Providing Culturally Sensitive Diabetes Care and Education for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community

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Members of the lesbian, gay, bisexual, and transgender (LGBT) community have unique health disparities and worse health outcomes than their heterosexual counterparts, which has clinical relevance in the delivery of diabetes care and education. People from every race, nationality, gender, class, and political and religious affiliation are represented in the LGBT community, which is present in 99.3% of all counties in the United States.[1–3] Clinicians care for patients, not populations; yet, if common health nuances within a population are unknown, how can best practices be applied?[4]

The National Standards for Diabetes Self-Management Education require an individualized assessment inclusive of cultural information, family support, and general psychosocial problems that may pose barriers to planning care effectively.[5] This is the standard of clinical excellence and a guiding light for diabetes care professionals.

The cornerstone of quality care starts with the assessment. If critical information is missed, in part because of institutional-level barriers (e.g., a climate that excludes LGBT individuals from equal-treatment models or forms that assume heterosexuality), provider-level barriers (unawareness of unique health traits or provision of substandard care solely based on presumed sexual orientation), and patient-level barriers (fear that disclosure could trigger provider homophobia and related harmful effects during their illness), then the diabetes care plan will lack completeness and potentially alienate these patients from seeking ongoing support.[6–8]

This article summarizes key concepts in providing culturally sensitive diabetes care for LGBT Americans by analyzing prevalence assumptions, unique health characteristics and diabetes risk factors, and patient concerns. It also offers tools to aid providers in caring for this underserved community. The author assumed that readers are allies for this special diabetes population and have first-hand experience or are familiar with the literature demonstrating that positive and supportive interactions with patients are crucial for successful ongoing support. The author also turned to nontraditional sources for some of the references because of a dearth of research on this subject in mainstream circles.

Prevalence Assumptions

Identifying diabetes prevalence within the LGBT community is no easy task. Data collection methods used to distinguish this subgroup within the U.S. population are not systematic, LGBT status is often underreported and prone to measurement error, and scientific evidence is also blocked.[9]

The Department of Health and Human Services refused to publish a 488-page *Healthy People 2010* companion document for LGBT health, thereby eliminating the incorporation of sexual minority issues into the nation's health care agenda. The intentional omission of LGBT health data into mainstream science is reminiscent of homophobic tactics that have been used in the past and may have resulted from a climate that continues today.[10]

For example, lesbians have the highest rates of polycystic ovarian syndrome (PCOS)—a fact that is not mentioned in articles about PCOS on two leading diabetes Web sites.[11,12] Data uncovered for this article were located almost entirely outside of standard diabetes sources. Searches for information about LGBT populations within professional diabetes Web sites and the stellar diabetes self-management education reference for diabetes educators, even when related to sexual dysfunction, yielded no results.[13]

Data on rates of diabetes within the LGBT community are lacking, which requires that assumptions be made based on currently available information and statistics. The 2000 U.S. Census has the most comprehensive data defining the gay and lesbian population. The census did not inquire about sexual orientation, behavior, or attraction—the three most common ways used to identify gay men and lesbians in surveys.[9] Instead, the census had relationship categories to define how same-sex individuals in the household were related to the "householder" and, thus, identified gay and lesbian couples indirectly.[14]

Several issues interfered with the accuracy of this information. More than half of all gay and lesbian individuals and all bisexual or transgender individuals were omitted because they were single. Further, many individuals are closeted and fear that any kind of indirect acknowledgment on the census may jeopardize their safety or employment status. Finally, during the 1990 census, same-sex couples who checked "married" (because in their eyes they were) were discounted because the census figured a mistake was made and literally changed their sex before tabulation.

A distrust of the census continues today and has inspired the grassroots movement "Queer the Census," wherein LGBT community members wrote their LGBT status on the census only to further jeopardize being included in the count. Calculating the undercount is challenging, with estimates suggesting that true counts are 10–50% higher than census figures.[9]

Recent data analyzing the percentage of lesbian, gay, and bisexual (LGB) individuals in the population found that 4.1% of adults identify as such. Specific regions reveal substantially higher rates (15.4%).[15] That indicates an estimated 8.8 million LGB adults in the United States. Additionally, more than one-fourth of same-sex couples include a racial or ethnic minority, the two largest of which are African American and Hispanic.[9]

How many LGB people have diabetes? (Transgender individuals are omitted from this discussion because of limited data.) If the United States has at least 8.8 million LGB people who belong to a subgroup with significant diabetes risk factors (as outlined below), and 15.3% reported diabetes as one of their top three chronic illnesses (following hypertension and arthritis), then it is possible that 1.3 million LGB individuals have diabetes, or at least 5% of the 23.6 million people with the disease in the United States.[16] The LGB population with diabetes is a sizable minority group equal to, if not greater in size than, the populations with type 1 or gestational diabetes.

Unique LGBT Risk Factors

LGBT individuals have unique health characteristics, disparities, and barriers that increase their risk for diabetes or its complications. Consider the following partial list:

- Cigarette smoking prevalence is highest in the LGBT community; rates have ranged from 38 to 59% among youth and from 11 to 50% among adults.[17,18] Smoking increases insulin resistance and the risk for type 2 diabetes.[19]
- PCOS prevalence is highest among lesbians (38 vs. 14% among heterosexual women).[20] PCOS is a risk factor for type 2 diabetes.
- Diabetes rates are highest among LGB African-American adults.[21] Diabetes rates among men receiving HIV treatment are four times that of HIV-negative men (not that HIV only affects gays).[22,23]
- Overweight and obesity rates are higher among lesbians than among heterosexual women.[7,24]
- Type 2 diabetes risk is increased in overweight transgender women who are on hormone therapy.[25]
- Uninsured rates and difficulty obtaining medical care occur most frequently for lesbians, bisexual women,[26] and LGB Latino adults.[21,27] Access to health care affects the detection of diabetes.[28]
- Rates in delaying or not filling prescription medicines are highest for LGB African-Americans.[21]
- Depression and suicide attempts are highest among LGB individuals.[6]
- Suicide attempts among LGBT youth are between 20 and 42%; gay men are six times more likely and lesbians are twice as likely as their heterosexual counterparts to attempt suicide.[7] This may explain why some type 1 (albeit closeted LGBT) youths withhold insulin, not as a diabulemic maneuver, but possibly as a suicidal gesture.
- Psychological distress is most likely experienced by LGB Asian or Pacific Islander adults.[21]
- Sexual orientation is a significant predictor of eating disorders among men, although not among women.[7]
- Illicit substance use is a serious health problem for the LGBT community.[7,24]
- Binge and heavy drinking is significantly more likely to occur in lesbians than in heterosexual women.[27]
- Alcohol abuse is more likely to occur in LGB Latino adults.[21]
- Papanicolaou tests and breast exams are less likely to occur in lesbian populations.[27] Whether this translates into less frequent diabetes maintenance tests has not been studied.
- The risk of HIV and other sexually transmitted infection (STI) acquisition and transmission is increased for gay and bisexual men.[29]
- Homeless adolescents include up to 40% LGBT individuals.[29]

- The risks of getting HIV or other STIs, committing suicide, becoming victims of violence, and developing substance abuse problems are high for transgender populations.[7]
- Outright hostility from health care providers is a common LGBT experience. Up to 39% of transgender people face harassment when seeking routine health care.[1]
- LGBT people of color face the combined impact of these barriers, thus increasing the likelihood of negative health outcomes.[21]

Patient Concerns

It is important to understand how homophobia and heterosexism manifest when LGBT individuals seek diabetes care to reduce any existing provider-level barriers. Individuals who approach the health care system are already vulnerable from their illness. For LGBT individuals who often fear dealing with or have faced bigotry in the health care arena, this has a far-reaching impact. Intolerance is the last thing anyone wants when seeking health care; it is certainly not a part of the caring diabetes professional culture.

Homophobia has been defined as hatred and fear of the sexual desires and practices of LGBT people, which may result in abuse. Heterosexism refers to practices that reinforce the belief that the world is and should be heterosexual and that other sexual orientations and practices are unhealthy and threatening to society.[30] Examples of provider homophobia include making demeaning comments, withholding information, sitting further away than necessary, making inappropriate mental health referrals, and engaging in episodes of hostility.[26] Examples of provider heterosexism include providing diabetes support materials that explicitly or implicitly address monogamously partnered heterosexuals and using forms and offering counseling that assume heterosexuality (per author discussions with Adam Jowett after reviewing his lecture on "Sex and Diabetes: Gay and Bisexual Men's Experiences" presented at the LGBT Health Summit held in Newcastle/Gateshead, U.K., 6–7 October 2009).

The following comments from two LGBT diabetes support groups yielded further insights (TLG, unpublished observations, 2010). Readers should keep in mind that these groups formed to fulfill a need for support that was lacking in their urban mainstream diabetes care facilities. This implies that similar, if not worse, sentiments exist in smaller cities with less visible LGBT communities.

- *I've argued with almost every health care provider who simply won't believe I don't have a chance of being pregnant (I don't look butch, so of course I'm hetero)—from the radiologist to quarterly lectures from my CDE [certified diabetes educator]. I've taken pregnancy tests and even accepted birth control prescriptions. It's disrespectful.*
- *I get chronic yeast infections with just one high sugar in a day of "good-range" numbers. I told my doctor this was causing stress at home because my partner ends up with yeast infections. The doctor said I was bringing on this problem myself. I have received poor service from her since.*
- *At the hospital or with a new specialist, my relationship is discounted. The role my partner plays in motivating me to improve my blood glucose control is, at best, ignored.*
- *I've asked my endocrinologist and CDE how to adjust my insulin when I use club drugs like "ecstacy." They never know what to say, other than, "Don't." I'm a young gay man with type 1. I want to be smart about it. Do I take less insulin? No one knows.*
- *Where can I find an LGBT-friendly CDE?*

Tools for Providing Culturally Sensitive, Competent Care

Most multidisciplinary professionals have not received tools to care for LGBT individuals. More than half of medical school curricula include no information about LGBT people, and programs in public health schools are also unlikely to include information beyond HIV/AIDS.[1] Furthermore, transgender treatment is rarely taught in medical curricula.[31] One of the earliest practitioners to work with transgender clients was endocrinologist Harry Benjamin. In 1979, he wrote clinical guidelines on gender dysphoria care. Those guidelines have been revised six times by an international professional consensus group but are virtually unknown within the diabetes community.[1]

Competency is a long process that starts with raising awareness about professional interactions with LGBT individuals, accepting responsibility for personal beliefs and biases, and becoming sensitive to the norms that shape patients' lives. This includes showing respect for family structures and roles within the LGBT culture. Competency requires the ability to effectively serve the public health needs of LGBT individuals and communities.[32] One way is to include sexual orientation as a standard demographic variable in public health surveys. This would provide data to support planning interventions toward improving LGBT health and help in assessing target populations and barriers to care—a requirement for diabetes self-management education and training programs.[33]

Does your work setting show LGBT cultural sensitivity? Would closeted LGBT individuals see visual cues that denote acceptance, such as a posted nondiscrimination policy that includes gender or medical brochures that address the health needs of diverse groups? Are there written forms, interview techniques, and educational materials in use that do not assume heterosexuality? Do health care providers have verbal interactions with patients that demonstrate a comfort level in treating LGBT people (e.g., by using words such as "spouse" or "partner" in addition to "husband" and "wife," both verbally and on assessment forms)? Is your facility inclusive of all patients' significant others regardless of their sexual preference? Without clear and visible signals from health care facilities and verbal interactions with health care professionals that demonstrate acceptance, many

LGBT people will not feel safe "outing" themselves.[1,29]

Being comfortable talking with sexual and gender minorities in a nonjudgmental way is a skill that comes naturally for some but must be learned by others. Discuss with patients the research on LGBT disparities to create an opportunity for open dialogue about self-care behaviors. With transgender individuals, it is best to ask how they wish to be addressed rather than use incorrect or outdated language. What pronouns do they prefer? The use of "he" and "she" do not accurately reflect every person's sense of self.

Also, providing a unisex restroom promotes safety for transgender patients. Although not ideal, it may be possible to use a non-gendered restroom provided for people with disabilities.[29]

Remember, humane treatment determines satisfaction with care for this population.[34] Competency continues through using resources that increase provider skills as needed and through training office staff, since the use of appropriate etiquette by all personnel promotes patients' confidence in the entire health care experience.[29] Two useful, comprehensive publications are *The Fenway Guide to LGBT Health*[29] and *The Handbook of Lesbian, Gay, Bisexual, and Transgender Public Health: A Practitioner's Guide to Service*.[2] You may also check examples of model health access programs: the Gay, Lesbian, Bisexual, and Transgender Health Access Project in Boston[35] and the Transgender Healthcare Access Project at the Transgender Law Center in San Francisco.[36] In addition, you may access a free online LGBT health care guide.[37]

Conclusion

Diabetes professionals have long partnered with high-risk populations and are poised to help the LGBT community, starting locally by ensuring an environment conducive to the patient-provider relationship and continuing globally by incorporating LGBT diabetes care issues into mainstream curricula and professional arenas. The American Association of Diabetes Educators articulates its vision as "successful self-management for all people with diabetes."[38] The American Diabetes Association's stated mission is to "improve the lives of all people affected by diabetes."[39] Clearly, "all people" should include previously marginalized LGBT people with diabetes. All people with diabetes deserve the benefit of our expertise and access to ongoing support.

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References

[1]Krehely J: How to close the LGBT health disparities gap [article online]. *American Progress* 21 December 2009. Available from http://www.americanprogress.org/issues/2009/12/lgbt_health_disparities.html. Accessed 9 March 2010

[2]Ferris JL: The nomenclature of the community: an activist's perspective. In *The Handbook of Lesbian, Gay, Bisexual, and Transgender Public Health: A Practitioner's Guide to Service*. Michael D. Shankle, Ed. New York, Harrington Park Press, 2006, p. 1–9

[3]Smith DM, Gates GJ: *Gay and Lesbian Families in the United States: Same-Sex Unmarried Partner Households*. Washington, D.C., Urban Institute Press, 2001

[4]American Diabetes Association: Introduction to Clinical Practice Guidelines. *Diabetes Care* 33 (Suppl. 1):S1–S2, 2010

[5]Funnell MM, Brown TL, Childs BP, Hass LB, Hosey GM, Jensen B, Maryniuk M, Peyrot M, Piette JD, Reader D, Siminerio LM, Weinger K, Weiss MA: National standards for diabetes self-management education. *Diabetes Care* 33 (Suppl.1):S89–S96, 2010

[6]Eliason MJ: Healthcare provider attitudes. In *Who Cares? Institutional Barriers to Healthcare for Lesbian, Gay, & Bisexual Persons*. New York, National League for Nursing, 1996, p. 107–129

[7]Gay and Lesbian Medical Association and National Coalition for LGBT Health: Healthy People 2010 companion document for lesbian, gay, bisexual, and transgender health [article online]. Available from www.lgbthealth.net. Accessed 3 March 2010

[8]Hernandez M, Fultz SL: Barriers to healthcare access. In *The Handbook of Lesbian, Gay, Bisexual, and Transgender Public Health: A Practitioner's Guide to Service*. Michael D. Shankle, Ed. New York, Harrington Park Press, 2006, p. 177–197

[9]Gates GJ, Ost J: *The Gay & Lesbian Atlas*. Washington, D.C., Urban Institute Press, 2004., p. 1–17

[10]Kennedy NJ: National and public infrastructure and policy: are we experiencing scientific McCarthyism? In *The Handbook of Lesbian, Gay, Bisexual, and Transgender Public Health: A Practitioner's Guide to Service*. Michael D. Shankle, Ed. New York, Harrington Park Press, 2006, p. 291–309

[11]American Association of Clinical Endocrinologists: What every woman and her doctor should know about polycystic ovary syndrome [article online]. Available from www.aace.com/public/awareness/pcos/pdf/WhatPCOS.pdf. Accessed 4 March 2010

[12]American Diabetes Association: Polycystic ovarian syndrome (PCOS) [article online]. Available from www.diabetes.org/living-with-diabetes/complications/women/polycystic-ovarian-syndrome.html. Accessed 4 March 2010

[13]Mensing CR, Ed. *The Art and Science of Diabetes Self-Management Education: A Desk Reference for Healthcare Professionals*. Chicago, Ill., American Association of Diabetes Educators, 2006

[14]Smith D, Gates GJ: *Gay and Lesbian Families in the United States: Same-Sex Unmarried Partner Households*. Washington, D.C., Human Rights Campaign Foundation, 2001

[15]Gates GJ: Same-sex couples and the gay, lesbian, bisexual population: new estimates from the American Community survey [article online]. Available from www.law.ucla.edu/williamsinstitute/publications/SameSexCouplesandGLBpopACS.pdf. Accessed 5 March 2010

[16]Jowett A, Peel E: Chronic illness in non-heterosexual contexts: an online survey of experiences. *Feminism Psychol* 19:454–474, 2009

[17]California LGBT Tobacco Education Partnership: Did you know? [article online] Available from www.lgbtpartnership.org/didyouknow.html. Accessed 5 March 2010

[18]Ryan H, Wortley PM, Easton A, Pederson L, Greenwood G: Smoking among lesbians, gays, and bisexuals: a review of the literature. *Am J Prev Med* 21:142–149, 2001

[19]Eliasson B: Cigarette smoking and diabetes. *Prog Cardiovasc Dis* 45:405–413, 2003

[20]Agrawal R, Sharma S, Bekir J, Conway G, Bailey J, Balen AH, Prelevic G: Prevalence of polycystic ovaries and polycystic ovary syndrome in lesbian women compared with heterosexual women. *Fert Steril* 82:1352–1357, 2004

[21]Krehely J: How to close the LGBT health disparities gap: disparities by race and ethnicity [article online]. *American Progress* 21 December 2009. Available from: http://www.americanprogress.org/issues/2009/12/pdf/lgbt_health_disparities_race.pdf. Accessed 9 March 2010

[22]Brown TT, Cole SR, Li X, Kingsley LA, Palella FJ, Riddler SA, Visscher BR, Margolick JB, Dobs AS: Antiretroviral therapy and the prevalence and incidence of diabetes mellitus in the multicenter AIDS Cohort Study. *Arch Intern Med* 165:1179–1184, 2005

[23]Jain RG, Furfine ES, Pedneault L, White AJ, Lenhard JM: Metabolic complications associated with antiretroviral therapy. *Antiviral Res* 51:151–177, 2001

[24]Boehmer U, Bowen DJ, Bauer GR: Overweight and obesity in sexual-minority women: evidence from population-based data. *Am J Public Health* 97:1134–1140, 2007

[25]Feldman J: New onset of type 2 diabetes mellitus with feminizing hormone therapy: case series. *Int J Transgenderism* 6:3074–3077, 2002

[26]Hutchinson MK, Thompson AC, Cederbaum JA: Multisystem factors contributing to disparities in preventive healthcare among lesbian women. *J Obstet Gynecol Neonat Nurs* 35:393–402, 2006

[27]Diamant A, Wold C, Spritzer K, Gelberg L: Health behaviors, health status, and access to and use of healthcare: a population based study of lesbian, bisexual, and heterosexual women. *Arch Fam Med* 9:1043–1051, 2009

[28]Zhang X, Geiss LS, Cheng YJ, Beckles GL, Gregg EW, Kahn HS: The missed patient with diabetes: how access to healthcare affects the detection of diabetes. *Diabetes Care* 31:1748–1753, 2008

[29]Makadon HJ, Mayer KH, Potter J, Goldhammer H (Eds.): *The Fenway Guide to Lesbian, Gay, Bisexual, and Transgender Health, 2007.* New York, Harrington Park Press, 2007

[30]Irwin L: Homophobia and heterosexism: implications for nursing and nursing practice. *Australian J Adv Nurs* 25:70–76, 2007

[31]Safer JD, Tangpricha V: Out of the shadows: it is time to mainstream treatment for transgender patients. *Endocr Pract* 14:248–250, 2008

[32]Turner KL, Wilson WL, Smith MK: Lesbian, gay, bisexual and transgender cultural competency for public health practitioners. In *The Handbook of Lesbian, Gay, Bisexual, and Transgender Public Health: A Practitioner's Guide to Service.* Michael D. Shankle, Ed. New York, Harrington Park Press, 2006, p. 59–80

[33]Dilley JA, Simmons KW, Boysun MJ, Pizacani BA, Stark MJ: Demonstrating the importance and feasibility of including sexual orientation in public health surveys: health disparities in the Pacific Northwest. *Am J Public Health* 100:460–467, 2010

[34]Harry Benjamin International Gender Dysphoria Association: Standards of care for gender identity disorders [article online]/ Available from www.wpath.org/documents2/socv6.pdf. Accessed 8 March 2010

[35]The Gay, Lesbian, Bisexual and Transgender Health Access Project in Boston. Available online from http://www.glbthealth.org/index.html. Accessed 9 March 2010

[36]The Transgender Healthcare Access Project at the Transgender Law Center in San Francisco. Available online fromhttp://www.transgenderlawcenter.org/do/transform.html#health. Accessed 9 March 2010

[37]A free LGBT healthcare guide from Straight for Equality. Available online from http://www.straightforequality.org/Page.aspx?pid=1130&srcid=-2. Accessed 9 March 2010

[38]American Association of Diabetes Educators: Guidelines for the practice of diabetes self-management education and training. *Diabetes Educ* 35:48S–107S, 2009

[39]American Diabetes Association: Mission statement. Available online from www.diabetes.org/about-us/?utm_source=Homepage&utm_medium=MainNav&utm_campaign=ABOUTUS. Accessed 10 March 2010

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