000 newborns are found to have ambiguous external genitalia, and that 100 to 200 pediatric surgical reassignments are performed in the U.S. annually. (*See Special Areas of Clinical Focus: Intersexuality for more information.*)

Gender Identity

At birth, individuals are assigned a socially defined gender, usually based on our reproductive anatomy. Babies with a penis are “boys” and babies with a vagina are “girls.” Gender identity refers to a person’s innate and inescapable perception of the person’s own gender, which may or may not be consistent with the person’s anatomical sex. Examples of gender identities that are not consistent with anatomical sex are: a transgender FTM who dates heterosexual women and identifies as a heterosexual man, or who dates only gay men and identifies as gay; or a transgender MTF who dates only heterosexual men and identifies as a heterosexual woman, or who dates gay women and identifies as lesbian. As stated earlier, gender identity and sexual orientation are interrelated but distinct dimensions of individual identity.

Sexual Orientation

Sexual orientation refers to the emotional and physical attraction to others of a particular sex, whether that is a different sex, as in heterosexuality, or the same sex, as in homosexuality. The term “sexual preference” is inappropriate since it implies that sexual orientation is a behavioral choice rather than an intrinsic personal characteristic. As discussed later, sexual orientation is not synonymous with sexual behavior. Likewise, sexual orientation and gender identity are interrelated but distinct dimensions of individual identity.

A person self-identifying as homosexual may have sexual experiences with the opposite sex. Current thinking no longer describes sexual orientation as a dichotomy between homosexual and heterosexual behavior. Sexual orientation is thought of as a continuum from exclusively heterosexual to exclusively homosexual. In fact, higher percentages of men and women report bisexuality than exclusive homosexuality. In a sample of lesbians, 95% had dated men and 25%-33% had been married to men.

LGBT Relationships

Although an increasing number of LGBT persons are using the terms “husband” and “wife” to refer to their same-sex partner, many struggle with finding an appropriate term to describe their partner that isn’t associated with a heterosexual context. In this handbook we use the term “partner.” Occasionally, an LGBT individual may use the terms “lover,” “roommate,” “significant other,” “spouse,” “companion” or “life partner.” The terms “partner” and “significant other” are widely accepted among LGBT individuals.

LGBT Families

Child rearing occurs in the LGBT population in various forms: foster care, adoption where legal, children from prior heterosexual relationships, artificial insemination, and co-parenting by gay and lesbian couples or individuals. In some situations, one gay and one lesbian couple co-parent, with one of each couple becoming the biologic parent of the child via artificial insemination. Therefore, families may consist of a child or children with “two mommies and two daddies.”

Although gay and lesbian parents have been threatened by courts in custody cases as being unfit by virtue of their sexual orientation, studies have not shown any negative outcomes for children raised by lesbian or gay parents. Research does not demonstrate any evidence that children raised by gay or lesbian parents are any more likely to be gay or lesbian than children with exclusively heterosexual parents.

Gay and lesbian families have few, if any, legal protections. This may change as more states recognize civil unions or marriage of same sex individuals. In the event of a separation, the courts rule frequently in favor of biological parents and against the interests of the non-

biological parent in custody cases. Agreements between known sperm donors and lesbian mothers are rarely recognized as legally binding. Courts typically recognize the known donors as parents, an unsatisfactory interpretation for the mothers raising the children in the absence of donor participation. Gay and lesbian families, particularly non-biological parents, face a range of impediments to care and custody of children, including exclusion from a spouse's health insurance coverage and hostility in school systems and health care settings. Some states expressly prohibit gay men and lesbians from adopting or serving as foster parents, and other agencies advise gay men and lesbians to pursue those options as single parents rather than introducing the subject of sexual orientation into the process.

Little research has addressed the effects of stress produced by such institutionalized discrimination or the ways in which gay and lesbian families must struggle with many psychosocial factors related to their alternative status. Factors include:

- Whether the non-biological parent will be recognized by others as a parent;
- How the extended families will react to the new family structure;
- How to deal with a surrogate mother or a known-donor father;
- Whether to choose a sperm donor who allows himself to be known later in the child's life;
- How to provide the children with peers who have similar families, and;
- What and when to tell the children about donors.

Education, Income and Occupation

Due to the limitations of conducting research on the LGBT population, there is scant information on the education, income and occupational patterns of this population, particularly among diverse racial and ethnic groups. A 1998 analysis of data from the General Social Survey, the 1990 Census and the Yankelovich Monitor indicated that gay and lesbian people earn less than their heterosexual counterparts. The study suggested that the gay and lesbian population has been falsely regarded as an affluent population based on the assumption that gay people tend not to have children and therefore, have more disposable income. In fact, the study concluded that gay, lesbian and bisexual people are found across the spectrum of income distribution.

Legal protections for employees based on sexual orientation and gender identity are often not available. The possibility for employment discrimination is always present, especially for transgender individuals who are living congruent with gender identities which are in transition, or different from their legal sex. Many transgender individuals are unemployed or underemployed because they may be without legal protections from employment discrimination.

Health Care Coverage

Systemic heterosexual bias often affects the health care coverage of many LGBT individuals in committed relationships. There are still numerous employers and insurance companies who deny health care coverage to LGBT committed partners. There are also legal barriers in many jurisdictions that do not allow coverage to domestic partners, even when the employer offers this benefit. Moreover, LGBT partners do not benefit from Social Security payments after a death of a partner, as do married heterosexuals.

Particular sub-populations of lesbian women may lack health care coverage. In 2001, the National Center for Health Statistics reported that Hispanic and Black members of the U.S. population are less likely to have health insurance. As a result of their further marginalized status, lesbian and bisexual women of color may be at an increased risk of lacking health care coverage.

LGBT individuals who possess health care coverage may be reluctant to access health services because of fear of discrimination, confidentiality issues and pervasive assumptions that all are heterosexual. A 2001 study reported that some LGBT individuals do not seek health care for themselves or their families due to fear of discrimination and stigma. The authors suggested that provider training on culturally competent care, researching LGBT-specific health issues and developing advocacy strategies at the consumer level are some approaches that may help to improve health care access.

Research Constraints

It wasn't until the AIDS epidemic in the early 1980's that the research community was forced to examine gay sexual behavior, despite Kinsey's hallmark work thirty years prior which examined many types of human sexual behavior, including the prevalence of homosexual behavior. Between 1974 and 1992, the National Institutes of Health (NIH) sponsored research on non-HIV related homosexual projects averaging \$532,000 per year compared to about \$20 million per year between 1982 and 1992 for HIV projects. The NIH has increased attention to the needs of lesbian and bisexual women and racial and ethnic minorities within the LGBT population. Recently however, research mentioning gay sex or safer sex has come under pressure and faced defunding due to homophobia. Numerous pressing questions remain unanswered regarding violence, psychosocial issues, morbidity, mortality and hormonal therapies.

Methodological Constraints

The 1999 Institute of Medicine's report "Lesbian Health: Current Assessment and Directions for the Future" presents some serious methodological limitations including:

- Non-standard definitions of sexual orientation.
- The use of small non-probability sampling methods that have relied on convenience samples (e.g., bars, music festivals).
- The lack of diverse samples. Most studies have sampled from White, middle class and well-educated populations.
- The lack of controlled studies with comparison to other samples (e.g., heterosexuals)
- The lack of longitudinal data. Longitudinal and prospective data are critical to understanding disease patterns, health beliefs and well-being over time.

Implications for Kaiser Permanente Care Providers

- Approximately 5 to 10% of your patient population may be lesbian, gay and bisexual and approximately 1 to 10% may be transgender. The specific health care needs of these patients differ in important respects from heterosexual patients.
- Be mindful of the fluidity of sexual behavior and that sexual behavior may not be synonymous with sexual orientation. For example, a woman may state that she is a lesbian, but may engage in occasional sex with men. The same could be true for a heterosexual male.
- Research demonstrates that the provision of health care is influenced by sexual orientation and gender identity. For example, employers and health care systems may routinely deny transsexuals necessary medical care, particularly hormone and surgical therapies.
- Heterosexism exists at the individual, group and institutional levels. Being aware of heterosexual biases will assist the provider to facilitate open communication in the patient-provider relationship.

HEALTH BELIEFS AND BEHAVIORS

Lesbian, gay, bisexual and transgender (LGBT) individuals bring with them diverse cultural norms and influences. Naturally, their gender identification and sexual orientation affect their health beliefs and behaviors. However, sexual orientation and gender identity alone do not shape LGBT behavior. Multiple influences relevant to LGBT health care must be factored into the individual health care considerations. At least eight categories of “otherness” are commonly experienced in U.S. society. These include, but are not limited to:

- Gender
- Race/Ethnicity
- Religion
- Socioeconomic Status
- Age
- Country of Origin
- Physical Ability
- Mental Ability

Each of these categories must be taken into consideration to understand the cultural influences on an LGBT patient. Western cultural norms and interpretations of sexuality and gender cannot be directly applied to other cultures. Although it is not possible to explore every culture, some key areas emerge:

- Immigrant populations may or may not be familiar with American systems of care that provide chronic disease management, mental health and group support services; in fact, “health” and “wellness” may mean different things in different cultures.
- A number of factors make it less likely for people of color and immigrants to be open about their sexuality. Fear of losing vital family and community support may force individuals to remain “closeted” and unable to take advantage of important health care resources.
- Individuals from various cultures may define or describe sexuality differently, thus requiring a culturally sensitive approach to obtaining relevant information.

Many LGBT people have relationships of different natures (i.e., social, professional, sexual, etc.) with people of the same sex and with people of the opposite sex, regardless of how they self-identify or other people identify them. Some individuals let everyone in their lives know about their sexual orientation or same-sex sexual behavior, while others opt not to disclose. As is true for heterosexual persons, LGBT people are varied in terms of their intimate relationships and sexual behaviors. For example, some LGBT persons are in monogamous relationships, while others have multiple partners; some participate in sadomasochistic play, while others engage only in traditional sexual practices.

Effects of Homophobia and Heterosexism on Health Care

It is safe to say that many LGBT persons have not been in an atmosphere conducive to fostering positive identities. “Internalized homophobia” occurs when homophobic cultural messages are incorporated into the LGBT person’s own self-concept. Internalized homophobia can manifest as feelings of shame about same-sex attraction, denial of sexual feelings, avoidance of sexual feelings, hate of self and other gay people, envy of heterosexuals, distorted body image, depressive affect, demoralization and lowered self-esteem. All theories

about the development of the LGBT identity recognize discordant stages where individuals have difficulty accepting their sexual orientation. During these stages the individual may be at risk for acting out by abusing substances, rejecting the heterosexual people in their lives, or even suicide attempts. The difficulties of self-acceptance may also lead to lower self-esteem, making them more likely to accept disparaging remarks or behavior toward them, and less likely to feel that they can succeed or deserve to succeed. In fact, preliminary research indicates that lesbian, gay, and bisexual people are at higher risk for suicidal thoughts and attempts than are their heterosexual counterparts.

Extensive research on attitudes toward homosexuals among health care providers shows a disturbing picture. Studies have shown that the attitudes of health care providers reflect those of the general population. Most health-related training ignores or does not adequately incorporate LGBT issues into the curricula. Few medical textbooks mention homosexuality at all, and those that do focus on gay men and HIV/AIDS, saying nothing about lesbians and bisexual women. This is not surprising given that prior to the late 19th century, homosexuality was seen primarily as a moral weakness and homosexuals and homosexual behavior were condemned as a crime, vice or sin. In the late 19th century, psychiatrists presented homosexuality as a disease and it was subsequently listed in the psychiatric diagnostic manual (DSM) as such. It was not until 1973, after intense debate among members of the American Psychiatric Association, that homosexuality was changed from being listed in the DSM III as a sexual deviation to "sexual orientation disturbance" only for those who were bothered by, in conflict with or wished to change their sexual orientation.

In the 1970s, gay counseling centers were formed in large urban cities around the U.S., providing affordable support and counseling for lesbians and gay men who did not want to change their sexual orientation. In 1987, homosexuality was changed in the DSM III-R from its own category to one of "sexual disorders not otherwise specified." This was done after psychologists and psychiatrists pointed out to the board that the research on homosexual identity indicated that most homosexuals go through periods when they are disturbed by their homosexuality as a part of healthy development. Currently, there are both treatments that attempt to cure homosexuality ("reparative therapy") as well as therapy for LGBT people who are not interested in changing and who want to work on acceptance of their sexual orientation. Professional organizations have policy statements that state that "reparative therapy" is not effective and has no place in a therapeutic environment. Homosexuality does not require treatment and is not changeable.

LGBT patients have reasonable fears of discrimination when they seek health care services. These fears have been supported by research that demonstrates a lack of understanding and sensitivity by health care providers toward lesbians and gay men that often results in the delivery of substandard care. When faced with an uncomfortable interaction with a provider, an LGBT patient may feel powerless to change the health care provider's conduct, to resolve an uncomfortable situation, or to speak to the provider about their discomfort. The negative attitudes of some health care providers about homosexuality, bisexuality and transgenderism may lead LGBT patients to be hesitant in revealing their sexual orientation to their providers. If they choose to remain closeted, they will be unable to discuss their health within the context of their full life experience and may feel isolated from their health care provider.

Difficulty communicating with a health care provider has been associated with delay in seeking health care. Health care providers not only provide medical care, but also counseling about healthy behaviors and referrals to support services. In fact, providers spend up to 25% of their time with the patient instructing and counseling, one of the primary functions of the patient interview. If the relationship between the provider and the patient is not open, then

this may affect the provider's ability to elicit accurate information, help their patient accept an illness, include a partner in treatment decisions, understand the full range of relevant behaviors, and counsel patients appropriately.

Older LGBT Adults

Older LGBT adults confront unique issues when dealing with their biological families. Many older adults who came out early in their lives, did so prior to the LGBT civil rights movement. They, therefore, did not have the kind of organized support and visibility that LGBT individuals now enjoy. They had more to risk and were more likely to keep their sexual orientation hidden from their families. Older adults often rely on adult children for care and assistance, however, closeted older LGBT adults are frequently isolated from their families due to this secrecy. This isolation can create problems gaining needed support. Like persons with disabilities, they are often seen as asexual by their families and, therefore, find it particularly difficult to come out to their adult children.

People of Color

Role of Racial and Ethnic Identity

Racial and ethnic identities play a large role in individual identity development. People of color are more likely than Whites to identify themselves as part of a racial or ethnic group. Whites who have grown up in strong ethnic enclaves are more likely to identify by their national or religious heritage, e.g., Irish, Italian or Jewish. A member of a dominant or advantaged social group rarely self-identifies as being a member of that group. For example, a heterosexual White man might only identify himself by his profession or marital status, while a homosexual White man may identify himself as gay, but not mention White. An Asian American homosexual man might identify himself as Asian and gay.

Some LGBT individuals of color may experience a conflict between a strong need to be a part of a racial or ethnic cultural group and wanting to belong to the LGBT community. For LGBT individuals, the racial or ethnic community provides critical societal support in an often hostile dominant culture. Even if they have the support of the LGBT community, they risk losing the support of their community of color, which is seen as essential to their very survival. Loss of the community can include loss of the family, which is particularly traumatic.

It is a well-documented fact that people of color tend to receive lower quality health care than Caucasians, even when socioeconomic variables are controlled. Some researchers speculate that these disparities may even be greater for LGBT people of color. In two large sample studies conducted at UCLA, lesbian and bisexual women of color were less likely to access preventive care services than their heterosexual counterparts.

Sexuality and Gender Roles

Communities of color can vary in their expectations of the two gender roles. For example, in some Native American cultures, gender was seen on a continuum from male to female with multiple genders between them. Understanding the variation in gender roles, which can be confused with sexual orientation, can facilitate a better understanding of the LGBT experience. In some cultures, such as Latino, Asian, and African American, strong gender roles may make it particularly difficult to be openly gay. In cultures that expect women to be submissive and willing to defer to men, lesbians can be seen as a threat to these expectations.

Cultural groups differ in their openness about sexuality, in the acceptable forms of sexuality within their communities, and in the consequences for diverging from these permissible

sexual activities. In many Latino, Asian and Native American cultures, women are not likely to talk about their sexuality. This can make it particularly difficult for a lesbian or bisexual woman to be comfortable talking with her provider about her sexuality. Coming out in these communities may be seen as breaking cultural rules about what should and should not be discussed.

In some cultures, women who have physical relationships with each other, are not seen as lesbians. The societal disapproval arises not from their behavior, but when they identify as lesbian or bisexual. Similarly, it is sometimes permissible for a man to be the anal insertive partner with another man as long as he is not the anal receptive partner. It may be permissible for same sex young people to have physical relationships with each other as part of sexual exploration.

Many Asian and Pacific Islander (API) cultures have deep-rooted social or cultural norms that allow for the expression of homosexual behaviors within socially prescribed contexts. For example, ritualized same-gender sexual behaviors are normative among men in areas of New Guinea. As part of adulthood initiation young males are expected to fellate older males to receive the masculine power of semen, transforming them into adulthood. Until the age of 19, the prescribed age of marriage, all young men participate in homosexual activities. After marriage, homosexual activities are limited to initiation of young men.

Transvestites in East Indian society are believed to derive special power from their familiarity with both sexes. Some are born intersex, others are transsexuals, and still others are gay men who dress in drag to have sex with men. In Filipino culture, a “bakla” is a man who assumes the role and behavior of a woman, not unlike the Native American Zuni concept of a “lhamana.” A “lhamana” man dresses as a woman, learns the traditional work of both sexes and performs the role of healer and arbiter in his community. Similarly, in the West African Dagara tribe, homosexuals are “gatekeepers” who maintain alignment between the spirit world and the world of the village. Without them, the gates to the spirit world would be shut. Gatekeepers also serve as mediators between women and men, ensuring peace and balance. They act as “the sword of truth and integrity.”

Although homosexual behaviors may be tolerated, the narrowly defined sexual identities prescribed for these individuals do not allow the development of a sexual identity as a lesbian, gay or bisexual person. In addition, public discussion of heterosexual behavior is often discouraged, much less homosexual behavior. Without a well-defined sexual identity, these individuals may deny to themselves that they are lesbian, gay, or bisexual while engaging in same-sex encounters. Including questions in the sexual history that focus on behavior, rather than sexual orientation, increases the likelihood of the disclosure of behavior that is relevant to the patient’s health status.

Relationship to Individual or to Group

Cross-cultural conflicts can occur between the individualist culture of mainstream America and collective structures in other cultures. White gays and lesbians may view it as their right to disclose their sexual orientation and to have equal rights in the larger society. Gays and lesbians of color may exist in a culture where “coming out” is perceived to negatively affect the family and the community. For them, coming out may not be seen as the individual’s privilege to disclose, but rather as disrespectful of the family collective. This increases the risks of non-disclosure to the provider.

Multiple Discrimination

LGBT persons of color may also confront discrimination from others within the LGBT population. Discrimination can be overt and similar to that found in the larger community, like greater scrutiny in the workplace, clubs, restaurants or stores. It can also be subtler; such as the absence of people of color in the leadership of outreach organizations. Because of experiences of discrimination, some LGBT persons of color may be all the more reluctant to rely on the support systems in the LGBT community.

Family

The way that individuals interact with their families and the importance of family in the community are important considerations when working with the LGBT population. In cultures where the family is particularly significant, such as Latino, African American, and some Asian groups, LGBT persons may struggle to choose between family and LGBT supports. For many people of color, the family helps protect against the effects of discrimination, so losing the support of the family is particularly traumatic. Families of color tend to accept LGBT family members as long as they do not disclose their sexual orientation or gender identity issues. This form of denial allows family members to maintain both their condemnation of same-sex orientations and their connection with LGBT family members. It may cause problems for individuals who are trying to accept their LGBT identity or are becoming involved with the LGBT communities. It can also create problems in couple relationships where one person is “out” about their sexual orientation and the other person is closeted.

Religion

Most mainstream traditional religions condemn homosexuality. This creates intense conflict for LGBT individuals whose families and communities are religious or who themselves have been involved in organized religion. They often find themselves denying their homosexuality to retain their religious beliefs, or they feel guilt or shame because of their attraction to same sex individuals. In some cultures it is difficult or impossible to remain within the culture and distance oneself from the religion. LGBT individuals in these cultures often have to choose between closeted participation and giving up their participation.

In some areas, especially urban areas with large LGBT populations, churches and temples serve LGBT communities. Some denominations are inclusive to the point of supporting commitment ceremonies for same-sex couples. Churches and synagogues that are open, accepting and affirming of gays and lesbians exist in many communities. Also, some Native American tribes see people who break gender norms or have differing sexual orientations as able to see through both eyes (two-spirited) and spiritually powerful. In these tribes, LGBT individuals may be treated with at least as much respect as their heterosexual counterparts. As an adjunct to or substitution for organized religion, some segments of the LGBT population have sought nature-oriented spirituality. This offers individuals an opportunity to come together in a positive way and express their spirituality, free from the guilt associated with the religions in which they were raised.

LGBT individuals may feel uncomfortable accessing services, such as homeless meals and housing or 12-step programs for drug or alcohol recovery that are available through religious organizations or held in places of worship. This should be taken into account and discussed when referring the LGBT patient to programs with any type of religious affiliation.

Role of Non-Traditional Families in Medical Decision-Making

End of life planning can be difficult for LGBT patients, especially without an Advanced Directive or Durable Power of Attorney for Health Care. In a health care crisis, partners may be denied hospital visitation rights, time off from work without benefits for a non-recognized family member, and face legal challenges from estranged or more traditional immediate family members. Providers (e.g., hospital-based specialists) who may be unfamiliar with their patients should familiarize themselves with the patient's social support system and assess the legal rights of any partners. Additional issues of income, property, parenting of adopted children and other issues may arise. These issues should be discussed early on and decisions written into the patient's medical record and appropriate forms.

Taking Medical Histories

Information from patient history and physical forms often sets up the relationship between the provider and the patient, creating a foundation from which the provider bases the rest of the patient interview. Reviewing forms is often the first interaction that patients have with their providers and can influence the way they feel about a provider. Most standardized forms that patients complete are not appropriate for the LGBT individual. For example, an LGBT individual with a lifelong partner cannot adequately answer a question about "marital status" with the usual categories of "married," "single," "separated," "divorced," or "widowed." Currently, such an LGBT person is neither legally married nor single; however, a lifelong partner may play a significant role in that individual's health behaviors and treatment. Another area of inquiry that is often inappropriate for the LGBT individual is the family structure. There is often room on a form for the spouse and for children, but inadequate space to explain complex family systems.

Similar to patient intake forms, taking a medical history is a bridge to communication between the provider and the LGBT patient. Once again, it is critical to be as sensitive and as culturally appropriate as possible. Often standard questions are inappropriate for the LGBT individual. In the clinical setting, the health professional has control over what questions to ask and what not to ask, the terminology to use (including but not limited to the use of pronouns), and how to defuse the situation if the patient becomes uncomfortable. The health care provider should think carefully about what information is relevant and make sure that the initial questions are open-ended enough for the patient to answer truthfully without having to correct the provider. Given the power dynamics of provider-patient relationships, it is often difficult for patients to correct false assumptions by their providers.

Confidentiality

An individual's medical information generally is protected from disclosure under state law, and federal law provides enhanced protection for mental health and substance abuse treatment records. The extent of such protection depends upon the law of the applicable jurisdiction. Usually, medical information is protected by the state or district within which the records are maintained, although the law of the jurisdictions within which the patient lives or the health professional practices, if different from the location of the records, may have interests which must be balanced. Since the precise scope of confidentiality protections vary by jurisdiction and can change with each session of a state legislature, the following are general comments regarding confidentiality.

In modern medicine, many health care professionals participate in providing health care to an individual, frequently without ever communicating directly to each other. It is therefore

essential that a patient's medical record contain all information that could be relevant to the patient's health care. Since some of this information may be sensitive, every health care provider who has access to the patient's information must take the obligation to preserve patient confidentiality very seriously.

There are some circumstances under which an individual's medical record must be disclosed through the legal process. Examples include criminal investigations and civil lawsuits. Medical records departments, or other individuals who respond to such requests or subpoenas, typically do not review the charts to delete information that does not come within the scope of a subpoena or records request. Therefore, health care providers should be careful to limit notations to those facts that are clinically relevant.

Particular care should be exercised with patients who are minors, since the parents of such a patient will ordinarily have the ability to review the patient's medical record. Some states give a health care provider, in limited circumstances, the legal ability to resist disclosure of a minor's medical information to the parents of such a patient, if the provider feels that such disclosure would interfere with the patient's care or safety. However, neither the patient nor the provider can assume that medical information will be inaccessible to parents or guardians. Therefore, it is advisable for the provider to be discrete in noting sensitive information in a minor's medical record, absent a need to do so for clinical care reasons.

Implications for Kaiser Permanente Care Providers

- Providers can set the example for staff in the office and hospital setting. This means avoiding sly jokes or innuendoes, and speaking of LGBT patients and their partners in the same respectful manner as any other patient. Coworkers will likely take the cues, and even if they harbor negative attitudes, they will be less likely to subject patients to them.
- Strong cultural or societal pressures may make it difficult for an individual to disclose same sex relationships, yet this information is important for effective care. Making the patient feel as comfortable as possible in the patient-provider relationship increases the chances of complete disclosure.
- Be sensitive to the patient's cultural milieu when suggesting resources or referrals for support services.
- LGBT people of color may be less likely than White LGBT persons to access mental health services and other social support services. Consider ways to communicate utilization of these services, if needed.

History and Physical Intake Form

- Patient intake forms should not include assumptions about gender (e.g., husband/wife, mother/father). Use gender neutral terms such as, "life partner/spouse," "parent," or plurals (e.g., parents) instead of singular pronouns or both pronouns.
- Whenever there is a sex or gender question, add a third category for transgender so that individuals can specify their particular circumstances.
- Questions about families should allow for alternative families including two parents of the same sex or more than two parents.
- For questions where there are other possible answers, an "other" category should be included with space to explain (e.g., single, married, widowed, other.)
- The form needs to include an explanation about how confidentiality will be protected and who has access to the information. Offer the patient the right to refuse to answer a question.

Patient Interview

- Make no assumptions. Any person who walks into a provider's office could self-identify as LGBT and/or have a history of relationships with members of the same sex. Similarly, they may have been born the opposite sex.
- Sexual behavior can change over time. Questions on sexual orientation and behavior need to be asked of everyone and asked again over time.
- A provider can simply apologize if a patient seems offended. A brief explanation about why information is necessary to provide the best care possible can be offered. Ask what terminology the patient prefers (e.g., if you call a partner a "lover" and the patient seems offended, ask what she/he usually calls him/her).
- Be completely comfortable talking about sex (slang and technical). Practicing interviews with friends can ease discomfort. (*See Risk Factors: Sexual Practices.*)
- Judgment and condemnation are never helpful. Providers have the right to their own morals and beliefs in their personal lives, but not when they interfere with the delivery of necessary care. LGBT patients are usually sensitive during the interview about what they perceive as the provider's attitudes toward them.
- A provider who is not comfortable or knowledgeable of particular behaviors, lifestyles, or orientations should refer the patient to a colleague who has expertise in LGBT health care. Explain to the patient that you are making the referral because your colleague has special expertise in this area.
- Explain how the patient's confidentiality will be protected, and who will have access to the information. Give the patient the option of refusing to answer a question. If the patient's confidentiality cannot be protected, it may be to the patient's disadvantage to provide specific information if it is recorded in the medical chart.
- Advocate for all patients to enact durable powers of attorney for health care and respect those choices when they are exercised.

RISK FACTORS

Socioeconomic Risk Factors

LGBT individuals may face risks from homophobic violence, inadequately trained health care providers and lack of knowledge about the risks of sexual practices. While health care professionals cannot directly impact the risk of homophobic violence, they can take into account the impact it has on their LGBT patients. Health care providers can directly impact the bias faced by LGBT patients by examining their own biases and educating their patients about lifestyle risks. Understanding these risk factors can facilitate the health care provider's role in providing higher quality care to LGBT patients.

Homophobia and Heterosexism

Homophobia

Homophobia, the most commonly used term describing anti-gay feelings, means literally, fear of the same, in this case, fear of same-gender sexuality. However, the term homophobia is commonly used to mean hatred toward homosexuals. Transphobia is the analogous term used to indicate fear and hatred of transgender individuals.

The most obvious examples of homophobia are hate crimes directed at people whom the persecutors perceive to be lesbian, gay, or bisexual. Hate violence can be physical, verbal, and/or emotional in nature, ranging from yelling verbal epithets to murder. In a 2001 FBI report on hate crimes, 72% of crimes based on sexual orientation were assault and intimidation and 28% were against property, such as burglary and vandalism. Of all hate crimes based on sexual orientation, male homosexuals tend to be targeted more than any other group. For example, 68% of hate crimes were against male homosexuals compared with 15% of lesbians. Less blatant, but potentially just as damaging, are the insidious stressors that the individual confronts on a regular basis such as dealing with homophobic jokes or constant pressure to conform to gender norms.

Heterosexism

Heterosexism is the belief, conscious or otherwise, that heterosexuality is the only form of sexuality. It is useful to differentiate between heterosexism and homophobia. In one framework, homophobia involves direct anti-gay feelings associated with some type of action, while heterosexism is a lack of acknowledgment of the existence of homosexuals or the assumption that all people are heterosexual. Heterosexism may not be intentional, whereas homophobia is intentional. Both occur at the individual, group and institutional levels, and both may negatively affect the health and well-being of LGBT individuals.

Traditional health care treatments and interventions are based on the assumption that all patients are heterosexual. As a result, many LGBT persons are afraid that they will not receive adequate health care due to heterosexism. These fears have been supported by research that demonstrates a lack of understanding and sensitivity by health care providers toward lesbians and gay men that often results in the delivery of substandard care. A study of nurses revealed that many nurses have homophobic attitudes and documented demonstrable differences between the quality of care given to homosexual patients and heterosexual patients. In 1994, the American Association of Physicians for Human Rights reported that some physicians are hostile toward homosexuals, for instance, performing particularly "rough" digital rectal examinations after discovering that the patients were gay.

Institutional manifestations of heterosexism exist in many areas. The dominant heterosexual culture provides few legal sanctions or public rituals for non-traditional relationships. In many cities and states, LGBT couples have no legal status in terms of hospital visitation, decisions regarding their partners' health care, child custody following the death of the biological parent, or rights to estates, unless clearly spelled out in a will or Advanced Directive. LGBT couples generally develop with little societal support to help them in an atmosphere that is usually oppressive and pessimistic about gay/lesbian lifestyles. This may be more difficult for males, as American heterosexual culture does not promote, and in fact, actively discourages men from relating intimately.

Hate Violence

Lesbian, gay, bisexual and transgender (LGBT) persons are at a higher risk for physical assault and violence than heterosexuals. These attacks have been documented in numerous settings including the workplace, schools, armed services, jails, homes and public places. According to 2001 FBI statistics, nearly 14% of all reported hate crimes were perpetrated against persons based on their sexual orientation, 46% were based on race, 18% based on religion and 22% based on ethnicity. Most of these attacks occurred at the victims' residence or on the street. Sixty eight percent (68%) of all reported hate crimes based on sexual orientation were perpetrated against gay men and 74% of those reported attacks were violent (murder, aggravated assault and simple assault). This is consistent with studies that have found that attacks on LGBT persons are frequently more violent, more likely perpetrated by strangers and are more likely to involve multiple attackers. Some studies showed that nearly one-fifth of all lesbians and more than one-fourth of all gay men report being the victim of a hate crime based on their sexual orientation, and young LGBT persons are especially vulnerable. It is difficult to generalize from these statistics since underreporting is common due to the victim's fears of becoming known publicly as a victim of a hate crime based on sexual orientation or fears of bias in the criminal justice system.

Violence aimed at youth is particularly alarming because of their dependence on adults for protection, especially if the violence is coming from their families or their schools. Many young LGBT individuals feel compelled to leave their homes to escape violence and discrimination because of their sexual orientation or the ways in which they express their gender.

Much of the violence directed at LGBT persons is believed to be the result of negative attitudes towards the LGBT population. Research has found that people who have the most positive attitudes toward LGBT persons are those who say they know one or more LGBT persons, often as a friend or co-worker. For this reason, psychologists believe negative attitudes toward LGBT people as a group are prejudices that are not grounded in actual experiences but are based on stereotypes.

Protection against violence and discrimination is very important, just as for any other minority group. Protection for LGBT persons varies from state to state and city to city. Some states include violence against an individual on the basis of his or her sexual orientation as a "hate crime," and currently ten U.S. states have laws against discrimination on the basis of sexual orientation. Educating all people about sexual orientation and homosexuality is likely to diminish anti-LGBT prejudice.

Medical Bias

Caregiver Attitudes

In 1973, the American Psychiatric Association removed homosexuality from its classification of mental disorders. Despite this, some health care providers may consider homosexuality deviant and may remain uncomfortable with LGBT individuals. Bias against LGBT individuals occurring in the medical community has enormous ramifications for the quality of care. A 1998 survey of nursing students showed that 8 to 12% (depending on whether the respondent rated gay, lesbian or bisexual) despised lesbian, gay and bisexual people, 5-12% found lesbian, gay and bisexual people disgusting and 40-43% believed that lesbian, gay and bisexual people should keep their sexuality private.

The physician community demonstrates no more open attitudes than the nursing community. In a 1996 survey of 1,027 New Mexico physicians, 4.3% indicated that they would deny gays and lesbians acceptance to medical schools and 10.1% believed that gay and lesbian physicians should be discouraged from seeking obstetrics/gynecology training. In the same study, over 20% of the general practitioners, 9.3% of family practice physicians and 4% of pediatricians reported that they would discontinue patient referrals to gay or lesbian surgeons. In a 1996 survey of U.S. family practice residency directors, 25% of the directors expressed hesitation in matching openly gay residents. From the preceding information it is clear that the majority of providers have attitudes that are either neutral or affirming of LGBT individuals.

Taking Medical Histories

Physician discomfort around issues of sexuality is evidenced by the fact that several studies indicate that only 11% to 37% of primary care physicians routinely take a sexual history from new adult patients. Without a sexual history, a provider may erroneously assume that a man is gay because he appears to be effeminate, that a married man is strictly heterosexual and monogamous or that a patient is heterosexual because they list dependent children. By assuming that female patients are heterosexual, providers risk alienating those who present for a routine gynecological exam by giving lengthy and unsolicited advice about contraception. The two main reasons cited by lesbians for not receiving health care are lack of financial resources or insurance and past negative experiences in the health care setting.

Biases affect provider-patient interactions. Patients will not reveal their sexual orientation or practices if they perceive criticism, fear or disgust on the part of their primary care provider. Forty-four percent (44%) of the gay men in a 1992 study did not reveal their sexual orientation to their primary care physician. Of the gay men in this same sample, 44% of the HIV+ men did not inform their primary care physician of their HIV status. As a result, these patients are failing to receive essential testing and vaccination for easily preventable disease (e.g., hepatitis A and B) and failing to receive appropriate treatment.

It is imperative to take a sexual history in a nonjudgmental manner and ask open-ended questions. It is equally important to focus on behavior rather than sexual orientation to gain an understanding of an individual's risk for HIV infection or other STDs. For example, in some communities of color, a man may identify as heterosexual and not consider occasional male-male contact as indicating bisexuality, particularly if the man is the insertive partner for anal or oral intercourse.

Lack of training and education about the health of LGBT individuals also means that providers may fail to consider, detect or discuss important medical and/or psychosocial issues and risk making incorrect assumptions. For example, providers may assume that LGBT patients are not

interested in parenting or may not even consider that they already have children from a prior marriage. Or providers may not consider domestic violence a possibility when dealing with same-sex couples.

Patient Communication

Personal biases do not belong in the medical encounter. Lecturing patients about what is right, moral, sinful or a societal standard alienates them, and may cause them to delay further medical care, limit what they say, or go to a different provider in the hope of finding someone to whom they can talk freely.

Assumptions can impact clinical decisions. A 1981 study showed that when a patient was known to be gay, physicians tended to interpret the presenting problem in sexual terms. When the patient was not identified as homosexual, other diagnoses were more often considered.

Providers need to be comfortable referring patients to local LGBT community resources. It is analogous to referring an older adult patient to a senior citizen center or a patient with a specific medical condition (e.g. multiple sclerosis) to the local and national foundation that can provide additional resources and appropriate group support.

Verbal and nonverbal communication will affect the amount of disclosure a patient will allow. It is similarly important to be explicit with a patient about documentation of sexual orientation in the medical record and to obtain the patient's permission to include this information. The potential lack of privacy of medical records is one additional factor in patient's reluctance to disclose personal information.

Implications for Kaiser Permanente Care Providers

- Homophobia, transphobia and heterosexism exist at the individual, group and institutional level. Being sensitive to personal and institutional biases in favor of heterosexuality can help a provider to see and address these biases.
- Personal religious or moral beliefs of providers should be separate from the dynamics of their relationship with LGBT patients. Assess how your biases impact the way you communicate with your patients and the way you interpret symptoms.
- Communicate a safe environment to facilitate discussion during interviews. Use non-judgmental and gender-neutral language.
- Use inclusive language on admissions/information forms and sexual/social history forms. (*See Appendix B: Intake Forms.*)
- Make no assumptions about a patient's behavior or health needs. Ask the patient and use his or her language to describe relationships, sexual behaviors and health concerns.
- Focus on behavior rather than sexual orientation. Do not assume that all patients are heterosexual, or if legally married, are heterosexual or monogamous.
- Discuss confidentiality, including documentation and access to records.
- Respect a patient's wishes or needs to disclose or not disclose his or her sexual or gender identity.
- Provide access and referrals to printed resources and services for LGBT persons. (*See Appendix A: Resources.*)
- In exam rooms, include magazines, newspapers, brochures that are inclusive of and specific to LGBT persons.

Behavioral and Lifestyle Risk Factors

Sexual Practices

It is critical for providers to understand the diversity of the sexual encounters to accurately assess their patients' risks, whether lesbian, gay, bisexual, transgender (LGBT) or heterosexual. Three crucial concepts should be considered:

- Sexual orientation is not synonymous with sexual behavior. Infectious disease risk is, therefore, based upon sexual behavior, not sexual orientation.
- Specific behaviors carry varying risk. Health care providers must be aware of the full range of sexual behaviors in order to provide appropriate care.
- Not all LGBT persons engage in all of these sexual practices. Health care providers can assess the sexual practices in which their LGBT patients engage and counsel them accordingly.
- Many of these sexual behaviors are practiced by heterosexuals, such as “fisting,” sadomasochism and “water sports.” All patients will benefit from a provider's knowledge of the health risks associated with specific behaviors.

LGBT individuals, including those that self-identify as gay or lesbian, may also engage in heterosexual sex. In a 1998 survey of 7,065 gay and bisexual men in New York City, 406 reported unprotected intercourse with women, and within this subgroup 30% self-identified as gay. Between 75-90% of lesbians report a history of heterosexual activity, in some cases with multiple male partners. A substantial number reported a sexual encounter with a male within the past year. This clearly illustrates the difference between sexual orientation and sexual behavior.

To have an accurate assessment of an LGBT patient, providers need to obtain a current as well as past sexual partner history. Health care providers must be comfortable taking a sexual history and assessing risk based on the particular sexual behaviors. This will allow for the provision of appropriate treatment for sexually transmitted diseases (STDs) and education on safer sexual practices, including transmission of STDs and appropriate partner treatment. Health care providers should become versed in the vernacular of the community, utilizing plain language to describe the sexual practices in which men having sex with men (MSM) or women having sex with women (WSW) may engage. There are printed reference materials on safer sex practices available through the Internet and local gay and lesbian community centers. (*See Appendix A: Resources.*) It is critical to remember that WSW can also transmit HIV/STDs. Lesbian sexual behavior has not been researched as a separate and distinct phenomenon in terms of incidence, rates and modes of transmission of HIV or other STDs.

Sexual practices and their associated risks are outlined in the following table:

SEXUAL PRACTICE “slang or colloquial term”	DEFINITION	RISK FACTORS FOR HIV AND OTHER STDs	PREVENTION
DEEP TONGUE KISSING “French kissing”	Insertion of the tongue when kissing.	Open mouth lesions such as cold sores or oral herpes.	Avoid brushing teeth or flossing prior to oral contact.
CUNNILINGUS (“going down on” or “eating out”)	Oral sex on a woman.	Menstruation by the receiving partner, open lesions such as herpes.	Recommend dental dams ¹ or plastic wrap barriers.
FELLATIO (“going down on,” “giving a blow job” or “giving head”)	Oral sex on a man.	Open sores in giver’s mouth. Ejaculation in the partner’s mouth.	Recommend condom ² use.
ANALINGUS (“rimming”)	Anal stimulation with the tongue or mouth.	Tears or abrasions in skin or mucous membranes of anus or mouth.	Dental dams should be used, as analingus increases risk of coliform bacteria and Hepatitis A to the administering partner.
“FISTING”	Insertion of fist in vagina or rectum.	Tears or abrasions in the skin or mucous membrane.	Recommend use of latex gloves and water soluble lubricants.
DIGITAL STIMULATION (“finger sex” or “fingering”)	Finger stimulation in the vagina and/or rectum.	Tears or abrasions in the skin or mucous membrane.	Recommend use of individual latex finger cots or latex gloves and water soluble lubricants.
“WATER SPORTS” (“golden showers,” “spiking”)	Practice of urinating on one’s partner. Expelling a douche or enema.	Tears or abrasions in the skin or mucous membrane.	Recommend use of disposable nozzles, latex gloves, personal bags and lubrication for “spiking.”
“SCAT”	Practice of defecating on one’s partner.	Tears or abrasions in the skin or mucous membrane.	Recommend use of plastic wrap and latex gloves.
“SOUNDING”	Inter-urethral stimulation.	Sharing of sexual toys.	Recommend no sharing of sexual toys.
TRIBADISM (“dry humping” or “frottage”)	Rubbing of pelvis to pelvis or to other body parts.	Contagious skin infections.	
SEX TOYS • Dildos • Vibrators • Butt plugs/anal plugs	Dildos and vibrators are used to penetrate the mouth, vagina and rectum. Dildos may be worn using a “strap on” device which holds the dildo against the pelvis or thigh. Butt plugs are used for rectal penetration.	Presence of blood and/or other body fluids on sex toys.	Toys should be covered in condoms; use lubrication to decrease friction, trauma and prevent disease transmission. Only water based lubrications should be used. Condoms should be changed between multiple partners and with each orifice penetration. Toys can be cleaned in 1:10 bleach/soapy water mixture.
SADOMASOCHISM “S&M,” “leather sex,” “bondage,” “whipping” or “paddling” (Non-S&M sex is often referred to as “vanilla sex.”)	Form of erotic play in which the use of mutually agreed upon scenes of domination and submission are played out		Health care providers need to ask if visible wounds were obtained voluntarily to rule out abuse or assault.

¹ Dental dams are latex squares, usually 6 inches, which are placed over the vulva or anus during oral sex.

² Condoms should be either latex or silicone.

Anal Intercourse

The vast majority (91%) of male homosexuals have had anal intercourse at some point in their lifetime. Anal intercourse can be either receptive or insertive and the majority of men switch roles. Few men are exclusively receptive or insertive. Anal insertive intercourse is viewed as “less risky” than receptive anal intercourse in the general male homosexual population. It is a commonly held myth within the medical community that anal receptive intercourse is associated with fecal incontinence. While it has been noted that resting anal pressures are decreased, combined resting and squeezing pressures remain intact.

Oral Intercourse

Oral intercourse is another common MSM practice. Fellatio may be either receptive or insertive and when unprotected, increases the risk of STDs as well as non-chlamydial non-gonococcal urethritis. Oral insertive intercourse accounts for as much as half of all urethral infections in MSM. As long as the gay male community perceives risk as lower with oral sex, condom use may be inconsistent. The reported condom use may actually exceed the actual usage based upon fear of judgment or misconception and insufficient disease prevention education. It should be noted that the relative risk for disease transmission varies dependent upon whether ejaculation occurred.

Oral sexual practice for women, cunnilingus, is also a risk factor for the spread of sexually transmitted diseases. All sexually transmitted diseases have been documented to have been transmitted orally at least once. Safer sexual practices, including the use of dental dams or plastic wrap, should be considered unless both parties have been screened and are in a monogamous relationship.

Substance Use

A number of methodological problems make it difficult to describe substance abuse patterns in the LGBT population. Closeted LGBT individuals are generally unavailable for epidemiological surveys. Studies of LGBT populations tend to oversample gay bars, sex workers and the homeless, leading to an overestimate of substance abuse disorders. If similar studies of heterosexual populations were conducted in the same venues, they would find very high rates of alcoholism, nicotine dependence and drug addiction. Nonetheless, evidence supports the belief that substance abuse disorders are more common in the LGBT population. There are major differences in substance abuse/dependence rates among and within each subgroup of the LGBT population.

Some gays and lesbians report the use of mood altering substances to deal with the pain of homophobia and discrimination, to deal with shyness, to fit in with others and to avoid dealing with problems. Alcohol and tobacco companies market extensively to the gay and lesbian communities. Finally, the “bar scene,” which may be one of the few places for LGBT individuals in a community to meet safely, tends to normalize the use of addictive substances.

Smoking

There are few studies of LGBT tobacco use. Surveys indicate overall higher rate of nicotine use than the general population (38% vs. 28%). Up to 50% of gay youth smoke, and lesbians have higher rates of smoking than heterosexual women. Unlike other groups, lesbian tobacco use increases with age. HIV+ smokers have been shown to have three times the risk of developing pneumocystis carinii pneumonia than non-smokers.

Alcohol

The results of surveys of alcohol use among LGBT individuals vary widely. Some studies indicate no increase over the general population, while others report a doubling of heavy drinking. Although experts and people within the communities agree that a greater LGBT drinking problem exists, no large-scale research confirms this.

Alcohol plays a large part in HIV and other risk behaviors. Intoxication has been associated with unprotected anal intercourse. Alcohol can affect the metabolism of many HIV medications, and abuse/dependence can diminish adherence to complex medication regimens. Alcohol has also been associated with higher rates of domestic abuse in both gay and lesbian relationships.

Drugs

The rates of drug abuse/dependence are affected by selection bias. One study of 187 gay men who had been tested and knew their HIV serostatus (31 positive) showed high rates of alcohol and drug dependence. Fifty-eight percent (58%) of those who met criteria for alcohol dependence also met criteria for drug dependence. A regression analysis demonstrated that serostatus was best predicted by a substance dependence diagnosis. This study and others suggest that alcohol abuse alone does not increase risk, but those personality factors linked to risk-taking behavior may link alcohol and drug use with risky sex.

The Young Men's Survey of HIV seroprevalence and risk behaviors among homosexual and bisexual men sampled 3,492 men from 7 diverse locations between 1994 and 1998. The Centers for Disease Control analyzed the data to compare differences between participants who were labeled disclosures and nondisclosures. Disclosure status was based on a self-reported scale of how 'out' a participant was about being sexually attracted to men. The HIV seroprevalence was 11% among disclosures and 8% for nondisclosures. Unprotected anal sex was reported in the last six months by forty-six percent (46%) of disclosures and thirty-three percent (33%) of nondisclosures. Injection drug use at some time in their lives was reported by seven percent (7%) of disclosures and five percent (5%) of nondisclosures, which is much higher than the national rate of less than 1%. The prevalence of intravenous drug use (IVDU) varied significantly by race: White (8% disclosures/10% nondisclosures), African American (4% disclosures/2% nondisclosures) and Hispanic (8% disclosures/3% nondisclosures).

Information from HIVNET, which examined substance use and sexual behavior of 3,220 men who have sex with men showed heroin and injection drug use was uncommon (under 2%). Current alcohol and drug use, including nitrites, cocaine and other stimulants and hallucinogens, increased the risk of unprotected sex. A past history of alcohol and drug problems, without current use, did not increase the risk.

There may be an association between age and substance use. In a study of heterosexual and gay men, there was no difference in the incidence of substance use/abuse between gay and heterosexual men for the cohort under age 30. However, after age 30 there seems to be a higher incidence of substance use and abuse for gay men compared to same age heterosexual men. This trend was not evidenced in lesbians, as they show a higher incidence regardless of age compared to heterosexual women. Lesbians were found to have somewhat higher rates of marijuana, cocaine and tobacco use while gay men reported higher rates of inhalant use (amyl or butyl nitrates), hallucinogens and overall illicit drug use compared to their heterosexual peers. These differences were even more evident among younger age groups with rates in excess of 80% among both gay men and lesbians. Further, older LGBT persons may be at even higher risk for substance abuse. Some studies estimate 40-60% of older LGBT persons may abuse substances.

Methamphetamine, both injected and smoked, and cocaine use have increased significantly over the past decade in the LGBT community, and are both correlated with unprotected anal intercourse, especially among gay youth. Some illicit drug use in combination with prescribed medications can cause fatal consequences. For example, the use of amyl or butyl nitrates (“poppers”) with sildenafil citrate (Viagra) can cause a fatal drop in blood pressure.

Lesbian and Bisexual Women

One recent study of 263 lesbians in New York revealed no increased rates of alcohol or drug abuse compared to heterosexual women. Likewise, a study of lesbian and bisexual woman in San Francisco recruited through random sampling failed to show a statistically significant difference in substance abuse prevalence. Nonetheless, there continues to be a commonly held belief within the lesbian and treatment communities that rates of addiction approach 35% of the population. Lesbians report that the use of alcohol and drugs eases social contacts and helps to avoid painful feelings. Here too, the bar scene as a social center encourages substance abuse.

Recovery

Research has demonstrated that there is a strong relationship between internalized homophobia, gender dysphoria and alcohol and drug addiction. While many LGBT individuals drink to avoid dealing with painful emotions, substance abuse has been shown to actually reinforce the destructive self-beliefs. Many LGBT individuals find that they are only able to accept their sexuality when they enter recovery. While early treatment of the addictions necessarily focuses on what all addicts share in common, programs should be sensitive to sexual orientation and gender identity issues.

Lesbians in recovery must face being a minority (lesbian) of a minority (homosexual) of a minority (alcoholic/addict) population. Being a person of color confers additional minority status. It is often difficult for gay women to discuss their sexuality in open 12-step meetings or in treatment programs.

Gay and lesbian bars play a central role in the social life of alcoholic and drug-addicted LGBT persons. Critical to their recovery is the substitution of a healthy, supportive community. Gay Alcoholics Anonymous, Gay Al Anon and other organizations can be an excellent resource. Many gays and lesbians attend both general and Gay Alcoholics Anonymous meetings. (*See Appendix A: Resources.*)

Circuit Parties

Circuit parties are typically large dance parties often occurring on an annual basis in cities throughout the U.S. and Canada, featuring pounding “techno” music, drugs like cocaine, ecstasy, and methamphetamines, and sexual contact. Many are held as fundraising events for HIV/AIDS service organizations. There are magazines dedicated exclusively to promoting circuit parties. The popular August 1998 Morning Party on Fire Island in New York had a crowd of about 4,500 men and raised about \$450,000. There is very little written about circuit parties and the associated behavior and risks, though some studies are now being done.

In the past several years, some gay men are reverting to risky behavior. People may blame the increased effectiveness of new drug therapies, but others link such behavior to self-esteem issues that gay men face in their everyday lives. One theory is that gay men have been systematically rejected by other men and turn to hedonistic behavior such as drug use and unprotected sex to escape the pressures of being a gay man in today’s society. Circuit parties may be the most obvious gatherings where this type of risky behavior goes on.

Possible interactions between “party drugs” and antiretrovirals are a cause for concern, as is drug overdose. Drug related deaths have occurred at a number of circuit parties and have resulted in cancellations of some events. One of the deadly drugs is gammahydroxybutyrate (GHB). Originally developed as a surgical anesthetic, it provides users with a relaxed, uninhibited feeling. But unlike other popular party drugs, such as ecstasy and crystal (methamphetamine), overdosing is all too easy with GHB, especially in combination with alcohol. And because one batch of GHB - the recipe for which can be found on the Internet - can differ greatly from the next, a dose that gives a mild high one day can kill the next. The government estimates that 32 people have died and 3,500 others have been treated for overdoses since 1990.

Ecstasy (MDMA) is chemically similar to amphetamine and causes an immediate surge in serotonin secretions. There is mounting evidence that exposure to MDMA may cause long-term damage to serotonin producing cells. Furthermore, HIV infection apparently causes decreases in brain serotonin.

Research suggests that the extent to which gay men use drugs is a strong, significant predictor of engaging in high risk sexual behaviors with the concomitant risk of HIV exposure.

Implications for Kaiser Permanente Care Providers

- LGBT individuals may be at an increased risk for substance abuse. Be knowledgeable about alcohol and drug use patterns and counsel patients accordingly.
- Recovery programs may need to be screened for the appropriateness for LGBT individuals, especially if there is religious affiliation.
- Ask about sexual behavior to address health risks but remember to also clarify the individual’s sexual orientation.
- Try to become familiar with both slang and technical terms used to define sexual practices.
- Be knowledgeable about sexual practices so that preventable risks can be discussed during an office visit.
- When questioning a person who has been hurt during sexual play, explore the consensual nature of the activity before counseling about abusive relationships.
- Be as knowledgeable as possible about slang and technical terms for street drugs.

MAJOR DISEASES

While all diseases can be found within a population as racially and ethnically diverse as the LGBT population, certain diseases have a specific impact. The purpose of this section is to highlight those specific aspects of diseases which have affected the LGBT population, utilizing evidence-based medicine whenever possible. The primary area of study for LGBT individuals has been infectious disease. Thus, review is limited by the paucity of studies available on many diseases affecting the LGBT community, especially lesbians. For example, since 1991, coronary heart disease (CHD) has killed more women than men; adequate data on the incidence of CHD and its risk factors in lesbians are lacking.

While diseases like HIV/AIDS are associated with the LGBT community in the U.S., the LGBT population does not equate itself with HIV infection or necessarily increased risk. Also, HIV is not the only disease that impacts the LGBT patient.

Attention must also be paid to different needs of the individual patients based on their race or ethnicity. Information on African American, Latino, Asian and Pacific Islander populations is covered in the companion handbooks on culturally competent care. Many women's health issues are discussed later in this handbook. (*See Special Areas of Clinical Focus: Obstetrics/Gynecology.*)

Cardiovascular Disease

Though definitive data are unavailable, CHD is the leading cause of death in American women. Thus, it is likely the leading cause of death among lesbians. In a lifetime, a woman is 10 times more likely to develop CHD than she is breast cancer. Thus, prevention of CHD is a major health issue for lesbians.

While age, race and family history are not modifiable risk factors for CHD in the population, there are some modifiable risk factors for women. Cigarette smoking is a major risk factor for CHD. The National Lesbian Health Care Survey found that 30% of lesbians smoked cigarettes daily. (*See Risk Factors: Substance Use.*)

Like heterosexual women, other modifiable risk factors that increase CHD in lesbian women are hypertension, diabetes mellitus and hyperlipidemia, all of which should be aggressively controlled.

An area of controversy for lesbians is post-menopausal hormone replacement therapy (HRT). While originally thought that HRT lowered women's risk for CHD, recent studies have cast doubt on its protective effect. In fact, the Women's Health Initiative, which was studying the effect of HRT in post-menopausal women, was halted early due to an increase in negative effect on the incidence of breast cancer in study patients. As such, HRT should not be recommended to post-menopausal patients, and emphasis should be placed on modifying any CHD risk factor. Exercise, diet and smoking cessation should be strongly encouraged as well as the appropriate use of calcium, lipid lowering agents (mainly "statins"), and low dose daily aspirin as indicated.

Cancer

On the cellular level, there are no differences in cancers affecting LGBT patients compared to heterosexuals. However, particular social habits, like cigarette use and alcohol use, which increase the risk of certain cancers (i.e., esophageal tumors, liver, lung, mouth, stomach, pancreas, kidney and bladder), have a higher incidence in the LGBT population and may lead to possible increased cancer risk among LGBT persons. In addition, depression is known to

increase in individuals who are socially marginalized, and this negatively impacts oncologic therapy. Lack of social support systems for patients also can negatively impact therapeutic decisions, resulting in the choice of less aggressive therapy.

Screening tools for cancer are no different in LGBT patients than in the heterosexual population, but access to care and screening may differ. It is important to emphasize appropriate screening by age, regardless of sexual orientation. Smoking cessation, safer sex, and decreased substance and alcohol use must be recommended.

Certain cancers are associated with HIV/AIDS. Lymphoma, anal carcinoma, certain sarcomas, and leukemia are all AIDS defining diagnoses and should prompt an HIV test in a patient with risk factors for HIV. This is especially true for men who have sex with men.

Anal Carcinoma

Several studies indicate that MSM are at a higher risk for anal cancer. A history of STDs has been shown to be a risk factor for the disease, especially HPV and anal squamous intraepithelial lesions. As concern over anal warts progressing to anal carcinoma is considerable, anal “pap smears” for patients with active anal lesions or history of anal warts (with HIV disease) are recommended. Some advocate any man with a history of receptive anal intercourse should be screened, but this is controversial. To perform an anal pap smear, the patient should be in a position of anal exposure. His anus should be inspected for any active lesions. A cytobrush is inserted as far as possible and rotated a full 360 degrees, while maintaining active control. After removal from the anus, a slide should be smeared with the brush and cytological fixative applied, as in a cervical pap smear. The laboratory requisition should note the sample is from the anus.

If HPV is detected, an anal coloscopy should be performed to detect anal carcinoma or dysplasia, and such lesions treated (usually in consultation with a rectal surgeon with experience in these diseases). What remains unclear is the frequency of follow-up after treatment of HPV or if no HPV is detected. At present, recommendations similar to those for cervical HPV and pap smear follow-up are reasonable.

If malignancy is diagnosed, referral to a colorectal surgeon and an oncologist with experience in treating anal carcinoma is necessary. Usually, excision of the lesion with clear margins is required. Post-operative radiation or chemotherapy is often required. Appropriate evaluation for metastases is necessary. Patients should be cautioned about manipulation and sexual activity involving the anus while being treated, as this could cause discomfort, severe trauma to the tissues and prevent adequate healing.

Support Groups

Support groups that exist for heterosexual cancer patients may not be welcoming or comfortable for LGBT patients and their concerns. As support groups usually discuss all aspects of a patient’s life, and especially their psychosocial needs, LGBT patients may not feel these groups fulfill their needs. In larger urban locations, LGBT support groups for certain cancers or cancer in general may be available, and patients should be encouraged to seek them out. However, these groups may not be available in smaller communities. An LGBT cancer patient may benefit from participating in an LGBT group composed of individuals with other chronic or life threatening illnesses.

Just as partnered heterosexuals rarely go to an oncologic consultation alone, LGBT partners should be encouraged to be involved. While always at the discretion of the competent

patient, it is the patient's prerogative to identify their life partners and support systems and these individuals should be included whenever possible.

Infectious Disease

HIV/AIDS

Since 1981, when an increased incidence of pneumocystis carinii pneumonia and Kaposi's sarcoma was described in a cohort of homosexual men in Los Angeles and New York City, AIDS has had a devastating impact on the LGBT population. Though worldwide, AIDS is predominantly a disease spread through heterosexual sex, the majority of cases in this country have been among men having sex with men (MSM). Since 1981, of HIV/AIDS cases in the U.S. in adults and adolescents, 87% are MSM (with or without injection drug use). Prevalence among male homosexuals is estimated to be 36%, with a MSM prevalence of >60% of all active HIV+ cases. Between 0.5-1.0% of MSM test HIV+ annually. In 2001, 35% of new AIDS cases in the US were among MSM. Of concern is the fact that a 1996 multi-city survey of MSM aged 15-22 years old indicated that HIV was highly prevalent (5-10%) in this population, coincident with a high rate of unprotected anal sex. Even though the epidemic has created legions of social service organizations (most major cities have care agencies devoted to AIDS services), political activists, and national research funds for AIDS research (e.g., AMFAR), the emotional and numerical loss to the gay population cannot be minimized or accurately quantified.

Mortality has significantly decreased since 1996 with the advent of protease inhibitors and highly active anti-retroviral therapy (HAART). Viral loads (direct measure of HIV in the plasma) have dropped significantly (often to below limits of quantification), opportunistic infection incidences have dropped drastically, and mortality has declined significantly. Evidence of immune function restoration has also been discovered. However, new cases are still occurring with increasing frequency. Prevention and safer sex measures are not completely effective, and deaths still occur. In addition, some patients become resistant and do not respond to any of the FDA approved anti-retroviral drugs currently available. Recent studies suggest that 15% of people in the U.S. newly diagnosed with HIV are already infected with HIV that is resistant to at least one anti-retroviral medication. Significant side effects of treatment are also being recognized clinically and can be publicly stigmatizing. Some at-risk patients have never been tested due to fear of diagnosis or homophobia.

Kaiser Permanente has had tremendous success with its HIV care, having a mortality rate of <1% in its Northern California Region between 1999 and 2003. Due to the complexity of the disease and its care, Kaiser Permanente has adopted a multidisciplinary specialty model for HIV care.

Prevention and Safer Sex Risk Assessment

To discuss HIV prevention, a provider, and especially a primary care provider, must be comfortable discussing safer sex. It is important to know the different risks of acquiring HIV from different sexual activities. While kissing without tongue insertion and mutual masturbation carry nearly no risk of HIV transmission, more vigorous sexual behaviors vary in degree of risk. The following table summarizes the risk for HIV transmission:

Behavior/Event	Risk for HIV Transmission With Each Exposure
Contaminated Needle Stick	.32%
Unprotected Receptive Vaginal Intercourse	.05% - .15%
Unprotected Insertive Vaginal Intercourse	.03% - .09%
Unprotected Receptive Anal Intercourse with Ejaculation	.8% - 3.20%
Unprotected Oral Sex	.04%

These data have led some organizations like the Gay and Lesbian Medical Association to list oral sex as a safer sex activity as long as the participants do not permit ejaculation in their mouths, acknowledging that most gay men do not use a condom with oral sex. (*See Risk Factors: Sexual Practices.*) A 2000 Centers for Disease Control and Prevention (CDC) report indicated that in a recent study of 102 San Francisco men, 8% of all cases of HIV infection possibly resulted from oral sex, most likely due to varying frequencies of sexual practices among MSM.

“French” kissing and sexual behavior with an intact latex condom carry significantly less risk. While HIV has been cultured from nearly all body cavities, fluids, and organs, risk from exposure to other fluids (e.g., urine, sweat or tears) appears minimal. Also, if any “sex toys” are used, HIV can be found on the toys. Cleaning with a diluted bleach solution between uses by each partner or using separate toys for each partner are recommended to ensure no viral transmission. (*See Risk Factors: Sexual Practices.*)

A few issues further complicate risk of transmission. HIV+ patients with higher viral loads, whether in early primary infection or in advanced HIV disease, appear to have higher seminal viral loads and thus are at greater risk of transmitting HIV to their sexual partner. Further, some studies indicate that the presence of STDs, including genital ulcer diseases and nonulcerative, inflammatory lesions, carry higher risk of HIV transmission. These “STD cofactor effects” have been shown for each of the following: syphilis, chancroid, HSV-2, gonorrhea, chlamydia, trichomonas and bacterial vaginosis. Also, some studies indicate that while a patient with HIV on highly active antiretroviral therapy (HAART) may have a viral load below limits of quantification in their plasma, the seminal viral load may still be quantifiable and infectious. In some major urban areas (e.g., New York, Los Angeles, San Francisco), transmission of HIV already resistant to some of the drugs used in HAART has been documented with estimates ranging up to 8% of clinically significant mutations. Finally, pre-ejaculatory fluid can contain HIV (though at levels significantly less than ejaculated semen), but the actual risk has not been calculated.

Confidential Versus Anonymous HIV Testing

In anonymous testing, neither the testing facility nor the laboratory know the patient’s name and a unique identifier is used with each patient. In confidential testing, the testing facility knows who the patient is but the lab does not. Some providers, like Kaiser Permanente, use confidential testing. At present, public health clinics mainly use anonymous testing. Patients should be made aware of this difference because many fear any disclosure of HIV status due to homophobia. Also, many patients fail to get HIV testing for fear of learning they are HIV+ or because of their denial of their risk of being exposed or infected. It should be noted that in many states, including California, it is now required to report all new HIV+ patients, albeit with anonymous unique identifiers.

Risk of HIV Transmission Amongst Lesbian and Bisexual Persons

As with monogamous gay men, monogamous lesbians and bisexuals have no risk of HIV transmission if both partners are HIV-. However, if either partner is HIV+ or his/her serologic status is unknown, then the risks of HIV transmission for the various sexual behaviors are the same as for gay men. Several studies have found that bisexually active men are often unlikely to disclose their sexual behaviors (and thus their serologic status) to their female sexual partners. An increasing proportion of all AIDS cases are women, especially young African-American women and Latinas. Women who have sex with bisexual men may be a particular population at risk. Data on the risk of transmission for lesbians to other lesbians are not available, but many women who identify themselves as lesbians who have contracted HIV from occasional heterosexual sex or IV drug use have been placed historically in the heterosexual or IV drug use categories. As of 1997, transmission of HIV between women, resulting from only lesbian sexual contact, may have occurred in nine cases.

Although lesbian risk for HIV appears low, lesbians should be counseled to avoid contact with cervical and vaginal secretions, menstrual blood, and blood from vaginal and rectal areas in untested partners. Latex barriers should be used, including gloves on hands, dental dams, and condoms on sexual toys if shared for vaginal penetration. It should also be noted that recurrent vaginal infections (bacterial or candidal) are an indication for HIV antibody testing.

Opportunistic Infections and Complications

Kaposi's Sarcoma

Kaposi's sarcoma (KS) is believed to be caused by Herpes Human Virus 8 (HHV-8). It is transmitted through sexual contact and appears to have a higher rate of transmission in MSM. It can be mucocutaneous or visceral. When only on the skin, lesions appear as irregular purple spots that usually grow at an increased rate. Isolated lesions can be treated with liquid nitrogen or a retinoid gel. If systemic or multiple lesions appear, systemic therapy is needed and consultation with an oncologist is required.

Infectious Diarrhea

Many HIV patients have chronic diarrhea from a variety of causes: medications, HIV itself, wasting and malabsorption, and infectious causes. In the past, gay men had been described as having an increased risk of many infectious diarrheas, presumably from increased oral-anal and genital-anal contact. An increased incidence in immunocompetent gay men has been described for HSV, cryptosporidium, cytomegalovirus, *Isospora belli* and giardia. The incidences are also higher in HIV+ gay men. When appropriate, screening should be done for these infectious causes.

Anal Warts, Dysplasia and Anal Carcinoma

All three of these conditions have increased incidence in MSM. Patients with a history of anal or genital warts or receptive anal sex should be screened for anal dysplasia or warts. (*See Major Diseases: Cancer: Anal Carcinoma.*)

Hypotestosteronism

Loss of libido and muscle wasting has been documented repeatedly in HIV+ patients. There is no clear explanation for why many HIV+ patients have lower testosterone levels than normal for their age. Correcting this abnormality often leads to return of sexual function and greater sense of well-being and restoration of lost muscle mass. This complication may in fact be

independent of viral load or CD4 count. It is important to note that many HIV+ men are less than 50 years old. Thus, they normally should have a testosterone level at the higher end of the “normal range” as reported by laboratory tests. Many clinicians use a level of 400mg/dl as the lower end of normal for these patients. Replacement of depleted testosterone is by usual methods and doses.

Adherence Issues

It is estimated that 95% adherence is required with highly active anti-retroviral therapy (HAART) in order to prevent the development of viral drug resistance in an individual patient. Additionally, cessation of effective HAART even after three years of therapy produces a very early rebound (within weeks) in viral load. As these drugs carry side-effects and complicated dosing schedules, adherence has become a growing issue in HIV management. Social demands, work schedules, and clinical mental health issues such as depression, further complicate adherence. Depression should be aggressively treated with medications that do not interfere with HAART drug metabolism. Adherence strategies have been found to be most successful with the involvement of pharmacists trained in HIV care.

It must be noted that while the biological mechanism is still debated, patients on HAART have an increased incidence of fat redistribution, with loss of fat in the extremities and face (loss of buccal fat pads) and accumulation of fat in the posterior neck (“buffalo hump”) and abdomen visceral fat (“protease paunch” or “crix belly.”) Because the specific drug causes for the fat redistribution (or other metabolic complications of HAART including hyperlipidemia and glucose intolerance) have not been firmly established, no clearly effective treatment for this complication has been described. Some studies have noted a tremendous emphasis on body image and physical self-image in the male homosexual population. Alterations of body image by HAART may have an impact on compliance. (*See Appendix A: Resources.*)

HEPATITIS

Hepatitis B

Hepatitis B is a serious blood-borne and sexually transmitted infection. It can cause severe acute and/or chronic hepatitis and has been a known cause of hepatocellular carcinoma for some time. It is reported by the CDC to be a significant cause of morbidity and mortality worldwide, including in the U.S.

Hepatitis B has an increased incidence in the gay population. It is transmitted through semen, vaginal fluid, and blood, and is recognized to be more efficiently transmitted in MSM. As it can be transmitted through sexual activity and semen, sexually active adults are at increased risk. Incidence increases with a greater number of sexual partners. Since 1990, the national Advisory Committee on Immunization Practices has recommended hepatitis B vaccination for all homosexual men and all sexually active adults.

Hepatitis A

As hepatitis A is transmitted through fecal-oral contact, gay and bisexual men who engage in anal-oral contact (“rimming”), have a history of STDs or have high numbers of sex partners are at increased risk. Outbreaks of hepatitis A among homosexual men have been reported in some countries, and three studies have documented incidence rates several times greater than those of heterosexual men.

While hepatitis A is most often a self-limited disease, significant morbidity can occur. Although most individuals recover within two months, 0.14-0.35% of hospitalized patients develop

fulminant disease. There is a safe inactivated vaccine for hepatitis A given twice six months apart. It is safe for immunocompetent or immunocompromised patients. The national Advisory Committee on Immunization Practices of the Center for Disease Control and Prevention recommends immunization against hepatitis A for sexually active gay and bisexual men.

Hepatitis C

Hepatitis C infection (HCV) is the most common chronic blood-borne infection in the U.S. It causes chronic liver disease and cirrhosis. In addition, it causes the course of HIV to be accelerated and increases liver function abnormalities with and without HAART in HIV+ patients. HCV is transmitted primarily through large repeated direct percutaneous exposures in blood. It is now screened for in the blood supply and no cases from blood transfusion have been reported in the U.S. since 1994.

Specific risk factors associated with HCV for both heterosexuals and men who have sex with men (MSM) include greater numbers of sex partners, a history of prior STDs, and failure to use a condom. In STD clinic settings, the prevalence rate of HCV infection among MSM has been shown to be similar to that of heterosexuals. People with evidence of high-risk sexual practices that deny intravenous drug use have a prevalence of HCV of 6%.

Presently, the greatest risk is among IV drug users, even with just a one-time exposure. Rates of HCV infection among young injecting-drug users are four times higher than rates of HIV infection. Case-control studies have reported associations between exposure to a sexual contact with a history of hepatitis or exposure to multiple sex partners and acquiring HCV. MSM and people with multiple sex partners are at increased risk of HCV infection.

While there is no vaccine available to prevent HCV, some therapies for acute and chronic HCV are being developed and are commercially available. People at risk for HCV are intravenous drug users (IVDU), patients with unexplained elevated liver function tests, MSM, and patients with multiple sexual partners, and should be screened for and educated about HCV transmission and prevention.

Other Sexually Transmitted Diseases

General Considerations About Men Having Sex with Men

Compared to other countries, the U.S. has the highest rate of sexually transmitted diseases (STDs) other than HIV. MSM, especially young men, continue to have high rates of STDs. The incidence of STDs among MSM declined substantially during the early 1980s as a result of a decrease in risky sexual behavior, but recent reports of increased incidence of high-risk behavior and STDs among MSM have occurred in some cities. HIV is more efficiently transmitted when the host and/or recipient patient has a concurrent STD. A history of STDs is a risk factor for anal warts and anal cancer. (*See Major Diseases: Cancer.*) When screening for one STD (as part of a routine examination or if specific infection is suspected), screens for other STDs and HIV are recommended and prevention management should be discussed. Confidentiality should always be discussed, as well as notification of sex partners by the patient.

It should be noted that an archaic term of “gay bowel syndrome” persists. This term, coined in the 1970s, referred to the higher incidence of gastrointestinal disorders noted in gay males who engaged in anal intercourse and anal manipulations. However, as newer diagnostic and microbiology methods permit more specific diagnoses of enteric pathogens, this term should be avoided.

General Considerations about Women Having Sex with Women

STDs in lesbian patients may be less frequent than in either heterosexual women or gay men. While sexual practices vary among lesbian women, one study indicated 77% of lesbians had engaged in prior heterosexual intercourse. From studies done in Massachusetts on STDs and sexual practices of lesbian and bisexual women, the true incidence of STDs among lesbians is underestimated because of ignorance regarding the variety of sexual behaviors that are possible between women. STD transmission occurs among lesbian and bisexual women, especially bacterial vaginosis and candidal vulvovaginitis, but little is known about the mechanisms and risk for transmission between women whose sexual partners are solely women.

Gonorrhea

In the pre-AIDS era, rectal gonorrhea was found in 13-45% of homosexual men seen at STD clinics. Since 1993, increased incidence of gonorrhea has been observed among MSM, while declining in most other populations in the U.S. While these surveys are from only eight different urban areas, the geography is diverse enough to presume greater incidence nationwide.

In 2000, 13.9% of gonorrhea cases in the U.S. were among MSM. Asymptomatic and symptomatic oral and anal gonorrhea has been well-documented in gay and bisexual men. These different presentations can occur in the absence of urethral gonorrhea. These facts are of even greater concern because HIV is transmitted more efficiently in the presence of gonorrhea. Diagnosis often requires taking cultures from the mouth and anus since "Gen-Probes" used for urethral gonorrheal infection are not effective in these areas. Treatment is the same as for other sites with gonorrhea. Follow-up should be based on etiology and severity of clinical symptoms. Reinfection may be difficult to distinguish from treatment failure.

Chlamydia

Chlamydia is a common STD, especially among women. While relatively amenable to treatment, untreated it can cause chronic pelvic inflammatory disease and sterility. Diagnosis can be with cervical/urethral swabbing ("Gen-Probe") or, more recently, with urine samples. As it is often asymptomatic, regular screening is essential, especially for women and bisexual men. Sexually active women between 18-25 are at especially high risk of Chlamydia infection.

Syphilis

MSM still comprise a high number of early syphilis cases. Since 2001, the CDC has reported 'epidemic' numbers of new cases of syphilis, including secondary syphilis, among MSM in major urban areas that include San Francisco, Los Angeles, New York, Washington, D.C. and Miami. Since most physicians were not trained in an era when treatment of secondary syphilis occurred frequently, suspicion for its presence should be high.

As with gonorrhea, primary syphilitic chancres have been diagnosed in the anus. If suspected, usual serology for syphilis should be performed. While there may be some cases of false positive syphilitic serology in HIV+ patients, for most HIV+ patients serologic tests for syphilis appear to be accurate and reliable. Treatment is the same as with heterosexuals. It should be noted that while neurosyphilis takes decades to develop in immunocompetent hosts, it could occur as rapidly as six months in untreated HIV+ patients.

Data from uncontrolled clinical studies indicate that lesbians seem to have a lower incidence of syphilis (and gonorrhea) than any other population. While this may appear to preclude routine screening for these diseases in lesbians, if prior or ongoing heterosexual sex has occurred, risk would be greater and screening should be considered.

Human Papilloma Virus

Human papilloma virus (HPV) is a very prevalent virus with many subtypes that can cause genital and anal warts that can then lead to cervical and anal carcinoma.

The main risk factor for anal cancer is HPV transmission from anal intercourse, either protected or unprotected. Other risk factors for HPV include rectal administration of recreational drugs and smoking. Genital-genital contact and genital-anal contact transmit this disease. There is higher incidence in MSM of anal warts and dysplasia, but not genital warts. Treatment of benign anal warts is the same as genital warts. All warts, anal or genital, should be treated. Active lesions appear to increase HIV transmission. (*See Major Diseases: Anal Carcinoma.*)

A 1999 study from the Centers for Disease Control and Prevention (CDC) reported that anal cancer incidence in gay men has been estimated to be between 12-35 cases per 100,000 individuals. This is much higher than the incidence rate of cervical cancer, which is 8 cases per 100,000 women. Anal cancer is higher in HIV+ men, and the CDC report acknowledged that the data were obtained prior to the onset of the AIDS epidemic.

Lesbians and HPV

HPV in lesbians is an area of controversy. While less common, lesbians who are exclusively WSW can get HPV (genitally diagnosed usually as an abnormal pap smear). The incidence of HPV, though, rises significantly if there is a history of heterosexual intercourse or sexual relations with someone who has been previously exposed to HPV. Therefore, pap smears are recommended for lesbians as for heterosexual and bisexual women. With the advent of screening for HPV, this recommendation may change. Therapy is the same as for heterosexual and bisexual women.

Herpes Simplex Virus

Herpes simplex virus (HSV) is a recurrent, incurable viral disease and can be found in nearly any mucocutaneous part of the body. It is the most common pathogen isolated from the rectum of symptomatic gay men, and is usually a viral reactivation of a previously infected patient. Diagnosis from most reservoirs is often clinical and made in the usual manner. It is unclear if the incidence of HSV in MSM (other than HSV of the anus) is higher than in other men. However, HSV does not appear to be higher in WSW than in other women. While HSV infections in lesbians appear to be less frequent than heterosexual women, it is still theoretically transmissible between WSW.

Implications for Kaiser Permanente Care Providers

Cancer

- Screen LGBT patients under standard protocols. Appropriate counseling for cancer risk must be given. Treatment strategies for the disease itself are identical, regardless of the host, but social issues can impact treatment options and decisions. Support systems should be assessed in detail, and utilized whenever possible. Encourage the formation of LGBT-specific cancer support groups.
- When treating MSMs, the “anal pap smear” should be considered to test for anal warts and/or anal carcinoma.

HIV/AIDS and Other Sexually Transmitted Diseases

- Developing comfort and confidence in taking a sexual history is critical to a comprehensive risk assessment.
- Identification and aggressive treatment of STDs can have a positive effect on the long-term survival and transmission rates.
- Screening for STDs is as important as screening for HIV. A primary care visit is an important opportunity to encourage testing. Maintain a high suspicion for syphilis among MSM.
- If a patient tests positive for an STD, he/she should be counseled about notifying current and previous sexual partners.
- For the HIV+ patient, social demands, work schedules, depression and issues with body image can impact treatment adherence. Recognition and support for difficult adherence should be provided along with available resources.
- Consider referral to an HIV specialty clinic for all newly diagnosed cases to optimize treatment and outcome.
- Gay and bisexual men should be screened for hepatitis A, B and C. If results indicate no exposure and no immunity to hepatitis A or B, vaccination should be offered and provided. Prevention for hepatitis C should be encouraged, including not sharing needles if intravenous drug use is noted. The use of condoms during sexual activity among MSMs should be advised.
- If patients are found to have acute or chronic hepatitis B or C, risks of transmission to others should be discussed. Liver function and chronicity should be assessed and therapy should be advised, if appropriate.
- Whenever possible and appropriate, discuss sexual risk behavior and risk reduction strategies for all STDs. Primary care visits are an important opportunity for education on safer sex practices.
- Providers need to be aware that MSM can present with STDs in less common locations, such as the pharynx or anus. Anal warts and dysplasia have a much higher incidence among MSM than in MSW.
- Sexually active gay or bisexual males should be screened for syphilis, gonorrhea, HPV, and chlamydia from the appropriate sources (genital, oral cavity, rectum) based on the patient’s sexual behaviors.

TRANSGENER HEALTH CARE

Transgender persons face numerous complex medical, psychological, and social issues, including a lengthy process of understanding their gender identity and sexual orientation. Often these issues are complicated by discrimination and denial of access to social and medical support systems, which are beyond the control of transgender individuals. Transgender individuals may also find themselves marginalized in the gay community.

Important Terms

Female to male transsexuals are sometimes referred to as “FTMs,” or transsexual men, and male to female transsexuals as “MTFs,” or transsexual women. Pre-operative or “pre-op” transsexuals are those preparing for sex reassignment surgery. Non-operative or “non-op” transsexuals either do not elect or cannot afford to obtain sex reassignment surgery and may or may not be receiving hormone therapy. Post-operative or “post-op” transsexuals have undergone sex reassignment surgery, hormone therapy and most likely counseling services. Usage of the terms “pre-op,” “non-op,” and “post-op” are decreasing with the transgender community.

Natal or Biological Sex

Biological maleness or femaleness, including the sex determining genes, the sex chromosomes, the gonads, the sex hormones, internal reproductive structures and external genitalia.

Sexual Orientation

Self-identification of erotic pairing with persons of either the same (homosexual) or different (heterosexual) sex or both (bisexual). Transgender persons may not self-identify with the usual definitions of lesbian, gay, or bisexual. Transgender and non-transgender persons may experience specific erotic attraction to transgender men and women. For example, a transsexual woman (a man who identifies as female) sexually attracted to women may not self-identify with the category “lesbian” and neither may her partner. Definitions of sexual orientation presumed to relate to immutable and exclusive sex identity often make little sense to transgender people, who have a much more fluid concept of sex and gender.

Secondary Sex Characteristics

Genetic predisposition to sex-specific anatomical, physiological, or behavioral characteristics, such as voice quality, abundance of facial and body hair, bone structure, subcutaneous fat distribution, or breast development, that first appear in humans at puberty and differentiate between the sexes without having a direct reproductive function.

Gender Roles

Behaviors, attitudes, or personality characteristics that a culture in a specific historical period designates as masculine or feminine.

Gender Identity

A person’s self-identification with maleness or femaleness. Biological sex is determined at birth and self-identification as male or female is usually congruent with this natal sex. However, gender identity may be incongruent with the person’s natal sex. Some people may self-identify as transgender, a third category of gender identity distinct from man or woman. It is important to keep in mind that the construct of gender identity is distinct from sexual orientation.

Gender Dysphoria

A state of emotional distress associated with the incongruity between one's natal sex and gender identity. The intensity of the emotional distress can vary greatly from mild and transient to intense and persistent. Persons with intense gender dysphoria often seek to change their secondary sex characteristics through sex hormones, and may desire a gender transition and genital surgery. Intense gender dysphoria can create a higher risk for clinical depression, suicidal risk and significant psychological dysfunction. However, not all transgender persons subjectively experience intense gender dysphoria.

Transgender

Transgender is an umbrella term coined by the transgender community to include all persons with diverse gender behaviors and identifications, including cross-dressing, bi-gendered, transgenderist, transsexual, and intersex persons. Transgender may be used to describe an individual or a community. It is not a diagnostic medical term. Transgender identity refers to a person who self-identifies as belonging to the transgender community. This term is usually considered respectful; however, some individuals may associate it with stigmatization and pathologizing intent. Not all individuals who alter their secondary sex characteristics self-identify as transgender, and may do so for social, political and aesthetic reasons.

The Spectrum of Transgender Identity

Cross-dresser or Transvestite

Cross-dressers are persons who dress in the clothing of the opposite sex for erotic pleasure, emotional satisfaction, or both. The original clinical term "transvestite" is falling out of usage in favor of the term cross-dresser. Partial cross-dressing may progress to complete cross-dressing. Cross-dressing is a behavior that explores diverse gender roles in various social contexts. Persons who eventually self-identify as transgenderist or transsexual may self-identify as a cross-dresser in the initial stages of gender exploration. Both males and females can engage in cross-dressing.

Transgenderist

Transgenderists live in the gender role of the opposite sex full-time. They may alter their common and legal names and/or other legal documents to assist their social transitions. There may be interest in cross-sex hormones and cosmetic surgery, but genital surgery is usually not performed.

Bi-gendered

Bi-gendered persons self-identify with their natal maleness and femaleness, and may live part-time as a man and part-time as a woman. Many bi-gendered people are referred to as cross-dressers.

Transsexual

A person who self-identifies with the gender of the opposite sex, who undergoes hormonal modification of secondary sex characteristics, genital surgery, and/or other transgender surgeries, in order to live permanently in the gender role of the opposite natal sex. Some individuals self-identify as transgender or transsexual men or women, while others do not consider themselves transsexual any longer after genital surgery.

Intersexuality

Intersexuality is a set of congenital variations of the reproductive and sexual system. Intersex people are born with "sex chromosomes," external genitalia, or internal reproductive system that are not considered "standard" for either male or female. It is also referred to as

“ambiguous genitalia” and in the past “hermaphrodite” (whose use is discouraged because it is seen as stigmatizing). It is conservatively estimated that one in 2,000 newborns are found to have ambiguous external genitalia, and that 100 to 200 pediatric surgical reassignments are performed in the U.S. annually. (*See Special Areas of Clinical Focus: Intersexuality.*)

The Transgender Person

Transgender people experience varying levels of incongruity between their natal sex, the gender roles society expects them to fulfill and their intrinsic identity and self-concept. With age, this incongruity often creates increasing gender dysphoria and often depression, as they begin to understand that their identification with the opposite natal sex will continue to be intensely conflicting. Any combination of gender identity and sexual orientation is possible. An individual with a male natal sex, who identifies as a female, may be sexually attracted to men or to women. The incongruity between natal sex, gender roles, and gender identity can be lessened and often eliminated through medical, psychological and social interventions. Interventions can include living part-time or full-time in the self-identified gender, hormonally inducing the secondary sex characteristics congruent with self-identified gender, and facial plastic surgery and genital surgery consistent with self-identified gender.

Transgender individuals must face the prejudices and risks associated with the reassigned gender. For example, health care professionals have reported that male to female (MTF) transgender individuals are often not prepared to experience the harassment faced by women. Decades of clinical experience with transgender persons since the 1950's have shown that cross-gender behavior and identity issues cannot be eliminated by psychotherapeutic approaches. However, transgender-affirmative medical and psychological care can play a vital role in assisting transgender people in the healing process and in establishing healthy and functional lives.

Economic discrimination may also be part of the transgender experience. Like lesbians, gays and bisexuals, transgender individuals are generally not protected from employment discrimination. With reduced educational and employment opportunities because of the harassment faced in both settings, transgender men and women face homelessness, unemployment and poverty. Many are unable to afford basic medical and mental health services. Although medical evidence demonstrates that treatments are available and successful in many cases, public and private insurers specifically exclude coverage for treatment on the grounds that the treatments are either cosmetic or experimental. Individuals with gender identity disorder are specifically excluded from the American with Disabilities Act and the Federal Rehabilitation Act, and do not receive the benefits or protections of these laws. State courts have often excluded transgender individuals from the protections of laws against sex discrimination. Transgender parents risk losing custody of their children and may be prohibited from marrying after sexual reassignment.

Because of financial barriers to legitimate medical care, unprincipled providers target many transgender individuals, offering hormones, silicone injections, aesthetic and genital reassignment surgery or other services, without prior procedures and follow-up. Yet, in several European countries, such as Great Britain and Holland, genital reassignment surgery is covered by national health insurance. Currently, U.S. health insurance almost universally does not cover the costs of gender reassignment surgeries.

Psychiatric Perspective

The American Psychiatric Association DSM-IV considers transgender persons to be afflicted by a disturbance in sexuality (Transvestic Fetishism) or gender identity (Gender Identity Disorder). The persistent desire to live as the gender of the opposite natal sex is described as a “disturbance.” However, the diagnosis of Gender Identity Disorder (GID) is only made for

persons with clinically significant distress or functional impairment. Health care professionals documenting assessment and treatment services often overlook this requirement. The term “transsexual” was introduced in the 1950’s to designate a person who aspired to or actually lived in the gender role of the opposite natal sex. The diagnostic category “transsexualism” was introduced into the DSM-III in 1980, and in 1994 it was replaced with “Gender Identity Disorder.” There is an alternative diagnosis “Gender Identity Disorder Not Otherwise Specified.”

Controversy Over Diagnosis of Gender Identity Disorder

Some transgender activists protest the pathologizing of transgender identity and the medicalization of modifying markers of biological sex. As a consequence of health care providers’ control of access to medical treatment for transsexualism, and the exclusion of insurance coverage for such treatment, many transsexual persons have been denied access to this type of health care. There is controversy about a strictly psychological diagnosis of transsexualism, since it may further stigmatize transsexuals as mentally ill. Transgender activists assert that transgender identity and expression is not pathological and is a normal variation of human gender identity. While there are objections to the medical provider’s role in controlling access to hormones and genital surgery, most transsexual persons recognize the value of medical and psychological evaluation and management.

For adolescents, gender identity issues are often confused with questions of sexual orientation. Like lesbian, gay, and bisexual youth, transgender youth are at increased risk for low self-esteem, depression, suicide, substance abuse, school problems, family rejection and discord. Transgender youth may be at higher risk of becoming runaways, homeless and forced into prostitution. (*See Special Areas of Clinical Focus: Child and Adolescent Health.*)

As applied to children and adolescents, the diagnosis of GID is also seen as prone to abuse, if used as the basis for behavioral modification of presumed cross-gender actions or expressions. Additional controversy has developed in the relations between gay/lesbian and transsexual advocates around concerns of psychopathology.

Diagnostic Criteria for Gender Identity Disorder

Any diagnosis of GID should be made in consultation with mental health professionals experienced in this area of medicine. The American Psychiatric Association DSM-IV diagnostic criteria for GID are as follows:

- A strong and persistent cross gender identification (not merely a desire for any perceived cultural advantages of being the other sex).
- Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.

Caring for the Transgender Patient

Unacknowledged negative attitudes can be unwittingly conveyed to transgender patients, and this can create a barrier to health care. Assumptions of moral corruptness, social depravity, religious sinfulness or psychological maladjustment should be avoided in a clinical relationship. It is likely that the patient has experienced some form of stigmatization and discrimination with health care professionals. Thus, increased sensitivity is vital to the trust relationship.

Transgender persons may adopt a second name other than their legal name with which they may prefer to be addressed. If making a permanent transition, the birth name is legally changed with a court order. Some states allow for the sex designation on the driver’s license

to be changed prior to genital surgery. Asking transgender persons for their preference and addressing them using pronouns appropriate to their gendered presentation conveys respect.

Transgender patients may experience anxiety and shame over their bodies, and should not be made to disrobe unnecessarily. If mistakes in names and pronouns occur, the provider should simply recognize the error, and offer an apology. Maintaining a comfortable degree of eye contact can put the patient at ease. The provider should guard against making assumptions with regard to marital status, sexual orientation, parenthood and employment. Another critical behavior is to be aware of the reactions of other health care personnel who come into contact with the patient. If inappropriate or discriminatory behavior is observed, education and guidance should be provided.

The degree of stereotypical maleness or femaleness of the natal body is not an indication of the degree of gender dysphoria. Prior to seeking medical help with transition, transgender men and women may create an attractive stereotypical physical appearance consistent with their natal sex in an attempt to compensate for their cross-sex gender identity. For example, gender dysphoric natal females may have had breast implants and may present an overtly feminine appearance prior to seeking masculinizing hormones. Gender dysphoric natal males are not necessarily overtly feminine in their appearance or behavior prior to seeking care.

Confidentiality

The social stigma attached to cross-dressing leads transgender persons to go to great lengths to conceal their transgender status. Patients will be concerned about what information and diagnosis will be placed in their paper or electronic medical charts, and who will have access to that information. Discuss any concerns about confidentiality and collaborate on a mutually acceptable solution. (*See Health Beliefs and Behaviors: Confidentiality.*)

Standards of Care for Gender Dysphoria

Harry Benjamin International Gender Dysphoria Association

The Harry Benjamin International Gender Dysphoria Association (HBI-GDA) is a multi-disciplinary professional society, representing the specialties of medicine, psychology, social sciences and the law. It is dedicated to furthering research and treatment of gender dysphoria, including transsexualism. HBI-GDA publishes a set of clinical guidelines, the “Standards of Care,” derived from the empirical research and clinical experience of experts in gender dysphoria. (*See Appendix: Resources.*)

The “Standards of Care,” introduced in 1979 and updated regularly, represent professional consensus about the multidisciplinary medical management of gender identity disorders. The “Standards of Care” were developed in order to minimize potential regrets following administration of sex hormones and/or genital surgery, and to codify expert clinical knowledge in defense of these procedures. Specialists in transgender health care almost universally follow the “standards” when making treatment decisions for sex hormones and genital surgery. Some transgender persons consider the “Standards of Care” unwarranted and overly restrictive or inflexible, and resent the medical provider as a “gate-keeper.” Providers working with transgender patients should obtain a copy of the “Standards of Care” from the HBI-GDA, be familiar with the clinical guidelines, and discuss any concerns with the patient.

The Health Law Standards of Care

The Health Law Standards are alternative “standards of care” developed by transgender activists and attorneys at the International Conference on Transgender Law and Employment

Policy. These standards assert the right of access to cross-sex hormones and genital and other surgeries, without a mandatory period of real-life-experience in the gender role opposite to natal sex and without the recommendation of a mental health professional, as long as there are no medical contra-indications to these procedures.

Stages of Gender Transition

The HBGDA describes the process of transition from living as one gender to another in three stages: 1) the real life experience, 2) hormonal therapy and 3) genital reconstructive and breast surgery. This transition can take several years from the time professional consultation is first sought. Psychotherapy is helpful in making a good adaptation to gender conflicts and should target the specific needs of the individual. Some individuals may resolve gender conflicts without full-time transition to the other sex, sex hormones and/or genital surgery.

Stage One: The Real Life Experience

Living in the gender role consistent with the gender identity is necessary in order to determine whether full time and permanent transition will substantially increase both psychological and social adaptation. Gendered physical appearance, style of dress, mannerisms, and voice, all evolve with experience. The long held fantasy of gender transition is now compared with the lived daily experiences. Prior to living full time in the gender opposite to the natal sex, the transgender individual should carefully consider the consequences to family relationships, interpersonal functioning, fertility, education and employment, and financial stability. Loss of important relationships, discrimination, stigmatization, and social disability may occur.

Stage Two: Hormonal Therapy

The purpose of cross-sex hormone administration is the acquisition of the secondary sex characteristics of the opposite sex to the fullest extent possible. The HBGDA “Standards of Care” state that cross-sex hormones are medically necessary for the rehabilitation in the new gender. The physical and psychological changes assist in feeling and appearing more like the desired sex. Hormones promote the alignment of physical appearance with gender identity and body image, and assist in passing into society in the new gender. As such, hormones limit psychiatric morbidity and increase quality of life. Hormones can have a strong effect on an individual’s emotional state; however, research on the effect of hormone therapy on mortality and morbidity has resulted in conflicting conclusions.

The risks of cross-sex hormones should be considered in all patients, especially those with cardiovascular, cerebrovascular, or thromboembolic disease, marked obesity, poorly controlled diabetes mellitus, liver disease, a family history of breast cancer or who have a prolactin-producing pituitary tumor.

Providers, unsure of how to manage cross-sex hormones, should refer patients requesting hormones to endocrinology specialists. Preventable delays in care should be avoided if possible, as these may have deleterious effects on psychological coping. Delay in access to hormone administration is a risk factor for self-administered treatment with hormones obtained illegally or from international suppliers. Self-treatment may result in higher levels of medical complications compared to medically supervised hormone administration, including hyperprolactinemia, elevated liver enzymes, and an increase in cardiovascular risk factors (i.e., thromboembolism, elevated LDL-cholesterol and triglycerides).

Estrogen Therapy

Estrogen therapy is designed to induce breast development with lesser hemi-circumference than in female family members, full maturation in 2 to 6 years and enlargement of the areola. Tenderness and transitory pain may occur within the first 1 to 2 years. Estrogen will also result in:

- Smoother, softer, less oily skin;
- An increase in subcutaneous fat;
- Redistribution of fat onto the lower abdomen, thighs and buttocks; and
- Diminished body hair on the abdomen and pubic area.

There are certain health risks of high dose oral estrogens, such as liver enzyme abnormalities, depressive mood changes, increased production of coagulation factors, mild elevations in triglycerides and renin, and increased pituitary prolactin production. Thromboembolism (blood clots in the legs, lungs, eyes, brain) is low in younger patients (2.1%), but substantially higher in patients over 40 years (12%). For this reason, transdermal delivery is recommended for patients over 40 years old.

Progesterone is added at onset of treatment to encourage breast development and help suppress testosterone production. After castration, it need not be continued.

Side effects for other hormone therapies such as Spironolactone, Fluamide, and Cyproterone Acetate include weakness, fatigue, decreased appetite, weight gain, headaches, and gastrointestinal disturbances.

Testosterone Therapy

The goal of testosterone treatment is to eliminate menses and develop secondary sex characteristics.

Some of the health risks associated with exogenous testosterone include increased cholesterol and higher lipid levels, heart disease, mood changes, male pattern baldness, and acne (50 to 60%). Severe cases of acne (12%) require dermatological treatment. In some cases weight gain is greater than 10%. Smoking increases the risk of coronary heart disease in individuals using testosterone.

Stage Three: Genital Reconstructive and Breast Surgery

For female to male (FTM) transsexuals, surgery can involve a bilateral mastectomy and chest reconstruction or, for very small breasts, liposuction. For genital reconstruction, FTMs can choose between two approaches. Metoidioplasty creates a micro penis by severing the suspensory ligaments surrounding the clitoris which has been enlarged with testosterone. Free tissue flap transfer phalloplasty transfers skin and muscle tissue from the forearm, groin, or thigh to create a penis. Other FTM surgeries include closing the vagina (vaginectomy), removal of the uterus and ovaries (hysterectomy and oophorectomy), scrotum construction (scrotoplasty), and urethral extension (urethroplasty).

Male to females (MTFs) can opt for breast augmentation, an Adams apple reduction (tracheal shave), hip enlargement or other plastic surgery. MTFs can choose vaginal reconstruction (vaginoplasty), penis and testicle removal (penectomy and orchiectomy), and labia construction (labiaplasty).

Post-surgical primary care services differ, depending on the surgical options chosen. Seeking medical care for medical conditions that are incompatible with the patient's physiological appearance can be difficult. Some health care providers utilize institutional barriers that force the patient to revert to their original gender in order to obtain services. This may keep transsexuals from receiving care. FTMs who have not undergone surgery to remove their uterus, ovaries or vagina may postpone or ignore their gynecological health care needs. Similar barriers exist for MTFs who need care for prostate or urinary tract problems.

HIV/AIDS in the Transgender Population

Certain behaviors within the transgender population put them at increased risk for HIV infection. The stigmatization and isolation discussed above create barriers to care for this population. Economic barriers force some transgender individuals into the sex trade. Individuals in the sex trade are at increased risk of alcohol and intravenous drug abuse, increasing the likelihood of unprotected intercourse. The lack of coverage for hormone treatments forces some individuals to purchase hormones illegally and share needles, increasing the risk of transmission. Even in populations where AIDS transmission is low, transmission is higher in the transgender segment of those populations.

The transgender population tends to experience rejection and ridicule more consistently and pervasively than any other sexual minority. The result is reluctance to seek health care services. Even when those services are obtained, health education strategies around AIDS prevention are often aimed at lesbian, gays and bisexuals, ignoring the transgender population.

Implications for Kaiser Permanente Care Providers

- Recognize that the construct of gender identity is distinct from sexual orientation.
- Become familiar with various anatomical, psychological and social indicators of sexual and gender identity; recognize that your patient may be at variance for one or more of these factors.
- Provide a safe and non-judgmental environment for your transgender patients. Recognize your personal feelings and/or biases about gender variance or about transgender individuals' motivations or mental status. Express your primary interest and concern in your transgender patient's general well being or specific complaint, as you would any other patient.
- If you are in doubt as to your patient's gender identity, respectfully ask the patient for preferences of address or self-description; use language consistent with these preferences.
- Discuss issues around confidentiality of personal and clinical information with your transgender patient.
- Be aware of the feelings of distress that transgender patients may feel about their bodies or life histories. They may be particularly sensitive about disrobing for examinations.
- Recognize that some patients may have physical characteristics modified by previous cross-sex hormone treatment or surgery. Ask them the nature of these treatments only if necessary.
- Avoid making assumptions about a patient's sexual orientation, relationships or parental status based on a particular gender identity or expression.
- Transgender individuals receiving hormone therapy should be monitored carefully.
- Conduct requisite screening exams for post-operative FTMs and MTFs, recognizing that not all natal sexual organs may have been surgically removed. For example, conduct prostate exams for the post-operative MTF and breast exams for the post-operative FTM.

SPECIAL AREAS OF CLINICAL FOCUS: INTERSEXUALITY

Introduction

Intersexuality features congenital variations of the reproductive and sexual system. Intersex people are born with “sex chromosomes,” external genitalia, and/or internal reproductive systems that are not considered exclusively male or female. It is also referred to as “ambiguous genitalia” and in the past “hermaphrodite” (whose use is discouraged because it is seen as stigmatizing). Several hereditary conditions that can cause this presentation at birth are androgen insensitivity syndrome, Klinefelter’s syndrome, congenital adrenal hyperplasia, vaginal agenesis, ovotestes, 5-alpha reductase deficiency, and gonadal dysgenesis. In many instances, the infant presents with an enlarged clitoris or very small penis with an inadequate vagina or under-developed testes. It is conservatively estimated that one in 2,000 newborns are found to have ambiguous external genitalia, and that 100 to 200 pediatric surgical reassignments are performed in the U.S. annually. Prior to the 1950’s these infants were assigned a sex based on anatomy and grew to adulthood without surgical intervention.

Treatment

The current model of treatment for intersexual infants and children, established in the 1950’s, asserts that since the human species is sexually dimorphic, all humans must appear to be either exclusively male or female, and that children with visibly intersexual anatomy cannot develop into healthy adults. The model therefore recommends “emergency” sex assignment and reinforcement in the sex of assignment with early genital surgery. Increased understanding of enzyme pathways and embryologic development has led to better diagnosis and less sense of “emergency.”

In recent years there has been increasing concern and questioning of these surgical procedures done in infancy to “assign” sexuality. These surgical procedures have been done even though there is a lack of research demonstrating efficacy. In most instances, surgery is done in infancy to provide external genitalia that are less likely to cause anxiety to parents and family members. Very commonly, these individuals still require extensive additional surgery as adolescents or adults to have “functional anatomy” as defined by this model.

A new model, supported by many physicians and patient advocates such as the Intersex Society of North America is based upon four principles:

- 1) Assignment of sex based on guidelines of likely sexual identity;
- 2) Avoidance of harmful or unnecessary surgery;
- 3) Receiving qualified professional mental health care for the intersexual child and his/her family; and
- 4) Empowering the intersexual person to understand his/her own status and to choose (or reject) any medical intervention when of age to make those decisions.

The primary recommendation is to avoid harmful or unnecessary genital surgery on infants and children and that no surgery should be performed unless it is absolutely necessary for the physical health and comfort of the intersexual child. Any surgery that does not meet these criteria is considered to be elective cosmetic surgery which should be deferred until the intersexual child is able to understand the risks and benefits of the proposed surgery and is able to provide appropriately informed consent.

As an evolving issue in the realm of medicine and medical ethics, this is an area where providers need to look at the current information available and advocate for appropriate care for these individuals using evidence-based research on the outcomes and efficacy of the treatment that these individuals receive. Evidence-based research must be conducted, since none is currently available.

Implications for Kaiser Permanente Care Providers

- Recognize the specific ethical issues concerning the care of intersex infants.
- Know about resources available to assist in the decision-making and care of these individuals.
- Understand the implications regarding the care of intersex members who have had previous surgeries to reassign sex.
- Establish referrals/teams that include mental health providers to support parents who have intersex children in order for them to consider options carefully. Provide therapy for families and children, so children understand their conditions at each developmental stage.

SPECIAL AREAS OF CLINICAL FOCUS

OBSTETRICS/GYNECOLOGY

The majority of lesbians have had some heterosexual experience. Many lesbians have been previously or are currently married. Many have children from these relationships. However, a small percentage has never been sexually involved with men, and an even smaller percentage has never been sexually active at all, but self-identify as lesbian because of emotional and libidinous connections to women.

Barriers to Health Care

Several studies have documented that between 53-72% of lesbians do not disclose their sexual orientation when they seek medical care. There are several barriers to effective health care for lesbians and bisexual women:

- It is difficult in a short patient visit to establish the necessary trust bond with a provider which would allow a woman to feel safe disclosing her sexual orientation.
- Choosing a lesbian-friendly provider is difficult, as no visible clues and few verbal cues help gauge a provider's attitudes.
- Recognition and inclusion of a lesbian's significant other is frequently denied. In some cases, a family, hospital or other institution may challenge the right of same sex partners to act as proxy, even when the patient has designated her partner on legal forms.
- Lesbian and bisexual women may have experienced or heard others' stories of homophobic prejudices. Such abuses include reluctance to treat and negative comments or attitudes towards the patient. Even rough handling and neglect have been documented. Any patient would be reluctant to expose herself to the possibility of unprofessional and potentially dangerous conduct, especially when she is sick and vulnerable.

General Patient Interview Principles

Primary care for women tends to be organized around reproductive health care needs. The first questions asked are usually about childbearing and birth control. Most health information and counseling presupposes heterosexual activity. When such presumptions are presented in a hurried interview, a woman may need a good deal of courage to speak up regarding her sexual identity. Apprehension regarding the provider's reaction becomes a barrier to establishing rapport and giving informed care. There are some very good ways of asking patients "reproductive questions," which fit all lifestyles and elicit honest information in a non-threatening manner. A provider can ask if the patient is currently sexually active, and if so, does she have a steady partner, and are they monogamous. If the patient has not volunteered the gender of her partner, the provider can then ask whether the partner is a man or woman. It is also important to determine if the patient or her partner have had heterosexual experiences, explaining that this information is helpful in determining her health risks and necessary screening tests. Providers cannot assume a woman is heterosexual because she has children or is pregnant. If a provider makes this assumption, a simple apology when discovered and rephrasing the question will usually set the woman at ease. For example, if the patient responds to a birth control question with some hesitance, and states her partner is a woman, and then her provider responds with "That works well." the woman may be able to discuss her relationship openly.

It is always a good idea to ask if the patient would like her partner present for the examination or discussion, if she is not already present. These courtesies and sensitivities will go a long way towards creating a bond of trust with the patient.

Finally, providers must set the example for staff, both in the office and hospital setting. This means avoiding sly jokes or innuendoes, and speaking of lesbian or bisexual patients and their partners in the same respectful manner we would of any other patient. Coworkers will likely take the cues and even if they harbor negative attitudes, they will be less likely to subject patients to them.

Sexuality and Health

Understanding lesbian sexuality is key to being able to evaluate and screen for health risks, as well as to counsel our lesbian and bisexual patients. This is by no means a homogeneous group. It has been estimated that 30-60% of lesbian and bisexual women have been pregnant, and over 40% of those over 35 have used oral contraceptives. About 20% of self-identified lesbians continue to have sex with men, and most bisexual women have both male and female partners. Among women who are exclusively relating to women, a large percentage of their partners have been sexually active with men in the past. Therefore, many of the same health problems exist among lesbians as among heterosexual women, since lesbian sex can transmit most sexually transmitted diseases (STDs).

Sexual Practices of Women Having Sex with Women

Lesbian sexual practices vary. Besides the usual erogenous zone love play, most women engage in mutual genital stimulation, both digitally and orally, clitorally and vaginally. Practices may include mutual genital contact, with vulva-to-vulva rhythmic rubbing, and vaginal penetration with fingers or fist is common, as is the use of dildos. Some women may also use anal stimulation and/or penetration with either fingers or sex toys, and sometimes orally, known as “rimming.” (*See Risk Factors: Sexual Practices.*) “Butch” and “femme” roles, while not the rule, are sometimes present.

Sexually Transmitted Diseases

STDs can spread between two women in several ways. Syphilis, gonorrhea and chlamydia rates are very low among exclusively lesbian partners. However, if either partner has contracted syphilis, gonorrhea and/or chlamydia, these STDs can be transmitted by vaginal secretions directly or on sex toys, fingers or orally. Herpes, both types I and II, can infect either oral or genital tissues. Human papilloma virus or condyloma can also be spread in these ways, and women who have never had heterosexual contact have been documented to have condyloma on a PAP smear or on examination of the vulva. This virus can colonize in the oral cavity as well as the genitals, and it can lead to cervical, vaginal or vulvar dysplasia and/or carcinoma. Screening should be performed for lesbians on the same basis as for heterosexual women. However, the barriers to health care, and a mistaken perception that they are not at risk, may lead many lesbians to avoid regular screening examinations. It is important to educate women about their need for regular exams.

Common vaginal infections can also be spread during woman-to-woman sexual contact. These include yeast, trichomonas, and bacterial vaginosis. Urinary tract infections (UTIs) can follow sexual stimulation as well, and those with a history of multiple UTIs can follow the same prophylaxis guidelines as heterosexual women.

HIV

HIV seroprevalence rates among bisexual women are statistically higher than among exclusively lesbian or heterosexual women, probably due to unprotected sex with multiple male partners. Illicit drug use also increases this risk. The risk of HIV transmission between

exclusively lesbian partners is very low, with only a few possible cases documented. However, high risk behaviors such as multiple partners, anal-oral contact, vaginal or anal penetration with bleeding, and oral sex during menses can increase the risk of both HIV and hepatitis transmission. Transmission of HIV has also been documented through the use of unscreened donor semen among lesbians seeking pregnancy. A safer sex discussion with WSW patients, including a discussion of these risks for STD transmission is important. These risks can be avoided using the following guidelines:

- Wash hands and sex toys before and after vaginal or anal penetration.
- Use a barrier such as a dental dam or doubled plastic wrap when having oral sex or rimming, or during mutual vulval contact. There is a female condom available which effectively covers the vulva and vagina with a thin, smooth barrier, lubricated with an antimicrobial agent.
- Avoid contact of mouth or genitals during menstruation and if sores are present.
- Use certified donor sperm banks to eliminate HIV transmission risk.

Cancer

Breast Cancer

Breast cancer risk has been theorized to be somewhat higher among lesbians than among heterosexual women. Epidemiological factors that put females at increased risk for breast cancer include obesity, never being pregnant, pregnancy at older age and lower breast feeding rates. Population studies have not supported these theories. Breast self-examination and screening mammograms should be performed for lesbians as for all other women, tailored to each individual's risk factors.

Other Cancers

Ovarian cancer is reduced epidemiologically by the use of oral contraceptives and tubal ligation, and possibly increased by the use of fertility drugs such as Clomid and Pergonal. To the extent that lesbians have utilized these fertility drugs and may not have used oral contraceptives, they may be at a statistical disadvantage. Currently, no studies are available, so lesbians should have a pelvic examination at least every two years if they retain their ovaries.

Cervical cancer and dysplasia have been demonstrated in several studies to be equivalent among lesbians and heterosexual women. Therefore, PAP smears should be performed on the same basis as other women.

Fertility and Obstetrics

Many single women, lesbian and heterosexual, as well as lesbian couples, are choosing to become parents. There are several issues of importance to the practitioner in caring for them.

Preconception Counseling

As with all women, lesbians should be screened for rubella, diabetes, syphilis and HIV. They should be advised to take a vitamin containing folate while attempting pregnancy to decrease the risk of neural tube defect. Basal temperature and fertile mucus methods of determining the fertile period should be explained, and several cycles charted to ensure the appropriate timing of insemination. If she chooses, ovulation kits are available. Though they are much more expensive, they allow her to predict ovulation 24 hours ahead. There are many roads to pregnancy for lesbians. The advantages and pitfalls should be discussed, to enable her to make the safest choice. The safest method is artificial insemination using frozen semen from a certified sperm bank. This method eliminates STD risks, as specimens are frozen and the

donor screened before and six months after donation for HIV and other STDs, before release of the specimen. Complete medical and family histories and some sociological information are usually given for the donor. Most sperm banks also keep track of the number of pregnancies per donor in a geographical area, reducing the risk of later blood relationship issues. Some sperm banks list whether a donor is willing to be contacted in the future, usually after the child turns 18. Impregnation through sperm banks ensures protection from parental claims by the father based on well-established laws. Many banks are available and most will ship specimens overnight. Some require the woman's physician to sign a requisition form ensuring she has been properly counseled. Some clinics or physicians may offer fresh semen for artificial insemination, which increases the pregnancy rate per cycle by about 25%. However, the risk for STDs and HIV is increased with the use of fresh semen.

Some women choose to use a known donor. The safest choice is to have the specimen donated to a sperm bank, frozen and the donor retested in six months for HIV and other STDs. The patient should be counseled regarding possible parental claims by the donor which may result if the father is known, particularly if he is involved with the child. (*See Appendix A: Resources.*)

In Vitro Fertilization

It is possible for one woman to have her eggs harvested, inseminated and the resulting embryo(s) implanted in her partner's uterus, so that both are biological parents. This option is currently available at some fertility clinics. Seeking a court's validation of both women as legal parents may be advisable.

Prenatal Care

Lesbian women presenting for prenatal care have special needs. First, discussion of method of impregnation and appropriate STD screening should be performed. As with all pregnant women, HIV screening should be offered. A discussion of whether she wishes her sexual orientation included in her chart should ensue, as well as whether to list her partner as significant other. (*See Health Beliefs and Behaviors: Confidentiality.*) A Durable Power of Attorney should be discussed and filled out for both the woman and her baby, so responsibility during labor, delivery and postpartum care is clearly indicated. (*See Appendix A: Resources.*)

During prenatal care, labor and delivery, and hospitalization of mother and baby, the mother's significant other should be accorded the same privileges and visiting status as a father of the baby. A note in the chart to this effect can help smooth the way for the couple.

Implications for Kaiser Permanente Care Providers

- Understand the reasons for the reluctance of many lesbians and bisexual women to seek care, and be aware of the potential negative impact of homophobia upon their care.
- Avoid making heterosexual assumptions when gathering social and medical information.
- Lesbian sex can transmit most sexually transmitted diseases. Therefore, it is important to screen lesbian and bisexual women based on the same criteria used for heterosexual women.
- Lesbians are as likely as heterosexual women to have breast cancer, but are less likely to access services. Encourage all of your female patients to have regular exams and mammograms according to clinical guidelines.
- Offer to involve a patient's partner in discussions about care.
- Provide appropriate resources to aid lesbian patients in assuring their medical and legal needs are met.

SPECIAL AREAS OF CLINICAL FOCUS: CHILD AND ADOLESCENT HEALTH

Adolescent Health Care Issues

Although no one knows exactly how many teenagers are gay, lesbian or bisexual, several books and references on this subject estimate 10%. Just as adolescence is a time of transition from childhood to adulthood, sexual orientation in adolescence is also in transition. A clinical interaction with a 15-year-old that includes a discussion of sexual orientation may well yield different responses than an interaction with the same individual at age 19.

Sexually Transmitted Diseases

Sexually transmitted diseases (STDs) are statistically significant health issues among adolescents. The incidence of chlamydia and gonorrhea is highest in the 15- to 24-year-old age group. According to the Centers for Disease Control and Prevention, young persons (ages 20 and younger) represent the fastest growing age category of HIV infection. It is known that within the U.S., half of all new HIV seroconversions are within persons younger than 25 years. Nationally, between 27 and 54 new cases of HIV among adolescents (those between the ages of 12 and 21 years) are reported daily. In the year 2000, 1,688 young people (ages 13 to 24) were reported with AIDS. Data suggest that young people often have spontaneous, unsafe sex because they feel invulnerable and don't relate to the AIDS epidemic. Many gay men in their teens and early twenties consider HIV infection a disease of older gay men. Yet, in a recent sample of young MSM ages 15-22 in seven urban areas, researchers found that, overall, 7% were infected with HIV, with a higher prevalence among young African American (14%) and Latino (7%) men than among young White men (3%).

Suicide

Suicide is the third leading cause of death among adolescents. Each year in the U.S., there are over 250,000 suicide attempts by adolescents and 5,000 of these result in suicide. Previous studies indicate that gay and lesbian youth may account for as much as 30% of adolescent suicides. A 2001 study reported that the suicidal behavior among homosexual adolescents cuts across gender, racial and ethnic groups.

With the Boy Scouts openly discriminating against gay members and the military's "Don't ask, don't tell" policy, today's environment sends a clear message to gay and lesbian adolescents that they do not "fit in" with American society. Health care providers should be aware of the adolescent pressure to "fit in" with their peers. This pressure, compounded with issues of sexual orientation and the risk of coming out to peers, can result in low self-esteem. Identify these adolescents and offer understanding and caring in a confidential clinical setting.

Identifying Invisible Youth

Adolescents are quite sensitive to a health care provider who through actions or words expresses disapproval of their behavior or appearance. Health care providers can build trust and foster openness with their LGBT adolescent patients by taking a sexual history in a non-threatening and non-judgmental manner. Providers need to be aware of the process of "coming out" for adolescents who are acknowledging their homosexual orientation. Many adolescent males come out at an earlier age than do adolescent females. Similar to LGBT adults, sexual activity does not necessarily reflect one's sexual orientation. Many young women may have had heterosexual intercourse because of peer pressure or "feeling that this would change their sexual orientation." In taking a sexual history on an adolescent, it is important to begin with asking questions about sexual attraction before questions about sexual activity.

A presumption of heterosexuality may produce misleading responses from the adolescent. Questions that do not lead to labeling are the most effective. For example, a clinician may question a 17 year-old male about his sexual attraction to females and males using a scale of 1 to 10. The query would be: "Are you attracted to females, males or both?" and then follow up that question with "On a scale of 1 to 10 in which the lowest level of attraction would be 1 and the highest level of attraction would be 10, what number best reflects your attraction to females?" The same question would then be used for attraction to males. When an adolescent answers "1 and 10" the orientation is clear. A response of "5 and 6" gives the provider an opportunity to discuss sexual feelings and attractions without labeling the teenager as heterosexual or gay. For some adolescents, "bisexual" may be the first step toward admitting that they are mostly attracted to someone of the same sex. However, some adolescents are truly bisexual.

Health care providers should note that among many adolescents, sexual orientation and the concerns of this orientation precede sexual activity. Simply asking an adolescent if he or she is sexually active, receiving a negative response, and continuing on to another topic will completely miss the opportunity to address sexual orientation. In addition, for some adolescents, terminology such as "sexually active" may mean sexual intercourse. It may be appropriate to simply ask if the adolescent has ever "come close to having sex" or "touching another person's private parts." It is also paramount to stress to the adolescent that the discussion is confidential.

In some situations, the adolescent's sexual orientation may only be known to the health care provider. If the adolescent is not at risk for personal harm, then further disclosure to other adults is unnecessary. Often the gay or lesbian adolescent will feel very much alone. For many, there may not be a known group of other gay or lesbian adolescents in their school or community with whom they can relate. It is important for clinicians to be aware of this dilemma. Coming out to unsympathetic or unsupportive parents will not be helpful to the adolescent.

Organizations and bars are available to adult LGBT persons to meet other people of the same sexual orientation. Teenagers often have no truly safe way to meet others of the same sexual orientation. Some teens will take risks such as anonymous meetings in restrooms or parks or meeting on the Internet and put themselves at risk for unsafe sex and even illegal activities that could result in a civil arrest. Some adolescents will use a false identification to enter gay clubs or bars that may lead to risky behavior such as cigarette smoking and alcohol use. For adolescents in some cities there are specific groups such as "LYRIC" and "QUEER YOUTH" that offer camaraderie to adolescents in a safe setting, and offer non-threatening ways to meet other young adults. (*See Appendix A: Resources.*)

Counseling a Parent Whose Child has Just "Come Out"

For many health care providers, a more difficult challenge than identifying or caring for the adolescent who is acknowledging his or her homosexual orientation is counseling the parent who has just been informed that a son or daughter does not have a heterosexual orientation. Often the parent may react with shock and sorrow. For many parents the first question is, "What have I done wrong as a parent?" Parents frequently have guilt, for example, a single mother who finds out that her son is gay, thinking that the absence of a male parent in the home is the reason for her son's sexual orientation. Sometimes a religious background will cause parents to worry about their son or daughter's salvation. Some parents' first reaction is that they will not have grandchildren.

Occasionally parents present with the adolescent requesting "reparative therapy," hormones to change the adolescent's sexual orientation, or a referral for psychotherapy, shock therapy, or boot camps to "change" the adolescent's sexual orientation. A more difficult issue arises when

the parent who refuses to accept this sexual orientation forces the adolescent to leave home. These adolescents may end up homeless, resorting to survival sex and prostitution to obtain shelter and food. These “street kids” often are at risk for violence, such as hate crimes. They have a high STD incidence, including HIV infection, from having unsafe sex.

It is possible that some runaway adolescents who have left home because of their sexual orientation may be living in a different geographic area than their parents, but still have health care coverage through their parents. Providing health care to runaway teenagers, who otherwise may think they are uninsured or are afraid they will not receive confidential care, can often save their lives.

Offering comfort and counseling to the parent is critical. Counseling services should be made available to the parents to help them come to terms with the new information. An excellent organization nationwide is Parents, Friends and Families of Lesbians and Gays (PFLAG). This support group is growing in membership throughout the country and is often the one door open to parents for comfort and support. In many situations, only one parent is aware of the adolescent’s homosexual orientation. This makes support groups such as PFLAG even more beneficial. (*See Appendix A: Resources.*)

Parenting

A nationwide survey of 255 lesbian and gay parents showed that most were satisfied with their children’s care. However, many pointed to deficiencies in the way they were approached by providers and support staff, particularly in emergency and urgent care settings. With an estimated one to five million lesbian mothers nationwide, and between one to three million gay fathers, providers will almost certainly encounter lesbian and gay parents. They will enter the clinical encounter either as couples or as a single mother or father.

Parenting Choices

Lesbians and gay men become parents in a variety of ways. Traditionally, the majority would “come out” while in a heterosexual marriage. Some adopt children as single or coupled gay parents. Increasingly, lesbian and gay men are using donor insemination, with either a known or unknown donor, or arranging a surrogate pregnancy. In a minority of families with surrogate mothers or known sperm donors, this biological parent is actively involved in parenting decisions and responsibilities. As in heterosexual families, there are variations of blended and step-families.

In some states, same-sex parents may adopt each other’s children in the same way as heterosexual step-parents. In cases where second parent adoption is not an option, the biological parent may assign medical power of attorney for the child to the partner.

Parenting Research

The majority of contemporary research on LGBT parenting has focused on lesbian mothers. The earliest studies were comparisons between custodial lesbian mothers and custodial heterosexual mothers in divorce cases. A recent review found no differences in gender identity, sexual orientation, self-concept, locus of control, moral maturity, intelligence or peer relations between children of heterosexual mothers and children of lesbian mothers. Children of divorced lesbian mothers are more likely to have contact with their biological fathers and other significant male role models than children of heterosexual divorced mothers. The research literature is somewhat limited because studies were conducted primarily in the U.S., using predominantly White, middle-class parents.

Child Rearing Issues

For the most part, LGBT parents confront the same child rearing issues as heterosexual parents. Gay and lesbian parents have concerns about homophobia and custody issues, a tendency to be more child-oriented and a greater degree of self-confidence than heterosexual parents do.

Research indicates that a child's adjustment is enhanced when a lesbian mother lives with her partner, when the lesbianism is acknowledged before the child reaches adolescence, and when the child has contact with peers from other lesbian families. These research findings could be extrapolated to gay fathers.

The decision by lesbian or gay parents to disclose or not disclose their sexual orientation to their pediatric health care provider or children's teachers can be stressful. In general, higher educational levels or socioeconomic status predict parents' tendency to disclose their sexual orientation to their children. Children entering their teens make decisions about disclosure of their parents' sexual orientations independent of their parents.

Implications for Kaiser Permanente Care Providers

Adolescent Health

- Become comfortable with issues of sexual orientation and gender identity as well as non-threatening and non-judgmental interview techniques.
- Often a health care provider may be the only person with whom an adolescent will share his/her sexual orientation.
- Be familiar with and have resources available for LGBT teenagers such as counseling services, peer groups, and groups for parents, such as Parents and Friends of Lesbians and Gays (PFLAG). (*See Appendix A: Resources.*)
- Be aware of the risk factors for the LGBT adolescent: suicidal ideation, increased risk for STDs and substance abuse (such as tobacco and alcohol).

Parenting

- The provider should not assume that a single parent is heterosexual.
- Discern and acknowledge the family structure, using questions such as "Who cares for this child?" and "What does the child call his/her parents?"
- Use health history forms that list neutral terms such as parent/guardian, rather than father and mother, facilitate the disclosure of alternate family structures and send a message of inclusion to parents.
- Even if no arrangements exist to give both parents legal rights of consent, couples who are committed to raising a child together respond positively when the pediatric provider acknowledges both parents' roles, maintains eye contact with both and includes both in discussions about the child's health care. Parents take offense when the provider refers to the child as only belonging to the biological or legal parent, or excludes the non-biological parent from discussions about the child's care. Parents have reported this type of negative experience most frequently in emergency and urgent care settings.
- Younger children and mid- to late adolescents tend to be more accepting of alternative family structures than older elementary or middle school children. Middle school, a difficult time for many children, can be especially difficult for children of lesbian and gay parents. These children may confront a surge of homophobic insults and a developmentally appropriate desire to conform to their peers. Ask the child if he or she encounters any teasing or harassment because of the parents' sexual orientations.

SPECIAL AREAS OF CLINICAL FOCUS: MENTAL HEALTH

Like most people, lesbian, gay, bisexual and transgender (LGBT) individuals have complex lives of which sexual orientation is only one factor. Over 35 years of objective, well-designed scientific research has shown that homosexuality is not associated with mental disorders or emotional/social problems.

Today, psychologists, psychiatrists and other mental health professionals agree that homosexuality is not an illness, mental disorder or an emotional problem. In 1973, the American Psychiatric Association removed homosexuality from the Diagnostic and Statistical Manual of Mental Disorders (DSM). In 1991, the American Psychological Association passed an additional resolution supporting this removal.

Most homosexuals live successful, happy lives. Some homosexual or bisexual people may seek to change their sexual orientation through therapy, sometimes coerced by family members or religious groups to do so. Homosexuality does not require treatment and is not changeable. Some therapists who undertake “conversion therapy” or “reparative therapy” report that they have been able to change their patients’ sexual orientation from homosexual to heterosexual. Close scrutiny of these reports indicates poor methodology and low validity. Many of the claims come from organizations with an ideological perspective that condemns homosexuality. The American Psychological Association, the American Medical Association and other professional societies are concerned about such therapies and their potential harm to patients. These professional societies have disavowed these therapies and have raised concerns that not only is “conversion therapy” and/or “reparative therapy” scientifically ineffective, but that it also may cause long term consequences such as severe depression, anxiety disorders, self-destructive behavior, loneliness, alienation and possible suicide.

Risk Factors Based on Societal Effects

Data from the National Comorbidity Study reported that homosexually active men and women are at an increased risk for psychiatric morbidity than heterosexually active men and women. For example, the study indicated that women in same sex relationships had significantly higher rates of major depression, simple phobia and post-traumatic stress disorder than women in opposite sex relationships. The authors speculated that stress from stigmatization and exposure to discriminatory behavior may contribute to these elevated rates.

Furthermore, in a large sample study of lesbian women in three metropolitan regions of the U.S., 51% of the lesbian respondents reported attempting suicide compared with 38% of those seeking therapy to address issues of depressive distress. The researchers hypothesized that this significant difference may be explained by life stress related to sexual orientation.

“Coming Out”

LGBT persons are largely an invisible minority, who often do not disclose their sexual orientation, gender identity or concerns about it to others. Some transgender individuals may be more visible, especially during the transition between genders. To “come out” is to disclose one’s sexual orientation or gender identity to others in one’s life. “Coming out” can occur at any time during a life span and is best described as a process that takes several years. Some people feel that the coming out process does not have a clear endpoint, and believe that each time someone reveals they are LGBT they come out. “Coming out” can also cause significant levels of anxiety, as it means risking rejection from others. Coming out is a complex process involving a change in both interpersonal and intrapersonal arenas.

Research has shown that on average there is an 8-10 year gap between first awareness of same sex feelings and self-labeling as a homosexual. People may come out to themselves, their friends, family, co-workers, health care providers, acquaintances, or any combination of these. For many LGBT people, the coming out process is difficult. Often lesbian, gay, bisexual and transgender people feel afraid, different, and alone when they first realize that their sexual orientation is different from the community norm. This is particularly true for people who become aware of their gay, lesbian, bisexual or transgender orientation as a child or adolescent. LGBT persons often fear and/or experience being rejected by family, friends, co-workers and religious institutions. Some LGBT people worry about losing their jobs or being harassed at school if their sexual orientation becomes known. "Coming out" in the workplace seems to be the most difficult, possibly because in many locales no protection is offered to LGBT persons from discrimination. While there is seemingly less at risk in terms of coming out to health care providers, studies have found higher levels of anxiety when coming out to medical practitioners as compared to other persons in their lives. Fears of stigmatization and the possibility of compromised health care seemed to contribute to this anxiety.

In spite of all the potential hazards, coming out has been found to be strongly associated with positive psychological adjustment. If a person has a positive self-concept as an LGBT person, they are more likely to manifest higher levels of self-esteem, which, as with all people, buffer against psychological problems.

Internalized Homophobia

It is safe to say that many LGBT persons have not been in an atmosphere conducive to fostering positive identities. "Internalized homophobia" occurs when these homophobic cultural messages are incorporated into the LGBT person's own self-concept. Internalized homophobia can be manifested as feelings of shame about same-sex attraction, denial of sexual feelings, avoidance of sexual feelings, hate of self and other gay people, envy of heterosexuals, distorted negative body image, depressive symptomatology, demoralization, and lowered self-esteem.

Older Adults

While the incidence of depression in older gays and lesbians is no greater than in the general population, problems of adjustment in the older LGBT population do exist. Problems of adjustment in aging gays and lesbians revolve around management of the stigma of being gay as well as of being old, in addition to general concerns of older adults around health, loneliness and income. Many LGBT persons over 50 years old came into adulthood prior to the emergence of the gay liberation movement of the early 1970's. Many of them are hesitant to disclose their sexual orientation to health care providers due to a lifetime of living in secrecy and fear that their "confidentiality" might not be respected. For many older adults, hiding one's sexual orientation has had survival value. For lesbians, this may have been in the form of economic stability and security, whereas for gay men it was more likely to ensure stability of employment and avoidance of physical attacks. Additionally, like other older individuals, they may have internalized societal beliefs that older persons are useless, worthless, helpless and dependent. This may lead to them not wanting to "make a fuss" because health care providers "have other patients with more important problems" than theirs, thus compounding the problem.

In a 2000 study of 416 lesbian, gay and bisexual adults aged 60 to 91 years old, the survey data suggested that better mental health was associated with higher self-esteem, less loneliness and less internalized homophobia. Of special note was that men reported significantly more internalized homophobia, alcohol abuse and suicidality related to their sexual orientation than women.

Eating Disorders

According to several theories on social stress and body image, an emphasis on thinness normally placed on feminine bodies may also influence gay men. In contrast, a decreased emphasis on physical appearance among lesbians may protect them against development of body dissatisfaction and eating disorders. A study of 135 men treated for eating disorders showed that 27% reported homosexual orientation and 42% of bulimic patients identified as homosexual or bisexual. Although the studies reported to date may overstate the problem, community studies have often found significant association between sexual orientation and negative body image among gay men. In a 1998 survey of more than 30,000 Minnesota students, grades 7-12, homosexual boys were more likely than heterosexual boys to report a poor body image, frequent dieting, binge eating, and purging behavior. Lesbian girls, by contrast, were more likely than heterosexual girls to report a positive body image, though they were no less likely to report disordered eating behaviors such as bingeing and purging.

Victims of Violence

Victims of violence are at higher risk for Acute Stress Disorder and/or Post Traumatic Stress Disorder. Acute Stress Disorder has an onset within one month of the violent act and is characterized by a variety of symptoms including sleep disturbance, nightmares, hyperarousal, uncontrollable crying spells, agitation and restlessness. If these symptoms last for more than three months the diagnosis becomes Post-Traumatic Stress Disorder. Increased drug and alcohol use is often evidenced in patients with these disorders. Early identification and treatment can help victims of violence cope and resume a pre-attack level of functioning.

Domestic Violence

Same-sex domestic violence is still an ignored and under-recognized issue both within and outside of the LGBT population. In one study, 31% of lesbians and gay men reported being victimized by a same sex partner. Little is known about how the cycle of domestic violence may differ in same-sex relationships. Substance use and abuse have been associated with a higher incidence of verbal and physical aggression and levels of substance use may be higher for the LGBT population. (*See Appendix A: Resources.*)

Suicide

The question of whether LGBT persons have higher rates of suicide is a hotly debated issue and the empirical evidence is inconclusive. Studies have found an increase in lifetime prevalence rates of suicidal ideation and attempts among LGBT persons. A 2000 UCLA study reported that MSM had a higher prevalence rate of suicide attempts (19.3%) than men only reporting female partners (3.6%). Among LGBT youth, rates of suicidal ideation and attempts are three to seven times higher than heterosexual youth.

HIV/AIDS

While HIV/AIDS is seen as an important medical issue, HIV/AIDS is also a mental health epidemic. Multiple personal losses became more commonplace. Some individuals have had their entire social networks decimated by AIDS-related deaths. Many LGBT persons who are dealing with HIV/AIDS live in a constant state of crisis. Unfortunately, much of the research on HIV/AIDS and mental health to date has been solely on gay men. It is difficult to extrapolate to lesbians, bisexual men and women, and transgender persons.

While not all gay and bisexual men are HIV seropositive, men who have sex with men (MSM) are one of the highest risk groups for contracting HIV in the U.S. Many gay men cannot

imagine that they will or could survive without contracting HIV due to the prevalence of the disease within the gay male population. Additionally, HIV/AIDS is often a stigmatizing symbol and a concrete expression of the disapproval, personal defectiveness and disenfranchisement that this population experienced long before there was AIDS. There is no definitive evidence of higher rates of psychopathology, including depression, in the HIV-positive individual than in the general population. Any association of HIV and mental health will depend largely on other psychosocial characteristics that foster vulnerability or resistance to distress. For example, knowing others infected with HIV and suffering multiple losses exacerbates psychological distress.

Testing and Notification of Seroconversion

Testing for the presence of HIV antibodies can be quite anxiety producing for many persons. Anxiety has been shown to be associated with refusal to be tested for HIV. In one study, 48% of people who decline an HIV test state that they would rather not know the results because if they were HIV+ they would worry excessively and be unable to cope. Anxiety may be particularly high among those who have engaged in high risk behaviors or for those who have not “come out.” With these individuals, education regarding the testing process, how the results are recorded and stored, and the implications of test results may be a first step to alleviating some of this anxiety.

Initial reactions to notification of a positive HIV antibody test are most commonly depression, anxiety and stress. The most frequently diagnosed clinical syndrome associated with HIV infection is adjustment disorder with features of depressed, anxious or mixed mood. The severity of these symptoms largely depends on a patient’s prior level of functioning. Multiple factors interact in HIV-related distress, including perceived responsibility for having contracted HIV, the potential for having unknowingly placed others at risk and changes in physical appearance. Additionally suicidal ideation may increase after notification, although prior suicidal ideation and/or attempts still serve as the best predictor of suicidal risk. There may also be an increase in substance use/abuse following notification of test results.

A negative HIV antibody test result can also be a stressful event. Many HIV- men have significant guilt and anxiety about surviving the HIV/AIDS epidemic (survivor guilt) and are frequently seen as the “worried well.” Survivor guilt is a complex, subtle and powerful psychological phenomena resultant from the LGBT population’s nearly 20-year experience in dealing with the HIV/AIDS epidemic.

HIV and Depression

Depression is the most frequently studied psychiatric condition among HIV+ patients. HIV+ patients with untreated depression are less compliant with their antiretroviral therapies and have a more rapid clinical decline than those receiving treatment for depression. Estimates range from 12-65% of persons with HIV/AIDS with symptoms of a major depressive episode. However depression is not an inevitable result of HIV infection. Strong relationships have been found between a past history of a mood disorder and current psychological distress. Depression must be differentiated from the transient feelings of sadness and shock following notification of HIV+ status, worsening immune status and bereavement. Taking a thorough history of depression (both treated and untreated episodes) may help in making this differential.

There is no typical pattern of depression in response to HIV. Reactions may include: feelings of sadness, worry, despair, confusion, as well as other cognitive and behavioral responses. HIV-related depression is often fostered by a sense of pessimism and hopelessness. Distress can also occur at several illness-related milestones, such as, notification of seroconversion,

initiation of treatment, development of symptoms, onset of opportunistic infections, the occurrence of the first AIDS-defining conditions and declines in immunologic markers.

Although there are cultural variations with respect to the manifestations of depression, sometimes distress is expressed through somatic symptoms that mimic symptoms of HIV infection. Additionally, many of the vegetative symptoms of depression are similar to symptoms of HIV infection. It is important to thoroughly assess for additional non-vegetative symptoms of depression (e.g., feelings of worthlessness, helplessness, anhedonia, etc.) in HIV-infected patients. Studies have shown that the treatment of depressive symptoms in those with HIV/AIDS may reduce mortality. Admitting physicians often discontinue psychotropic medications, either because they believe these medications are not important for the patient's care, or because they do not know that the medications have been prescribed for the patient.

Depression may also be a side effect of some medications used to treat HIV/AIDS. Although relatively infrequent in clinical practice, AZT (Retrovir®), efavirenz (Sustiva®), acyclovir (Zovirax®), sulfonamide antibiotics, androgenic steroids, anticonvulsants, narcotics and isoniazid (INH) may contribute to or trigger depressive symptoms in some patients.

HIV and Suicidal Risk

People with HIV infection have higher levels of suicidal ideation and more frequently attempt suicide as compared to their non-HIV infected counterparts. Thirty percent of those undergoing HIV antibody testing reported suicidal ideation before being tested and 27% of HIV+ and 17% of HIV- persons continued to consider suicide one week after test results. Studies have shown that those with early symptoms of infection have the most elevated suicide risk. Common predictors of suicidal attempts among people with HIV infection parallel those of the community at large: prior history, untreated mood disturbance, feelings of hopelessness and substance abuse.

HIV and Anxiety

Anxiety is another common psychological complication associated with HIV/AIDS. Common anxiety symptoms include excessive worry, gastrointestinal distress, sleep disturbance, preoccupation with physical symptoms and memory/concentration problems. Appropriate identification of anxiety in patients with HIV can be difficult, because physical symptoms resulting from general anxiety may be mistakenly attributed to the presence of HIV.

Disclosure of HIV+ Status

A positive HIV antibody test can sometimes lead to loss of employment, threats of eviction, denial of life insurance, denial of health and dental care, loss of pets (due to infectious pathogens in the animal's feces), social supports, physical affection/contact and future goals and aspirations. Individuals testing positive for HIV must decide how and when to disclose their HIV status to sexual partners, family and friends. Studies have shown that 96% of gay men told their exclusive and long-term sexual partners that they were HIV-positive, whereas only 44% disclosed to regular, but not exclusive partners. Disclosure of serostatus continues to be a source of great anxiety and stress for many with HIV.

Bereavement

To work effectively with LGBT patients, it is important to be aware and sensitive to particular issues surrounding loss and grief. Most people live with the loss of persons, places or things that were once an important part of life. Generally, more significant loss causes more significant or intense grieving and developmental change. The loss of a person, through death, divorce, separation (legally formalized or otherwise) or another kind of change in the nature of a relationship such as geography, general health or mental incapacitation can all cause measurable grief reactions and chronic, perhaps life-long mourning. The loss of a pet, changes in lifestyle, physical mobility, former living situations, vision, or any other event perceived by the member as a loss will require engaging a series of steps or tasks described by a number of authors across multiple disciplines. Thanatology experts, spiritual guides, clergy, and rehabilitation counselors seem to agree, at least in part, that a person facing perceived loss (or losses) will typically move through a theoretical framework which is characterized by a series of reactions most popularly described by Kubler-Ross nearly thirty years ago. Her five step model includes denial, anger, depression, bargaining and acceptance. These steps are considered descriptive, not predictive and are not sequential or linear.

The grief process is made more complicated for the LGBT population by a number of losses best described as “disenfranchised grief.” Disenfranchised grief encompasses losses not generally affirmed by our social system, including the death of a partner or any other important relationship not socially sanctioned. For some LGBT persons, biological families are either not supportive, disapproving, or hostile toward their personal lives. As a result, many LGBT persons develop extensive “kinship” networks composed of friends and partners. These people become important in their lives, but are not viewed by society as formally or closely connected. Thus, the loss is invalidated and the opportunity for public, healthful grieving is denied. The death of a gay partner is often treated as the death of a casual friend or roommate by some, despite years of relationship, depth of intimacy, religious ceremonies of union, domestic partner benefits, civil domestic partner registration and other markers of intensity in human relationships.

Bereavement over AIDS-related deaths appears to be most pronounced among people who are HIV+. There seems to be a close relationship between the number of AIDS-related deaths and the degree of psychological trauma. Increases in demoralization, sleep disturbance, affective disturbance, intrusive thoughts and illicit as well as prescription drug use is positively correlated with the number of AIDS-related deaths experienced.

Issues with Being HIV Negative

In the age of HIV/AIDS, the phenomenon of multiple loss reactions is a significant issue. A catastrophic grief reaction occurs as a segment of the population recognizes that a major portion of their generation has died. This has been seen in those who have survived a war, natural disaster or plague. Reactions may include a sense of “survivor guilt,” wherein survivors wonder if they really deserve to be living at this time. Reactions may also include a severe sense of guilt about not being HIV+. As they review their own lives and actions, HIV- people may feel that they do not deserve to be disease free, and that others who have already succumbed should have “escaped,” not themselves. This guilt of negative serostatus has clear implications for how well a patient may comply with staying healthy, follow medical guidelines, choose to stay HIV- and practice safer sex behaviors.

Implications for Kaiser Permanente Care Providers

- Homosexuality does not require treatment. “Reparative therapies” are potentially harmful.
- Providers need to be aware of the stress of living in a community with AIDS so that care can be delivered in a compassionate and non-judgmental manner. This information can be obtained by assessing the patient’s scope of presenting medical concerns, sexual history, high risk behaviors, recent stressors (including significant losses), and other relevant information in addition to the standard history and physical. The providers can consider recommending a psychosocial evaluation.
- Many LGBT persons may be reluctant to discuss their sexual orientation with health care providers.
- When assessing risk, ask about sexual behaviors.
- Ask questions in a non-threatening, non-judgmental manner.
- Welcome the inclusion of same-sex partners in health care decisions.
- LGBT adolescents may be at increased risk of suicide. Assess and make appropriate referrals.
- Assess for alcohol and drug use, as well as for sexual behaviors in elderly LGBT patients.
- It is important to screen for domestic violence among LGBT persons as well as heterosexuals.
- Ask patients about a personal history of hate crimes/violence. Victims of violence are at increased risk of post-traumatic stress disorder.
- Differentiate between depression and sadness, shock or bereavement. Seek consultation if appropriate.

HIV/AIDS

- A negative HIV test result may increase anxiety/stress.
- Appreciate and acknowledge that personal judgment and philosophy on both the parts of the patient and provider may play a larger role than usual in HIV/AIDS care.
- Destigmatize feelings regarding treatment failures. Reassure patients that they can endure temporary setbacks. Be willing to revisit and revise the treatment plan.
- While news of new treatments brings hope, it can be very confusing. Openly discuss latest news and developments and their implications for the patient’s treatment plan.
- Be aware of potential interactions between psychiatric medications and medications used in the treatment of HIV/AIDS. Consult with your pharmacist as appropriate.
- A prior history of depression may put HIV+ patients at increased risk for suicidal ideation or attempts.
- Enlist the assistance of HIV M.D. specialists and other providers (e.g., psychologists, dietitians, social workers, etc.) who have expertise/experience caring for HIV/AIDS patients.

CONCLUSION

This handbook is intended to engender dialogues on LGBT health care issues, increase clinical awareness, and improve the level of the quality of health care that we deliver to the LGBT member and increase satisfaction with care. The LGBT individual faces significant obstacles in the health care environment and we must be cognizant of them. Five major barriers to the provision of culturally competent care for the LGBT person are:

- 1) Invisibility of many of these individuals due to a lack of willingness to self-identify because of fear of discrimination through historically negative interactions with health care institutions and providers;
- 2) Homophobia and transphobia;
- 3) Heterosexism;
- 4) Limited epidemiological research; and
- 5) Lack of provider knowledge of specific LGBT health care issues.

Many LGBT communities have developed unifying coalitions, task forces and initiatives to foster inclusiveness and interest specific to LGBT health care needs. Health care organizations committed to diversity and inclusiveness must take on the responsibility to do the same by encouraging awareness and acceptance via research, education and training and increased collaborative community efforts.

On an individual level, providers can make their practices more open and welcoming to all patients by implementing changes described in this handbook. Another important step is to learn about resources available in the community for LGBT patients. Other proactive steps are hiring openly LGBT staff, displaying inclusive materials in medical office waiting areas and exam rooms, and visibly exhibiting in the workplace a commitment to diversity through addressing derogatory and stereotypic comments.

Together with larger institutional changes, providers can work to create a health care environment whereby LGBT health care issues are addressed effectively and positively.

APPENDIX

Appendix A: Resources

The following are national resources. Check with your local Kaiser Permanente health education department for additional materials, videos and local resources. Appearance of a web site link or resource does not necessarily imply endorsement by the National Diversity Department or by Kaiser Permanente.

AGENCY	SERVICES	PHONE	WEBSITE
Bisexuality			
Bisexual Resource Center	A Boston-based resource center providing information, resources and technical assistance.	617-424-9595	www.biresource.org
Domestic Violence			
National Domestic Violence Hotline	A national resource that refers callers to local domestic violence resources. This organization can link callers to LGBT sensitive services, where available.	800-799-SAFE 800-799-7233 (24 hours in English and Spanish) TDD: 800-787-3224	www.ndvh.org
Families			
Parents, Families and Friends of Lesbians and Gays (PFLAG)	PFLAG is a national organization which promotes the health and well-being of LGBT persons, their families and friends.	202-467-8180	www.pflag.org
General Health Issues			
The Gay and Lesbian Medical Association (GLMA)	The GLMA is an international organization of LGBT physicians and medical students. The GLMA's primary work involves combating homophobia and promoting quality health care for LGBT and HIV+ people.	415-255-4547	www.glma.org
The Gay, Lesbian, Bisexual and Transgender Health Access Project	The Gay, Lesbian, Bisexual and Transgender Health Access Project is a community-based program funded by the Massachusetts Department of Public Health that provides training, technical assistance and materials to agencies across the state and nation to help service providers learn more about the health care needs of LGBT populations.	617-988-2605	www.glbthealth.org
HIV/AIDS			
National HIV and AIDS Hotline	Centers for Disease Control and Prevention sponsored information phone line on HIV/AIDS.	1-800-342-2437 or 1-800-227-8922 (English) (24 Hours/ 7 Days) or 1-800-344-7432 (Spanish): 8 am- 2 am EST (includes STD information) TTY: 1-800-243-7889: M-F 10 am - 10 pm (EST)	www.ashastd.org/nah

AGENCY	SERVICES	PHONE	WEBSITE
AIDS Info U.S. Dept. of Health & Human Services	Hotline providing HIV/AIDS health information and treatment options. Also offers live on-line help.	1-800-448-0440 12 - 5 pm M-F EST (English & Spanish)	www.aidsinfo.nih.gov/
Project Inform	Hotline providing HIV/AIDS health information and treatment options.	1-800-822-7422 9 am - 5 pm M-F 10 - 4 pm Sat (PST)	www.projectinform.org
University of California, San Francisco AIDS Information	Excellent AIDS resource for clinicians.		hivinsite.ucsf.edu
Medscape	Excellent resource for clinicians and CME credit.	888-506-6098	www.medscape.com
The Body	Web site devoted to the latest in HIV/AIDS care and prevention.		www.thebody.com
African American AIDS Policy and Training Institute	Engages Black institutions and individuals in efforts to confront the AIDS pandemic in Black communities.	213-353-3610	www.blackaids.org
American Foundation for AIDS Research (amfAR)	amfAR is a national organization dedicated to the support of HIV/AIDS research, prevention, education and advocacy.	212-806-1600 1-800-39-amfAR	www.amfar.org
Aids Education Global Information System (AEGIS).	Clinical website updated hourly on AIDS/HIV.		www.aegis.com
Gay Men's Health Crisis	Provides health information, legal services and advocacy information	1-800-243-7692 M-F 10 am - 9 pm (EST) Sat 12 - 3 pm (EST)	www.gmhc.org
Intersexuality			
Intersex Society of North America	Peer support, education and advocacy for intersexuals.		www.isna.org
Legal Issues			
The National Center for Lesbian Rights	The NCLR provides free information and counseling to LGBT individuals, and technical assistance to attorneys.	415-392-6257 9-5 pm PST	www.nclrights.org
Lambda Legal Defense and Education Fund	A national legal organization working for the civil rights of lesbians, gay men, bisexuals, the transgendered and people with HIV/AIDS.	National Headquarters 212-809-8585	www.lambdalegal.org
American Academy of Matrimonial Lawyers	The American Academy of Matrimonial Lawyers is composed of legal experts in the field of matrimonial law, including divorce, alimony, prenuptial agreements, legal separation, annulment, child custody and visitation, property division and valuation, child support and the rights of unmarried cohabitators.	312-263-6477	www.aaml.org

AGENCY	SERVICES	PHONE	WEBSITE
People of Color			
National Black Lesbian & Gay Leadership Forum	The only national organization dedicated to empowering the nation's 2.5 million black lesbian and gay men. Founded in 1988, the Forum has thousands of members nationwide.	510-302-0930	NBLGLF@aol.com (send email for info)
National Latina/o LGBT Organization	An online bilingual Spanish and English resource providing education surrounding issues affecting the lives of Latina/o LGBT people and their families.	202-408-5380	www.llego.org
Substance Use			
Alcoholics Anonymous	Free twelve step recovery and support meetings available nationwide.	212-870-3400 Contact your local office for LGBT sensitive meetings.	www.alcoholics-anonymous.org
Al Anon/Alateen	Services for friends, families and loved ones of alcoholics and recovering alcoholics.	888-4AL-ANON or 888-425-2666	www.al-anon-alateen.org (English and Spanish)
KP Online	Kaiser Permanente member web site which provides information on a variety of health topics, including smoking cessation, substance use and an ongoing LGBT alcohol and drug use discussion group.		www.kaiserpermanente.org
Sober Dykes Hope Page: Women in Recovery for Substance Abuse	Web site resource for women recovering from alcohol and other drugs.		www.soberdykes.org
Transgender Health Care Issues			
International Journal of Transgenderism	Journal that provides many full-text references, studies and academic papers.		www.symposion.com/ijt/
Harry Benjamin International Gender Dysphoria Association (HBIIGDA)	The HBIIGDA provides full text and references regarding the "Standards of Care" for transsexual treatment.	612-625-1500	www.hbigda.org
International Foundation for Gender Education	An educational organization that addresses crossdressing and transgender issues.	781-899-2212	www.ifge.org
Youth			
California Youth Crisis Hotline	Counseling on friends, family, school, pregnancy, rape, violence, depression, suicide, sexual issues or running away.	1-800-843-5200, 24 hours/7 days	www.ccyfc.org
Children of Lesbians and Gays Everywhere (COLAGE)	International and national organization supporting young people with LGBT parents.	415-861-5437	www.colage.org

AGENCY	SERVICES	PHONE	WEBSITE
Lavender Youth Recreation and Information Center Talkline (LYRIC)	Peer support and counseling phone line on coming out, family, friends, dating, sex, school, work, HIV and relationships. All listeners are LGBT or questioning youth ages 13 to 24. The Youth Talkline is 100 percent safe and confidential. You can call and hear the Infoline, a 24-hour recording that lists hotline numbers and local resources.	1-800-246-7743 (CA) 1-800-969-6884 (nationwide)	www.lyric.org
National Gay, Lesbian, Bisexual Youth Hotline	Counseling and support lesbian, gay and bisexual youth.	1-800-347-TEEN 7 pm - 10 pm EST: Fri-Sat	
The Gay, Lesbian and Straight Educational Network (GLSEN)	GLSEN is a national network of youth and adults working to end discrimination against LGBT youth in K-12 schools.	New York (national headquarters) 212-727-0135 Washington, DC Public Policy Office 202-347-7780 San Francisco 415-551-9788	www.glsen.org

Appendix B: Sample Intake Form

Suggested questions for an LGBT-friendly patient history and/or intake form:

1. Gender

- a) Male _____ b) Female _____
c) Transgender (please specify) _____

2. Relationship Status

- a) Single _____ b) Legally married _____ c) Marriage type relationship _____
d) Divorced/Separated _____ e) Widowed _____ f) Other (please specify) _____

3. Gender of Partner(s) (Check all that apply.)

- a) Male _____ b) Female _____
c) Transgender (please specify) _____

4. Sexual Orientation or Sexual Identity

- a) Heterosexual _____ b) Lesbian/gay/homosexual _____
c) Bisexual _____ d) Other (please specify) _____

5. Are you sexually active?

- a) Yes _____ b) No _____

6. If yes, are you sexually active...

- a) with men (a man)? _____ b) with women (a woman)? _____ c) both? _____

7. Is birth control necessary?

- a) Yes _____ b) No, specify why not? _____

8. If yes, do you use birth control?

- a) Yes _____ What type? _____
b) No _____ If no, would you like more information about your options? Yes ___ No ___

9. Do you or your partner(s) have any children?

- a) Yes _____ b) No _____

10. Do any children live in your household?

- a) Yes _____ b) No _____

11. Describe your family structure

(e.g., are the children's mother/father living in the household, are there other parental figures?)

Appendix C: Patient Interview Suggestions

WORKING WITH LESBIAN, GAY, BISEXUAL AND TRANSGENDER PATIENTS

The following tips are general patient interview recommendations.

Avoid making assumptions about sexual orientation. Any one of your patients could identify as gay, lesbian, or bisexual or could have been born a man and now identifies as a woman, or was born a woman and now identifies as a man.

Use gender-neutral language. Instead of asking whether someone has a husband/wife or boyfriend/girlfriend ask, “Do you have a significant partner?”

Focus on sexual behavior, not on sexual orientation. Individuals who do not identify as gay or lesbian may engage in same sex sexual behavior. Asking open questions and taking a thorough sexual history on all of your patients will get you the information you need to provide quality care.

View sexual behavior on a continuum. Instead of asking whether a person is gay or lesbian, ask them to rate their sexual attraction to individuals of the same sex and the opposite sex on a scale of 1-10, with 1 being the lowest level of attraction and 10 being the highest. This will give you a better sense of their likely sexual behavior. When the answer is a 1 or a 10, sexual orientation is clear. When it is in the 5 or 6 range, the provider can discuss possible sexual behavior without labeling the patient as straight or gay.

Use broad and inclusive questions. When taking personal histories, ask questions broad enough to include all the possibilities. For example, “Are you sexually active? With men, women, or both?”

Be aware of your language and facial expressions. Smile, nod, and make eye contact. It takes practice to take a sensitive history and be comfortable in all situations, so practice with someone with whom you are comfortable.

Be non-judgmental and matter-of-fact. Nervousness or discomfort can make the patient feel uncomfortable and can be a barrier to open communication. Ask the questions you need to know. Patients expect their physicians to ask difficult, sometimes sensitive questions in a professional, matter-of-fact manner.

Simply apologize if you use a term or make an assumption that offends. Ask patients how they would like to be referred to or how they would like you to refer to their partners.

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Additional Resources

For additional resources, KP staff may access the following Kaiser Permanente website: <diversity.kp.org>. All others should contact National Diversity at Kaiser Permanente, (510) 271-6663.

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