LESBIAN, GAY, BISEXUAL, AND TRANSGENDERED HEALTH:

AN ANTHROPOLOGICAL LITERATURE REVIEW

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ABSTRACT

The LGBT community faces a large variety of mental and bodily health issues, as well as a need for cultural acceptance, that differs from the general population. This paper will provide a literature review of some of these issues, including stigma, HIV, and mental health, in order to provide the reader with a broader understanding of the complexities of being LGBT and a knowledge of where further research is needed. This paper does not focus on one geographic region, but rather looks at global case studies in order to provide the reader with a strong introduction to these issues.

Keywords: *medical anthropology, health, quality of care*

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INTRODUCTION

Medical anthropology addresses the issue of marginalization through an understanding of how different socioeconomic and political factors affect illness and suffering of specific populations. Marginalization is discrimination or violence based on social constructions of acceptable characteristics or actions. People who identify as lesbian, gay, bisexual, and transgendered (LGBT) are often lumped together as one population and are globally marginalized due to their sexual preferences and gender identities, in contradistinction to a heteronormative male-female gender binary system. Marginalization can come in the form of restricted access to safe living and health care environments, as well as challenges in obtaining biomedical technologies, such as mental health medications, in vitro fertilization (IVF) treatments, and gender reassignment surgeries (Lock 2009). Medical anthropologists are best able to interrogate how demographic variables such as socioeconomic and education status, ethnicity, and sexual and gender identities, articulate with the everyday lives and complexities that shape health disparities

In order to gain an understanding of a marginalized group, medical anthropologists are charged with conducting a "systematic focus on the health-relevant aspects of social life" (Kleinman 1995:205). Several anthropologists have studied the effects of both perceived and actual limited access to care (Baker and Beagan 2014, Levine 2008), and much more research needs to be undertaken to understand the effects of the Affordable Care Act (ACA) and the 2015 Supreme Court ruling to legalize gay marriage at the federal level (Supreme Court of the Unites States 2015). The purpose of this paper is to identify the different health needs, both mental and physical, that are found within LGBT communities, in order to promote understanding, healing, compassion, and the necessity for reevaluated policies that affect their equal access to health care. I will then discuss how medical anthropology can influence policy change through a better understanding of the unique issues faced by the LGBT community in order to protect their rights to health and health education. I will also discuss some health issues that are shared across sexual identity divides and critique their marginalization based off of an ideal heteronormative state. In order to expose larger scale issues with LGBT health and health care access, this paper does not focus on a specific geographic region. Through a greater understanding of the specific health needs of the LGBT community and proactive interdisciplinary work, medical anthropologists may be able to advocate for better access to and quality of care, promote equality through deconstruction of social discrimination, and provide qualitative analysis of policy implementation that directly affect LGBT identified individuals.

METHODS

This paper is a literature review conducted around the concept of LGBT medical anthropology, conducted using the George Washington University's

Gelman Library online reference system and the DC area university consortium loan services to find both articles and books written by anthropologists, behavioral scientists, and sociologists who have conducted research on the health of LGBT young adults and youths all over the world. This paper does not focus on a specific geographic region, noting that there will always be regional peculiarities, as the goal is to expose larger scale issues with LGBT health and health care practices. LGBT anthropology is a relatively new topic of study, surfacing around the feminist anthropology movement of the 1970s (Fox 2012) and progressing in the 1980s and 1990s to include bisexuality and transgendered identities (Haggerty 2000), and there also is not a large body of literature from one geographic region. Many articles and books that focused on this topic were not used in my review because they were not anthropological, which illustrates areas where research is lacking. I will discuss these areas of future anthropological research later in this paper.

BACKGROUND

Early anthropological scholars who commented on cultural sexuality, including Mead and Malinowski, portrayed sexuality and gender as a binary issue and labeling all other formulations of these two identity constructions as unusual (Fox 2012). In the 1970s, Foucault challenged these ideas by shifting the discourse to how sexuality is both a perception and a physical act. For example, in the Victorian period, Western sexuality was repressed and seen only as a byproduct of marriage; in reality, people were claiming their sexual identities through unconventional and secretive acts (Foucault 1979). Butler's ideas regarding sexuality as a performance of culture further redefined the field and rejected binary sexuality as a universal truth. Stylized, repetitive acts, such as acts of heterosexual desire, she argues, are culturally constructed rather than natural occurrences as performed by social actors (Butler 1990). Butler refutes the idea that sexuality and gender are choices that people consciously make, and finds instead that sexuality is "a ritual reiterated under and through constraint, under and through the force of prohibition and taboo, with the threat of ostracism and even death controlling and compelling the shape of the production, but not… determin[ed] fully in advance" (Butler 1993:95). Through her scholarship, Butler became a champion for the LGBT movement.

Many anthropologists engaged in the LGBT movement focus on human immunodeficiency virus and acquired immunodeficiency syndrome (HIV/AIDS), since it was originally stigmatized as a homosexual disease (Haggerty 2000). Gay and transgendered identified people have continued to face stigmatization with regards to HIV/AIDS (Mandal 2013). Some of the discourses surrounding HIV/AIDS involve how ideas about disease, sex acts, and risks are understood within global populations (Farmer 1999, Haggerty 2000). I will focus on the importance of sexual literacy, defined by Herdt as "the ways in which people become knowledgeable and healthier sexual beings," (Herdt 2007:3) which will play an important role in the

fight against HIV/AIDS, as well as the struggle for understanding and equality for LGBT identified people.

DISCUSSION

Lesbian and feminist anthropology emerged at the forefront of sexuality studies in the 1970s and 1980s (Blackwood 2012). Lesbian feminism and feminist anthropology are not to be confused, though they draw on the same themes of repression and rebellion. Feminist anthropology stems from the idea that the dichotomies between men and women are not universal, constant, or warranted. Moore discusses feminist anthropological theory as a way to ask how economics, kinship, and ritual are structured and experienced (Moore 1988). Lesbian feminism, on the other hand, seeks to empower lesbians to embrace their femininity and assert their equality to men (Blackwood 2012). Both lesbian feminism and feminist anthropological theory play an important role in lesbian medical anthropology.

Assisted reproduction and fertility is a common experience for lesbian would-be-parents, and a particularly relevant topic in medical anthropology given the present global political climate with regards to definitions of marriage and family structures. In Australia, as dictated by the Sex Discrimination Act of 1984, assisted reproduction through IVF and donor insemination became available for lesbians in order to bear biological children (Chapman 2012:1879). As of the early 2000s, biological children of Australian lesbian mothers were either conceived in a previous heterosexual relationship or by IVF (Chapman 2012:1878-1879). In order to receive IVF, a woman must obtain a referral from a doctor disclosing possibilities for infertility, which, in the case of lesbian women, is the lack of a male donor. These women are then termed "socially infertile" (Chapman 2012:1881), thus marginalizing and stigmatizing a potentially fertile woman. This marginalization also dictates how kinship can be classified in a lesbian family. Baker and Beagan (2014) discuss how lesbian mothers are rendered invisible by the Canadian healthcare system as second mothers do not fit within the health care categorization for kinship and problematized routinized procedures due to heterosexism. Butler states that the "heterosexually-based system of marriage…requires the reproduction of human beings in certain gendered modes which, in effect, guarantee the eventual reproduction of that kinship system" (Butler 1988:524) and argues that oppression does not have to be the lone consequence of individual performative acts. Levine (2008) discusses how lesbian and gay parents resist defining families on the basis of genetics and procreation and the modes through which these families adopt or use medical treatments to have children. She also notes how biogenetics are present in alternative medical fertilization practices, stating that lesbians often denote the sperm donor or other lesbian families who have used the same donor as kin (Levine 2008:380). Anthropologists will be able to study the recent effects of the ACA on

alternative kinship structures going forward, and will need to work with community health and public policy experts in order to reshape kinship dialogues.

Many stereotypes about homosexual males influence specific mental health needs of the population. One prevalent stereotype is that gay males are well groomed, "pretty," and in general take good care of their physical health (Madon 1997). This is by no means a recent stereotype; in the 1900s, Duncan (2010) discusses how homosexuality was represented by the 'dandy,' who is described as a man who wanted to be pretty, took great care in grooming himself, and generally was not very muscular. This stereotype creates disconnects between self-, sexual, and cultural identity, which may lead to poor body image and mental health issues among homosexual men. The idea of the 'new gay identity' prompted Duncan to study the body as a performative site, where gay males pose questions of the self, sexual identity, and masculinity in Australia. While his sample size was small (n=16), he concluded that, sculpting their bodies to look like the 'ideal' man- muscular and lean, embodying masculine features that are attractive to both other gay men and women- these gay men increased their self-confidence in their body and their gay identity (Duncan 2010). Potential downsides to this ideal body performance may also lead to body image issues and illnesses (Allensworth-Davies 2008), mental health issues, and high risk sexual behavior.

Several studies have attempted to document how homosexual male body image leads some gay males to engage in sexually irresponsible and high risk behavior (Ames et al 2010). Ames et al studied the intersection of "duty and desire" in the US Navy which may have links to the high levels of STDs in servicemen (Ames et al 2010). Allensworth-Davies et al conducted a study about body image and satisfaction in relation to anal intercourse, and found that "muscle-dissatisfied" men had more eating issues, anxiety, and depression than men who were more satisfied with their physical appearance (Allensworth-Davies 2008). Their study also found that most homosexual men surveyed at the 1988 Minnesota Gay Pride Festival were able to realistically identify themselves as average size, and found that body satisfaction seemed to not play a large role in the majority of the men's sex lives. The outliers of the study, underweight and overweight gay men, had the most "body shame" (Allensworth-Davies 2008:55), greater percentages of eating disorders and depression, and were less likely to engage in risky sexual activities than the average men who took care of their bodies and felt comfortable with their body image.

Bisexual and transgendered identified people are often absent from mainstream discussions of homosexuality, perhaps because they deviate from heteronormative and homosexual communities (Jones 2010:42-43). Bisexuals are often misunderstood because they acknowledge fluidity in their sexuality, while labels like "straight," "gay," and "lesbian" still denote a stable sexual identity (Boellstorff 2007; Jones 2010). Lesbian and bisexual communities often experience a

good deal of tension due to differing ideas of feminism and the necessity of men in order to understand one's sexuality (Jones 2010). However, lesbian and bisexual identified people share issues related to nontraditional sexual partnerships and family organization with regards to policy issues about kinship structures and legal definitions of family.

Bisexuality can be described as sexual preference at a particular moment in time, which does not lend support to the idea of a sexual identity over a lifetime (Jones 2010:51). Jones provides several case studies of people discovering the fluidity of their sexuality later in life, after one had originally identified as straight, gay, or both previously. In one instance, a woman had been married, lost her husband, then lost her long time lesbian partner, and then fell in love with another man (Jones 2010:50). She felt shunned by her long time lesbian friends, whom she wanted to spend time with in order to honor her partner's memory, but was unable to. Her new husband did not provide the support she needed for her grief over her lost partner, either, and she was left with incredible mental anguish and nowhere to turn for mental health help. Without someone to help her understand that sexuality is not a binary construction for every individual, she will be unable to move past her grief and confusion. A more critical approach to bisexual studies will provide greater understanding of alternative sexual identities and more useful mental health treatments.

Kammerer et al (1999) studied transgendered individuals living in Boston in 1995 who identified as pre-operative, post-operative, non-operative, and cross-living people aged from mid-twenties to forties. They sought to expose the problems trans identified people face to obtain mental health counseling, to access health services and shelter, and the relationship of marginalized identity to rates of HIV/AIDS infection. They found that many transgender identified people are employed as sex workers which lead to higher rates of HIV/AIDS infection within the community. This study also found that there was a lack of alcohol and drug counseling specific to transgendered people, and many physical and mental health care practitioners do not understand the needs of this population. "The social stigma that transgenders face is translated …into psychological problems, notably, low self-esteem and even loathing, often to the point of suicidal tendencies. Transgendered people are thus frequently in need of sensitive and knowledgeable counseling" (Kammerer et al 1999:5). Research by Clements-Nolle, Marx, Guzman, and Katz (2001) provided evidence that transgender communities are disproportionally affected by HIV, as well as substance abuse, and mental illness which may in turn be a symptom of poverty and discrimination (Baker and Beagan 2014). This population requires assistance from applied medical anthropologist and community health workers in order to affect real and permanent change with regards to mental and physical care. Homeless facilities and counseling support leaders need to be trained to understand

the needs and concerns of transgendered people in order to provide a safe space for them to live and seek physical and mental care.

Alleyn and Jones write about how transgenderism is not about sexual preference or body mismatch. It is instead what Alleyn terms "genital mismatch" (Alleyn and Jones 2010:57). Allyen describes her own experience, waiting seven years for genital reassignment surgery and only receiving counseling during the last two years, and how she found it impossible to believe that trans people were being forced to "live for 1-2 years as their new 'role' if what really is the problem is that [he] has boobs but [he] should have a penis" (Alleyn and Jones 2010:57). Counseling before genital reassignment surgery is mandated to ensure that gender reassignment is really what the transgendered individual needs. Countering this with her personal experience, Alleyn discusses how the mandatory counseling often takes place too late into the transition and is not helpful for many of the patients, as the main issue facing transgendered people is not a mental but a physical problem, contributing to the mental anguish of being transgendered. The only reason she can posit that this counseling is mandated before surgery is to satisfy heteronormative social convention and to alleviate legislative headaches (Alleyn and Jones 2010). Even the process of getting a birth certificate reissued after the genital reassignment surgery is incredibly difficult.

Another issue that affects the mental health of transgendered and transsexual people is being able to "pass" as their gender identity and face discrimination from both hetero- and homosexual communities. This can produce difficult situations for receiving health care and counseling, finding employment, and having place to live. Alleyn and Jones (2010) view transgenderism as not being about sexual preference or body mismatch, but rather what Alleyn terms "genital mismatch." Allyen describes her own seven year transition experience waiting for her reassignment surgery and not having access to psychological counseling for five years of the process, despite the fact that the United States mandates counseling before genital reassignment surgery (Bowman and Goldberg 2006). Alleyn and Jones (2010) further discuss how mandatory counseling often takes place too late into the transition and is not helpful for many of the patients, contributing to the mental anguish of being transgendered.

Kleinman states that "medical anthropology insists that the only valid grounds for understanding illness and treatment are the microcultural worlds in which patients and families engage in everyday social activities" (Kleinman 1995:151). I have shown through an analysis of studies that reveal mental and physical health needs of each population that lesbians, gays, bisexuals, and transgendered identified people are marginalized in health care systems worldwide. The question that I now pose is to better understand why these distinct populations would be lumped together under the acronym of LGBT when it has been illustrated that there are different medical needs for each subgroup. The answer could be to

create a sense of identity for all nonheteronormative identifying people, but, as briefly discussed in this paper, many of these subgroups do not agree with each other, and thus do not support each other. For example, Jones discussed how lesbians and bisexuals do not agree over feminism, and many lesbians do not recognize the legitimacy of bisexuality (Jones 2010). Anthropologists as a group have a tendency to categorize and group human behaviors and populations, but I would argue that the issue of LGBT is a result of heteronormative legislation and a lack of compassion from the greater human population. This is particularly true in the United States. At present, the country is engaged in a heated discussion about same-sex marriage laws. If we cannot, as a country, accept the legalities of same-sex marriage and kinship structures, we are not in a position to discuss the sexual education reform required in order to include the needs of LGBT youths.

Eaglesham discusses legislation in the UK that does show a concerted effort to address many of the needs of the LGBT populations (Eaglesham 2010). He describes how employment protection laws, such as sexual discrimination acts and the Employment Equality regulations, apply to transgendered citizens (Eaglesham 2010:4). They also have a Gender Recognition Act, which states that you can gain legal recognition of your gender identity, and the Human Fertilization and Embryology Act of 2008, which states that both lesbian mothers are recognized as the legal parents of a child *at birth* (Eaglesham 2010:4). Not enough research had been done at the time of Eaglesham's publication to determine if these laws have improved the lives of LGBT people living in the UK, and this research is outside of the scope of this paper. However, it would be prudent to continue to follow the changes that this type of legislation will bring about and discuss the translatability of this legislation on a more global scale.

AREAS FOR FUTURE RESEARCH

As previously discussed, research on the long term effects of policies regarding LGBT health is outside of the scope of this paper. While this paper uses a global focus to analyze the larger issues in the LGBT community that need to be addressed by medical anthropologists, this review indicates that future research should be conducted as geographically specific case studies. Much of the research cited in this paper was not conducted in the United States, and there appears to be a lack of anthropological data on LGBT health specific to the United States. Based on this analysis, American medical anthropology lacks depth with regards to studies of sexual and gender identities and the mental health issues specific to LGBT needs, as well as stigmatization of reproduction and alternative kinship structures. I implore American medical anthropologists to turn an eye inward at the LGBT communities within the United States in order to affect change at home.

Another topic that was outside of the scope of this paper is the early education system and sexual education programming. Alleyn and Jones state that

"the ultimate goal for health and social care is to recognize the complexity of all sexual and gender identities and to challenge the heteronormativity and the inequalities that stem from it." (Alleyn and Jones 2010:88). In order to complete this goal, we have to start by introducing comprehensive sex and gender education in schools. Without this type of programming, school aged youths are learning only about "packaged sex," or sex that they can find on the internet, and is not an adequate way to learn about sexual education, versus healthy, real sex (Herdt 2010:17). This is not just a program for LGBT youths. This type of programming needs to be written in to the general sexual education curriculum, as the goal is to not only educate LGBT youths about their sexual identity, but to educate heterosexual students about acceptance of their peers, of difference, and rejection of the idea of sex and gender binaries.

Pettett discusses the use of derogatory LGBT terms that she heard in schools, often hurled at heterosexual identified students (Pettett 2007:29), and how this kind of behavior leads to LGBT students being further ostracized, stripped of their agency and identity. Further research should be conducted, along with collaboration with groups like the Human Rights Watch, about the effects of structural violence, such as bullying, committed against students. Structural violence can become internalized, leading to PTSD, low-self esteem, and depression (Kleinman 1995:177). Though this paper looks broadly at global LGBT health issues, specific geographic case studies should also account for structural violence due to ethnicity, socioeconomic status, and family structures of LGBT identified youths.

Other areas of future research include a greater understanding of the types of counseling services that are available to young adults through the educational system. In the United States, medical anthropologists, along with public health officials and policy experts, need to assess both access to and quality of care that LGBT identified people receive as a part of the ACA; it will also be important pursue research on aging LGBT identified people and the ACA. Domestic medical anthropology will be crucial to assessment of access to new programs and care options. In 2007, Marcia Inhorn, President for the Society for Medical Anthropology, urged young medical anthropology students to study policy and utilize ethnographic work to reframe policy discourse within broader sociocultural frameworks (Inhorn 2007). This paper has provided several examples of health policy that need critical assessment and clear understanding of biosocial structures within which they are implemented.

Finally, I would be remiss if I did not mention that this paper does not deal with Queer Theory, and purposely drops the Q from the larger classification of LGBTQ. Some of the main ideas of Queer Theory are present in Butler and Alleyn's articles, which include challenging the role of gender as essential to identity, challenging heteronormative categories, which instinctively set all outliers as

deviants, and examining how sexual acts are socially constructed (Butler 2006). A firm understanding of Queer Theory will be essential in transgender anthropology; however that undertaking is too large for this broad of an introduction to LGBT medical health issues.

CONCLUSIONS

Based on the preliminary research for this literature review of anthropological materials, medical anthropology provides a useful lens with which to view LGBT health needs and advocate policies in response. While there are health challenges within the LGBT community that are similar to the heteronormative community, such as body image issues in relation to self-esteem and depression (Duncan 2010; Allensworth-Davies 2008; Kleinman 1995) or issues of bullying (Haas 2010, Pettett 2007), this paper serves to demonstrate the diversity of health issues uniquely faced by members of the LGBT community. Some of the issues that the LGBT community face include reproductive discrimination and alternative kinship definitions, the need to address the confusion regarding differences between sexual activity and gender identity, and a lack of responsible sexual education, which involves heterosexual, homosexual, and transsexual information. Based on this preliminary analysis, the broad categorization of LGBT needs to be unpacked in order to be able to apply and compare communities in terms of policies, programs, and health care needs. Medical anthropologists can aid in an understanding of alternative sexual identities and the correct physical and mental health treatments, as well as provide policy-makers with a broader understanding of kinship structures and educational needs.

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