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## Introduction

This chapter provides a brief history of the lesbian, gay, bisexual, and transgender (LGBT) community and its relationship with medicine. While a full review of LGBT history cannot be covered in a single chapter, there are crucial historical developments and concepts that health-care providers should grasp in order to put their patient care in context (Fig. 2.1).

We will focus on medical interventions for LGBT individuals, and also explore some concurring social developments and artistic representations of those developments during several time periods. Throughout, we will try to shed light on issues that are useful for health-care providers. For instance, how have LGBT people and physicians in different eras understood the concept of sexual orientation – i.e., which sorts of partners a person is attracted to? How have LGBT people and medicine understood gender identity (the gender one perceives as correct for one's self) and gender expression – the choices one makes to demonstrate gender identity? This entanglement between sexual orientation, sexual behavior, sex, gender, and gender expression is what makes LGBT history so difficult to translate to the modern era. To understand LGBT patients today, clinicians should grasp what these terms mean today, and also understand how their meanings have changed over time.

## Nineteenth and Early Twentieth Century

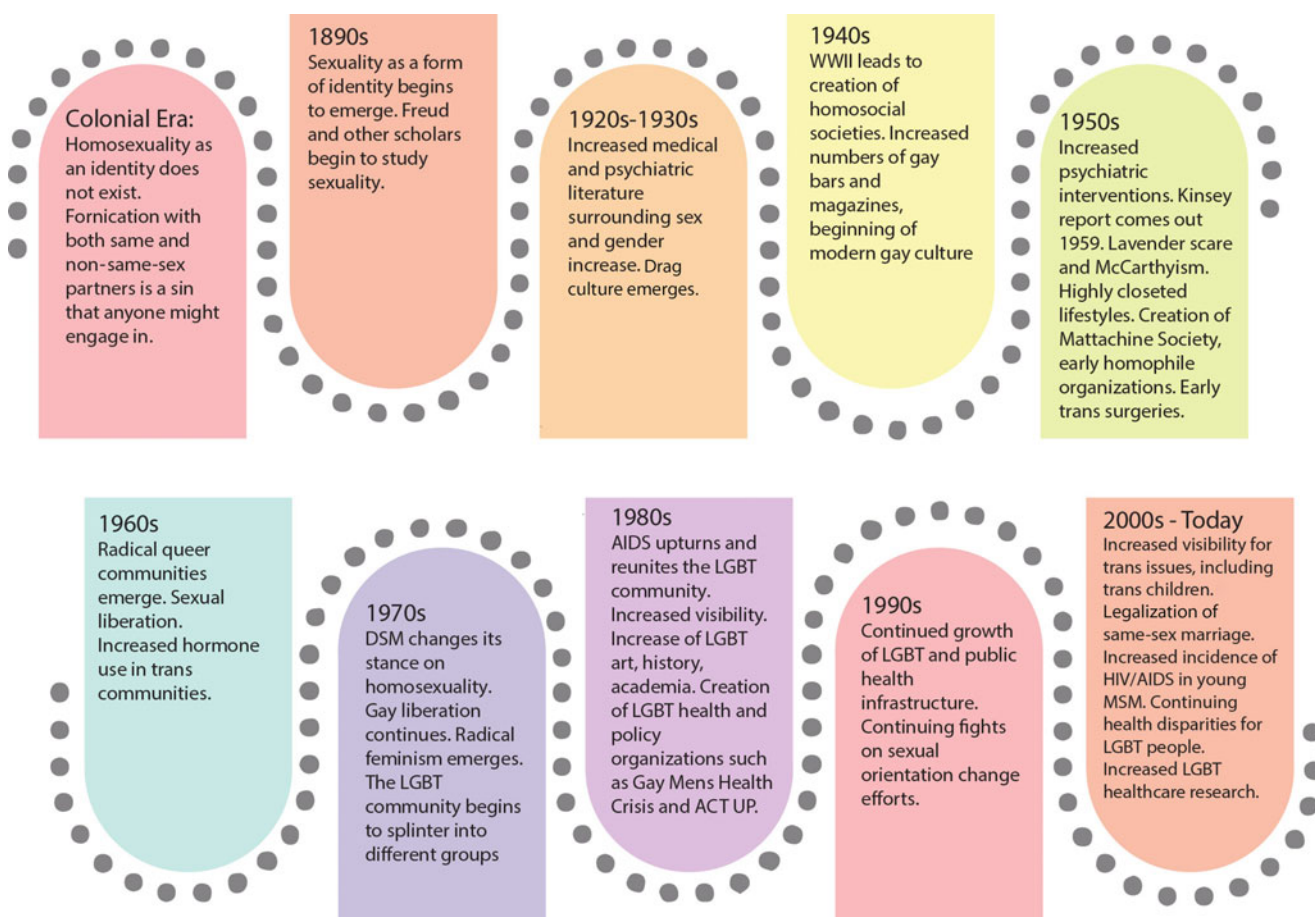
Before the turn of the last century, the concept of a person identifying as gay, i.e., someone whose primary sexual attractions are to same-sex partners, did not exist. Sexual acts between persons of the same sex have been described since pre-history, but using sexual orientation as a way of organizing or labeling people did not begin until the 1890s. In American culture prior to this, sex outside of marriage was forbidden, but masculinity was not dependent upon heterosexuality. A man might still be “normal” and retain the stature associated with his masculinity even if he participated in sex acts outside of marriage, whether they were with men or women [2]. Essentially, same-sex sexual practices were viewed as sinful acts that any type of person could commit – that is, as behaviors in which any person might engage – rather than the actions of a specific type of stigmatized person.

In the late nineteenth and early twentieth century, physicians and others began to incorporate sexuality into the increasingly detailed taxonomy of medical and mental illness. These nineteenth-century doctors, psychologists, and scientists attempted to find a cohesive theory that would explain why some people desired members of the same sex, while others did not. One early theory was that of Richard von Krafft-Ebing, a late-nineteenth-century German psychiatrist, who argued that homosexuality resulted from an in-utero sexual “inversion,” causing men and women to invert their normal sexual desire and pursue sexual interactions more typical of the other sex [3]. British psychiatrist Havelock Ellis built upon the work of Krafft-Ebing to draft his massive six-volume *Studies in the Psychology of Sex* and used the term “invert” to classify transsexuals and transvestites [4]. This work formed the basis of the early twentieth-century conception of sexual orientation as inextricably linked to gender presentation. To be attracted to women is inextricably masculine, and to be attracted to men, inextricably feminine. To invert one is

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**Fig. 2.1** Outline of US LGBT history

to invert the other. For instance, a man who was attracted to men was seen as more womanly, and a woman attracted to women more manly; there was simply no space for a masculine man who desired other men, or a feminine woman who similarly desired other women.

An intriguing literary example of Ellis' theory emerges from *The Well of Loneliness*, a 1929 novel by Radclyffe Hall [5]. The main character, a masculine woman whose father named her Stephen because he wished for a son, typifies the author's and society's attempt to explain same-sex desire as a simple inversion of gender. Stephen (and by extension Radclyffe Hall herself) desires women because her internal life is that of a male. When Stephen falls in love with a more feminine woman later in the novel, Hall depicts the woman's attraction to Stephen as temporary since she is also attracted to men, but also as resting upon Stephen's masculinity. The book offers no concept of a feminine woman who is attracted to women because of their femininity.

Krafft-Ebing, Ellis, and others offer a view of homosexuality as an illness rather than a moral failing. Some might see this shift from crime to illness as an improvement over earlier concepts of same-sex behavior as criminal, which commonly resulted in corporal punishment for homosexual

behavior. However, the notion of illness as a kinder and gentler theory of homosexuality is a rebuttable hypothesis. For one, the aggressive medical interventions assigned to attack same-sex behavior were at times of such a damaging nature that a prison sentence would have been more humane. For another, same-sex behaviors remained criminalized in many jurisdictions, even while the concept of illness was added. This resulted in medical treatments mandated by law, as a form of punishment, without appropriate consideration of either efficacy or side effects, as we shall review below.

Freud himself accepted the work of Krafft-Ebing, and referred to homosexuals as inverts. He further delved into the theory of why homosexuality exists, suggesting that it represented a failure to fully sexually mature. However, he also cautioned that homosexuals should not be blamed for their nature. He felt that conversion to heterosexuality was unlikely in all but very unusual circumstances, and discouraged attempts to use psychoanalysis to change sexual orientation. His views were famously summarized in this letter to the mother of a gay son:

"Homosexuality is assuredly no advantage, but it is nothing to be ashamed of, no vice, no degradation; it cannot be classified as an illness; we consider it to be a variation of the

sexual function, produced by a certain arrest of sexual development” [6].

This medicalization of homosexuality as an accidental deviation from normal development, rather than a moral failing, led to further study of the growing homosexual social group by scientists and doctors. However, the idea of removing blame from the development of same-sex orientation may also have had a profound impact on the emerging subculture in some major cities. This culture included those who based their lives around homosexuality, but also others who engaged in same-sex sexual acts without identifying as part of a homosexual community. At the same time, communities based around gender presentation, flamboyance, and performance flourished in the 1920s, an era that challenged long-standing restrictions on gender presentation and behavior norms, including dress and sexual behavior. During this time of Prohibition, the police ignored many acts that were officially illegal, from drinking alcohol to cross-dressing, at least within specific times and places, a lenience often supported by bribes. While same-sex attraction largely went unnoticed except during specific noteworthy events, cross-gender performance was hugely popular. There were wildly successful male impersonators during the vaudeville era, and some drew huge crowds, such as Vesta Tilley and Hetty King [7]. Various drag balls were held in major cities on Halloween and New Year’s Eve, and boasted attendance by prominent members of society, as well as cross-dressing performers who made the balls so successful [2]. These cultures, one based on gender, one on sexuality, one publicly performed, and one hidden, were seen as related because frequently the participants were the same and because the social theories of the day assumed “inversion” was the only plausible cause of same-sex attraction. George Chauncey has argued that it is the urge of middle-class, masculine men to create an identity distinct from both cross-dressers and “normal” men that creates the concept of homosexuality and creates a private community distinct from both the dominant heterosexual society and the public cross-dressing, gender-inverted community [2].

Just as same-sex sexual behavior was present long before homosexual communities emerged, cross-dressing, passing as another gender, and non-binary gender identification existed long before the popularization of drag balls and cross-gender culture entered the public consciousness. Instances in which women passed as men date back centuries, as women sought to gain access to jobs, join the military, and travel without harm. However, those who passed in these situations may have done so out of external motivations, and did not create a community of like-minded individuals in the way that the drag ball culture and male and female impersonators of the late nineteenth and early twentieth century did. The birth of a subculture of nonnormative gender presentation and same-sex attraction in major cities

allowed scientists to create taxonomies describing individuals within this subculture. The application of this reductive framework shaped medical views of the culture even as it formed, sorting people into binary categories, and aligning sexuality with gender. This scientific emphasis on drawing distinctions and sorting into categories persists in modern terminology (e.g., the moniker LGBT), despite the nuanced differences in identity and lived experiences espoused by members of these communities. As we will discuss later, physicians today still face this burdensome tendency to pigeonhole patients, and instead should seek to understand patients’ own self-understanding of sexual orientation and gender identity.

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## WWII and Beyond: The Era of Medical Intervention

The 1950s represented an era of bold moves in medicine and science. Not coincidentally, this was also a time of few ethical protections for patients and human research subjects, leading to some disastrous consequences. Post-WWII confidence levels were high, and included overwhelmingly positive views on the merits of science and medicine. Esteem for science emerged from successes like the discovery of penicillin, which provided enormous gains in the ability to treat infectious diseases. Throughout medicine, physicians took up the “battle” against other diseases in a manner that paid scant attention to the command, “first, do no harm.” For example, radical mastectomies removed not only the breast from cancer patients, but sometimes substantial parts of the chest wall, the arm, and even the torso [8]. As the saying of the day went, “lesser surgery was for lesser surgeons.” Similarly, early efforts in transplant medicine and cancer chemotherapy brought both medical progress as well as significant failures, at times with a frightening cost in human lives [9, 10].

Psychiatry, too, developed aggressive treatments to attack disease. Lobotomy gained traction as treatment for a wide range of mental illnesses, earning the Nobel Prize in 1949 for Egas Moniz, one of its main proponents. Lobotomy resembles other invasive psychiatric treatments of that era, in that claims of major therapeutic advances rested on a slim to absent evidentiary basis. Over the next two decades, therapeutic claims were not only discredited, but deleterious side effects emerged as far more common than previously documented [11]. Thus, this was an era in which physicians plunged ahead, hoping for scientific progress but with seemingly little concern for untoward consequences among their patients. Science meant progress, and related scandals (thalidomide, Tuskegee) had not yet emerged to tarnish its reputation and to encourage greater caution. While psychiatric treatment with electroconvulsive therapy, insulin coma,

and cold packs burgeoned, rights for patients with mental illness remained severely curtailed. Physicians, with the permission of a family member or judge, could commit a patient to a psychiatric facility and administer treatments without the patient's consent. In some cases, patients were held in psychiatric facilities for years without noticeable treatment. Only in the 1970s did the US Supreme Court forbid the practice of confinement without treatment [12]. Thus, a significant and unfortunate effect of the medicalization of same-sex attraction was that it solidified in this era of bold interventions without recognition for patient rights and safety.

While all persons viewed as mentally ill were subject to the treatments prevalent at the time, LGBT people faced additional interventions purported to change sexual orientation and/or atypical gender presentation. Common methods used in the attempt to control sexuality included electroconvulsive therapy, psychosurgery, and psychoanalysis. Chemical castration was often used for gay men caught engaging in sex acts with other men. Victims of this practice included Alan Turing, the British mathematician and engineer credited with inventing the first computer during WWII. After being arrested for sexual behavior with men, he was sentenced to chemical castration. After several years he committed suicide, leaving behind an apple poisoned with cyanide, a possible allusion to his identity as a "wicked queen" like that in *Snow White* [13].

Turing may have been among the more famous people to suffer from legal sentences and medical treatments on the basis of sexual orientation and/or behavior, but he was hardly alone. Many narratives document the damaging legal and medical practices common through the 1960s. One young man's family, disturbed by suggestive postcards and other indications of his same-sex orientation, had him forcibly admitted to psychiatric facilities on several occasions during the 1960s, where he received extensive electroconvulsive therapy. Though these interventions had no impact on his sexual orientation, he suffered substantial memory loss and trauma for years after treatment, as noted in this interview:

For the first eight years after shock treatment, I never knew if I would be able to connect my thoughts. I'd be walking down the street in New York and would have these flashes – and there would be nothing. I'd suddenly not know where I was. I'd think, "My God, I have to find out where I am. Why doesn't anything look familiar?" I would be typing at work and suddenly not be able to remember what city I was in. . . A lot of times I'd forget my name and address. That might last an hour and a half. But that's a long time when your mind is really going. The feeling was panic. . . The fear of loss of memory is one of the worst experiences I had after shock treatment, the fear that I might at any point experience this amnesia. That amnesia happened maybe a thousand times. [14]

In the 1950s and 1960s, doctors and social scientists produced a substantial volume of work investigating the nature and frequency of same-sex attractions and nonnormative gender identities. Much of this "scientific" work, selectively edited, reinforced existing prejudice and provided a powerful set of arguments to support social and legal harassment of LGBT people, creating a terrible era for LGBT human rights [15]. Repressive social and political culture confronted anyone who failed to fit strict codes of social conduct. Anti-communist sentiment often coincided with anti-gay fears during the McCarthy era, thus blending both the red scare and the "lavender scare." As David K. Johnson outlines in *The Lavender Scare: Cold War Persecution of Gays and Lesbians in the Federal Government*, gay men and women were thought of during the McCarthy era as "fellow travelers" to communists [16]. Anti-gay activists conjured up the circular argument that gay men and women were susceptible to blackmail by spies because of their hidden identities, ignoring the fact that this persecution is what made gay men and women susceptible to blackmail in the first place. Because of this supposed susceptibility to blackmail and theories that same-sex behavior indicated moral laxness, McCarthy succeeded in banning gay men and lesbians from many government positions. Many were fired from the Departments of State and other federal agencies, or were discharged dishonorably from the military. Job loss under this circumstance was highly damaging and could easily preclude successful employment in the private sector as well [17].

Gay men and lesbians were forced even deeper into the closet, and many sought treatment for their sexuality from medical professionals with the hope they might be able to return to prestigious jobs if "cured" of their sexuality. Others were forced into medical treatment by a legal system that understood their sex acts as a medical condition or perversion, an illness that was also a crime. Same-sex sexual interaction between males was illegal, and arrests were frequent. Police raided gay bars often, and used entrapment methods to arrest gay men in public places known as meeting locations. Patrons faced weeks of jail time for minor infractions including cross-dressing, generally defined as wearing more than three items of clothing associated with the opposite sex [18]. Beatings and sexual assault were common in jails, for both gay men and lesbians [19]. Any arrest could take people away from work with no acceptable explanation, and permanent records of the incident might make them unemployable. Instead of jail time, those convicted of "sexual perversion" might opt for medical intervention, or were ordered to undergo a medical intervention as part of their sentencing. These interventions aimed to curb sexual attraction, especially in gay men. The state



claimed a vested interest in controlling the sex lives of its citizens, based on the idea of what created a moral society.

Psychiatric theory and practice of that time generally aided repressive legal actions by insisting, despite Freud's advice to the contrary, that homosexuality was an illness and that invasive treatments could "cure" it. However, some researchers began to explore sexuality in a less pejorative fashion. Notably, Kinsey's detailed reports surprised many both by their relatively neutral stance and their data documenting that same-sex behavior and attraction were far more common than previously believed [20].

Similarly, hopeful legal developments also emerged during the 1950s, either despite or because of increasing repression. Indeed, the 1950s became a tipping point, leading to the formation of the country's earliest LGBT human rights activism. These early "homophile" organizations arose from the freedom of movement and homosocial gatherings made permissible by WWII [21]. Early organizations such as the Mattachine Society and the Daughters of Bilitis protested the exclusion of gay men and women from government jobs and other prohibitions on their participation in public life.

During the post-war era, a more nuanced understanding of the difference between sexuality and gender presentation began to emerge, perhaps because of the growth of the trans identity during this era. Without the means to transition medically, it was difficult for society to understand an individual's decision to live as another gender, as distinct from choosing to present one's birth gender in a nonnormative way, or even to engage in sex acts not normally associated with that gender. Importantly, we also see the first introduction of medical treatments intended to support, rather than suppress, the needs of those outside the heterosexual mainstream. With the development of synthetic estrogen, testosterone, and early sex-reassignment surgeries, we start to hear of people who we can recognize as transgender in the modern sense. These pioneers, such as the GI-turned starlet Christine Jorgensen, showed that transsexuality was a distinct identity, rather than a continuation of the sexual desires of "inverts" [22]. Jorgensen introduced to a wider public the idea that a desire for same-sex partners was separate from an identity with a gender other than that given at birth. She was so clearly different from a gay man that people began to perceive a real difference between sexual orientation and gender identity. Thus, these two concepts begin to diverge, though they remain confusingly intertwined in much current public discourse even today.

## 1960s–1990s: Civil Rights in a Changing Political Era

We will highlight only the most important developments in the evolving relationship between the LGBT and medical communities between 1959 and today. The past four decades have seen drastic changes in how LGBT individuals are viewed by society and by doctors. In addition, historical moments rooted in the LGBT community have shaped the medical community, our nation, and the world at large. In this section we will cover the emergence of the gay civil rights movement in the late 1960s, the removal of homosexuality as a psychiatric illness from the DSM, the grappling of the medical and psychiatric community with transgender issues, and the AIDS crisis, which shaped gay identity and medical practice the world over.

While there were LGBT activists working for legal reform in the 1950s, the 1960s and 1970s saw a shift in the radical nature of the LGBT civil rights movement, as with other civil rights movements, and a huge boom in the number of "out" LGBT individuals. For many, the Stonewall riots of 1968 represented the first pivotal event in the LGBT rights movement. Though accounts vary, the consensus is that patrons of the Stonewall Inn, most likely a group of young, black, and Latino drag queens, butch lesbians, and transgender people, decided to resist arrest after police invaded the bar during one of their frequent roundups in the neighborhood. Instead, these young, marginalized patrons fought back, trapping the police in the bar and starting riots that lasted for several days, as more and more people from the community joined the fray to protest police abuses [18]. Other events around the country soon followed. Similar riots broke out in the Compton Cafeteria in LA, a gathering place for similarly marginalized, black and Latino gay and trans youth, when police attempted a raid. The next year, the first gay pride march commemorated the Stonewall riots. Over time, more radical protests emerged against discrimination, and called for more gay people to live their lives out of the closet. This shift in tone marked a difference from the philosophy of homophile organizations such as the Mattachine Society, which sought to project an image of respectability. These pioneering activists secured important legal victories, resulting in decreased raids on gay bars and the repeal of various anti-sodomy laws. However, some jurisdictions retained stigmatizing laws for far longer. Sodomy was still illegal in several states until the *Lawrence v. Texas* decision in 2003. Other states today still have

limited legal protections for LGB employees, and many states have laws discriminating against trans individuals.

Large shifts also occurred in the 1960s and 1970s with regard to transgender history. Hormones became more accessible, both via doctors and black market channels. Gender affirmation surgeries improved and slowly became more accessible in the USA. At the same time, however, the LGBT community began to fragment as it grew, and many of its members tried to prioritize the voices and desires of their particular subgroup over others. Gay men began to focus more on sexual liberation, while lesbians took up radical feminism, and transgender rights were often overlooked. Some lesbians rejected members of the trans community, by describing trans women (male to female) as false women who did not belong to their community, and trans men (female to male) as self-hating misogynists. While lesbian and gay rights expanded greatly during this era, the trans community remained marginalized, both by society at large and by the LGB community.

The revision of the Diagnostic and Statistical Manual (DSM) to delete homosexuality as a psychiatric diagnosis was a critically important development in LGB history. This history is well chronicled in Ronald Bayer's excellent work, *Homosexuality and American Psychiatry: The Politics of Diagnosis* [23]. Briefly, psychiatry's annual meeting became the scene of increasingly visible protest for several years in a row. At one point a disguised psychiatrist addressed a large group, discussing his experience as a closeted gay man and physician. Initially, homosexuality as a diagnosis was removed in 1973 but replaced with the category *Sexual Orientation Disturbance* in DSM II, which still was grounded in the idea that same-sex attraction and behavior was abnormal. Activists protested the medicalization of same-sex attraction and garnered support from key American Psychiatric Association (APA) leaders, including Robert Spitzer, who had a pivotal role in drafting relevant versions of the DSM. A protracted, controversial, yet ultimately successful effort led to the elimination of homosexuality as a diagnosis in 1987.

Acquired Immune Deficiency Syndrome, or AIDS, propelled same-sex behavior and LGBT politics into the national spotlight in the 1980s. AIDS caused the deaths of hundreds of thousands of people in the USA alone [24], including many gay leaders in the fields of politics, the arts, and academia. The horror of the disease stirred widespread anti-gay sentiment, with many denouncing the LGBT community, refusing housing, medical and other services, and damning the "sinful" behavior that put people at risk for the illness. Indeed, one early medical acronym for AIDS was WOG – for Wrath of God – suggesting the illness was a righteous punishment. Surgeon General C. Everett Koop was one of the first public officials to embrace the fight against AIDS, sending out brochures across the nation in

1988 promoting strategies to prevent transmission, including condom use [25]. While many protested President Reagan's slow response to the epidemic, he was still the first sitting president to use the word gay in a public speech, marking a huge turning point both in the nation's acceptance of LGBT issues and in the fight against AIDS.

Within the community, some rifts that had grown between lesbians, gay men, and trans communities began to heal as these groups banded together to care for the sick. Grassroots LGBT health organizations such as Gay Men's Health Crisis and AIDS Coalition to Unleash Power (ACT UP) created a new infrastructure that agitated for social change and protested government and medical inaction. Eventually, as the medical community rallied around the AIDS epidemic, generating increased funding for research on the epidemiology, treatment, and prevention of the disease, these organizations began to work with the medical community. Thus, the AIDS epidemic shaped the medical community by creating some of the first community-based participatory research partnerships, forging new leaders in public health, and catalyzing groundbreaking infectious disease research and drug development. As researchers developed drugs for AIDS, and courageous doctors, many of them members of the LGBT community, cared for AIDS patients, respect gradually grew between the LGBT and medical communities. While gay men were the main focus of this shift in public health dialogue, as they comprised the majority of the early victims of the AIDS epidemic, lesbians, bisexuals, and transgender people were affected as well. The creation of LGBT-focused health organizations allowed LGBT people to access care in ways that did not exist before AIDS. Many of those who were identified as bisexual and/or trans were also vulnerable and continue to this day to be disproportionately affected by HIV infection [26].

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## Current Issues in LGBT Medicine

### Health Inequities

Health inequities persist for all LGBT populations compared to peer groups similar in race, ethnicity, income level, and education. Young MSM (men who have sex with men) comprise one of the few groups in the USA for whom the incidence of HIV infection continues to rise and are a focus of continued partnership between the medical and LGBT communities [26]. Trans patients continue to face poor access to general medical care, and many lack coverage for transgender-related therapies specifically. All LGBT people face extremely high rates of sexual violence, a problem that physicians should address in their patient care. Lesbians and bisexual women have higher rates of smoking and lung cancer

and a higher stage at diagnosis for gynecological malignancies. However, there have also been many success stories in the arena of LGBT health, particularly with regard to public health measures. By partnering with at-risk LGBT communities, public health officials have been able to decrease transmission of meningitis, hepatitis A, and HIV. In recent years, public health advertisements have attempted to target and engage specific demographic groups, such as lesbians or young MSM of color, with regard to a range of issues including smoking, frequent screening for STIs, domestic violence, and more frequent gynecological follow-up. In large cities, we have also seen the development of LGBT-specific health centers, such as the Callen-Lorde Community Health Center in New York and Fenway Health in Boston. Therefore, while LGBT patients have historically faced significant challenges in obtaining appropriate health care, medical and public health workers are taking strides to end some of the disparities.

### **Sexual Orientation Change Efforts**

Despite the removal of homosexuality from the DSM decades ago, and the proven ineffectiveness of reparative therapies, some psychotherapists continue to attempt to change their patients' sexual orientations. All major relevant professional organizations have now produced consensus documents condemning therapies intended to change sexual orientation. Nonetheless, such therapies continue despite ample evidence that they have deleterious effects, especially for LGBT youth [27]. The attempt to eliminate such therapies is now shifting to the courts, with some significant success in attempts to use consumer fraud and other statutes to prevent these practices [28]. Some jurisdictions have created laws banning anti-gay therapies, though even these measures generally contain loopholes, for instance for clergy providing anti-gay counseling [29].

### **Trans Issues**

Trans issues have moved to the forefront of the LGBT political agenda in the last decade, with a focus on such issues as trans mental health, homelessness, and lack of access to care. While LGBT patients generally have less insurance and poorer access to care than their peers [30], trans people are the most marginalized group within the LGBT community, and often have even fewer resources than their lesbian, gay, and bisexual counterparts. Thus the extreme expense of hormone therapy and gender affirmation surgery weighs especially heavily on this group. While some insurers are beginning to cover these procedures, many trans people lack access to the hormones and surgeries that allow

them to pass safely in society, apply for jobs, feel secure in their identities, and in many cases alleviate intense depression. Several recent high-profile legal decisions have highlighted questions around whether trans people have the right to access gender-affirming medical and surgical care, particularly when they are incarcerated or lack insurance [31]. Because so many trans people have no legal pathway to hormones and surgery in the USA, many travel to foreign countries for cheaper and occasionally black market procedures without proper postsurgical care. Others receive sex hormones from unofficial sources, and even participate in "injection parties" where non-official providers will inject silicone for body contouring, a highly dangerous procedure that causes disfigurement as often as it results in desired cosmetic changes to facial, hip, or other anatomical structures [32].

Another battle that trans people face is the right to define their own transitions. In prior decades some clinics followed rigid guidelines regarding the use of hormones and surgery. For instance, a patient required an evaluation and permission from a physician before beginning medical and surgical steps for transition, and might need to agree in advance to have both "top" and "bottom" surgery before any intervention could begin. Today trans people prefer to tailor their choices to suit their specific needs, rather than follow one set pathway. For instance, some trans people identify with a gender that is neither male nor female and must negotiate with doctors to attain the services they seek. Because prescription medications, surgery, and insurance reimbursement all require the participation of physicians, trans people continue to work with the medical community, though now insisting that a much greater emphasis be placed on informed consent, shared decision-making, and respect for individual values and preferences. The challenge of working toward a respectful, safe, and fair approach to gender transitions is particularly evident in the emerging field of childhood and adolescent transitioning, with its complex dialogue between parents, professionals, and children about the appropriate time to transition.

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### **Conclusion**

This chapter presents an historical overview intended to help providers care more thoughtfully and sensitively for their LGBT patients. We have explored some of the historical roots that underlie changing definitions of common terms, including gender identity and sexual orientation. It is important for clinicians to grasp these concepts and to understand what they still do not know about patients' lived experiences, in order to work respectfully with LGBT patients. Consider, for instance, the task of a clinician who encounters a male-identified, masculine-presenting, natal

female patient who is attracted to and sexually active with men. Currently, few providers possess the knowledge and skills needed to sensitively explore and understand such a person's gender identity and orientation. However, such competence is crucial for many aspects of health care, including assessment for pregnancy, STIs, and long-term gynecological follow-up, as well as possible trauma and sexual assault. Rather than focus on rigid classification schemes that are so much a part of medicine, we urge practitioners to follow their patients' values and preferences in exploring issues of sexual orientation and gender identity. Our goal as professionals is not to fit patients into a taxonomy but to help people attain and maintain wellness through the tools that medicine provides.

Scientific understanding of gender and sexuality continues to evolve. Because of this, it is necessary to maintain clinical humility and let our patients guide us. What is right for one patient is not necessarily correct for another; we must allow each of our patients to shape their own identities and communicate how those identities affect their lived experiences and health-care needs. While education for health-care providers on LGBT issues is increasing, to date it remains insufficient. We must do our best to address the health-care issues affecting our patients, but we must also recognize there is much we do not know and view our LGBT patients as our educators. As clinicians, we must remember medicine's historical errors and avoid making similar mistakes in our own practices. By maintaining compassion and asking honest questions, we can form effective partnerships with our patients to help us all navigate the health-care system successfully and aim for the best possible care.

## Resources

Those interested in additional reading should consider the texts listed below.

1. Chauncey, G. *Gay New York: Gender, Urban Culture, and the Making of the Gay Male World, 1890–1940*. Basic Books; 1994.
2. D'Emilio, J. "The Homosexual Menace," in *Making Trouble: Essays on Gay History, Politics and the University*. New York: Routledge; 1992.

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