

# Health and Health Care of Sexual and Gender Minorities

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## Abstract

Research on the social dimensions of health and health care among sexual and gender minorities (SGMs) has grown rapidly in the last two decades. However, a comprehensive review of the extant interdisciplinary scholarship on SGM health has yet to be written. In response, we offer a synthesis of recent scholarship. We discuss major empirical findings and theoretical implications of health care utilization, barriers to care, health behaviors, and health outcomes, which demonstrate how SGMs continue to experience structural- and interactional-level inequalities across health and medicine. Within this synthesis, we also consider the conceptual and methodological limitations that continue to beleaguer the field and offer suggestions for several promising directions for future research and theory building. SGM health bridges the scholarly interests in social and health sciences and contributes to broader sociological concerns regarding the persistence of sexuality- and gender-based inequalities.

## Keywords

health care barriers, health disparities, LGBTQ, minority stress, stigma

Research on the health and health care experiences of sexual and gender minorities (SGMs), including but not limited to lesbian, gay, bisexual, transgender, queer, and intersex people, has been productive since the early 2000s. Although the scholarship has been interdisciplinary, with major contributions from psychology, public health, sociology, and social work, few have offered a synthesized review across disciplines. Despite sociology's influence on the theoretical development and empirical investigation of this field, its contribution has not been widely acknowledged within or outside sociology.

Sociology is renowned for its research on the consequences of gender and sexuality in interactions (e.g., Schilt and Lagos 2017; West and Zimmerman 1987) and institutions such as education (e.g., Mollborn and Everett 2015; Pascoe 2011) or family (e.g., Acosta 2013; Meadow 2018; Pfeffer 2017). But its scholarship on *how* sexual and gender categories matter in structuring interactions and outcomes in medicine and health has received less attention. Although theoretical insights from the sociology of sexuality and gender such as social constructionism and sociological queer theory (Gamson and Moon 2004) have not yet been elaborated to offer

compelling explanations for the health experiences of SGMs, other sociological theories have provided useful frameworks for understanding SGM health. The continued lack of cross-disciplinary conversations—between theorists of sexuality and gender and health scholars and between health scholars in sociology and other disciplines—leaves gaps in the collective knowledge of SGM health, duplicates research efforts, and hinders theoretical and methodological advancement across the social and health sciences. This review aims to bridge the current understanding of SGM health across disciplines, highlight major areas sociologists have made advancements in and could contribute more, and introduce health scholars to basic premises in sociological theories that elucidate how sexuality and gender structure health.

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SGMs are not a monolithic group (see Appendix A for definitions of key sexuality and gender terms used in this review). Several decades of work has documented how there is a diverse range of identities, experiences, and structural forces that shape their experiences. However, we combine sexual and gender minorities within one review because historical and contemporary social norms, legal practices, and medical guidelines have shaped their health care experiences in paralleled ways. As we discuss later, both sexual and gender minority categories have been labeled as an illness, which enables the medical establishment and society at large to pathologize, stigmatize, and discriminate against SGMs and causes harm to their health. Policies regarding nondiscrimination in health care based on gender identity and sexual orientation continue to shift at the U.S. state and federal levels, leaving SGMs' access to health care uncertain (Mallory 2020).

Although gender and sexuality are distinct, they are socially constructed, fluid and dynamic (Hart et al. 2019), and often mutually constituted (Pascoe 2011). Feminine men, for example, are often read in social life as gay men. These assumptions, based in gendered expression and mapped onto presumptions about people's sexuality, may affect day-to-day interactions at school, work, health care, and other domains that accumulate to create durable health inequalities. As we document in this review, there are many more instances in the existing SGM health scholarship that demonstrate distinct but overlapping experiences among SGMs.

We organize this review into two broad themes: health care and health behaviors and outcomes. Within each theme, we discuss major theoretical paradigms and empirical findings. We conclude each theme by addressing limitations in the current research and identifying promising areas for future research. Although this review attempts to be comprehensive, we recognize that it is far from exhaustive in terms of discussed topics and findings. Because most studies covered in this review were conducted in the United States in the past two decades, it misses diverse voices from societies with different gender, sexuality, and health systems and historical insights from older research. However, where pertinent, we refer readers to scholarship that addresses SGM health beyond the United States. We also highlight across the sections how intersectional forms of oppression combine to shape the health experiences of SGMs. We anticipate that this concise review will encourage more efforts in SGM

health research and form a stronger connection across disciplines.

## HEALTH CARE

Sexuality and gender are omnipresent, meaningful, and meaning-making categories in health care. Rarely explicitly noticed, gender and sexuality fortify institutional barriers and restrictive cultural norms (Ridgeway and Correll 2004) while foregrounding social interaction (West and Zimmerman 1987). Health care providers may unwittingly interact with SGMs with bias as they draw on cultural scripts to guide their behaviors and interpret situations and individuals who are unfamiliar in their routine clinical practices (Shuster 2021). Thus, clinical encounters that are anchored in cis- and hetero-normative understandings of "proper" gender and sexual behavior and expression can have lasting negative consequences in the diagnosis and prognosis of illness, health care utilization patterns, and barriers to care for SGMs.

In what follows, we first examine how sexuality and gender categories become medicalized through labeling processes. Then, we turn our attention to how stigma shapes health care utilization patterns before concluding the section by synthesizing the common barriers to care that SGMs experience.

### *Creating Categories and Labels*

Labeling processes inform a lively tradition in the social study of health and offer tools for analyzing the historical and social conditions that shape how illness or disease is defined and acted upon by social actors (Brown 1995). A lasting concern for many SGM health scholars is how sexual and gender categories become recognized and labeled as a medical problem: a process referred to as *medicalization* (Conrad and Schneider 2010). Medicalization restricts gender, sex, and sexuality by placing these categories within biomedical models of understanding, which has been found to pathologize difference, rather than treating diversity as a part of natural variation (Fausto-Sterling 2000).

In health care interactions, labels have advantages and disadvantages for patients and providers; they can offer patients a sense of a shared experience and a way to make meaning of unnamed symptoms (Brown 1995). In the mid-twentieth-century United States, for example, the medical diagnosis of "transsexualism" offered trans people a sense of community and validated their experience (Stryker 2008). However, much of the existing

health scholarship has emphasized the negative consequences associated with labeling processes, including social control and increased surveillance over nonnormative behaviors or people (Conrad and Schneider 2010). For example, Davis, Dewey, and Murphy (2016) found that providers working with intersex and trans people pathologized non-normative bodies. In so doing, they maintained authority over trans and intersex people while going to great efforts to align embodiment along binary and normative constructions of sex and gender.

Although labels help providers identify illnesses and diseases by offering the basic building blocks of diagnostic and prognostic processes (Jutel 2014), scholars have also highlighted how difficult it is to change or abandon diagnoses. "Homosexuality" was removed from the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* in the 1970s after a contentious battle with gay activists. Even after removal, gay activists were suspicious that the appearance of a new diagnostic category, "gender identity disorder," would enable the medical establishment to continue treating LGBTQ sexuality as a disease (Rottnek 1999). Currently, the *DSM* maintains a diagnosis for what is now referred to as "gender dysphoria," which remains contested because it symbolically conveys that being a gender minority is an illness (Dewey and Gesbeck 2017; Johnson 2019). Furthermore, the historical practices of labeling SGMs as "abnormal, perverted, or deviant" has disempowered these groups by the medical establishment and remains a key driver of the maintenance of medical authority over sexual and gender nonnormativity (Paine 2018; Shuster 2019).

### Health Care Utilization

From the moment they step into a health clinic, SGMs may experience discrimination in the intake forms, examination rooms, and seeking and receiving quality care. SGMs are more reluctant to seek care, to not see a regular health care provider, and to skip medication or other needed treatment compared to their cisgender and heterosexual counterparts (Agénor et al. 2014; Dahlhamer et al. 2016; Hsieh and Ruther 2017). Once an individual has entered a health encounter and is labeled as unhealthy or sick, there is often stigma attached to the diagnosis that may exacerbate social withdrawal and rejection because people are subject to discriminatory treatment after being labeled (Link 1982). Stigma can be alleviated by using core social networks for support, including family and friends

(Perry 2011). However, SGMs may be less likely to have a spouse/partner and supportive families (Hsieh and Liu 2021) and therefore lack vital resources because of their sexual and gender identities that heterosexual and/or cisgender people have easier access to in managing stigma. As such, stigma is a fundamental cause of health disparities because it enacts multiple pathways leading to negative health outcomes (Link and Phelan 2001).

How stigma plays out in health care is informed by Goffman's ([1963] 2009) classical work that differentiated visible and invisible stigma. These differences are relevant for health disparities among SGMs given that some are read in social life as visible sexual or gender minorities, whereas others may not be as visible. Research utilizing the stigma process among SGM communities has begun to show that visibility as an SGM creates a double-bind where being out may expose SGMs to stigma in health care encounters while not being out may result in internalized stigma (Cruz 2014) and health care avoidance.

SGMs are at risk for chronic health issues because of delaying care that might exacerbate the stigma that these groups already experience in health care. Oftentimes, SGMs delay care because providers are not knowledgeable of their specific health care needs or able to make competent referrals to other providers (Agénor et al. 2015; Cruz 2014; Poteat, German, and Kerrigan 2013). Those with poorer health conditions are also more likely to delay seeking care than those with better health (Diamant et al. 2004). This means that people who face discrimination show up in medical spaces potentially more ill than those who inhabit dominant social positions. When SGMs seek treatment, they are more likely to use the ER for nonurgent health situations due to the difficulty of finding competent providers (Dahlhamer et al. 2016; dickey et al. 2016). Related, the tendency for SGMs to delay preventive care has downstream consequences including the increased need for emergency services because conditions left unaddressed can become acute (Willging et al. 2019).

Although the scholarship consistently finds that SGMs are more reluctant to use health services and delay care, it is important to consider within-group differences given that SGMs are not homogenous. Considering sexual identification, some studies have noted that bisexual individuals fare worse than gay and lesbian individuals (Dahlhamer et al. 2016; Ross et al. 2016). Disparities in preventive and primary care utilization is more pronounced among sexual minority women than sexual minority men

(Boehmer et al. 2012; Buchmueller and Carpenter 2010; Everett and Mollborn 2014).

Scholars have also begun to document how the bodies of SGMs are often mishandled by the medical establishment, which leads to further delays seeking care. Paine (2018:354), for example, found that gender-nonconforming individuals experience “embodied disruptions” in medical settings because providers refer to body parts using standard medical language that is explicitly gendered, such as referring to a trans man’s chest area as breasts, which is not a term used to describe cisgender men’s chests. Furthermore, providers have been found to reassign nonbinary patients within a binary gender, which leads to avoiding future health encounters (Shuster 2016). People who have particular kinds of sex with particular kinds of bodies that cannot lead to conceiving children have also reported delaying care because of invasive questions or unnecessary tests, such as mandatory pregnancy tests (Venetis et al. 2017).

These findings on health care utilization among SGMs point to a vital need for the medical establishment to become more attuned to how SGMs relate to, define, and identify with their bodies, sexuality, and relationships. In so doing, medical providers can help alleviate delays in accessing health care that exacerbate preexisting health conditions and inequality.

### **Barriers to Care**

SGMs consistently experience barriers to care, including macrolevel barriers, such as a lack of insurance or restrictive treatment guidelines (Dickey et al. 2016); provider-level barriers, including a lack of culturally competent training in medical education (Giffort and Underman 2016) and prejudice, refusing treatment, and disrespectful behavior (Davis et al. 2016; Sabin, Riskind, and Nosek 2015); and patient-level barriers, such as not disclosing personal information because of mistrust in providers and the medical establishment (McNair, Hegarty, and Taft 2012). Combined, these multiple levels of barriers to care situate SGMs in precarious health encounters and contribute to compounding inequalities.

Economic inequalities structure a multitude of health barriers experienced by SGMs. Of note, compared to their cisgender and heterosexual counterparts, SGMs experience greater financial difficulty accessing care due to higher underemployment and unemployment and poverty rates resulting from labor market discrimination that is amplified when

considering additional characteristics such as race and ethnicity (Badgett, Choi, and Wilson 2019; Hsieh and Ruther 2017; Streed, McCarthy, and Haas 2018). The cumulative effects of economic inequality that SGMs experience means that these groups often lack health insurance, a primary care physician, and access to health care facilities (Gonzales and Henning-Smith 2017; Skopec and Long 2015). An additional barrier for those seeking gender-affirming hormone therapy or surgery is the prohibitive costs (Puckett et al. 2018). Yet accessing gender-affirming care can have prosocial benefits, including reduced risk of suicide and suicide ideation, lower rates of depression, and higher quality of life (Padula and Baker 2017).

Formal policies also present structural barriers. The United States has a fractured insurance landscape where each state has different insurance coverage policies in which SGM-specific coverage is warranted or denied based on categorical exclusions (Bakko and Kattari 2021). Some states, for example, perceive gender-affirming interventions as “cosmetic,” whereas others perceive it as a medical necessity. Depending on geographical location or place of employment, gender minorities may find themselves excluded from care (Bakko and Kattari 2021). Related, before the legalization of same-sex partnerships, sexual minorities were often discriminated against in accessing employer-sponsored dependent health benefits because of partner status stipulations (Buchmueller and Carpenter 2010). Although the gaps in health coverage by sexual orientation have been closing since the implementation of the Affordable Care Act and legalization of same-sex marriage, sexual minorities continue to report more delayed or unmet care compared to heterosexuals (Hsieh and Ruther 2017; Skopec and Long 2015). Concurrently, the gains that have been made in alleviating coverage disparities state by state remain vulnerable to federal policy changes.

Although U.S. medicine has shifted over the last several decades toward evidence-based medicine to align decision-making with scientific data, values surrounding gender and sexual normativity continue to negatively influence health care access for SGMs (Shuster 2016). Relying on biologically essentialist ideas wherein “sex” and “sexuality” are treated as innate, providers perceive their role as determining what a patient’s identity is or should be (Davis et al. 2016). Within these logics, providers may unintentionally invalidate the embodiment of SGMs while patients must present as normative and in alignment with diagnostic categories (Shuster

2021). In the process, they become, as Dewey and Gesbeck (2017:68) describe, “the empirical evidence that justifies their regulation.” But patients have agency in negotiating diagnostic categories and clinical guidelines. Johnson (2019) found that trans people strategically leveraged diagnostic categories by rejecting, reframing, or reintroducing them as a tool to gain access to gender-affirming interventions.

Medical professionals’ lack of training to work specifically with SGMs further amplifies gender- and sexuality-based barriers to care. Many SGMs choose not to disclose their gender and/or sexual identities out of fear of judgment, discrimination, and receiving poor medical treatment even though disclosure of such information may facilitate treatment and healing processes through revealing unique health risks and associated health care needs (Cruz 2014; Everett and Mollborn 2014; McNair et al. 2012; Petroll and Mosack 2011).

Taking a “neutral” stance by avoiding gender- and sexuality-related conversations reinforces heteronormativity and cisgenderism in medicine. Providers’ sense of discomfort, fear, and lack of knowledge demonstrate implicit bias against SGMs (Sabin et al. 2015) and reflect the fact that most providers do not receive training on SGMs in school or on the job. Medical students are exposed to, on average, between two to five hours devoted to SGM topics (Obedin-Maliver et al. 2011; Ufomata et al. 2020), and most medical education continues to teach sexual- and gender-normative practices (Murphy 2016; Poteat et al. 2013).

Furthermore, SGMs have also reported that they are met with paternalism and suspicion because of bias held by providers (Baker and Beagan 2014; Meyer et al. 2020; Shuster 2019). For example, Shuster (2019) documented how providers of trans medicine say they used informed consent in their work with trans patients, but how they described their practices had little resemblance to an informed consent model. Instead, providers leaned on paternalistic medicine that amplified their authority and veiled power differences between provider and patient. As they suggest, and others have corroborated (Davis et al. 2016; Kattari et al. 2020; Lykens, LeBlanc, and Bockting 2018), medical authority imposed on patient groups can increase mistrust and perpetuate barriers to health access.

Health care encounters are also populated by stories of SGMs being treated like specimens (Meyer et al. 2020) and extensive gatekeeping (Shuster 2016). When these situations happen, individuals report feeling caught off guard, embarrassed, or

harassed (Meyer et al. 2020) and less likely to use preventive care (Willging et al. 2019). Patients have also reported that providers may be unwilling to listen to, admit their lack of knowledge of, and seek out relevant information for their needs; this can happen even among providers who self-claim as experts in SGM health (Baker and Beagan 2014).

Despite the fact that many health care organizations convey interest in strengthening their programs and policies to enhance the care of SGMs, only a few in the United States offer any SGM-competent training, and even fewer have procedures in place to refer patients to SGM-competent physicians (Giffort and Underman 2016). It is therefore difficult for SGM patients to find competent providers in their insurance networks (Martos, Wilson, and Meyer 2017; Poteat et al. 2013; Ross et al. 2016). Finally, although LGBTQ community health centers may provide certain services tailored to the needs of SGMs, they tend to be located in urban areas or coastal states, and only some have general health clinics (Martos et al. 2017; Ufomata et al. 2020).

As we have documented, SGMs face extenuating challenges interfacing with the medical establishment at both the macro and micro levels. Although the body of scholarship on SGM health care utilization and barriers to care has grown over the last decade, in the following section, we pinpoint areas for future scholarship to continue accumulating empirical data on SGM health care while proactively addressing limitations in the existing scholarship.

### *Limitations and Future Directions for Health Care*

The very building blocks for medical decision-making—labeling and diagnosis—may undermine the health utilization and experiences of SGMs. Because labels and diagnoses are based on cultural understandings, they seem self-evident. Scholarship at the intersection of sexuality and migration studies documents how sexual and gender identities and practices may shift over one’s lifetime and according to the place that one is located (Carrillo and Fontdevila 2014). Scholarship in the Global South offers insight into practical and symbolic challenges gender-nonconforming individuals face when they consider adopting a nonbinary gender identity (Nisar 2018). As such, we suggest that scholars of SGM health build on these insights and carefully consider how SGMs fare transnationally or beyond the United States but caution against using Eurocentric

perspectives on sexual and gender identification. Additionally, we further encourage scholars to consider how language is used by SGMs and medical providers while not remaining tethered to the often implicit idea in social scientific scholarship that gender and sexuality are static over one's lifetime and unchanging from one situation or geographical location to the next. In so doing, our collective understanding of SGMs would become more nuanced in how, when, and why sexuality and/or gender matters in health encounters as well as the strategic responses to oppression that SGMs enact in health systems.

The consequences of stigma are wide reaching and, therefore, difficult for any individual to work around. Recent scholarship in stigma processes shows potential pathways toward alleviating stigma by using one's networks (e.g., Perry 2011), but we caution that the evidence is mixed. For example, Acosta (2013) found that families of origin exacerbated stigma for sexual minorities because of a lack of acceptance. In contrast, Meadow (2018) found that families of origin were strong advocates and actively worked to dampen the stigma their trans children experienced. Less is known about how families of origin and friends help SGMs navigate stigma and discrimination in health care settings from a social networks perspective. We recommend that SGM health and social network scholars work together to determine under what contexts and constellation of identities families mitigate stigma in health care. These types of collaborations would enable scholars to offer public health interventions for SGMs and address the unique challenges they may face in social life and navigating health care systems.

As we described earlier, medical education—both the formal curriculum and informal ways that medical students learn what it means to be a provider—is an important place to intervene in stigma-related health disparities (Giffort and Underman 2016). We also recommend that scholars of SGM health begin looking beyond the obvious and build bridges with other areas of scholarship. For example, insights from science and technology studies offer a fruitful avenue for examining how the barriers to care that SGMs experience begin well before entering health encounters. The scientific evidence that exists for SGM-specific populations is sparse, and most decision-making is based on proxy science, or data accumulated from scientific evidence on heterosexual and cisgender people, to make inferences about the health and treatment of SGMs (Shuster 2021). What are the consequences of proxy data on SGMs, and how are

those consequences tied to the histories of health inequalities that other marginalized groups have experienced?

Future scholarship that seeks to bridge multiple areas of inquiry might examine the consequences of new health infrastructures and technologies on SGM health utilization and barriers to care. For example, electronic health records are advantageous for providers who can share information across health systems. But how personal health data travel may amplify nondisclosure among SGMs because of a concern for privacy. How new informational landscapes complicate communication between SGM patients and providers is a novel topic worth investigating. Additionally, as social media has changed how people connect and exchange information, how do SGMs make use of them to form communities and acquire relevant health information? Bringing social media studies into SGM health scholarship affords different vantage points to uncover the complex ways that health care utilization unfolds and how barriers to care become stabilized among SGMs.

Finally, we cannot stress enough how future scholarship must take seriously the interlocking forms of inequality that present different challenges within SGM groups, such as confronting racism and other forms of discrimination in health (see Olsen 2019). Centering intersectional perspectives in health and health care scholarship would help alleviate the oppression that providers may unintentionally perpetuate while enabling providers to work from a patient empowerment model (Vinson 2016).

## HEALTH BEHAVIORS AND OUTCOMES

Most research on health behaviors and health outcomes shows that SGMs exhibit poorer behaviors and outcomes compared to their heterosexual or cisgender counterparts (National Academies of Sciences, Engineering, and Medicine [NASEM], 2020). One theoretical explanation for these health disparities is stigmatizing and stress processes (Link and Phelan 2001; Pearlin et al. 1981). As elaborated in the minority stress theory, sexual- and gender-specific stigmas expose SGMs to additional stressors, including distal stressors (e.g., discrimination and violence against SGM status) and proximal stressors (e.g., internalization of homophobia/transphobia), leading to poor health behaviors and consequences (Hendricks and Testa 2012; Hughto, Reisner, and Pachankis 2015; Meyer 1995, 2003). Concurrently,

stigma both positively and negatively shapes access to social and personal coping resources. For example, stigma may strengthen connections with SGM communities, which can ameliorate the health consequences of stigma, but it may also reduce self-esteem and family support, which can exacerbate the health consequences (Hatzenbuehler 2009; Thoits 2011).

Another theoretical framework explaining SGM health behaviors or outcomes is the gender-as-relational approach (Thomeer, Umberson, and Reczek 2020; Umberson, Donnelly, and Pollitt 2018; West and Zimmerman 1987). Transcending a static, binary, and heteronormative view of gender, this approach posits that gender is enacted in interactions, thereby regulating and facilitating the health of individuals in relational contexts (e.g., same-sex marriage). Gender dynamics at the institutional, societal, and/or transnational levels may also influence health through economic, power, affective, and symbolic relations (Connell 2012). For instance, the historical legacies of European colonialism and contemporary inequities of global geopolitical power continue to shape gender and sexual orders in the Global South, thereby introducing health risks such as violence and shortage of health services (see also Brown et al. 2010).

A third theoretical framework critical to understanding SGM health is intersectionality, which originated from black feminist scholarship (Collins 2015; Crenshaw 1991). Like any other human experience, health is shaped by multiple systems of oppression and privilege. SGM populations not only face sexism, transphobia, and/or heterosexism, many of them also bear the health consequences of other inequalities such as racism and classism. When the intersection of structural positions and social identities is taken into account, research can more accurately examine SGM health disparities and identify heterogeneous causal pathways leading to varying health challenges experienced by diverse SGM communities (Bauer 2014; Bowleg 2008). In the following sections, we discuss major findings on SGM health behaviors and outcomes and their theoretical implications in more detail.

### **Health Behaviors**

SGMs are more likely to engage in certain health-harming behaviors compared to their heterosexual or cisgender counterparts. Research on sexual minorities shows that people who self-identify as LGB or report same-sex sexual behavior have higher rates of smoking, excessive drinking, and illicit drug use than those who self-identify as heterosexual or report

no same-sex behavior (Boehmer et al. 2012; Conron, Mimiaga, and Landers 2010; Fredriksen-Goldsen et al. 2013; McCabe et al. 2009; Ueno 2010). An emerging body of research on gender minorities also indicates that compared to their cisgender counterparts, trans and nonbinary people experience higher rates of tobacco, alcohol, and drug use (Reisner et al. 2015; Rimes et al. 2019; Streed et al. 2018). Minority stress has often been cited as a major cause of unhealthy behaviors observed among SGMs (Meyer 2003). Stigma associated with minority sexuality and gender may increase stress and/or mental distress, thereby encouraging unhealthy behaviors as coping methods (McCabe et al. 2009; Meyer 2003; Reisner et al. 2015). Negative coping may be sought out more often among SGMs in part because positive coping resources such as social support, mastery (sense of control), and self-esteem are diminished by sexuality- and gender-based stigma (Hatzenbuehler 2009; Hsieh 2014; McLemore 2018).

In addition to the stress process, norms of community networks and intersections of multiple inequalities/identities may also play important roles in shaping health behaviors. Community involvement, such as volunteering for LGBTQ and AIDS organizations, may lower the impact of sexual and racial stigmas on sexual risk behaviors among Latino SGMs due to peer support for safe sex (Ramirez-Valles et al. 2010). Some networks, however, may introduce and reinforce a subculture of unhealthy behaviors, such as substance use, in SGM communities. For example, Carpiano et al. (2011) found that gay men whose networks were predominantly composed of other gay men had relatively higher levels of drug use, and Ueno (2010) showed that the permissiveness of drug use in social networks partly explained why sexual minorities consumed drugs more frequently than heterosexual people.

The intersection of sexuality and gender with other axes of inequality further complicates power dynamics and resource access, which in turn influence the negotiation and practice of health behaviors. For example, Green (2008) argued that in the gay community, white middle-class men in their 20s and early 30s were perceived as more sexually favorable than Asian or black men, working-class or poor men, and older men. Those with lower sexual status experienced more social rejection and isolation in the community and possessed less power in negotiating safe-sex practices such as condom use. Consistently, Quinn, Bowleg, and Dickson-Gomez (2019) suggested that racism, homonegativity, and HIV stigma jointly inhibit PrEP use, an effective

HIV-prevention measure, among black gay, bisexual, and other men who have sex with men.

Research on SGM health behaviors is not limited to studying individual-level behaviors but extends to couple-level behaviors. Using a gender-as-relational approach, studies have demonstrated that gender is enacted and performed in daily interactions of intimate partners and that the gender composition of partners influences their health behaviors (Thomeer et al. 2020; Umberson et al. 2018). For example, some studies showed that same-sex couples perform health work (e.g., making health appointments and discouraging unhealthy diet) in a more cooperative and egalitarian manner than different-sex couples (Reczek et al. 2018; Umberson et al. 2018). This is likely because in same-sex relationships, traditional gendered expectations (e.g., woman as a nurturer/health expert for the relationship) are more often challenged. Thus, partners are more likely to take equal responsibilities for health regulation and facilitation and agree on health concerns. In different-sex relationships, female partners often provide the majority of health-related care work for their male partners, and disagreement over health occurs more frequently (Reczek et al. 2018; Umberson et al. 2016).

There are few studies on gendered dynamics of health work in relationships beyond gay, lesbian, and heterosexual couples. Yet some initial findings encourage more efforts to test and refine the gender-as-relational approach in gender/sexuality-diverse relationships. For example, Hsieh and Liu (2019) compared bisexual people in same- and different-gender partnerships and found that those in same-gender partnerships had healthier behaviors and outcomes than those in different-gender partnerships. The finding suggests that individuals' health behaviors may shift with the gender composition of their relationship, regardless of their sexuality. Similarly, Pfeffer (2017) showed that cisgender women performed a disproportionate share of health work in their relationships with trans men partners. This seemingly normative gendered dynamics highlights how structural gender inequality continues to shape health, even in gender-diverse relationships.

### *Health Outcomes*

Many studies have consistently shown disadvantages in health outcomes among SGMs in comparison to heterosexual or cisgender peers. Health disparities by sexual orientation exist from mood and anxiety disorders (e.g., Bostwick et al. 2010; Everett 2015; Ueno 2010) to self-rated health (e.g.,

Denney, Gorman, and Barrera 2013; Hsieh and Liu 2019), chronic conditions (e.g., Dyar et al. 2019), functional limitation (e.g., Fredriksen-Goldsen et al. 2013), and mortality (e.g., Hatzenbuehler et al. 2020). Despite limited data, health disparities by gender identity have also been identified in a number of mental and physical health conditions (e.g., Cicero et al. 2020; Hughto et al. 2015; Lagos 2018). One shared mechanism underlying SGM health disparities is the minority stress process, which emphasizes how stigma compromises health through multiple pathways, including inducing stressful events, devaluing a sense of self-worth, and weakening social support (see also earlier discussion).

Although the overall pattern indicates health disadvantages of sexual minorities (in comparison to heterosexual people) and gender minorities (in comparison to cisgender people), the prevalence or severity of health conditions varies across SGM subgroups. This notable finding implies heterogeneous stress processes such as differential stigmatization experience and unequal access to coping resources. For example, an increasing number of studies show that bisexual people experience more health problems than their monosexual counterparts, including gay and lesbian people (e.g., Dyar et al. 2019; Gorman et al. 2015; Thomeer and Reczek 2016). Pervasive negative stereotypes, invisibility or erasure, and relatedly, a lack of community belonging, poorer relationship quality, and lower socioeconomic status may be some of the primary reasons for the greater health disadvantages faced by bisexual individuals (Bostwick et al. 2010; Hsieh 2014; Ross et al. 2016).

Consistently, a few studies on gender minorities also noted that nonbinary people face higher rates of mental distress and other health conditions than their binary trans counterparts (Cicero et al. 2020; Crissman et al. 2019; James et al. 2016; Lagos 2018; Rimes et al. 2019). Although the evidence is sparse, being misunderstood or mistreated from a binary perspective may be a key contributing factor (Scandurra et al. 2019). Findings about bisexual and nonbinary people appear aligned, implying that more fluid or ambiguous identification is associated with poorer health outcomes compared to relatively finite identification. As Sumerau, Mathers, and Moon (2020) document, across interactional and institutional domains, gender and sexual fluidity is often erased or foreclosed through the maintenance of static sexual and gender categories. As such, we would anticipate that fluidity would translate to poorer health outcomes among nonbinary and nonmonosexual people compared to their binary and monosexual counterparts.

The heterogeneity of health experiences among SGM populations is also revealed in the scholarship on transitioning and discordance between different dimensions of gender/sexuality constructs. For example, Turban et al. (2020) found that access to gender-affirming care such as pubertal suppression in adolescence is associated with a lower risk of suicide in adulthood among trans adults who wanted the treatment, which supports the proposition that affirming a gender transition may enhance mental health. Everett (2015) showed that when transitioning to same-sex-oriented identities, individuals may experience increased depressive symptoms due to initial exposure to prejudice and discrimination. But maintaining a stable sexual identity over time, including a minority one, is linked to higher self-acceptance and better mental health.

Furthermore, different dimensions of sexual orientation or gender may not overlap, and discordance between dimensions can alter social and health experiences. For instance, discordance between sexual identity and behavior (e.g., heterosexual-identified while having a same-sex partner) may lead to poorer health outcomes because of cognitive-behavioral inconsistency, lack of support from a minority-identified community, and/or internalized homophobia/biphobia (Bauer and Jairam 2008; Talley et al. 2015). Boys assigned male at birth who do not perform culturally expected masculinity may experience severe scrutiny and sanctioning by members of their family, school, and/or community that lead to mental distress from early childhood (Meadow 2018; Pascoe 2011). Given these findings, the affirmation of SGM youths and adults whose identities, expressions, and practices diverge from cultural norms may lessen stigma and social isolation and have long-term health benefits.

Finally, gender and sexuality interacts with other dimensions of structural inequalities to create health disparities among the general population and between SGM populations. Rather than treating sexuality/gender as a source of oppression additional to and separable from race, class, weight, or other oppressive systems, intersectional theories seek to understand how multiple inequalities come together to contextualize and produce stigma, stress, coping, resilience, and health outcomes for individuals with a unique constellation of identities (Bauer 2014; Bowleg 2008). For example, Quinn et al. (2019) noted that anticipated and experienced racism and heterosexism from health care providers constitute a major barrier to care among black sexual minority men. Bowleg (2013) showed that the intersection of

racism and heterosexism constrains access to community resources among black sexual minority men, who are often rejected or silenced in both sexual minority communities (majority white) and black communities (majority heteronormative).

A few population-based studies also found unique health disparities at the intersection of multiple identities. For example, Veenstra (2013) demonstrated that additive models of race, gender, class, and sexuality poorly predict the risk of hypertension, particularly for those with both privileged and disadvantaged identities. Liu, Reczek, and Brown (2013) found that although marriage/cohabitation is generally associated with better health, the health benefits are larger for white women than for black or Hispanic women in a same-sex relationship, suggesting that compounded stigma and economic disadvantage faced by sexual minorities of color may attenuate the health protection of intimate relationships.

As we have documented, the body of scholarship on SGM health behaviors and outcomes has grown over the last decade to show how sexuality and gender minorities face poorer health outcomes and engage in potentially risky behaviors not because of their identities but because of structural and interactional inequalities. In the following section, we offer suggestions for future scholarship to address persistent limitations in this area of inquiry.

### *Limitations and Future Directions for Health Behaviors and Outcomes*

Although there is an emerging body of SGM health research emphasizing the importance of intersectionality as a framework to understand health disparities, the majority of this research focuses on sexual health (e.g., HIV risk and prevention) among sexual minority men of color. Fewer studies on the health experiences of sexual minority women and gender minorities have taken an intersectionality approach. There is also a lack of research at the intersection of nonnormative sexuality and gender identification, likely due to the fact that until recently, LGB and T populations were conflated in social scientific research (Stone 2009). Although methodological challenges of conducting intersectionality research are not negligible (e.g., difficulty in sampling and recruiting participants of intersecting minority identities), the lack of willingness or ability to design research questions and interpret data with consideration of intersecting inequalities/identities impedes health scholars from fully grasping how health disparities emerge (Bowleg 2008).

More empirical investigation based on an intersectionality framework, whether it is qualitative, quantitative, or mixed-methods research, will reveal health disparities and associated factors/processes currently overlooked in the SGM health literature.

Another understudied area of SGM health research is change in structural stigma and health at the population level. As societies increasingly acknowledge gender and sexuality categories beyond cisgender and heterosexual and offer more protections for SGM rights, it is worth investigating whether and how social climate and policy changes impact SGM health, which SGM groups experience the most or least impact, and why. Because sexual and gender identification questions have only been routinely included in a limited number of population-based surveys in recent years (NASEM 2020), research explaining SGM health status/disparities remains largely cross-sectional and lacking analysis of health change in relation to shifts in societal attitudes or policies over time. However, a few European-based studies have explored temporal trends. For example, Boertien and Vignoli (2019) examined change in subjective well-being among individuals in same-sex unions before and after the legalization of same-sex marriage in the United Kingdom. Their finding supports that marriage equality improves the well-being of partnered sexual minorities, including those cohabiting. Hatzenbuehler, Bränström, and Pachankis (2018) showed that the gap in psychological distress between gay/lesbian and heterosexual people in Sweden closed during 2005 to 2015, which was associated with declining structural stigma toward sexual minorities. However, the same trend and association was not observed for bisexual people. More research on how structural stigma, including social climate and institutional discrimination, influences SGM health will further illuminate the health ramifications of structural inequalities.

To advance the understanding of SGM health and health care, more effort to collect information about SGMs is needed across data-collection tools. Measurements for sexual orientation (identity, behavior, and attraction) have been included in a growing number of publicly funded population-based surveys. The effort to measure gender and sex beyond binary definitions, to differentiate current gender identity from gender and sex assignment at birth, and to include dimensions of gender other than identity (e.g., femininities and masculinities) remains relatively limited (Federal Interagency Working Group on Improving Measurement of Sexual Orientation 2016; NASEM 2020).

Furthermore, categories and meanings of sexual and gender identification are neither fixed nor universal. For example, labels that represent SGM communities of different generations, socioeconomic status, race-ethnicity, and nations/regions of origin are often left out in measurement designs (Brown and Herman 2020; Eliason et al. 2016), resulting in undercounting SGM populations who do not identify with a generation-specific, upper-middle-class, white, or Eurocentric label (e.g., LGBT). We recommend using qualitative and community-based research to better operationalize the intersectional and ever-changing landscape of SGM definitions and to inform measurement designs in population-based surveys. We also suggest survey questionnaires offer a write-in option for response categories like “something else” to accurately capture how SGMs identify on their own terms. Otherwise, the instrument may cause difficulty in interpretation and contribute to the literal “othering” of certain SGM groups.

## CONCLUSION

Findings in recent scholarship on SGM health make clear how this area is no longer a marginalized sub-field but, rather, a lively area for research across disciplines. As we have demonstrated throughout, the health barriers and inequalities that SGMs experience are not “outliers” because of their sexuality and gender. Rather, they are consequences of persistent oppression experienced by these diverse groups and reflective of broader concerns in the study of health and medicine and that of sexuality and gender. There remain challenges and opportunities, but sociologists are well poised to address them theoretically, methodologically, and empirically. This review offers the essential tools for current and future researchers to grow the body of knowledge on SGM health and health care.

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## APPENDIX A

### Definitions of Key Terms of Sexuality and Gender.

Key Term	Definition
Sexual minority	A person whose sexual attraction, behavior, and/or identity diverge from heterosexual practices.
Gender minority	A person whose gender identity diverges from their sex or gender assignment at birth (which is often limited to the binary categories of female or male and/or woman or man, respectively).
Lesbian	A sexual identity term for a woman who is attracted to women.
Gay	A sexual identity term for a person who is attracted to people of the same gender. More often used for a man who is attracted to men.
Bisexual	A sexual identity term for a person who is attracted to people of multiple genders. Some use it for individuals who are attracted to people of two genders, usually men and women.
Transgender or trans	A gender identity term referring to a person whose gender identity does not align with their sex or gender assignment at birth.
Queer	A term sometimes used to refer to the entire LGBTQ community and sometimes used as an identity term for a person who is not heterosexual or cisgender or who embraces fluid sexual or gender identities.
Intersex	A general term used for a variety of situations in which a person is born with reproductive or sexual anatomy and/or chromosomes that do not align with medical or societal definitions of male or female. Some, but not all, members of the intersex community use it as an identity term.
LGBTQ	An acronym that refers to lesbian, gay, bisexual, transgender, and queer or questioning people. Sometimes “LGBTQ+” is used to show inclusivity of additional sexual and gender minority groups.
Cisgender or cis	A gender identity term referring to a person whose gender identity aligns with their sex or gender assignment at birth.
Gender nonconforming	A term describing a person whose gender expression or identity does not conform to the societal expectations that accompany their gender assignment at birth.
Gender nonbinary	A gender identity term referring to a person who does not identify with either of the binary (i.e., woman and man) gender categories.
Homosexual	A sexual identity term referring to a person who is sexually attracted to people of the same sex or gender. Currently considered dated and offensive to many in the LGBTQ+ community.
Heterosexual	A sexual identity term referring to a person who is sexually attracted to people of different sexes or genders from their own. Often interchangeably used with <i>straight</i> .
Heteronormative	A term denoting the perspective that heterosexuality is the only “normal,” natural, or preferred expression of sexuality.

Note: Identity terms may carry different meanings for different individuals. The definitions in this table reflect the general understanding of these terms at the time of writing. We acknowledge that the language around sexuality and gender is always changing.

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