Conceptualizing Trauma in Clinical Settings: Iatrogenic Harm and Bias

3

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This chapter uses several frameworks to describe the types of trauma that are commonly faced by lesbian, gay, bisexual, and transgender (LGBT) people, how these experiences influence LGBT patient expectations of healthcare treatment and treatment outcomes, and how providers can offer care that is LGBT-affirmative, culturally responsive, and embeds patient advocacy within its approach. A multilevel model is used to frame the types of discrimination and trauma that LGBT people often experience (Fig. 3.1). The biopsychosocial model, trauma theory, and resilience theory are used to provide a structure for conceptualizing LGBT trauma experiences (Fig. 3.2). The chapter ends with a trauma-informed care (TIC) model that can be used to improve healthcare for LGBT patients.

Defining Trauma

Trauma has been defined as the psychological reaction occurring in response to adverse events, such as sexual violence, a car accident, or a natural disaster [1]. These experiences manifest in myriad ways. For example, many survivors experience denial and shock immediately following a traumatic event, and people who have survived trauma often do not display outward emotional symptoms, yet may experience physical symptoms such as headaches [2]. The age at which trauma occurs, type and duration of trauma experienced, and process of coping add a developmental component to trauma, and clinical outcomes are strongly influenced by the resources available to support healthy coping [3].

Trauma experiences have been studied extensively; however, relatively little attention has examined the ways in which specific trauma experiences and coping may differ between LGBT people and those who are cisgender and/or heterosexual [4]. Because LGBT people often experience trauma in the form of micro- and macroaggressions related to multiple overlapping societal oppressive forces (e.g., cisgenderism, heterosexism, racism, classism), this unique context of discrimination influences the way in which LGBT people respond to traumatic experiences [5].

What Do We Know About Trauma and Experiences of LGBT People in Healthcare?

A national report on the healthcare experiences of LGBT people found that experiences of discrimination were widespread [6]. When asked about details of the discrimination, almost 56% of lesbian, gay, or bisexual (LGB) respondents reported at least one of the following experiences: being refused needed care, being blamed for their health status, or healthcare professionals using harsh or abusive language, refusing to touch them or using excessive precautions, or being physically rough or abusive. Seventy percent of transgender and gender-nonconforming respondents reported one or more of these experiences; respondents of color and low-income respondents experienced even higher rates of discrimination and substandard care.

These experiences of trauma can be described across multiple levels: institutional, interpersonal, and intrapersonal (see Fig. 3.1). Institutional trauma (also termed structural trauma) describes routine, repetitive exposure of LGBT people to microaggressions (e.g., heteronormative and cissexist assumptions) and macroaggressions (e.g., heterosexist and cissexist violence). These experiences can lead LGBT people to conceal their sexual orientations and/or

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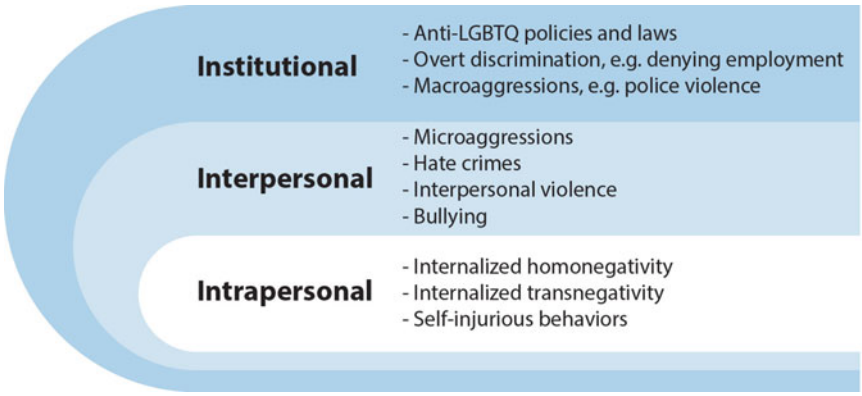

Fig. 3.1 Examples of multilevel types of trauma experienced by LGBT people

gender identities [7]. LGBT people also experience cumulative interpersonal trauma, defined as trauma experienced with at least one other person, such as sexual assault, intimate partner violence, and childhood sexual abuse [8]. Similar to institutional trauma, interpersonal trauma experiences can lead LGBT people to manifest distrust, hypervigilance, and other self-protective responses in their relationships with partners, family members, friends, and other people and systems in which they have experienced trauma and with whom they interact [9]. Lastly, LGBT people are at great risk for experiencing intrapersonal trauma, such as non-suicidal self-injury and suicide, often as result of experiencing multiple levels of societal discrimination. LGBT people may turn to non-suicidal self-injury – or other maladaptive behaviors – in an attempt to manage the pain, anxiety, distress, and dissociation that result from exposure to multiple levels of trauma. These multiple levels of trauma may also exacerbate maladaptive thought processes, including internalized homonegativity and/or transnegativity. For example, in a recent survey of transgender people [10], over 41% of the sample reported at least one suicide attempt, and rates of suicide attempts increased in the context of job loss and other life stressors related to being transgender.

Unfortunately, institutional, interpersonal, and intrapersonal traumas can also be enacted within healthcare. At the institutional level, the healthcare system itself may create harm. For example, a transgender man who needs cervical cancer screening may face discrimination from an insurance company that refuses to pay for Pap testing because he is identified as male. In order to get the exam, he may also face the discomfort of sitting in the waiting room of a gynecologist's office where he receives stares because he is the only male patient. These experiences may be traumatizing and deter future healthcare seeking, even though the patient's interactions with his healthcare provider are positive overall.

Qualitative research suggests that providers may unwittingly perpetuate interpersonal discrimination and trauma through well-meaning efforts to manage their lack of LGBT-specific medical knowledge [11] and/or to treat every patient the same [12] despite the existence of identity-specific needs. For example, providers may not routinely ask about a patient's sexual orientation outside of the context of sexual health, assuming that this information is not clinically relevant. Providers may feel uncomfortable asking about sexual orientation and gender identity altogether, due to fear of offending a patient. However, failure to gather this information conveys the message that these essential aspects of patients' lives are not important to the provider. Moreover, without information on sexual orientation, for example, providers may make heteronormative assumptions about who constitutes family for that person and inadvertently exclude important decision-making partners from engagement in the patient's care.

Even when aware of LGBT identities, lack of knowledge can lead providers to rely on stereotypes in the provision of care. For example, a well-meaning provider may tell a concerned lesbian with multiple partners that she does not need screening for certain sexually transmitted infections because her partners are female. The provider's lack of knowledge of same-sex sexual practices as well as assumption that lesbians have only female sexual partners may therefore result in substandard care and miss an opportunity for safer sex education.

Healthcare providers should also be aware that many LGBT people have low expectations of providers before even entering a healthcare setting [13]. For instance, lesbian women may experience significant distrust when working with healthcare providers due to societal heterosexism and interpersonal trauma experiences. Transgender people may also distrust mental healthcare providers due to the long history of pathologizing and gatekeeping perpetrated by the mental health profession, with particular regard to

accessing hormone therapy [14]. LGBT individuals may anticipate that healthcare providers will not be affirming and culturally competent with regard to sexual orientation and gender identity and therefore may delay or avoid accessing care altogether.

The expectation of mistreatment or a lack of LGBT-affirmative training is not an unrealistic expectation, as research has consistently identified that healthcare settings and providers are underprepared to serve LGBT people. For instance, in a study of medical residents and their knowledge, attitudes, and skills regarding working with LGBT adolescents, Kitts [15] found that the majority of the sample of trainees did not assess sexual orientation or gender identity when conducting a sexual history with adolescents, nor did the majority correctly identify a connection between being a LGBT adolescent and suicide despite the existence of a significant body of literature identifying LGBT adolescents as the population at highest risk for suicide attempts. In addition, studies have reported that healthcare practitioners feel uncomfortable discussing sexual health concerns with their LGBT patients [16] and that disclosure of LGBT identity remains a concern for LGBT people accessing healthcare due to anticipated discrimination and prior experiences of stigma [17].

In addition to the above experiences of trauma and discrimination, LGBT people may also experience de novo trauma or trauma-related symptoms as they begin to interface with healthcare settings. For example, in a large survey of transgender adults, 24% reported being denied equal treatment, 25% reported being harassed or disrespected, and 2% reported being physically assaulted, such as being hit or punched, in a healthcare setting [10]. Sometimes trauma in the healthcare setting is enacted by lack of acknowledgment, as exemplified by inadequate options on intake and ongoing paperwork to denote gender identity (e.g., only having two options of male or female) or to denote partners (e.g., having the option of "spouse" without options of "partner" or recognizing people who are polyamorous). At other times, trauma is promulgated by micro-inequities, as when healthcare providers display nonverbal behaviors that communicate anti-LGBT bias, such as disdainful looks, avoiding eye contact, or maintaining excessive physical distance. Often, these experiences of de novo trauma in healthcare settings cause LGBT people to feel that they are being judged for who they are in terms of their sexual orientation and gender identities, as opposed to being served in an affirmative manner.

Affirmative care occurs when, for example, a transgender woman survivor of trauma meets with her gynecologist and receives both verbal and nonverbal affirmative messages welcoming her to the practice, which include being asked questions about her correct pronouns, name, and terms to use when discussing her body, and having her choices respected throughout the encounter. Insurance coverage can also be a major source of trauma for LGBT people, as many transgender people cannot access important medical care and surgeries and LGBT people may be underenrolled in healthcare coverage. Fortunately, the Affordable Care Access Act has made affordable healthcare available to many LGBT people and prohibits discrimination on the basis of sexual orientation and gender identity [18]; for instance, transgender people's access to hormone treatment and some surgeries has been increased. Nevertheless, there are still many restrictions that transgender people face in accessing gender-specific services.

Theoretical Approaches to Understanding and Addressing Trauma with LGBT Patients

Biopsychosocial models, trauma theory, and resilience theory can assist in understanding and addressing trauma with LGBT patients. A biopsychosocial model attends to three dimensions of health: biological (e.g., physical), psychological (e.g., emotions, cognitions, behaviors), and social (e.g., cultural backgrounds, contextual environments; see Figure 3.2). This framework aids in conceptualizing how illness and health intersect with LGBT patients' mental well-being and social support (or lack thereof) in their environments.

Trauma theory can inform how healthcare providers work with LGBT people who have survived trauma, including those who have experienced mistreatment in healthcare settings. For instance, people who have had trauma

Fig. 3.2 Biopsychosocial model of health and illness

experiences may manifest hypervigilance and intrusive symptoms, such as flashbacks and nightmares [5]. Alternatively, individuals who have survived trauma may not manifest symptoms at all. For all LGBT individuals, it is important to evaluate what life experiences have been challenging or traumatic, and how these experiences continue to impact their lives. Understanding that both societal and interpersonal discrimination and violence influence how LGBT people interact with healthcare systems, providers can anticipate the likelihood of past discrimination and trauma, and assess for common symptoms within intake paperwork and patient interviews. When interacting with LGBT people who have survived trauma, providers can also be cautious not to misdiagnose trauma symptoms as clinical disorders that are not trauma-specific (e.g., anxiety disorders that are not triggered by history of a traumatic event) [9]. Such misdiagnoses may cause further stigma and lead to inappropriate interventions that compound the negative consequences of prior trauma.

Trauma theorists also note that there may be differential coping reactions based not only on the developmental age at which a major trauma occurs but also related to the amount of stress a person has experienced previously [8]. For example, Shipherd et al. [19] showed that transgender people are more likely than cisgender individuals to display trauma symptoms that impair function after experiencing discrimination or violence. Because trauma survivors often experience guilt and shame relating to the trauma, healthcare providers should be aware that LGBT people may feel reluctant to disclose their history of trauma. They may further benefit from having their experiences validated and affirmed by healthcare providers, as LGBT people live in a society that is often invalidating.

Resilience has been defined as an individual's ability to cope with adverse events [20]. A resilience model can help providers identify patient strengths and coping resources to leverage their healing. Integrating a resilience approach to working with LGBT survivors builds on understanding the impact of trauma by recognizing that LGBT people develop coping resources and strengths in response to trauma [21]. Resilience research with transgender people of color who have survived traumatic life events, for example, has identified that simultaneous development of gender and racial/ethnic identity pride as well as connection to transgender communities of color are sources of resilience for navigating oppression in society. Because resilience development can vary tremendously across communities and environmental contexts, healthcare providers should be prepared when working with members of LGBT populations to encounter individuals with a wide spectrum of coping strategies that range from maladaptive to resilient.

While healthcare providers may encounter many challenges in delivering LGBT-affirming care, a crucial starting point is to focus on the quality of the relationship they build with their patients – whether brief or long term – and work to ensure that their patients have a positive experience in this relationship. This often one-time interaction with healthcare providers, when positive, informs and assures LGBT patients that their lives are valuable and their experiences of discrimination and trauma are believed and validated. These positive experiences can encourage LGBT individuals to continue to access rather than avoid healthcare in the future and to share their positive healthcare experiences with members of the larger LGBT community, potentially encouraging these individuals to also seek care.

Trauma-Informed Care for LGBT People

Trauma-informed care for LGBT people is a unifying, culturally responsive approach that is inclusive of the multiple levels at which LGBT people can experience trauma. When healthcare providers use a trauma-informed care approach in their work with LGBT individuals, there is an opportunity to validate patients' experiences of trauma and minimize inflicting further trauma as a provider. Such validation and awareness are crucial in healthcare settings, as research has consistently shown that LGBT people have negative experiences within healthcare settings [6, 10, 22]. Trauma-informed care for LGBT patients is discussed in detail in Chap. 16; however, a succinct description of TIC will be described here given its importance when working with LGBT patients.

Identifying Trauma

Healthcare providers have a better chance of addressing trauma if they are aware of a patient's history; therefore, it is good practice to screen all patients routinely. Several screening tools are available [23]. While none of these tools have been specifically validated among LGBT patients, the Primary Care Post Traumatic Stress Disorder Screen (PC-PTSD) has been designed for use in primary care and other medical settings [24]. The PC-PTSD consists of the following questions:

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

1. *Have had nightmares about it or thought about it when you did not want to?*
2. *Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?*
3. *Were constantly on guard, watchful, or easily startled?*
4. *Felt numb or detached from others, activities, or your surroundings?*

If a patient answers "yes" to any three items or more, it suggests trauma-related problems. A cut-off of three affirmative answers on the PC-PTSD has a sensitivity of 0.78, specificity of 0.85, positive predictive value of 0.65, and negative predictive value of 0.92 for PTSD [24]. Patients who meet the cut-off may benefit from referral to a mental health professional with both expertise in trauma and experience with LGBT clients. All patients who have experienced trauma should be screened for suicidal thoughts given the greater risk for suicide in this context [25].

Staying attuned to a patient's body language, tone of voice, eye contact, and level of participation can provide important clues to the existence of a trauma history. Signs of rising anxiety or emotional arousal may indicate that the patient has experienced a trigger. When this happens, it is important for the provider to remain calm and supportive, without becoming defensive or pressuring the person to talk about what may have triggered them. A key element of preventing harm and promoting resilience is empowering the patient to determine what information they want to share and what components of the physical exam they are willing to undergo. Explaining the purpose of the question and/or exam is key. For example, when asking about sexual orientation, one might begin with a statement/question such as: "I ask about the sexual orientation of all of my patients because it helps me to provide better care. Are you willing to tell me your sexual orientation today?"

Some LGBT patients may not feel safe disclosing or discussing traumatic experiences with a healthcare provider, especially if the healthcare setting itself has been a site of trauma. For some LGBT patients, simply entering a medical facility may be triggering. Moreover, healthcare providers may unintentionally participate in interactions that can cause retraumatization due to lack of awareness, implicit bias, and their own reactivity [26].

Addressing Implicit Bias

Implicit bias results from subtle cognitive processes that operate without awareness or intent. The underlying implicit attitudes and stereotypes responsible for implicit bias are automatic beliefs or associations that are ascribed to a specific sociocultural group [27]. Most research on implicit bias has been conducted with racial/ethnic minority groups; however, recent studies suggest that implicit bias toward LGBT people is also common [28] and may influence clinical care in a similar fashion [11, 29].

Although automatic, implicit bias can be changed [30]. According to a recent review [30, 31], providers can take a number of actions to reduce implicit bias, including:

1. Consciously affirming egalitarian goals and considering specific implementation strategies;
2. Considering "gut" reactions to specific individuals or groups as potential indicators of implicit bias and reflecting on the potential effect of these reactions on professional interactions;
3. Acknowledging and reappraising rather than suppressing uncomfortable feelings and thoughts;
4. Considering the situation from the patient's perspective;
5. Considering changing situations that increase negative or stereotypical responses, for example, removing images that associate all gay men with STIs.

In addition, consistent exposure to counter-stereotypic examples of people can inhibit negative implicit attitudes [32, 33]. Professional development opportunities that provide training in cultural sensitivity and foster the acquisition of egalitarian communication strategies (e.g., asking every patient what pronoun they use) may be useful in reducing bias. *Trauma-Informed Medical Care (TI-Med)* is one example of a continuing medical education course designed to enhance trauma-informed, patient-centered communication [34]. This curriculum is not specific to LGBT survivors of trauma; rather it focuses on building self-awareness, respect, empowerment, collaboration, and connection into any provider-patient relationship.

Reducing Reactivity

It is common and normal for healthcare providers to feel uncomfortable and uncertain when faced with clinical situations that are unfamiliar and or even contradict their core values. Acknowledging those feelings as well as understanding and validating their source are important steps toward reducing reactivity. When feeling reactive, providers should make sure to pause before responding so as to recenter and assess what they need both for self-care and to provide the best care for the patient. If necessary, a provider may want to let the patient know they need to gather more information or make a consultation in order to obtain the most up-to-date and helpful information, then schedule a visit in the near future at which to follow-up. Reducing reactivity allows the provider to approach the patient encounter feeling clear and calm, and reduces the likelihood of inadvertently contributing to the patient's trauma burden [26].

Preventing Harm to LGBT People in Healthcare Settings

Harm prevention includes addressing both the clinical environment and the quality of interpersonal interactions [35, 36]. Welcoming environments include images and patient information that include diverse LGBT people and families, mission statements and policies that explicitly

preclude discrimination on the basis of gender identity and sexual orientation, and forms and electronic health records that allow patients to identify themselves as they wish, regardless of the legal status of their relationships or gender [37]. Ideally, the clinical setting will permit disclosure of LGBT identities in a private and confidential manner to avoid exposing the patient to potential discrimination by other patients or providers. For example, transgender patients should be able to designate the appropriate name and pronoun on clinical forms at registration and have these used during all interactions with clinical staff, both administrative and medical.

Development of a trusting patient-provider relationship is key to preventing harm. Such a relationship is facilitated by respectful communication that honors the identity and relationships of LGBT patients and avoids making assumptions about sexual relationships, partners, and family structures. Open-ended, nonjudgmental questions and active listening strategies are the best strategies to promote effective communication and trust. Ensuring that every member of the healthcare staff has basic education in cultural competency, including an understanding of how LGBT identities intersect with other identities such as race, ethnicity, and class, is integral to avoiding iatrogenic harm. Opportunities for such training are available both online and in person. The National LGBT Health Education Center (http://www.lgbthealtheducation.org) provides webinars and publications that address LGBT cultural competency. The Human Rights Campaign (www.hrc.org) and discipline-specific organizations such as the American Medical Association (http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/glbt-advisory-committee/glbt-resources.page) provide LGBT cultural competency benchmarks for organizations and providers.

Promoting Resilience

Incorporating resilience promotion into clinical practice is part of a providing trauma-informed care. Engagement, empowerment, and collaboration are key elements of trauma-informed care that promote resilience [25]. Providers should strive to ensure that clinical systems are transparent, healthcare personnel are trustworthy, care is collaborative, and that LGBT patients feel emotionally and physically safe in the clinical setting and have both voice and choice in their care. Subsequent chapters will focus on the specifics of trauma-informed care.

Advocacy on Behalf of LGBT People in Clinical Settings

Because of the multiple levels of trauma many LGBT people have experienced over the lifespan, healthcare providers can play a crucial role by supporting or participating in advocacy efforts for LGBT trauma survivors. Advocacy entails working to reduce instances of oppression encountered by LGBT people both within and outside of clinical settings [38], as well as using the privilege accorded healthcare providers to enact social change to affirm the human rights of LGBT people. Healthcare providers can engage in advocacy in two ways: *with* LGBT people and *on behalf of* LGBT people [39]. For example, advocacy might entail teaching LGBT survivors of trauma on how to advocate for their own affirmative care. This might include making sure that the survivors are aware of and able to describe their trauma symptoms when interfacing with healthcare providers in order to set the stage for more responsive treatment, in addition to being able to identify when healthcare provision is not affirmative or appropriate. Alternately, advocacy on behalf of LGBT people includes advocacy actions that healthcare providers can take when LGBT people are not present, such as beginning a working group or committee to ensure that intake processes and other clinical documentation are LGBT-affirming.

Healthcare providers can engage in advocacy collaboratively with LGBT people and on behalf of LGBT people within three domains: micro level, meso level, and macro level [39] (Fig. 3.3). The micro level includes individual interactions within healthcare settings, such as physician assistant and patient or mental health counselor and patient. In these micro-level interactions, healthcare providers can advocate collaboratively with LGBT people to recognize barriers they face within and outside the healthcare setting, and advocate on behalf of LGBT people by identifying potential LGBT-allies within the healthcare setting. The meso level of advocacy includes the healthcare setting itself and the community. Within the meso level, healthcare providers can advocate collaboratively with LGBT people to develop action teams within the healthcare setting to address how to provide more affirmative treatment to LGBT survivors of trauma, while advocating on behalf of LGBT people might include developing and implementing an LGBT-affirming treatment plan in the healthcare setting that anticipates potential barriers and challenges and works to address these proactively. The third level of advocacy is the macro level, referred to as the public arena. Healthcare providers can collaboratively advocate with LGBT people by writing publications (e.g., newsletter articles, letters to the editor) about a particular healthcare barrier faced by LGBT survivors of trauma, and advocating on behalf of LGBT people could include lobbying legislators at the local, state, and national level for LGBT-affirming policy changes (e.g., insurance coverage of transgender surgeries). See Table 3.1 for more examples of opportunities for healthcare provider advocacy with LGBT patients.

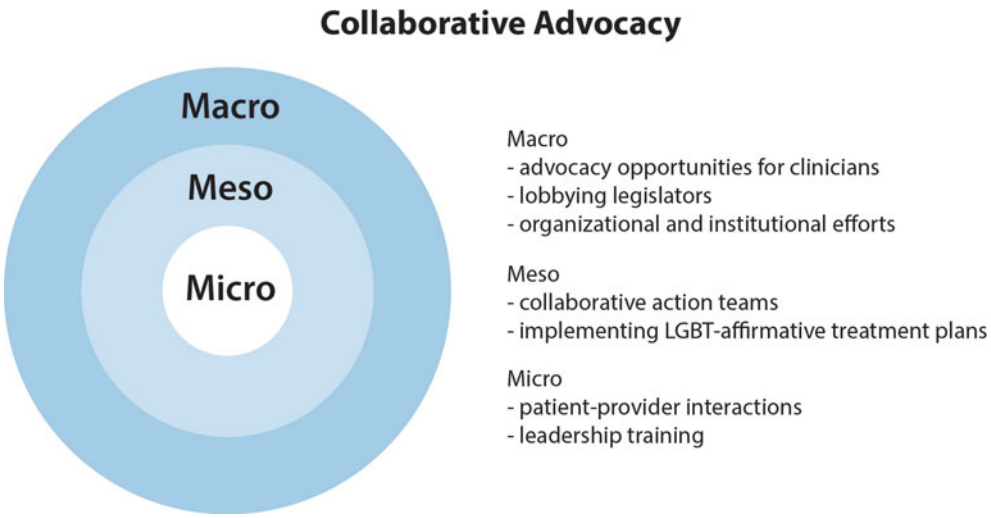

Fig. 3.3 Strategies for healthcare providers to advocate for LGBT people

Table 3.1 Opportunities for healthcare provider advocacy

Levels of advocacy	Types of advocacy activities
Micro level	Advocating on behalf of individual patients and addressing cissexist and heterosexist bias from fellow healthcare providers
	Teaching LGBT patients self-advocacy skills in working with healthcare providers
Meso level	Organizing education and training opportunities for healthcare providers on working with LGBT patients
	Leading an action team identifying how to make the healthcare environment and paperwork more LGBT-affirmative
Macro level	Advocating for healthcare professional organizations to lead on LGBT-affirming policy change
	Lobbying legislators and other local, state, or national leaders to create LGBT-affirming healthcare laws and increase access to LGBT-affirmative healthcare

When engaging as advocates for LGBT patients, healthcare providers can expect to encounter resistance at micro, meso, and macro levels. Heterosexism is a deeply embedded structural feature of healthcare systems, which reflect the values of society at large; therefore, providers who engage in change efforts may experience frustration and dismay as they face challenges in making healthcare settings more affirmative to LGBT survivors of trauma. Although it is impossible to eradicate these challenges, healthcare providers can leverage their efforts through consultation and collaboration with a wide variety of community stakeholders that already provide and/or support LGBT-affirming healthcare. For example, before embarking on development of a new community health clinic program for LGBT patients experiencing homelessness and intimate partner violence, one might consider forming a task force that includes not only healthcare providers and administrators from the clinic but also representatives from local organizations that serve people in the community affected by these issues. In these instances, collaboration can not only bolster healthcare provider advocacy efforts but also expand the influence of their LGBT-affirming advocacy and assure that the voices and choices of LGBT patients and their supporters are heard and incorporated.

Clinical Scenario

Tierra is an 18-year old trans woman whose parents immigrated to the United States from Trinidad before she was born. She socially transitioned at a young age and grew up in a community where her gender identity was respected. She excelled academically, engaged in multiple extracurricular activities, and was elected president of the student council during her senior year in high school. She has now enrolled in a college far from home and comes to see you at the student health center for routine medication refills. When you enter the room, you notice that she jumps a bit and looks startled. During the medical history, she repeatedly glances toward the door. When you ask her about this, she quickly asserts that everything is fine. As you introduce the sexual history, she becomes irritable and refuses to respond to any questions, stating: "You think all transgender girls are good for is sex!"

While her response comes as a surprise, you stay calm and warm in your demeanor. You let her know that you ask sexual history questions of all of your patients and reassure her that she doesn't have to answer any questions that make her uncomfortable. You then ask if there's anything she'd like to talk with you about. She says no and asks if she can come back later to finish the encounter. A week later, she calls and asks to speak only with you. During the conversation, she discloses that she was recently taunted and sexually assaulted on campus by a group of boys who locked her in a classroom where she was studying. Until now, she was reticent to tell anyone about this experience because she was ashamed and didn't want to disappoint her parents.

Discussion Questions

1. What are signs that an LGBT patient may have experienced prior trauma?
2. What role do providers play in identifying and responding to trauma among their LGBT patients?
3. How do intersectional factors impact an LGBT person's experience of trauma?
4. What strategies can health professionals use to provide a safe and empowering experience for LGBT patients?
5. What community resources are available to support LGBT patients who have experienced trauma?

Summary Practice Points

- Hyperarousal is common among people who have experienced trauma.
- Staying very busy by taking on extra activities may be one way that people avoid experiencing feelings and thoughts related to the trauma.
- Creation of a calm and empowering environment facilitates engagement in care for people who have survived trauma.
- Health professionals play a key role in identifying and responding to trauma among LGBT patients and connecting them with appropriate resources.

Resources

1. FORGE. *Transgender Sexual Violence Survivors: A Self-Help Guide to Healing and Understanding*. September 2015. Available at http://forge-forward.org/2015/09/trans-sa-survivors-self-help-guide/
2. Substance Abuse and Mental Health Services Administration. Trauma-Informed Approach and Trauma-Specific Interventions. Available at http://www.samhsa.gov/nctic/trauma-interventions. Includes
   (a) Key principles of a trauma informed approach
   (b) Links to trauma-specific interventions
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4. University of California, San Francisco. LGBT Resource Center. Available at: https://lgbt.ucsf.edu/lgbt-education-and-training. The site includes links to articles, publications, and online trainings.
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