SEXUAL AND GENDER MINORITY HEALTH

Edited by Allen J. LeBlanc
and Brea L. Perry

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VOLUME 21

SEXUAL AND GENDER MINORITY HEALTH

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ADVANCES IN MEDICAL SOCIOLOGY VOLUME 21

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EDITED BY

ALLEN J. LEBLANC
San Francisco State University, USA.

BREA L. PERRY
Indiana University, USA.

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CONTENTS

PART I
HEALTH DISPARITIES: RISK FACTORS, MINORITY STRESS, AND INTERSECTIONALITY

PART II
RESILIENCE AND RESISTANCE: IDENTITY, SOCIAL RELATIONSHIPS, AND COMMUNITY

PART III
THE ROLE OF INSTITUTIONS: HEALTHCARE AND SOCIAL SERVICE SYSTEMS

LIST OF CONTRIBUTORS

Suyanna Linhales Barker	La Clínica del Pueblo
Grayson Bodenheimer	Indiana University
Caleb Cooley	Washington State University
Ana María del Río-González	The George Washington University
Justin T. Denney	Washington State University
Carrie Elliott	Syracuse University
Bridget K. Gorman	Rice University
Debra Guckenheimer	California State University, East Bay
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Cristiana Little	American University
Andrew S. London	Syracuse University
Sonja Mackenzie	Santa Clara University
Emily S. Mann	University of South Carolina
Christopher Norton	American University
India J. Ornelas	University of Washington
Jennifer Pearson	Wichita State University
Brea L. Perry	Indiana University
Laura Rapoport	American University
Corinne Reczek	The Ohio State University
Anna Sheppard	University of South Carolina
stef m. shuster	Michigan State University
Natalee Simpson	Independent Researcher
Russell Spiker	Vanderbilt University

Lawrence Stacey	The Ohio State University
Mieke Beth Thomeer	University of Alabama at Birmingham
Stacy Torres	University of California, San Francisco
Rebecca Wang	Syracuse University
Tre Wentling	University of Colorado Colorado Springs
Lindsey Wilkinson	Portland State University
Jamie Lyn Wooley-Snider	Wichita State University
Thespina J. Yamanis	American University
Zhe Zhang	Rice University

RESEARCH ON SEXUAL AND GENDER MINORITY HEALTH: HISTORICAL DEVELOPMENTS AND FUTURE DIRECTIONS

Brea L. Perry and Allen J. LeBlanc

ABSTRACT

Purpose: *The goal of Volume 21 of* Advances in Medical Sociology*, entitled* Sexual and Gender Minority Health*, is to showcase recent developments and areas for future research related to the health, well-being, and healthcare experiences of LGBTQA+ (Lesbian, Gay, Transgender, Queer, Asexual, and related communities that do not identify as heterosexual) persons and communities.*

Approach: *In this introduction to the volume, we trace the historical development of research on sexual and gender minority (SGM) health, discussing how priorities, theories, and evidence have evolved over time. We conclude with brief suggestions for future research and an overview of the articles presented in this volume.*

Findings: *Research on SGM health has flourished in the past two decades. This trend has occurred in conjunction with a period of intense social, political, and legal discourse about the civil rights of SGM persons, which has increased understanding and recognition of SGM experiences. However, recent advances have often been met with resistance and backlash rooted in enduring social stigma and long histories of discrimination and prejudice that reinforce and maintain health disparities faced by SGM populations.*

Value: *Our review highlights the need for additional research to understand minority stress processes, risk factors, and resiliency, particularly for those at the intersection of SGM and racial/ethnic or socioeconomic marginality.*

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Research on sexual and gender minority (SGM) health has flourished in recent years. This trend has occurred in conjunction with a period of intense social, political, and legal discourse about the civil rights of SGM persons, which has increased understanding and recognition of SGM experiences. However, recent advances have often been met with resistance and backlash rooted in enduring social stigma and long histories of discrimination and prejudice. The goal of Volume 21 of *Advances in Medical Sociology*, entitled *Sexual and Gender Minority Health*, is to showcase recent developments and areas for future research related to the health, well-being, and healthcare experiences of LGBTQA+ persons and communities. In the following introduction, we trace the historical development of research on SGM health, discussing how priorities, theories, and evidence have evolved over time. We conclude with brief suggestions for future research and an overview of the articles presented in this volume.

The evolution of research on SGM health, 1950–2000. Early pioneering research on SGM health in the US in the 1950s occurred in the context of a sexually repressive culture that formally or informally sanctioned “crimes against nature,” including masturbation, oral sex, interracial marriage, and homosexual activity. At this time, “sexual inversion” (i.e., homosexuality) was considered by most medical experts and lawmakers to be a rare and criminally deviant pathology, and most research on the topic focused on revealing its biological basis (Henry, 1948; Hirschfeld, 1948). Homosexuality was included as a psychiatric disorder in the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders* (DSM) until 1973, at which time it was removed due to increasing social pressure and contradictory evidence regarding its pathological nature (Conrad, 2007). However, shortly thereafter, a formal diagnosis of gender dysphoria (i.e., severe discomfort with one’s gender identity or role; IOM, 2011) was introduced to the DSM and remains today.

During the first wave of research on SGM health, efforts focused on establishing that homosexuality itself is not a disease. Two early pioneers whose work exemplifies this midcentury research are Alfred Kinsey (a biologist) and Evelyn Hooker (a psychologist). Kinsey was among the first scientists to argue that homosexuality was not pathological, contending that, “nearly all the so-called sexual perversions fall within the range of biological normality (Brown & Fee, 2003, p. 1039).” The *Kinsey Reports* – a two-book series consisting of *Sexual Behavior in the Human Male* (1948) and *Sexual Behavior in the Human Female* (1953) – supported this claim in at least two ways: First, the *Kinsey Reports* demonstrated that homosexual behavior in both males and females was commonplace (e.g., 60% of teenaged boys). Second, Kinsey developed the Heterosexual-Homosexual Rating Scale, which documented that people rarely fit into exclusively heterosexual or homosexual categories. Kinsey’s research using the scale showed that sexual behavior varied over time and was often inconsistent with sexual identity (Kinsey et al., 1948).

Kinsey's work was supported by anthropological research demonstrating that homosexual behavior in humans existed across 76 different cultures and was present in multiple other mammalian species (Kinsey et al., 1953). This research contradicted the mainstream clinical view that homosexuality was rare and pathological.

Using a different approach, Evelyn Hooker addressed questions with implications similar to Kinsey's. With funding from the National Institute of Mental Health, Hooker undertook research on "normal gay men," comparing 30 self-identified homosexual men to 30 heterosexual men matched on age, educational attainment, and IQ (1957, 1958). Hooker asked experts to blindly evaluate participants' tests of psychological adjustment, finding that they were unable to differentiate the results of homosexual and heterosexual men. This study, and her subsequent body of research, demonstrated that psychologically healthy homosexuals exist, and thus these behaviors fall within a normal range of human sexual variation. Hooker's findings were instrumental in efforts to compel the American Psychiatric Association to remove homosexuality from the DSM, and she was an instrumental figure in the establishment of homosexuality as a field of study (APA, 1992).

Following the demedicalization of homosexuality, gay and lesbian communities grew in size, number, and visibility throughout the 1970s, but research on the health of SGM persons remained scant. In the 1980s, research on SGM health, and particularly gay men's health, increased precipitously, but was driven largely by the HIV/AIDS epidemic and studies of sexual risk behavior. While attention to HIV/AIDS and funding for behavioral and clinical studies was woefully inadequate in the early stages of the epidemic, the Department of Health and Human Services committed increasing resources throughout the 1980s and 1990s. Because research on SGM health, in general, has not historically been prioritized by federal funding agencies, much of the work conducted by social scientists during this period was tied to resources earmarked the study of HIV/AIDS among men who have sex with men (IOM, 2011). Therefore, the HIV/AIDS epidemic strongly influenced what was learned about SGM health during the latter part of the twenty-first century. Specifically, many studies adopted a "risk behavior" framework that disproportionately focused on men, inadvertently re-pathologized same-sex behavior, and diverted attention away from social or structural inequalities (e.g., the San Francisco Men's Health Study; Winkelstein et al., 1987; see Herek, Widaman, & Capitanio, 2005).

In the 1990s, a new wave of research on SGM health developed largely independently of HIV/AIDS research. This body of work focused more broadly on the health and well-being of SGM persons, beginning with observations about disproportionate risk for mental health problems. Though heightened risk for psychiatric conditions and suicidality was first identified in 1972 in a clinical psychiatric study of 60 young gay men (Roesler & Deisher, 1972), this issue was largely ignored for decades. In the 1980s, a handful of small studies chronicled the psychological challenges, harassment, and stigmatization of SGM youth, focusing on school settings and the coming out process (Hunter & Schaecher, 1987; Martin, 1982; Ross-Reynolds & Hardy, 1985). This was followed by research documenting alarmingly disproportionate risk for suicidal ideation, attempt and mortality among SGM youth and adults using postmortem psychological autopsies, representative school-based data on adolescents, and population-based approaches (DuRant, Krowchuk, & Sinal, 1998; Faulkner & Cranston, 1998; Fergusson, Horwood, & Beautrais, 1999; Garofalo, Wolf, Wissow, Woods, & Goodman, 1999, 1998; Remafedi, French, Story, Resnick, & Blum, 1998; Rich, Fowler, Young, & Blenkush, 1986; Shaffer, Fisher, Hicks, Parides, & Gould, 1995). Ultimately, this body of work culminated in calls for additional research on risk for suicide in SGM populations in reports from the US Surgeon General (2012) and the Institute of Medicine (Goldsmith, Pellmar, Kleinman, & Bunney, 2002), and growing interest in SGM health disparities more generally.

Contemporary research on SGM health. The early findings on suicide disparities and related risk and protective factors paved the way for examining other morbidities, and the turn of the century marked a significant turning point for research on SGM health. Since that time, a large body of evidence has amassed suggesting that SGM persons face persistent health disparities, including more chronic conditions, poorer self-rated health, and higher rates of disability (Fredriksen-Goldsen, Kim, Shui, & Bryan, 2017; IOM, 2011). Inequalities between SGM and heterosexual populations have been found across a broad range of physical and mental health outcomes, including affective disorders and suicidality (Bostwick, Boyd, Hughes, & McCabe, 2010; Clements-Nolle, Marx, Guzman, & Katz, 2001; Cochran, Sullivan, & Mays, 2003; King et al., 2008), substance use disorders (King et al., 2008), obesity (Boehmer, Bowen, & Bauer, 2007), hypertension (Fredriksen-Goldsen, Kim, Barkan, Muraco, & Hoy-Ellis, 2013), cardiovascular disease (Diamant & Wold, 2003; Fredriksen-Goldsen et al., 2013), Type II diabetes (Beach, Elasy, & Gonzales, 2018; Corliss et al., 2018), chronic pain (Fredriksen-Goldsen et al., 2017), and cancer (Simon Rosser et al., 2016; Stinchcombe, Wilson, Kortes-Miller, Chambers, & Weaver, 2018).

One of the most commonly used theoretical frameworks for understanding SGM health disparities is minority stress theory (Meyer, 1995, 2003). It posits that SGM populations experience chronic social stress as a function of unique forms of stigma, prejudice, and discrimination. Chronic stress is attributed both to distal experiences of prejudice and discrimination events perpetrated by others, and to more proximal feelings of internalized homophobia and perceived stigma among SGM persons (Meyer, 1995, 2003). Importantly, the stressors faced by SGM populations are purported to be persistent due to enduring social and cultural conditions, and fundamentally *social* because they are created and reinforced through social interactions, institutions, and structures (Herek & Garnets, 2007; Meyer, 2003; Wight, LeBlanc, De Vries, & Detels, 2012). Notable systemic issues include the historic denial of the right to marry, lack of legal protections against discrimination in the workplace, and persistent disenfranchisement from religious institutions (Schilt & Lagos, 2017).

More recent research has begun to examine minority stress as a process that unfolds over the life course, and which interacts with other forms of marginality. Studies suggest, for example, that minority stress tends to proliferate and create cumulative disadvantage, as SGM persons are disproportionately likely to experience a host of other major stressors that are interrelated, including homelessness, sexual assault, violence, child abuse, and harassment (IOM, 2011). Research in the past few years has turned to a focus on minority stress proliferation within couples (i.e., linked lives), documenting individual and joint experiences of stress resulting from the stigmatized status of their same-sex relationship (LeBlanc, Frost, & Wight, 2015). Finally, though much more work is needed, researchers have begun to study the multiplicative effects of minority stress processes occurring at the intersection of marginalized statuses, demonstrating that the burden of minority stress associated with SGM status is disproportionately experienced by people of color and those in lower socioeconomic groups (Cyrus, 2017; English, Rendina, & Parsons, 2018; McConnell, Janulis, Phillips, Truong, & Birkett, 2018; Shangani, Gamarel, Ogunbajo, Cai, & Operario, 2020).

A key proposition of minority stress theory is that SGM persons must be more resilient and adaptable than their heterosexual peers because they face excess stress associated with their minority status on top of general life stressors (Meyer, 2003). Research conducted in the past two decades has aimed to identify resiliency factors in this population (Kwon, 2013). Some studies suggest, for example, that supportive policy environments are associated with better health outcomes. Prior to the Supreme Court's Obergefell decision recognizing the right of individuals in same-sex relationships to legally marry, SGM couples living in states with marriage bans reported higher rates of psychological symptoms, stress, mood and anxiety disorders, and substance abuse than those in states without such laws (Hatzenbuehler, McLaughlin, Keyes, & Hasin, 2010; Kertzner, 2012; Rostosky, Riggle, Horne, & Miller, 2009). Moreover, married SGM adults have better health outcomes than their single counterparts, due to greater economic stability, consistent source of social support and companionship, and social regulation of health behaviors (LeBlanc, Frost, & Bowen, 2018; Reczek & Umberson, 2012; Riggle, Wickham, Rostosky, Rothblum, & Balsam, 2017; Wight et al., 2012). Social networks, more broadly, are an important coping resource for SGM adolescents and adults, providing affirmation of positive queer identities, minimizing the impact of prejudice and discrimination, and offering emotional and instrumental support and other resources that help promote and maintain good physical and mental health (Doty, Willoughby, Lindahl, & Malik, 2010; Hatzenbuehler, McLaughlin, & Xuan, 2012; Kwon, 2013).

Another common area of contemporary research on SGM health documents disparate access to health care and quality of care. SGM adults are less likely than heterosexuals to have a regular physician, to obtain preventative care, such as routine cancer screenings, and to be unable to afford care (Albuquerque et al., 2016; Buchmueller & Carpenter, 2010; Kerker, Mostashari, & Thorpe, 2006; Ward, Dahlhamer, Galinsky, & Joestl, 2014). Such patterns have been attributed to lower rates of health insurance, experience or fear of stigma and discrimination in healthcare settings, and perceived lack of physician knowledge about issues specific to SGM health (Bolderston & Ralph, 2016; Grant, Koskovich, Frazer, & Bjerk, 2010; Heck, Sell, & Gorin, 2006; Newman, Roberts, Masongsong, & Wiley, 2008). Research suggests that SGM persons are less likely to be satisfied with their health care, and receive lower quality care, as well (Blosnich, 2017; IOM, 2011). This is likely related in part to the paucity of training and guidelines on caring for SGM persons, and especially transgender patients, as well as discomfort doing so (Gibson, Radix, Maingi, & Patel, 2017; Zelin et al., 2018).

Though significant progress has been made in understanding SGM health disparities, risk and resiliency factors, and healthcare experiences in the past two decades, there is much work left to be done. First, the volume of research examining gay men and lesbians has far outpaced studies of bisexual, transgender, and other gender nonconforming persons (IOM, 2011). While preliminary research suggests that these groups experience the worst health outcomes among SGM populations (Friedman et al., 2014; Newcomb et al., 2020), more work is needed to understand the social and psychological conditions underlying these patterns. Second, additional studies adopting longitudinal perspectives that produce life-course understandings are needed to identify cumulative effects of the unique challenges and strengths of SGM persons at different ages and within distinct historical cohorts. The recently completed Aging with Pride: National Health Aging, and Sexuality/Gender (NHAS) Study is an important advancement and will likely yield further research producing critical knowledge for improving the aging experiences of older SGM adults (Fredriksen-Goldsen & Kim, 2017). Third, there remains a gap in knowledge about the heterogeneous experiences of multiply marginalized groups. Specifically, additional attention is required to understand the distinct risk and protective factors faced by SGM people of color, immigrants, religious minorities, and those in less advantaged socioeconomic groups.

Advancing research on SGM health: Volume Overview. As the above discussion underscores, the time is ripe for deeper examinations of the social determinants of SGM health, broadly defined to include social, mental, and physical indicators of well-being. Sociologists are uniquely situated to investigate the social factors that shape SGM health directly as well as indirectly through associations with other causal factors. Thus, this edited volume includes chapters that draw from classic and contemporary sociological frameworks and constructs (e.g., minority stress processes and sources of support, coping, and resilience), as well chapters that reflect broader and intersecting interdisciplinary approaches to understanding SGM health. Chapters focus on sexual and/or gender minority populations as a whole, as well as the diverse subpopulations within them.

The first section of the volume – *Health Disparities: Risk Factors, Minority Stress, and Intersectionality* – addresses theoretical and empirical explanations for SGM health disparities, and how being SGM interacts with other social statuses and identities. The volume begins with a systematic review of the literature on social class and SGM health by Russell Spiker, Lawrence Stacey, and Corinne Reczek ("Sexual and Gender Minority Health: Toward a More Complete Accounting of Social Class"). They argue that despite the numerous and critical ways in which SGM experiences and outcomes differ across social class groups, insufficient theoretical and empirical attention has been devoted to this intersection.

Next, Justin Denney and coauthors conduct an analysis of smoking, drinking behaviors, mental health, and suicidal ideation (i.e., factors linked to "deaths of despair") by sexual orientation using representative Behavioral Risk Factor

Surveillance System (BRFSS) data from 2011 to 2018 ("Substance Use, Mental Well-Being, and Suicide Ideation by Sexual Orientation Among US Adults"). They find alarmingly high risk for poor mental health days and suicidal ideation among sexual minority adults relative to their heterosexual counterparts, and elevated risk for all adverse outcomes among bisexual adults. This paper highlights the need for additional research explaining a wide spectrum of health disparities in this particularly vulnerable population, which faces stressors associated with expectations of fitting into binary understandings of sexual orientation.

In the third article, Jennifer Pearson, Lindsey Wilkinson, and Jamie Lyn Wooley-Snider narrow in on the issue of state policy effects on adolescent SGM suicide risk using representative data from the 2017 Youth Risk Behavior States Data ("State-Level Policy, School Victimization, and Suicide Risk among Sexual Minority Youth"). The authors find that disproportionate risk for bullying, suicidal ideation, and suicide attempt among SGM high school students is diminished in states with high levels of policy support for LGBTQ equality and nondiscrimination in education laws. This important article offers compelling empirical evidence to reveal how experiencing structural stigma through social policy or the lack thereof shapes exposure to minority stress and ultimately threatens the well-being of SGM youth.

The next article, by Thespina J. Yamanis and coauthors, examines fear of deportation among Latinx men who have sex with men (MSM). They use a mixed-method design to develop and assess the psychometric properties of fear of deportation, finding that the highly reliable scale is significantly associated with anxiety, vigilance, restricted movement, and avoidance of the healthcare system among these men. Yamanis and coauthors discuss the unique implications of being at the intersection of life experiences as MSM, Latinx, and undocumented immigrants for health outcomes and access to health care.

The second section – *Resilience and Resistance: Identity, Social Relationships, and Community* – focuses on coping resources and conditions that strengthen SGM persons' resilience to stress, discrimination, and marginality. In the first paper in this section, Mieke Beth Thomeer, Corinne Reczek, and Allen J. LeBlanc integrate social network and life course theories to develop a model of the role of social relationships in SGM health ("Social Biographies and Health Among Sexual and Gender Minority People"). They examine how "social biographies" (e.g., as defined by the intimate relationships that people form – or do not – and endure or end across a lifetime) change across the life course and across SGM cohorts, and, in particular, discuss how social relationships can be sources of both risk and resilience for health outcomes. In providing a blueprint for studying how SGM health disparities and close relationships of all kinds coevolve and coemerge over time, this article will help to guide future research.

Staying with the life course theme, the second chapter by Stacy Torres and Griffin R. Lacy offers a critical review of the formal and informal social safety nets that provide resources to older SGM adults during the aging process ("Life Course Transitions, Personal Networks, and Social Support for LGBTQA+ Elders: Implications for Physical and Mental Health"). Their review reveals that many older SGM adults have experienced strained relationships or rejection across the life course due to conservative social attitudes toward sexual or gender diversity. In response, many are able to fulfill social needs and avoid social isolation by creating extrafamilial communities of support or accessing formal social or healthcare services, highlighting the strength and resiliency of this population.

In her article, Sonja Mackenzie documents how SGM families buffer the adverse effects of minority stress by leveraging supportive community ties and by engaging in forms of minority coping ("Experiences of Gender and Sexual Minority Stress Among LGBTQA+ Families: The Role of Community Resilience and Minority Coping"). Mackenzie draws on in-depth qualitative interviews with parents in SGM families (i.e., where a parent, child, or both are SGM persons), finding that parents are exposed to stress by virtue of stigmatization of their own or their child's identity. While some parents cope with this adversity proactively by cultivating interpersonal, community, and institutional supports on behalf of themselves or their child, this is more difficult for those who are also racial or ethnic minorities and those who are relatively socioeconomically disadvantaged.

In the last article in this section on resilience, Anna Sheppard and Emily S. Mann interrogate the intersection of gender, obesity, and SGM status ("Resisting and Reframing Explanations for 'Lesbian Obesity': LBTQA+ Young Women's Narratives of Sexual Identity as a Protective Factor"). These authors draw on in-depth qualitative interviews with SGM women to explore how they perceive, experience, and resist dominant discourses about "lesbian obesity." The women in their study conceptualized their sexual or gender identity as a protective factor, allowing them to opt out of standard cultural body norms and discourses that are less prevalent in the queer community. In short, the public health narrative about obesity and overweight in this group did not accurately reflect SGM women's experiences, and typical public health solutions are unlikely to be effective in changing their health behaviors.

Finally, the third section – *The Role of Institutions: Healthcare and Social Services Systems* – documents the complex experiences of SGM persons navigating social institutions, particularly those in the larger healthcare system. An article by stef m. shuster and Grayson Bodenheimer draws on in-depth interviews with medical providers and observations of transgender healthcare conferences to examine how healthcare providers use accountability processes to secure compliance from transgender patients ("How Healthcare Providers Hold Trans Patients Accountable to Medical Authority"). Although healthcare providers often have little or no training in transgender health, and the clinical literature is sparse, the authors find that they nonetheless actively work to suppress challenges to their authority in physician–patient interactions with trans persons. The authors discuss how such accountability processes may be an overlooked mechanism through which SGM health and healthcare inequalities are produced and reproduced.

Tre Wentling and coauthors also examine the issue of medical encounters, focusing more narrowly on the case of sex-specific cancer screenings ("'Every Now and Then I Get Flagged for a Pap Smear': Gender Transition,