AN OVERVIEW OF GENDER AND SEXUALITY MINORITY (GSM) HEALTH DISPARITIES FOR HEALTHCARE PROFESSIONALS

JULIANNA WISNIEWSKI, M.P.H.

OBJECTIVES

- Define and identify the differences between sexual orientation, sex assigned at birth, gender identity, and gender expression.
- Identify and discuss GSM health disparities using the Minority Stress Framework.
- Define and identify the differences between cultural competency and cultural humility.
- Discuss some practices that can be implemented in patient care settings to better serve GSM populations, including trauma-informed care.

Sexual Orientation:

Who one is attracted to sexually, romantically, and/or emotionally.

Sex Assigned at Birth:

Designation made by medical professional at birth; male, female, or intersex.

Gender Identity:

One's own inner understanding, sense, and experience of their gender; man, woman, transgender, etc.

Gender Expression:

External gender-associated presentation; appearance, behaviors, pronouns, etc.

While individuals with intersecting identities exist, these four attributes do not explicitly inform one another.

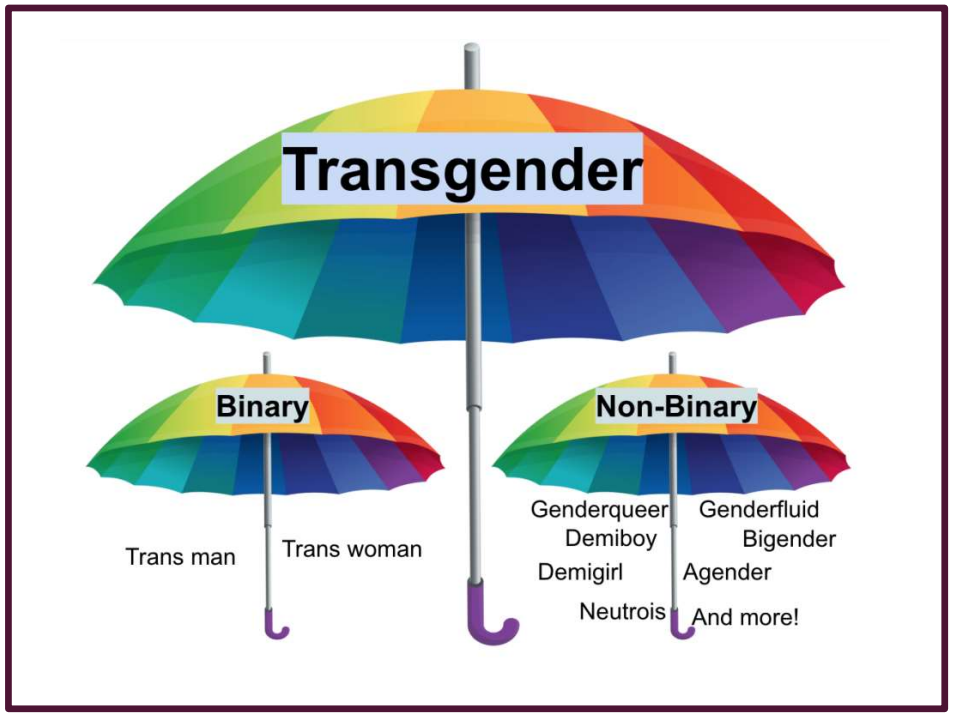
SEXUAL MINORITY IDENTITIES

- Lesbian: Women who are attracted to women.
- Gay: Men who are attracted to men. Sometimes used as a blanket term for multiple sexual minority identities.
- Bisexual: Someone who is attracted to two or more genders.
- Queer: A blanket term used to identify oneself as someone as not heterosexual and/or not cisgendered.
    - May be offensive, particularly elder LGBTQ+, due to being a term historically used to abuse LGBTQ+.
        - Reclaimed by many LGBTQ+ individuals.

What about the "+"?

- Asexual: Someone who does not experience sexual attraction; may experience romantic attraction.
- Demisexual: Someone who does not experience sexual attraction until a close emotional bond has been formed.
- Pansexual: Someone who is attracted to all genders.
- And many more…

GENDER MINORITY IDENTITIES



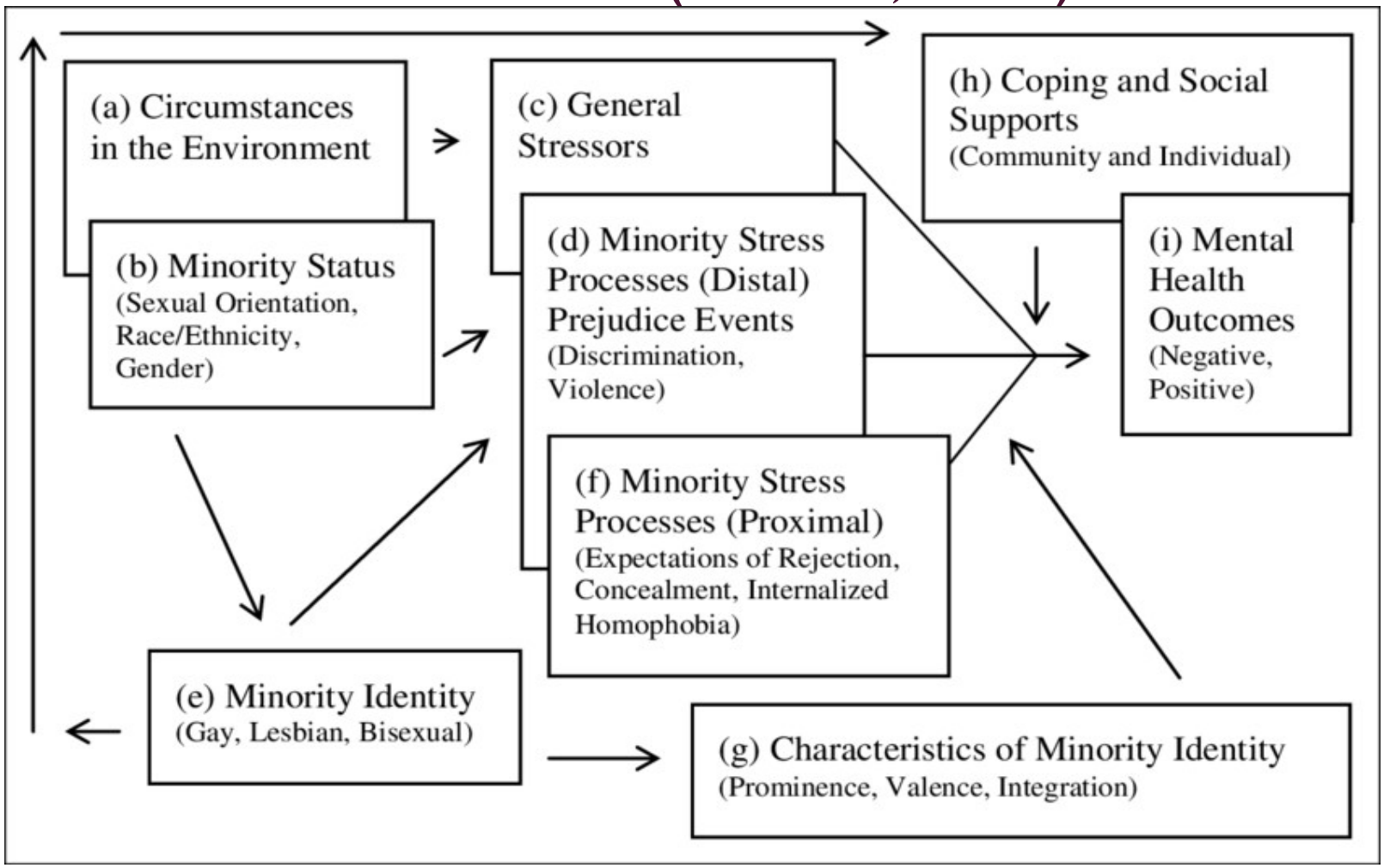
- Transgender: An Individual who has a gender identity different from the sex they were assigned to at birth.
  - Binary: Man or Woman.
  - Non-binary: Not explicitly man or woman.
  - Pronouns?
    - There are many.
    - Ask how the patient would like to be addressed.
      - Be mindful of the environment. Not all environments may feel or be safe for someone to disclose.
    - Never assume pronouns based on gender identity or gender expression.

HOW IDENTITY SHAPES HEALTH

- Impact on health risks, health behaviors, health beliefs, and protective factors
- Impact on accessing healthcare and healthcare experiences
  - Particularly, appropriate and comprehensive healthcare

- Minority Stress: Framework built on the, "underlying assumptions have been that minority stress is
  - (a) unique—that is, minority stress is additive to general stressors that are experienced by all people, and therefore, stigmatized people are required an adaptation effort above that required of similar others who are not stigmatized;
  - (b) chronic—that is, minority stress is related to relatively stable underlying social and cultural structures; and
  - (c) socially based—that is, it stems from social processes, institutions, and structures beyond the individual rather than individual events or conditions that characterize general stressors or biological, genetic, or other nonsocial characteristics of the person or the group" (Meyer, 2003).

MINORITY STRESS MODEL (MEYER, 2003)



45%

of LGBTQ+ youth seriously considered suicide in the past year.

Trevor Project's 2022 *National Survey on LGBTQ Youth Mental Health*

1 in **5**

transgender youth attempted suicide in the past year.

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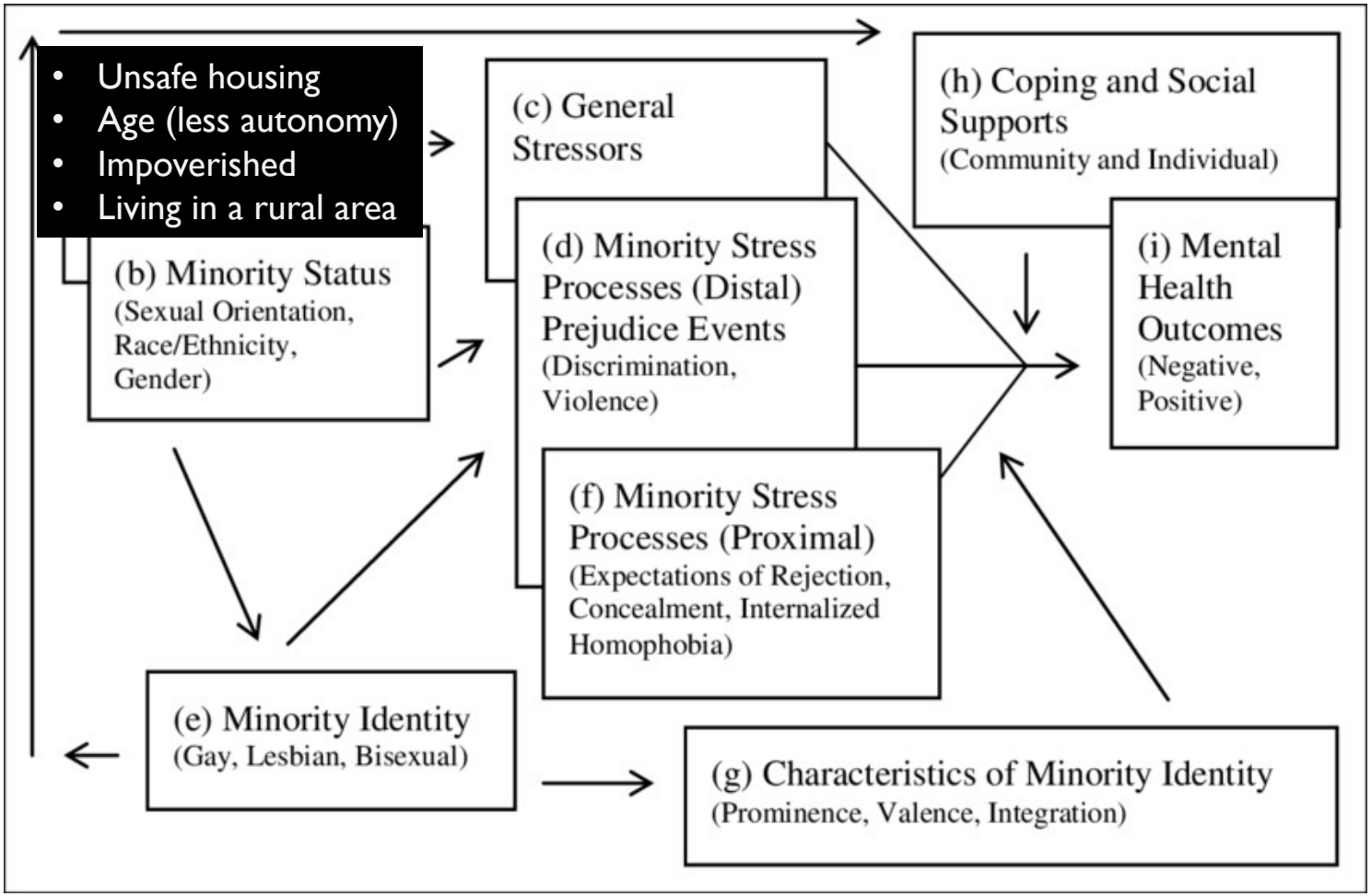
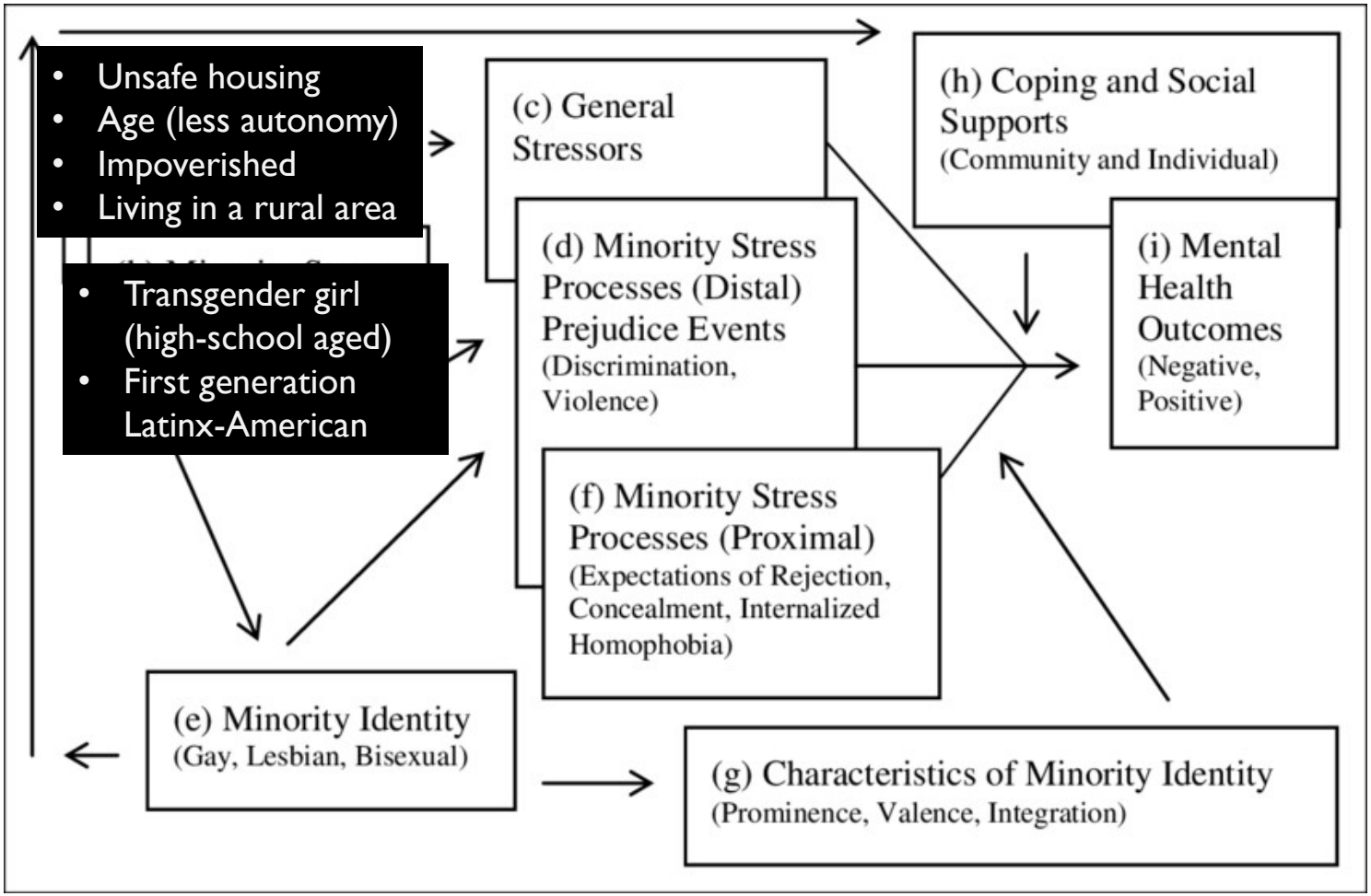

• Unsafe housing
• Age (less autonomy)
• Impoverished
• Living in a rural area
(b) Minority Status
(Sexual Orientation, Race/Ethnicity, Gender)
(c) General Stressors
(d) Minority Stress Processes (Distal) Prejudice Events
(Discrimination, Violence)
(f) Minority Stress Processes (Proximal)
(Expectations of Rejection, Concealment, Internalized Homophobia)
(e) Minority Identity
(Gay, Lesbian, Bisexual)
(g) Characteristics of Minority Identity
(Prominence, Valence, Integration)
(h) Coping and Social Supports
(Community and Individual)
(i) Mental Health Outcomes
(Negative, Positive)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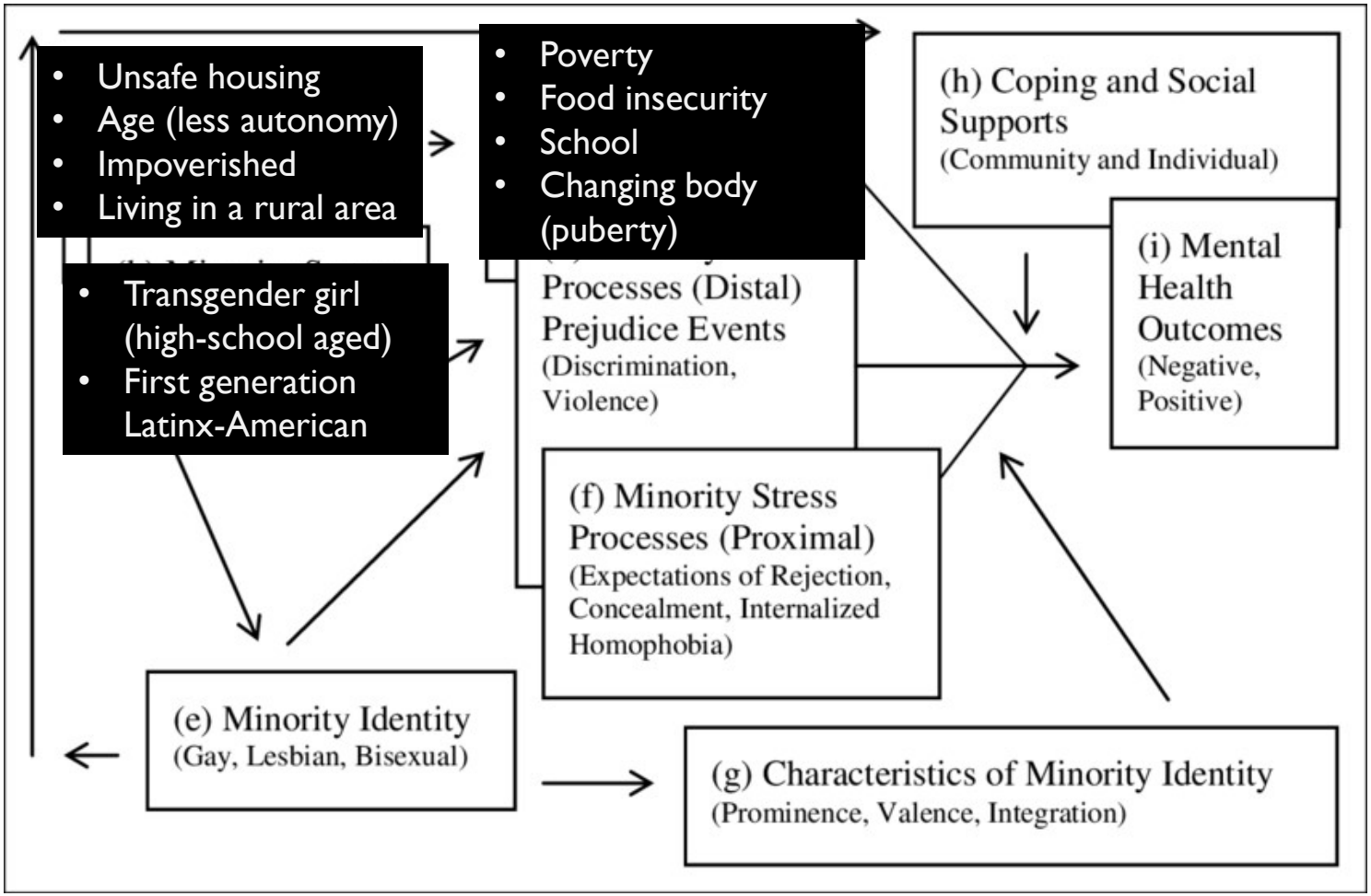
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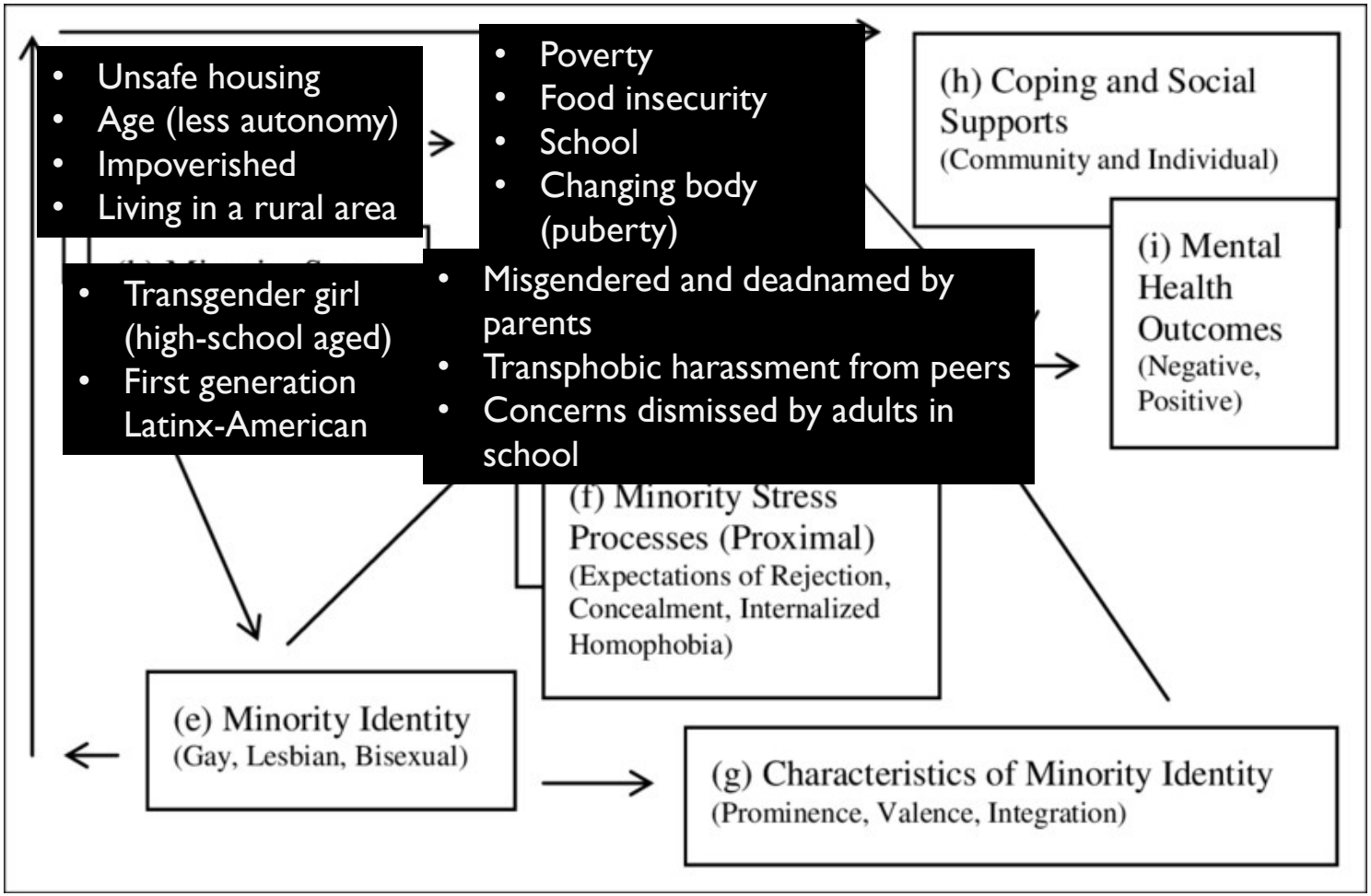
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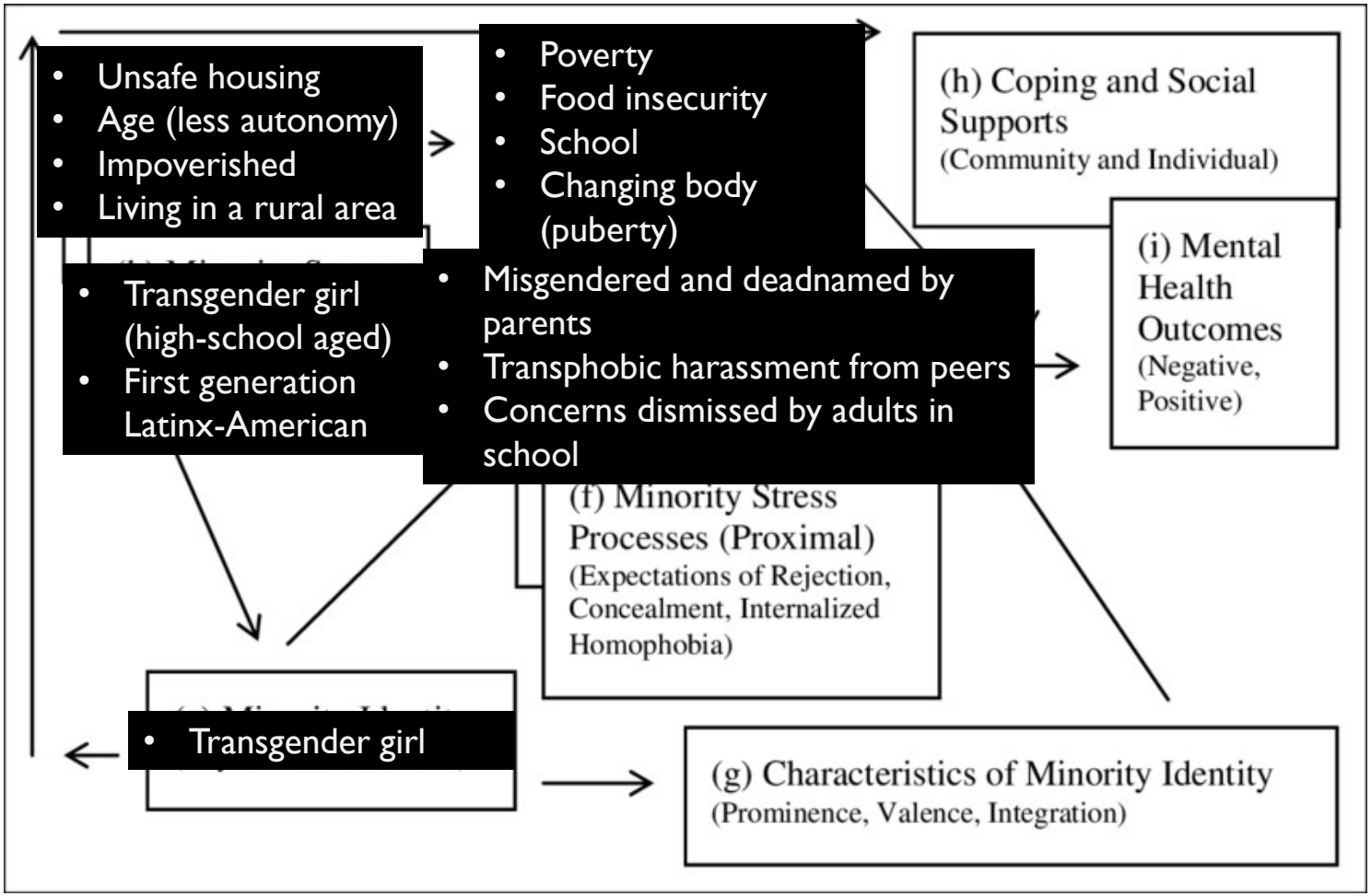
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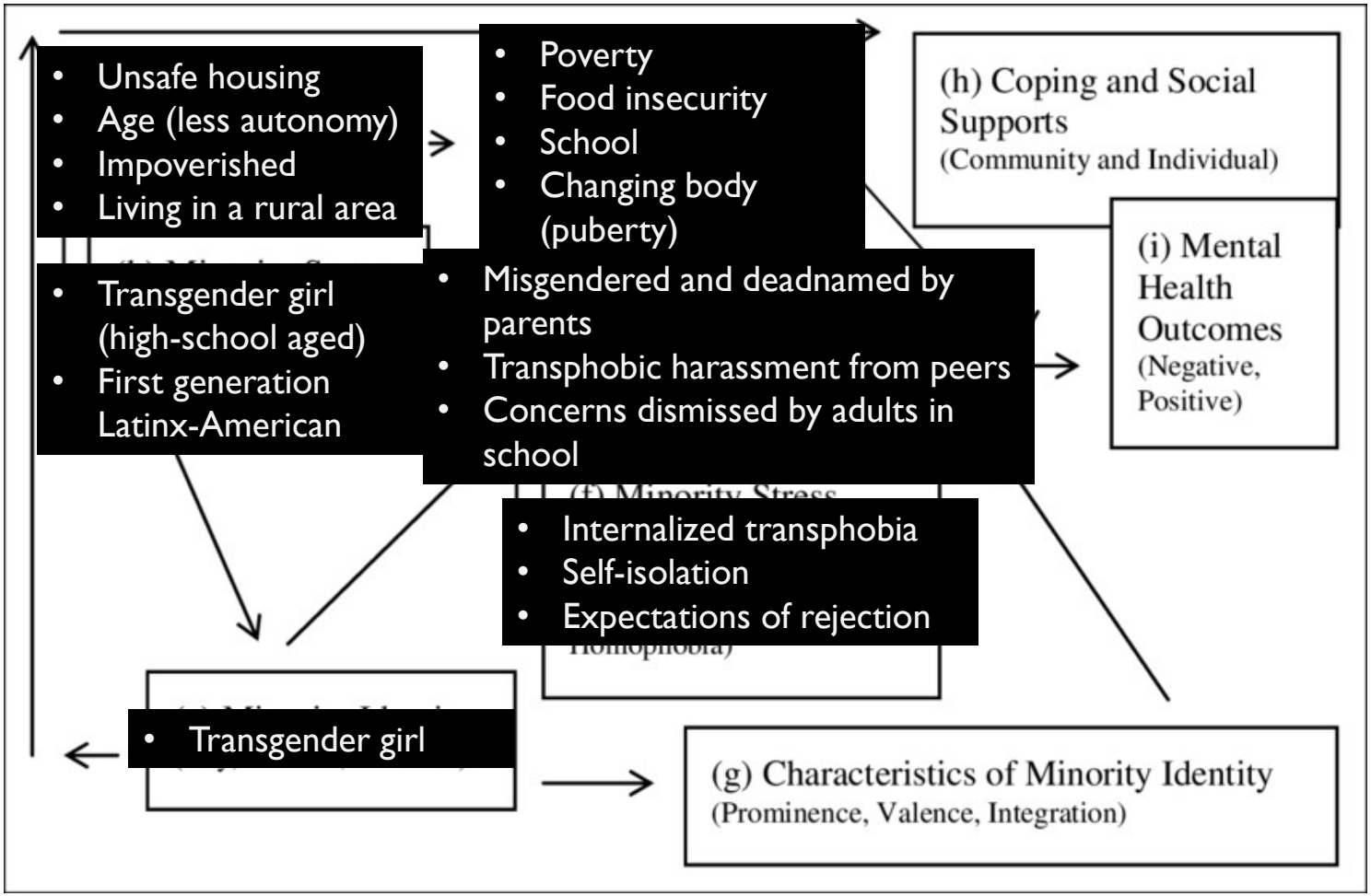
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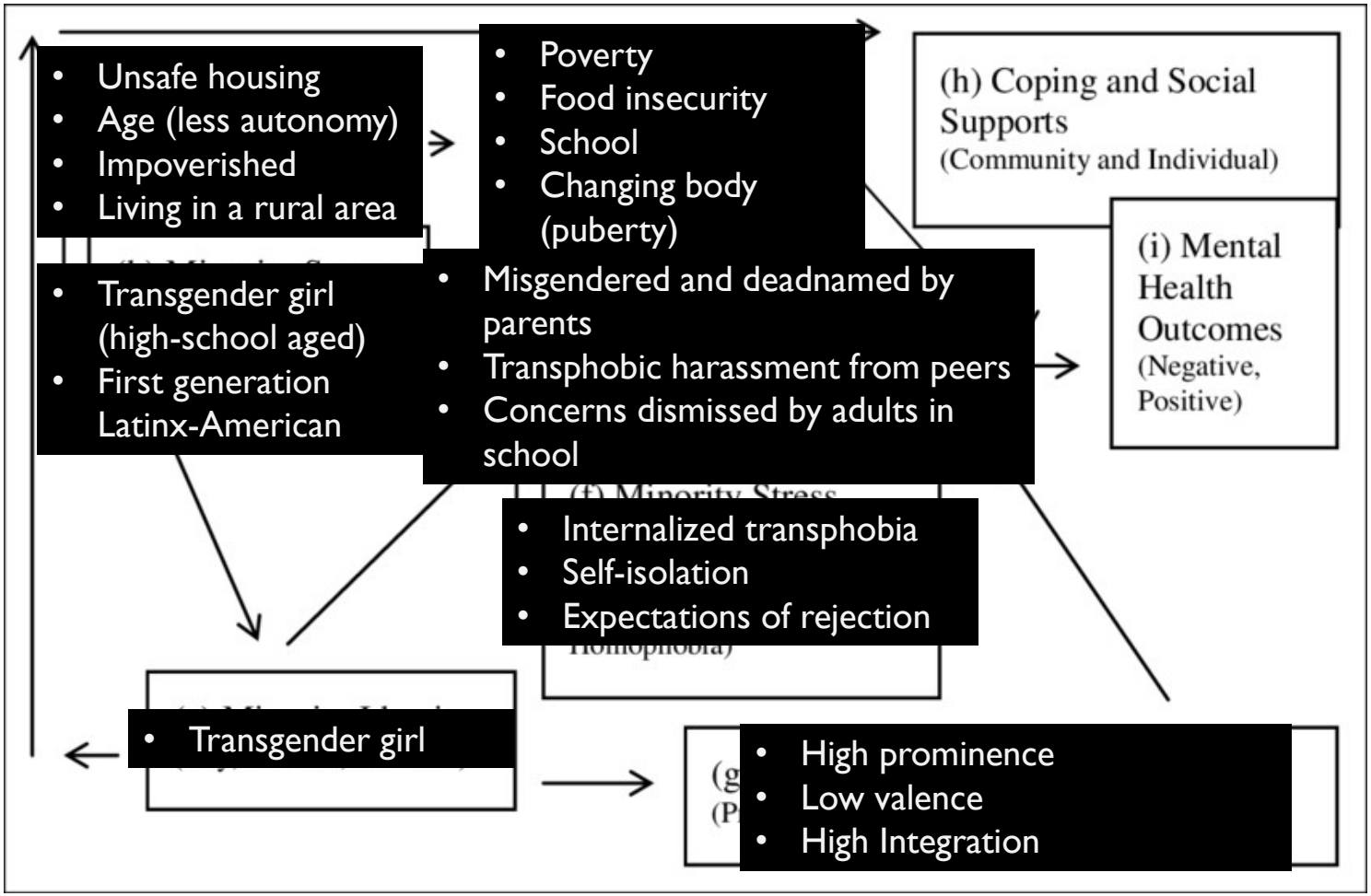
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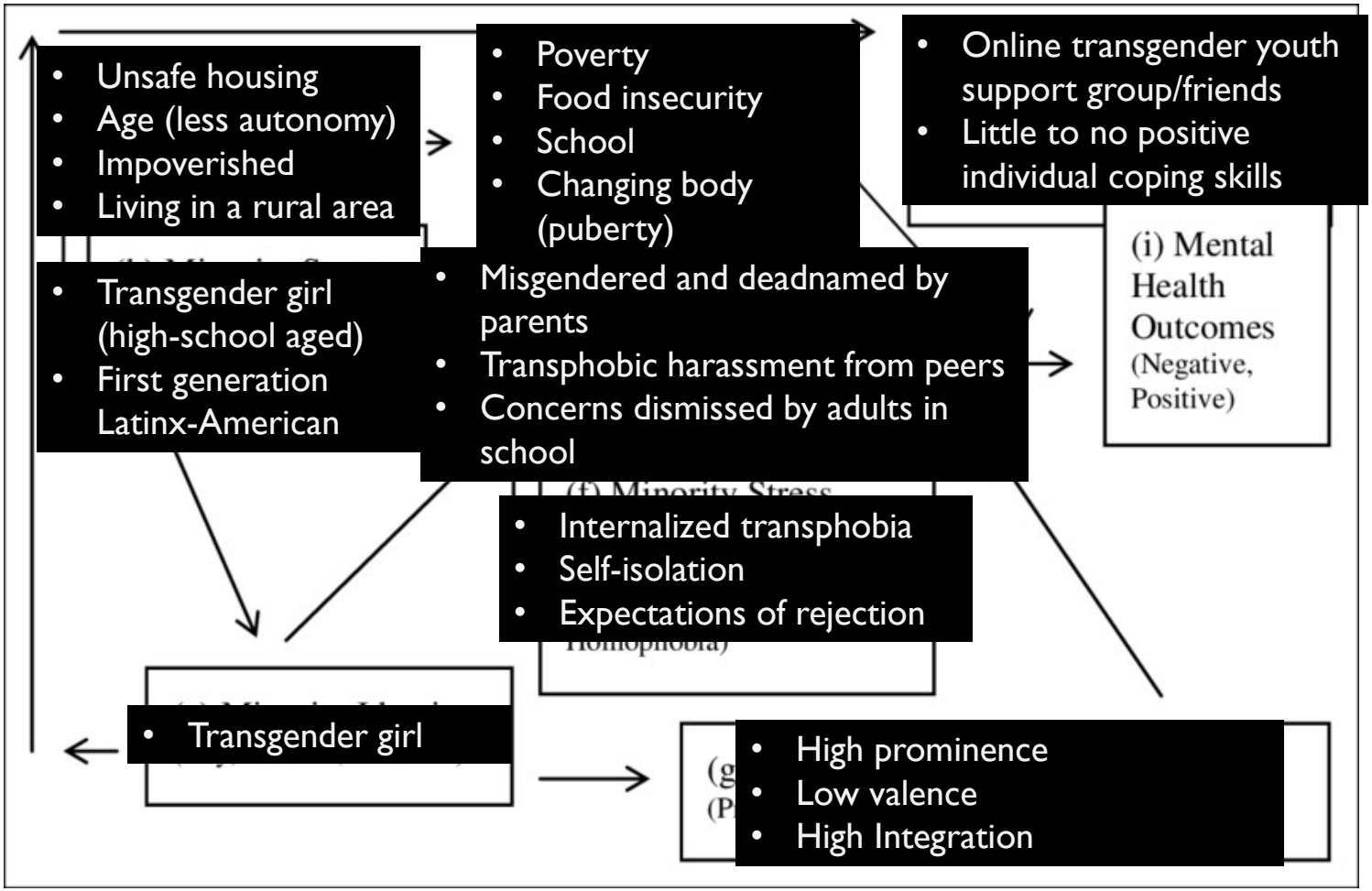
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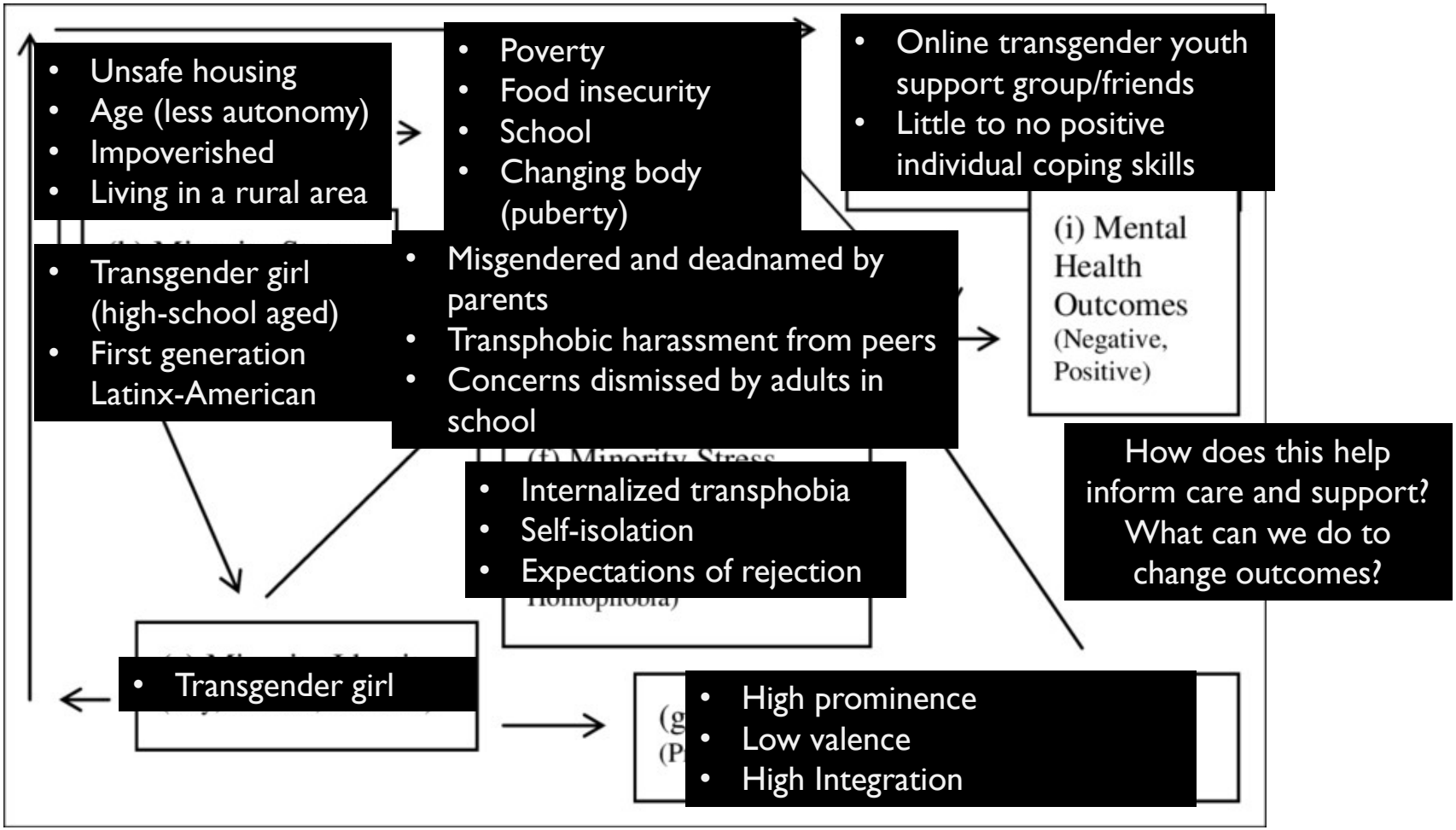
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How does this help inform care and support? What can we do to change outcomes?
• Transgender girl
• High prominence
• Low valence
• High Integration

CULTURAL COMPETENCY

Definition: "Cultural and linguistic competence is a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals that enables effective work in cross-cultural situations" (Cross et al., 1989).

Benefits

- Aims to increase healthcare provider's knowledge on different social and cultural groups.
- Can inform provider on disease incidence and prevalence (Beach et al., 2005).
    - Is the training on actual disease burden or attitudes and skills?

Disadvantages

- Culture is ever-changing and can be shaped by different interactions and experiences with the world.
- Impossible to be "competent" in every culture.
- Essentializing the patient can lead to genuine illness or symptoms being attributed to beliefs held by providers about someone's culture instead of actual cause (Causadias et al., 2018; Shepherd, 2019).
- Cultural competency trainings given in the US assume the consumer is a white non-hispanic, cis-gendered male, heterosexual, and English speaking (Patallo, 2019).
- Furthers "othering".

CULTURAL HUMILITY

Definition: "Cultural humility means admitting that one does not know and is willing to learn from patients about their experiences, while being aware of one's own embeddedness in culture(s) (Lekas et al., 2020)".

Advantages:

- Establishes a power-balanced relationship between provider and patient (Agner, 2020).
  - Empowering and trust-building.
- Encourages provider to engage in self-questioning regarding their own bias and assumptions, while immersing themselves into the patient's point of view through active listening (Chang et al., 2010).
  - True person-centered care is more likely to be provided.
- **Extremely helpful and valuable when little research is conducted on population and when there are many within-population differences.**
  - **Such is the case with the LGBTQ+ community.**

LGBTQ+ COMMUNITIES & TRAUMA

- Higher risk for PTSD/greater prevalence than general population (Livingston et al., 2020; Goldstein et al., 2016).
  - Up to 48% LGB individuals report meeting PTSD criteria.
  - 42% of transgender and gender non-conforming individuals report meeting PTSD criteria.
- Almost 4x more likely to experience violent assault (Flores et al., 2020).
- More experiences of child abuse, as well as sexual and physical assault (Balsam et al., 2005).
- Stressor due to minority identity (Meyer, 2003).
  - Discrimination, violence, microaggressions, identity concealment, expectations of rejection, internalized homophobia/transphobia.
- 2015's *Transgender Survey* conducted by the National Center for Transgender Equality states 48% of participants report interpersonal discrimination due to their gender identity in the past year.
- History of mental healthcare
  - Homosexuality as psychiatric diagnosis until 1973.
  - Gender affirming care gatekept by meeting DSM-5 gender dysphoria diagnosis criteria.
    - Difficulty accessing healthcare.

TRAUMA-INFORMED CARE

"Trauma-informed care acknowledges that understanding a patient's life experiences is key to potentially improving engagement and outcomes while lowering unnecessary utilization (Center for Healthcare Strategies, 2018)".

- Realize the widespread impact of trauma and understand pathways for recovery
- Recognize signs and symptoms of trauma
- Integrate knowledge about trauma into policies, procedures, and practices
- **Actively avoid re-traumatization**

(Menschner and Maul, 2016)

- 10 Key Ingredients for Trauma-Informed Care

CONTACT

Julianna Wisniewski, M.P.H. (She/Her)

TB Program

Division of HIV, STD, & TB Services

New Jersey Department of Health

Julianna.Wisniewski@doh.nj.gov

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