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REVIEW ARTICLE

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Dermatologic care of sexual and gender minority/LGBTQIA youth, part I: An update for the dermatologist on providing inclusive care

Markus D. Boos MD, PhD[1] | Howa Yeung MD[2] | David Inwards-Breland MD, MPH[3]

[1]Division of Dermatology, Department of Pediatrics, University of Washington School of Medicine and Seattle Children's Hospital, Seattle, Washington

[2]Department of Dermatology, Emory University School of Medicine, Atlanta, Georgia

[3]Division of Adolescent Medicine, Department of Pediatrics, University of Washington School of Medicine and Seattle Children's Hospital, Seattle, Washington

Correspondence
Markus D. Boos, MD, PhD, Seattle Children's Hospital, 4800 Sand Point Way NE, OC.9.833, Seattle, WA 98105.
Email: markus.boos@seattlechildrens.org

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Abstract

Sexual and gender minority (SGM) persons, including lesbian, gay, bisexual, transgender/gender diverse, questioning/queer, intersex, and asexual (LGBTQIA) individuals, represent a historically underserved population within the field of medicine, though their unique health needs are increasingly recognized. Unfortunately, our understanding of these needs as they relate to dermatology is still nascent, particularly with respect to children and adolescents. This two-part review will discuss the dermatologic care of SGM youth, with Part 1 providing practical advice for dermatologists seeking to provide more culturally mindful and accessible care for SGM children and adolescents. A more comprehensive understanding of the psychosocial and physical needs of SGM youth will allow dermatologists to more actively and compassionately care for this health disparity population.

KEYWORDS
bisexual, gay, genderqueer, lesbian, sexual and gender minority, transgender

1 | INTRODUCTION

Sexual and gender minority (SGM) individuals (an expansive term that includes those who identify as lesbian, gay, bisexual, transgender/gender diverse, questioning/queer, intersex, asexual, or other than cisgender/heterosexual) represent a historically underserved health disparity population within the field of medicine. Recently, the SGM population has become more visible in public life, and with this change, a greater awareness of their social, emotional, and physical health needs has developed.[1,2] Advocacy, educational, and research efforts from clinicians and organizations such as the American Academy of Dermatology (AAD) Expert Resource Group on LGBT/SGM Health have improved our understanding of common and unique dermatologic concerns of SGM patients.[3,4] Nevertheless, many providers may still be unaware of this unique population's distinct needs or feel ill-equipped to deliver the compassionate and inclusive care SGM individuals deserve.[5,6] This uncertainty is often amplified for pediatric patients.[7] Clinical practice guidelines addressing the optimal care of SGM youth exist to assist providers in best supporting their patients.[8-12] Part 1 of this review, focusing on the dermatologic care of SGM youth, offers dermatologists guidance toward respectful and inclusive care that addresses the developmental and physical needs of this health disparity population.

2 | THE ROLE OF THE DERMATOLOGIST IN THE CARE OF SGM YOUTH: ADDING VALUE

Effectively providing optimal, affirming care for SGM children and adolescents requires an understanding of the special developmental and social challenges facing this group. In much the same way that pediatric dermatologists provide dedicated, developmentally specific care to children that differs from their adult counterparts, a dermatologist who actively engages with SGM youth adds value to their health care by providing the specialized dermatologic attention that these patients may desire and need in the context of their psychosocial development. This holds true even when an individual presents with cutaneous concerns that may not be directly related to their sexual behavior or gender identity. Moreover, recognizing that skin is an important aspect of an individual's physical appearance and that SGM adolescents are at increased risk of poor body image, the role of the dermatologist in the care of SGM youth is likely underappreciated.[10-12] Although the field of SGM dermatology is still relatively nascent,[5] clinical studies are currently under way to identify unmet dermatologic needs of SGM children and adolescents and how they may differ from their cisgender/heterosexual counterparts.

Multiple barriers exist for SGM youth seeking comprehensive and compassionate medical care. Specifically, finding available, knowledgeable, and compassionate providers who understand the unique developmental and emotional needs of SGM youth, who are easily accessible, who provide acceptable, culturally humble, and confidential care, and whose care is equitable, regardless of patients' sexual or gender identification, is often a challenge for this population.[13] Recently established gender clinics are an encouraging development in the comprehensive care of transgender youth, although the majority do not have a dermatologist directly integrated into patient care.[14] Moreover, for many SGM children and adolescents, providers who recognize and are facile in managing the unique or more frequent challenges facing this population (increased mental health and body image problems, high-risk substance use or sexual activity, homelessness, bullying) are missing in their communities.[13,14]

Why does an increased workforce of dermatologists with improved expertise in managing the issues of SGM youth matter? An increase in societal acceptance of SGM persons over time has correlated with an increased percentage of individuals in the United States who self-identify as SGM.[15] As such, a larger number of patients who identify as SGM or engage in same-sex sexual activity are likely to be encountered in the clinical setting. Furthermore, as more children identify and are accepted as transgender, the need for dermatologists as a component of multidisciplinary care teams may increase, particularly in the context of transitioning (the process by which individuals change their physical presentation and/or sexual characteristics to align with their internal gender identity). Anecdotally, it is often difficult for SGM patients to identify dermatologists in their communities who are able to provide comprehensive and empathic care, whether because of availability, accessibility, limits based on insurance coverage, or provider discomfort.[16,17] Implicit and unconscious bias against sexual minorities among health care providers has also been recognized and may hinder dermatologic care access.[18,19] However, an improved, empathic understanding of this population as well as frequent positive interactions among health care providers and their SGM patients have been shown to reduce the disparities encountered by the SGM community secondary to such bias.[18-20]

Dermatologists often form longitudinal relationships with their patients, affording them the opportunity to provide ongoing psychosocial support to SGM patients. As dermatologists screen for depression in patients with acne on isotretinoin, assess dermatologic manifestations of sexually transmitted infections, and evaluate cutaneous findings of substance abuse and eating disorders, they should inquire during clinic visits about these and other psychosocial factors disproportionately affecting SGM youth.[21] Subsequent management, however, is best undertaken by specialists trained in these disciplines (psychiatry, adolescent medicine, infectious disease, social work, etc). Dermatologists should identify and partner with individuals or multidisciplinary clinics in their institutions or communities to whom they can refer patients as needed.[14]

3 | UNDERSTANDING SGM YOUTH: TERMINOLOGY AND CHILDHOOD DEVELOPMENT

Recognizing that SGM is an expansive term that encompasses a variety of sexually and gender-diverse youth is essential when providing respectful and affirming care, and language is a central component of communicating such compassion (Table 1). Sexuality is defined as an individual's persistent pattern of physical and emotional attraction to another; however, when inquiring about a specific patient's sexuality, it is also important to recognize that an individual's sexual orientation may not reflect their sexual practices. For example, approximately one-quarter of high school students who identify as heterosexual have had sexual contact with members of both sexes or exclusively with same-sex partners.[22] Therefore, assumptions about patients' sexual activity should not be made based on their self-identified sexual orientation.

In contrast, gender identity is distinct from sexuality and refers to an individual's internal sense of self as male, female, or other. Transgender individuals are those whose gender identity differs from the sex assigned to them at birth based on their genital anatomy ("natal sex" or "sex assigned at birth"). The vocabulary used by patients is fluid and evolving, dependent on both the individual and cultural context, and patients should be encouraged to state how they prefer to be identified (Table 1).[23,24] This is particularly vital, as individuals may identify as gender diverse or nonbinary.[23,25] It is again important to note that gender identity and sexuality are separate but intercepting concepts; transgender and gender-diverse individuals may identify themselves anywhere along the spectrum of sexuality.[9,26]

The prevalence of SGM adults is estimated at approximately 3.5% of the U.S. population.[15] In contrast, up to 8% of high school–aged adolescents identify as gay or bisexual, while another 0.7% identify as transgender.[22,24] These demographic differences may reflect the length of time that an individual requires to understand and accept

TABLE 1 Terms used to describe an individual's sexual and gender identity[3,13,23,26]

Terms	Definition
Heterosexual	Those with physical and emotional attraction to individuals of the opposite sex
Cisgender	An individual whose sex assigned at birth based on genital anatomy corresponds to their internal sense of gender
Same-sex attracted/Gay/Homosexual[a]	Those with physical and emotional attraction to individuals of the same sex
Lesbian	Specific term to denote a female with same-sex attraction
Bisexual	Those with physical and emotional attraction to both men and women
Pansexual/Queer	Those whose attraction is not constrained by notions of sexuality or gender identity
Queer	Broad term often used to denote sexuality and/or gender identity that exists outside of a heterosexual/cisgender norm
Gender diverse	Those whose gender expression differs from social norms
Transgender	An individual whose sex assigned at birth based on physical anatomy differs from their internal sense of gender
Assigned female at birth transgender male/ transman/transmasculine	An individual assigned female at birth based on natal sex who identifies as male
Assigned male at birth transgender female/transwoman/transfeminine	An individual assigned male at birth based on natal sex who identifies as female
Transsexual[a]	Term historically used to describe transgender individuals, no longer commonly used given its negative connotation
Gender nonbinary/asexual/third gender/genderfluid/genderqueer[b]	Those whose gender identity exists outside of either a male or female binary and/or who identify as both. This identification is independent of natal sex or sexual attraction.
Intersex	An individual whose natal sex/genital anatomy does not correspond to strict definitions of male or female. These individuals may possess any sexual orientation or gender identity.

[a]This term may be considered offensive.
[b]Some transgender individuals may also identify as nonbinary; these terms are not mutually exclusive.

their own sexual and gender identity. It is estimated that most gay or lesbian youth self-identify as such at 15 to 16 years of age,[27] but an individual may initially have a fluid concept of their sexuality, about which they become more certain over time.[26,28] Intergenerational differences and a reduced stigma against SGM persons with time may also contribute to this difference in incidence, as more people feel safe to identify as SGM. Most children have an understanding of their gender by 2 to 4 years old, which becomes more secure with age.[29] Transgender children may also be aware of feeling "different" during this time period, though they typically self-identify as transgender at approximately 13 years of age.[29,30]

The process by which SGM youth disclose their sexual orientation or gender identity ("coming out") to others can be challenging and stressful. It may also be compounded by episodes of bullying or other forms of victimization.[31] Supportive reactions from parents appear to result in better long-term health outcomes and decreased risk behavior in SGM adolescents.[11,26,32,33] Dermatologists also play an important role in providing thorough and supportive care to yield similar positive effects.

4 | CREATING A WELCOMING ENVIRONMENT FOR SGM YOUTH

Studies examining SGM adolescents' preferences when receiving medical care demonstrate that this population's needs and expectations for quality care do not differ considerably from their cisgender/heterosexual counterparts.[13,16,31] Namely, SGM youth desire health care that is accessible, that respects patient confidentiality and autonomy, and that delivers counseling in a private, nonjudgmental manner.[31] Confidentiality is of the utmost importance in this population, however, as children and adolescents who trust their provider to maintain privacy (especially around issues of gender identity, sexuality, and sexual practices) are more likely to divulge personal details that are relevant to their health care.[31] One-on-one time without parents is recommended during visits with adolescent patients in general and SGM adolescents specifically; during this time, the patient's privacy should be reassured, and providers should inquire about to whom the patient has disclosed their sexual and/or gender identity.[13,34] Inappropriate disclosure of such personal details by physicians to family members or others not only harms the doctor-patient relationship but can also lead to negative acute and long-term physical and mental health outcomes for these patients if the recipient of this information regards it negatively.[13,32] It is recommended that a more detailed psychosocial history be taken without a parent when a child begins to demonstrate the psychologic or physical signs of puberty;[34] in our practice, we typically offer one-on-one time with children 12 years of age and older. For children presenting with basic dermatologic concerns that may not require long-term follow-up (a single wart, epidermal inclusion cyst, epidermal nevus, etc.), such questioning is often deferred; similarly, given the time constraints of office visits, it may not be feasible or appropriate to have more intimate conversations at an

TABLE 2 Recommendations for pediatric dermatology providers and their clinics/institutions to engage in supporting LGBTQ youth[9,13,16,18,31,43]

Provider level
Using and documenting the name and pronouns used by the patient
Using open and nonjudgmental language to discuss a patient's sexual orientation, sexual behavior, gender identity, and anatomy
Discussing patient confidentiality, with particular attention to confidentiality issues and disclosure around family members and in medical documentation
Educating about culturally aware care and implicit bias
Apologizing for errors in use of incorrect terms
Advancing provider understanding on dermatologic concerns of LGBTQ youth
Institutional/Clinical level
Providing employee training in LGBTQ health and cultural competence/humility
Interacting with patients' parents, caretakers, or partners appropriately and respecting patients' support system beyond biological family members
Developing partnerships or referral pathways for pediatric dermatology from specialized gender clinics for transgender youth
Providing gender-neutral or all-gender restrooms or enabling patients to use restrooms corresponding to their gender identity
Creating and maintaining a culture with zero tolerance for discrimination
Posting nondiscrimination policies and signage specifically welcoming to LGBTQ patients and families
Incorporating dedicated "patient navigators" to help patients with care coordination and/or insurance concerns
Incorporating pediatric providers and social workers to help LGBTQ patients with psychosocial issues that are often barriers to effective and consistent care (mental health issues, homelessness, etc.)

initial visit for adolescents presenting with common dermatologic conditions such as psoriasis or atopic dermatitis. Nevertheless, as a therapeutic relationship develops, over time we typically take a more comprehensive psychosocial history (including sexual orientation and gender preference) in a private setting to provide optimal, comprehensive care.[21]

Sexual and gender minority youth also identify open-mindedness and an understanding of issues facing their community as among the most important qualities that they seek in their health care providers; however, they seek evidence of this in meaningful ways.[31] This means that symbolic signals (rainbow stickers, SGM-related literature, or signage in a waiting room), while recommended to telegraph that a given clinic is a safe space for SGM youth, may matter less than a provider who is knowledgeable about SGM health and engages patients openly and with sensitivity.[31] One way that providers and staff can exhibit openness is by evaluating their own implicit bias and not assuming heterosexuality or a cisgender "norm" with their patients.[35,36] Directly asking a patient with which gender they identify and what pronoun they prefer (eg, "he," "she," "they," or other) and inquiring about their sexuality in a direct, nonjudgmental manner ("Are you attracted to or do you have sex with women, men, or both?" "Do you have oral, vaginal, or anal sex?" "When was the last time you had sexual intercourse?") are simple but effective ways of demonstrating inclusiveness.[16,32,35,37] For providers and staff concerned about offending cisgender/heterosexual (non-SGM) patients who may regard such questions negatively, it may be helpful to preface such questions by stating, "To make sure that our clinic is a safe space for all of our patients, we like to ask everyone…," thereby normalizing the process by which gender and sexual identity/activity is obtained during the clinical encounter. Alternatively, SGM status may be acquired via patient intake form, a method that was found to be preferred by SGM adults in the emergency room setting, while non-SGM adults were comfortable with either approach.[37] Patient intake forms may be less applicable for the pediatric population for whom parents often complete medical intake forms, however. Electronic medical record systems that subsequently incorporate this information into a patient's profile may also help providers and staff address patients appropriately (specifically with respect to preferred pronouns), strengthening trust with their SGM patients.[38] Finally, though certain dermatology-relevant conditions such as sexually transmitted diseases are more common in specific subsets of the SGM population, it is important to avoid assuming risk factors or behaviors based on an individual patient's sexuality or gender identity alone, which can be offensive and damaging to the doctor-patient relationship.[31,36]

Little has been written specifically about approaching skin examinations in SGM patients, but dermatologists should remember that communication is always central to a successful examination that promotes patient comfort, security, and autonomy. Patients should be given space and time to undress in private, with a gown to change into. One concern unique to transmasculine and gender-diverse patients is the potential use of chest binders to compress breast tissue and provide the appearance of a flat chest. In order to attain this physical change, patients often employ various chest binding techniques for up to 10 to 12 hours daily.[39] Besides contributing to skin problems (scarring, swelling, acne, itch, infections), particularly in individuals with large chests,[39] binding practices may also inhibit or preclude a total body skin examination. It is therefore important to inquire about the use of chest binders in these populations. After establishing an initial rapport, patients who engage in chest binding may be invited to remove their binders prior to a relevant skin

examination, to be replaced afterward. Patient self-determination should always be supported and requests for limited skin examinations honored. In these instances, patients should also be made aware of the inherent limits of not assessing the entire skin surface for diagnostic purposes, and a follow-up visit should be offered at a time when the patient may feel more comfortable with their dermatologist and be better psychologically and physically prepared for a more comprehensive skin examination, if desired.

Providers should also inquire what terminology patients feel most comfortable with when addressing/describing their anatomy (ie, chest vs breast, ovaries or testicles vs groin or gonads). When performing the examination, each area should be uncovered, examined, and covered sequentially with a sheet or blanket to avoid making the patient feel as though they are on display. Communication of intent should be ongoing throughout inspection ("Now I am going to take a look at your back."), and permission should be requested and granted before examining sensitive areas, including the chest/breasts, buttocks, and genitalia, and always before palpating the skin.

Unfortunately, many health care professionals, despite professing a desire to care for SGM patients in a compassionate manner, may feel unprepared to do so.[7,40] SGM-specific education is underrepresented in American and Canadian medical school curricula; the most recently reported data indicate that a median of 5 hours is spent on SGM-related content in undergraduate medical education, and one-third of schools have no requirement for SGM education.[41] This may explain why many providers feel unequipped to manage the needs of these patients.[7,40] Although it is unknown whether dermatologists specifically share this sentiment, the AAD's Basic Dermatology Curriculum has a similar paucity of learning modules dedicated to SGM concerns, which acts a barrier to adequate care for this population.[42] Encouragingly, however, is the advent of an increasing number of educational opportunities to improve dermatologists' understanding of SGM health, including symposia and educational sessions at the AAD and Society for Pediatric Dermatology (SPD) annual meetings. Seeking out and advocating for more SGM-specific educational experiences are ways that dermatologists and professional organizations can remedy this practice gap. Table 2 summarizes specific ways that pediatric dermatologists can further provide and advocate for accessible, acceptable, and equitable care for SGM patients.[13]

5 | CONCLUSION

Sexual and gender minority youth benefit from readily available care that is accessible, acceptable, culturally humble, and equitable. Unfortunately, these elements are often missing in dermatologic care, as pediatric dermatologists are few in number, and access may be limited by cost or insurance considerations.[17] Furthermore, as SGM-specific education is underrepresented in medical school and dermatology professional curricula, many dermatologists may feel ill-equipped to effectively and empathetically care for this group. Providers who understand the unique developmental, emotional, and physical needs of SGM youth and who actively seek to offer respectful, confidential, and non-judgmental care, whether independently or in conjunction with larger multidisciplinary groups, are more likely to provide the quality of dermatologic care that this population desires and deserves. Improvements in SGM-specific medical school experiences and educational opportunities through the AAD and SPD may promote continued reduction in health care disparities for this at-risk group.

CONFLICT OF INTEREST

The authors of this manuscript report the following conflicts of interest: MDB, DIB: none; HY: Dr Yeung has received honoraria from Syneos Health.

ORCID

Markus D. Boos https://orcid.org/0000-0002-7179-5168

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