The Impact of Sexual and Gender Microaggressions on LGBT Accessibility to Healthcare

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Objectives

1) Etiology of Microaggressions
2) Terminology
3) Social Ecologies of Identity
4) Chilling Effect of Microaggressions
5) Barriers to Accessibility of Healthcare
6) What Providers Can Do
Sexual or Gender Microaggressions often occur with the use of assumptive or heterosexist terminology: Hence necessity to review some basic terminology.
Terminology:

**Microaggression:** Whether intentional or unintentional - verbal, nonverbal, behavioral, or environmental indignities that communicate hostile, derogatory, or negative connotations about a particular culture. Term that originated in 1970’s regarding racial microaggressions.

**Sexual or Gender Microaggression:** is a subtle negative attitude conveying that one’s sexual or gender identity is less-valuable than dominant culture’s defining identities resulting in missed screening, late interventions, and avoidance of the healthcare system. Using improper terminology is one form of a sexual or gender microaggression.
Terminology:

Heterosexism: is the assumption that all people are or should be heterosexual, which excludes the needs, concerns, and life experiences of LGBT individuals.

Homonegativity: as an alternative to using the term homophobia, which implies an “irrational fear”, homonegativity is used to describe negative attitudes towards homosexuality or homosexual people.

Heteronormative: a concept of natural or normal roles that differentiates people into two complementary genders (man or woman) and holds heterosexuality as the normal sexual orientation.
Terminology:

**LGBT:** From a clinical perspective acknowledging the acronym tells your client that you recognize a spectrum of sexual expression, and more importantly, that you recognize the unique needs, concerns and issues specific to those identities. The Guild uses the Term LGBT as an All-Inclusive term for these identities.

**Sexual and Gender Minorities:** is used as an encompassing term to identify the social disparity of non-heterosexual identities that conform to dominant society. Similar to some disabilities, LGBT identities are often considered an invisible minority.
Terminology:

**Sexual Orientation:** Affectional or loving attraction towards another person, but even that excludes asexuality.

**Gender Identity:** one’s basic sense of how they identify in terms of gender expression (appearance or demeanor), gender role conformity (adhering to masculine or feminine constructs), or gender dysphoria (disconnection with one’s sex assigned at birth).

(NOTE: Gender identity does not determine sexual orientation & gender non-conformity is frequently more socially provoking than sexual orientation
Assumptions:

Sexual Behavior (Expression) is different that sexual orientation: may not align with self-perceived sexual orientation (MSM, WSW, down low, etc)

Gender Identity is different than sexual identity: (e.g. some transgender individuals who were ascribed an identity of “homosexual” (prior to discovering their gender identity) are in reality “heterosexual”

Gender Presentation: is oftentimes defined from socially-codified gender-role expectations (more than adornment or aesthetic)
Terminology:

**Queer:** can be thought of as a broader movement that challenges concepts of normalcy and challenges conventional thinking. Queer culture, in this context, embraces difference as uniqueness as opposed to difference as abnormality. (Note: a historically stigmatized word that is being reclaimed)

* Other variations: Gender Queer, Queer Theory
Terminology:

**Transgender:** is an all-encompassing term used to identify a wide variety of gender-variant identities and expressions. Also “trans-people”, “trans-folks”, “trans-identified”

* Specifiers: MTF (male-to-female), FTM (female-to-male)
Problematic Terminology:

**Gay/Straight:** “in proper order or condition, conventional or respectable” “live an honest life”, i.e. it has right or wrong connotations. Still used for efficiency-sake, however.

**Homo/Heterosexual:** denigrating term that emphasizes a sexual act versus identity. It is also tied to the historic pathologization of LGBT identities (until 1973 in the DSM).
Problematic Terminology:

Transsexual/Hermaphrodite/Transvestite: generally post-operative/Intersex is more accurate, historically denigrating/focused more on cross-dressing, autogynephilia. Unless you know specifically, Transgender is a broader more inclusive term.

Transgendered: (unless used by the individual to describe themselves) implies that something has been done to the person (follows in line with: neutered, castrated, etc.)
Social Ecology of Sexual and Gender Identities
Our Ecological Layers of Personal Identity

**LGBTQQAIA12**

- **LGBTQQAIA12**
- **MFP MFQ HHQ THHB EVF GEP FFP**
- **BFQA MPO FQM HHQ THHB EVF GEP**
- **MPPA MPOF FTMSC HTQ CMHB AVF RGE**
- **APM APM MPOF FTHQ COJHB CMP HES**
- **FEF NAPM MCOF HQT KJHB MPC HES**
- **TBKF NAPM MCOF HQT KJHB MPC HES**

- **Sexual Orientation**
- **Gender Identity**
- **Gender Presentation**
- **Relationship Expression**
- **Relationship Dynamics**
- **Orientation Fluidity**
- **Sexual Expressivity**
Responding to: “Why is there a need to focus on LGBT issues?” Or “I don’t work with LGBT People”...

- One undeniable fact about “sexual variability” is that the odds dictate nearly everyone has some type of personal relationship with someone who is LGBT.

- That person may be “out”, “hiding”, “mindfully unaware”, “still developing”... or friends/family of

- Invisibility can lead to increased exposure to sexual or gender microaggressions and increased misunderstanding
Chilling Effect of Microaggressions Impairs Accessibility to Healthcare
The Chilling Effect of Sexual Microaggressions

“Acknowledgement of the existence of sexual orientation microaggressions and taking the risk to challenge microaggressions can set a therapeutic tone to foster enhanced conversations regarding power, privilege, and sexuality, likely improving the quality of the therapeutic relationship.”
Sexual Microaggressions

Theme 1: Assumption that sexual orientation is the cause of all presenting issues.

Theme 2: Avoidance and minimizing of sexual orientation.

Theme 3: Attempts to over identify with LGBQ clients.

Theme 4: Making stereotypical assumptions about LGBQ Clients.
Sexual Microaggressions

Theme 5: Expressions of hetero-normative bias.

Theme 6: Assumption that LGBTQ individuals need psychotherapeutic treatment.

Theme 7: Warnings about the dangers of identifying as LGBQ.
Case Studies

- 32 year old female, disclosed to provider her immense pain surrounding her breakup with her first girlfriend she’s ever experienced, licensed therapist moralized “this is what you get”

- 29 year old male, grew up in rural KS, disclosed to provider he thought he might be gay, licensed therapist encouraged the client to “pray away the gay”

- 15 year old male, rural Iowa, identified as gay since 13 years old, wanted an ally to help him deal with harassment at school and social isolation, licensed therapist counter-transferred that his own brother was just diagnosed with AIDS and that the client too would live a life of disease and isolation
Barriers to Accessibility of Healthcare
Systems Erasure of LGBT Identities Impacts Health Care of LGBT Individuals

The processes of erasure in information production and dissemination and in institutional protocols, practices, and policies create a system that produces further social marginalization of LGBT people, which creates inequities in health... (JANA, 2009)
Reasons for Not Disclosing to Healthcare Providers

- Felt it wasn’t relevant (although relevancy is not always transparent)

- Fear of negative judgment, awkwardness with practitioner, lack of understanding, humiliation

- Fear of loss of confidentiality and that physician will report to others – i.e. insurance, staff, other HIPPA authorized reviewers

- Feared poor treatment, stereotyping, biased-assumptions, or discrimination
Reasons for Wanting to Come Out to Healthcare Providers

- Would like to be asked but do not want to have to bring it up themselves
- Would like to be seen as a whole person as they are
- Increase their own comfort levels and understanding regarding their identity
- To increase chances of proper diagnosis, relevant information provided, and appropriate referrals
- So providers will be sensitive to the issues they are facing
- Important to overall emotional and mental wellness
Challenges Faced by LGBT Clients

- Less likely to disclose to healthcare providers because of biased assumptions and poor treatment:
  - equating sexuality to a sex act versus identity
  - not receiving safer sex info for both male/female partners
  - LGBT as being viewed as part of their health problem (placing blame)
  - Moralizing or judgment surrounding identities
Misunderstanding of the Dynamics of Particular Identities Leads to Avoidance

- “The most awkward times have been with regular doctors at hospitals or walk-in clinics, with feelings of judgment, or real awkwardness or voyeurism from male doctors . . . stupid jokes like ‘the more the merrier.’”

- “I’ve given up therapy basically. It’s tough to find somebody who gets the bi thing. I’ve had to deal repeatedly with biphobic remarks.”
Affects on Accessibility to Healthcare

“Lack of safety to disclose within health care contributes to health care avoidance and poor care-seeking behaviors” (Schilder, et al., 1999).
Affects on Accessibility to Healthcare

- Previous negative or inadequate experiences with healthcare providers makes the client more skeptical of returning to the healthcare system.

- Assumption that everyone in the practice is straight creates a non-welcome or unsafe feeling towards the environment.

- Not being asked about sexual identity may come across unwelcoming and therefore hostile.
Affects on Accessibility to Healthcare

- Even when providers do not demonstrate negative attitudes, they may still be lacking the education needed to work well with LGBT clients.

- Lack of research on trans, bi and LG issues and lack of intervention targeted for populations remains a significant barrier.

- Institutionalized heterosexism, transphobia and biphobia remains a barrier to care.

- Diminishment or exclusion of sexual minorities within sexual minorities and minorities within sexual minorities.
Examples of Specific Challenges

- Sexual fluidity is often off the radar for most providers, therefore a woman who is perceived by her provider as being lesbian may feel uncomfortable asking for birth control or safer sex information for sex with men. LB women may still need or want information about fertility, pregnancy, infertility, abortion, etc.

- Barriers to substance abuse treatment services for Trans population often includes discrimination, provider hostility and insensitivity, strict binary gender (male/female) segregation within programs, and lack of acceptance in gender-appropriate recovery groups.
Affects on Accessibility to Healthcare

- Lesbians, gays, and bisexuals (LGBT) are at increased risk for alcohol use during young adulthood.

- Current intervention is not geared towards unique problems faced by LGBT clients, hence a lack of substance abuse prevention programming geared towards specific needs of LGBT clients.
How Lack of Provider’s Knowledge Impacts LGBT Healthcare

- Not only increased risk of STI, but also increased risks of cancers due to STI’s: oral/anal HPV, Hepatitis, Syphilis
- Screening/intervention for elevated risks of suicide, depression, anxiety, substance abuse, tobacco use
- Eating disorders among LGBT are higher than heterosexual females, who are generally considered highest risk
- Transgender, Bisexual and LGBT minorities elevated risks for harassment, IPV, STI’s, suicide, substance, tobacco...
How do we determine if LGBT disclosure is pertinent? Four Specific Case Studies:

- 21 year old male, gender conforming, went to student health center with a sore throat

- 23 yr old male with STI discharge disclosed having sex with men, “this is what you get”

- 29 yr old gay male, never occurred to get HPV anal pap

- 35 yr old gay male, colonoscopy due to perceived intestinal blockage, at LDS hospital in Utah by a GI practitioner who’s biography focused on the Mormon church, feared disclosing identity prior to procedure
What Providers Can Do
The more “different” clinicians perceive themselves to be from their patients (and vice versa), the more likely it is that either or both parties will feel uncomfortable during clinical interactions.
Specific Provider Changes that Could Increase LGBT Accessibility to Healthcare

- Providers just need a basic understanding of the layers of sexual and gender identities – “know that we exist, that we are real, legitimate, and did not chose our path that lead to this disparity”

- How LGBT (sexual and gender) identities are not just about sex or gender roles

- That identities are important even when the individual is not in a relationship

- That each identity within the LGBT spectrum has unique health issues different from one another
Specific Provider Changes That Could Increase LGBT Accessibility to Healthcare

- Visible inclusion in all public health services, with programs focused on specific needs to LGBT clients
- Validate your client’s identities, viewpoints and concerns
- Specific education for providers and staff
- Healthcare providers serving as advocates for community partnerships that will enhance a reconnection of LGBT to society, communities and spiritual communities
- Specific outreach targeting “at-risk” LGBT folks: LGBT youth, LGBT elderly & aging, trans-identified.
APA Guidelines on Multicultural Competency:

- Self-Aware of one’s own cultural worldview and biases

- Respect towards cultural differences and cultural plurality

- Developing Skills in addressing and negotiating cultural differences in a respectful and dignified manner.
Assessing Your Office for Care of Lesbian, Gay, Bisexual, and Transgender Patients

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Practitioners act as guide, protector, and confidant to their patients’ most vulnerable health care concerns. Arguably, one of the most important times to consider the dynamics of a health care relationship is when treating culturally diverse populations such as lesbian, gay, bisexual, and transgender (LGBT) patients. This article outlines several recommendations for how physicians can begin the process of assessing their office and practice habits for supportive care of LGBT patients, including evaluating your belief systems, understanding risk factors associated with LGBT patients, modifying medical intake forms and interview practices, reviewing staff training and office procedures, and becoming familiar with available tools and resources. With several minor but effective changes, you can offer your LGBT patients a practitioner who is (1) knowledgeable of relevant LGBT health care and basic human sexuality, (2) mindful and sensitive to the needs of diverse sexual and gender identities, and (3) capable of making interpersonal and office-related adjustments for the purpose of providing them with the best possible medical care. Key words: cultural competence, LGBT care, vulnerable populations

- Gender neutral terminology. If you are unsure about a person’s gender identity, or how they wish to be addressed, ask politely for clarification.
- Staff training
- Non-Discrimination policies
- Brochures, Posters, Lobby materials that are LGBT friendly
- Advocacy with local LGBT organizations
Why it is Important to Recognize the Complexity of Sexual/Gender Expressions

- Perhaps rethink how “we think” (difference as uniqueness rather than abnormality)

**Our Ecological Layers of Personal Identity**

- Sexual Orientation
- Gender Identity
- Gender Presentation
- Relationship Expression
- Relationship Dynamics
- Orientation Fluidity
- Sexual Expressivity

**Systems Erasure of LGBT Identities Impacts Health Care of LGBT Individuals**

The processes of erasure in information production and dissemination and in institutional protocols, practices, and policies create a system that produces further social marginalization of LGBT people. Social marginalization creates inequities in health... (JANA, 2009)
Perhaps What the Queer Movement Is Trying to Teach Us is:

That we as humans do not need to possess pre-fabricated ideas of what gender identity or sexual expressivity “should look like or behave like,” and instead, simply nurture and appreciate these variations of identities as part of a broad spectrum of human expression... free from judgment.