The Reinforcement of Power Structures in Medicine:

An Analysis of Heteronormativity and Cisnormativity in Pediatric Healthcare

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PREFACE

This thesis means much more to me than just a major requirement paper. I chose to focus on the topic of health disparities of queer youth because what I learned throughout this writing process and what I hope to convey to readers is important to me. LGBTQ+ representation has grown easier to come by as the years go by, and luckily so has justice for this community too. As someone who plans on working in the healthcare system in the future, I wanted to understand how my actions affect others. Not only do the actions that I carry out have an impact, but so do the words and language that I use in those interactions. I want to be able to help patients with my knowledge, and now my knowledge is further developed about the power of language and how it will impact the individuals that I speak with. I'm grateful that I have the ability to meet and interact with people who live true to who they are, and I'm happy that with this knowledge, I will be able to impact them positively.

The purpose of this paper is not only to shed light on a social issue, but it's also to bring awareness to the fact that change can be done. I know that I don't hold all the answers or even have solutions to a large social problem like this, but I do know that there are a great number of people that care and are willing to push for change.

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INTRODUCTION

Is medical treatment truly equal? In the United States, everyone is legally considered to be born free and equal.[1] Health equality is the equal treatment and availability of medical services, to uphold fairness in our country. However, health equality does not equate to health equity, which prioritizes social justice in healthcare. It may come across that all peoples receive the same medical treatment and care. However, health disparities exist because of populations and communities that are socially disadvantaged and therefore receive different medical care. For instance, the lesbian, gay, bisexual, transgender, queer, plus (LGBTQ+) community receives different medical treatment because of the regular reinforcement of heteronormativity and cisnormativity in the medical setting.

This thesis examines how the use of heteronormative and cisnormative language and communication styles by a medical professional can psychologically detrimentally impact the LGBTQ+ patient. Through the analysis of Reddit subgroups where individuals of this marginalized community share their personal experiences with harmful assumptions made by their doctors and associates, my argument that heteronormativity and cisnormativity are reinforced in the medical field is further supported. This leads to the confirmation of some psychological stereotyping awareness and then decreases the patient's overall trust in the physician. Through this lack of trust, less health-relevant information is disclosed between the patient and physician. Health conditions then arise from the lack of disclosure and therefore result in disparities between the LGBTQ+ community and those who are not a part of this group. Additionally, the sexual orientation of adolescents has become increasingly medicalized and has

[1] National Archives and Records Administration. (2023).

developed into being under medical jurisdiction. With the heteronormative language that is used in the medical setting, there is especially difficulty with having trust in the physician when the patient is young and may still be questioning their sexuality. When sexual orientation becomes under the control of medicine when there is no need, it develops into an issue of social control. Not only is there a problem in the control of adolescent sexual orientation by medicine, but there is also a problem with the lack of support for transgender individuals despite biological support that not everyone can fit in the binary system. Some individuals are born with both genitalia, neither, or a variation of both, and they are physically altered at birth by doctors to fit into the female or male category. With the assertion of medical authority in sexual orientation but lack thereof in transgender-affirming societal debates, the question of the purpose of medicalization arises.

This thesis consists of four chapters. Although they discuss varying topics and issues, they can be overall used to see that power dynamics exist and are reinforced throughout these systems. The first chapter investigates the history of the LGBTQ+ community and the treatment that they have endured over the past decades. Homosexuality along with any other deviating sexualities from heterosexuality was treated as a mental illness. Those who came out as homosexual were forced to undergo treatment, therapy, or medical procedures to "undo" or "cure" their illness. This chapter sets the scene that heterosexuality was always seen as the superior and preferred sexuality compared to anything else, and therefore had power over the LGBTQ+ community. In the second chapter, stigmas and stereotypes are introduced in relevance to how they affect LGBTQ+ youth. LGBTQ+ patients encounter stigmas and stereotypes that are conveyed through heteronormative and cisnormative language used by medical professionals. LGBTQ+ youth have higher than average rates of mental illness and suicidal thoughts, compared

to youth that are not LGBTQ+. Although heteronormative or cisnormative values may not be intentional, they can be relayed to someone aware of stigmas or stereotypes that might apply to them or a community that they identify with. This chapter looks at the power dynamic between a highly educated adult who is a physician or medical professional and an adolescent who is part of a marginalized group. Chapter three looks at the power structure that exists between medicine and society as a whole. Medicalization of a condition, that may not even be a disease or illness, is a way that medicine tries to gain social control over a specific group. In this case, the sexual orientation of adolescents has become medicalized and moved under the jurisdiction of medicine. Although the medicalization of sexual activity is important, it's also important to question what is typically medicalized in the first place. Usually, conditions and illnesses are medicalized, whereas sexual orientation is neither of those. Medicalization typically occurs when something deviates from the standard, which implies that not being heterosexual is deviating from what is thought to be the norm. Lastly, chapter four develops the idea that medicine has grown its role and jurisdiction in transgender and non-binary lives, due to gender-affirming care such as hormone therapy or procedures. However, there remains a double standard of involvement when looking at the biology of intersex individuals and individuals who have Klinefelter and Turner Syndrome. People who are born intersex don't easily fall into the two categories of sex that are set forth by the binary system. Doctors physically alter newborns' genitals for them to be categorized, but then societal norms do not agree with transitioning between genders. This chapter looks into the flaws of the gender binary system and how it doesn't take into account the naturally occurring instances of deviation from this system. This reveals the power dynamic between cisgender and transgender people in our society. Throughout

this paper, multiple power structures are exhibited, and they are all impactful to the marginalized groups that are seen as inferior.

Defining Terminology

Along with the close analysis and examination of language and word choice, it is vital to define the terms that will be throughout this thesis for complete understanding. First and foremost, the gender binary system is the classification model that is used to categorize all people into one of two groups, male and female. This classification is almost always done right after the birth of a baby. It is a cultural norm to classify gender solely based on the baby's genitalia. Sex is defined as the two main categories that most living things, such as humans, are differentiated based on their reproductive functions and physical reproductive anatomy.[2] Although it may seem that sex and gender are the same, this paper will further develop the idea that there is a difference between sex and gender. Gender is now often referred to as a part of identity that does not necessarily align with one's established sex at birth, but rather based on socially constructed features and self-expression. The differentiation between sex and gender allows for the introduction of the term transgender. Transgender is a broader term for someone who does not conform to the gender identity or gender expression that is typically affiliated with that person's birth-assigned sex. It refers to a community of people who do not align with the rigid and inflexible binary system and includes those who seek or may seek gender-affirming care, either medically or socially. Gender-affirming care is when the individual is undergoing some personal change that will enable their outward appearance to align with their internal gender identity. Along with transgender individuals, non-binary individuals also do not fit into

[2] *LGBTQIA Resource Center Glossary*. LGBTQIA Resource Center. (2022, March 24).

the binary system. This is an umbrella term for people whose gender identities are not exclusively male or female. People who feel as though they do not fit into a specific gender category may use pronouns that are not standardly used for their sex assigned at birth. Pronouns are a tool used in language to function by themselves about a specific noun. The use of gendered pronouns is also a part of all languages, and the LGBTQ+ community has now started to combine gender identity with pronoun choice. Gender pronouns can look like: he/him/his (masculine), she/her/hers (feminine), they/them/theirs (neutral), ze/zir/zirs (neutral), and ze/hir/hirs (neutral). However, they are also not limited to this list.[3] As individuals choose gendered pronouns that don't align with the sex that was assigned at birth, pronoun privilege grows more apparent. Pronoun privilege is typically known as the privilege of not worrying about what pronoun someone uses to refer to you or how they perceive your gender. This term usually resonates with an individual that has not changed their gendered pronouns from the ones that are typically used with the sex that they were assigned at birth.

Understanding each part of the LGBTQ+ group is important for the understanding of this piece of writing. The L stands for lesbian, which is referring to women who are sexually or romantically attracted to other women exclusively.[4] The G stands for gay, which is referring to men who are sexually or romantically attracted to other men exclusively.[5] Those who are lesbian or gay would typically fall under the homosexual category, which means that the individual is romantically or sexually attracted to the opposite sex. The B stands for bisexual, which refers to an individual that is sexually or romantically attracted to both men and women or more than one sex or gender. The T refers to transgender. The Q stands for queer, which is a broader and less

[3] *Gender Pronouns - New York City Department of Social Services*. Gender Pronouns. (2017).
[4] *LGBTQIA Resource Center Glossary*. LGBTQIA Resource Center. (2022, March 24).
[5] *LGBTQIA Resource Center Glossary*. LGBTQIA Resource Center. (2022, March 24).

restrictive term to label an individual whose sexual or gender identity doesn't align with the other established sexualities or gender. The plus in LGBTQ+ represents the other sexual identities, such as pansexuality and asexuality.[6] Pansexuality is similar to bisexuality, but the individual is attracted, sexually or romantically, to people regardless of the person's sex or gender. Asexuality is the experience of no attraction to anyone. Homosexuality is often viewed as the opposite side of the spectrum of sexuality compared to heterosexuality. Heterosexuality is characterized as being sexually or romantically attracted to people of the opposite sex.

In this paper, I mention that heteronormativity and cisnormativity are reinforced in medical settings. Heteronormativity is the view that heterosexuality is the normal and preferred sexual orientation. Cisnormativity is the view that being cisgender is the norm and experiences privileges that other forms of gender identities do not. I also think it's important to address that I identify as cisgender and use the pronouns that standardly coincide with the sex that I was assigned at birth. I have the privilege of not worrying about what gender others perceive me as or what pronouns they will use to refer to me. I wanted to acknowledge that I am privileged, unlike a lot of the individuals whom I quote in my writing, and that it takes courage and strength to stay true to who you are.

A Note on Theoretical Approach

Science, technology, and society as well as sociological theories are important in the structure of this thesis. More specifically, *Critical Theory*, first defined by Max Horkheimer in his 1937 essay, is the main framework of this paper. He establishes that this social theory is aimed to attempt to reveal or critique power structures that exist in our society to later make

[6] *LGBTQIA Resource Center Glossary*. LGBTQIA Resource Center. (2022, March 24).

positive changes. This theory argues that societal problems originate from problems with social structures and cultural assumptions made from these structures. Horkheimer created this theory to emphasize the importance of questioning the dominant societal culture through the encouragement of listening to marginalized groups.[7] In the case of my thesis, it is important to listen to the personal experiences of the LGBTQ+ group as well as look at the statistics of this marginalized group in terms of health disparities and mental illness disparities. I will look at the power structures between cisgender vs. transgender, heterosexuality vs. homosexuality, and physicians and medical professionals vs. adolescent patients. All three of these relationships demonstrate that there is an underlying power structure that our society has created and has stuck by through reinforcement.

Furthermore, the *Symbolic Interaction Theory* will be used to build the framework of this thesis. This sociological perspective created by George Herbert Mead in his book *Mind, Self, and Society* states developed the idea that humans use shared language and common symbols to develop and relay meanings or intentions in intra- and interpersonal communication.[8] With that being said, language is a key component of how medicine is practiced. If there is specific language that is used in a medical setting that conveys the message that heterosexuality and being cisgender is the standard, then feelings of invisibility and ostracization can develop and overall impact the patient's experience and health.

To reiterate, I will utilize Critical *Theory* and *Symbolic Interaction Theory* as theoretical frameworks to examine and understand the relationships that exist in our society related to science and technology. This goes to say that power structures that are created by those who are not oppressed or marginalized are also reinforced by these same people. Through the analysis of

[7] Horkheimer, M. (1975).
[8] Mead, G. H., Huebner, D. R., Joas, H., & Morris, C. W. (2015).

language and its symbolic meaning, the enforcement of heteronormativity and cisnormative is established and conveyed to those who are young and impressionable.

The goal of this piece of writing is to call attention to the societal power structures that exist between marginalized groups and groups that have set these structures in place and continue to reinforce these values. Despite other overall improvements in the treatment of the LGBTQ+ community and individual members, the occurrence of microaggressions in the form of heteronormative or cisnormative communication is still present. This thesis contains a range of quotes from strangers, both to me personally and also to the online community due to the use of aliases to maintain privacy. I intend to understand the meanings and emotions behind every Reddit post and the moment of openness and vulnerability that I present. Through the examination of personal experiences between individuals in the LGBTQ+ community and medical professionals shared in subreddits on Reddit.com, the argument that there remain to be heteronormative and cisnormative ideals being promoted is supported further.

The scope of this thesis is limited to only the personal experiences of LGBTQ+ individuals that are in the United States and speak English. This is due to the resources that were available to me and my ability to only speak the English language. I hope that this thesis can highlight what some would see as small instances of stigma in a medical setting and see that despite them being seemingly innocent, they still have the ability to cause harm. The power dynamics that exist between a medical professional, such as a doctor, and an LGBTQ+ adolescent patient allow for susceptibility to stigmas and stereotyping.

CHAPTER ONE: HISTORICAL CONTEXT OF THE LGBTQ+ COMMUNITY

The history of the lesbian, gay, bisexual, transgender, queer plus (LGBTQ+) community is a very long internal history, and it dates to ancient civilizations. Same-sex love has been around for a much longer time than same-sex marriage was even legalized. Although terms such as 'gender,' 'gender identity,' and 'gender role' were only truly established around the 1950s, evidence of non-binary and third-gender identities is recorded in many cultures of history. The first openly transgender person was Christine Jorgensen and this widely publicized sex reassignment surgery occurred in 1952. Although this was a worldwide sensation at the time, she has become a part of the total 1.3 million adults who identify as transgender in our country.[9] Her being the first openly transgender person allowed more of the population of people that felt the same way as her to express themselves. Despite the growing representation of the LGBTQ+ community in the United States today, this was not the case in more recent decades.

People who are queer have always existed, although they have hidden this part of their identity at times. Through speculated same-sex relationships, gender fluidity or non-gender affirming presentation, and other ways that people expressed themselves without the labels of being LGBT, this community has been in existence since the beginning of time. However, most of its well-documented history starts with transphobia, homophobia, and hatred from outside of this group. The term 'homosexuality' was created in 1868, before the American Civil War, coined in a letter from Koraly Maria Kertbeny to Karl Heinrich Ulrichs. At this point in history, the majority of the American population lived in rural areas, and group identification for those who participated in same-sex relations had no way of being created because there was no urban

[9] Herman, J., Flores, A., & O'Neill, K. (2022, September 27).

community to bring them together. Homosexuality was deemed as falling under the term 'sodomy,' which includes forms of nonproductive sexuality such as oral sex and masturbation. Through the interpretation of the Holy Bible, specifically Romans 1:26-7, sodomy was seen as sinful enough to have the justification to be penalized. Therefore, forms of homosexuality and acts of same-sex were likely to be punished. Deriving from English laws, the punishment in American colonies for homosexuality was as severe as death. Former US President Thomas Jefferson even suggested castration as the punishment for sodomy, as well as punishment for rape and polygamy.

Male homosexuality was the first side of the LGBTQ+ community that was targeted socially. In the early 1800s, New York City's population was exponentially growing. With this very large urban growth, the largest city in the United States at the time started the emergence of seeing the population of homosexual subculture. A very well-known American poet, Walt Whitman, wrote many passages about young men. He wrote about their ages, physical characteristics, and more. He would even begin to write more explicitly about these men, developing a coded voice for more homosexuals to migrate to New York City to join this growing community.

By the early twentieth century, American society was becoming more aware of the homosexual subculture that had been growing throughout the years. At the beginning of the 1900s, an estimated three million people were a part of the queer subculture that was based in New York City. With the growing public and societal presence also came growing hate and backlash from others. Purity campaigns began to emerge, trying to combat the homosexuality and homosexual activity that had been occurring. Individuals were beginning to get arrested for their actions of homosexuality. Despite this societal backlash, the LGBTQ+ community

continued to express their identities. Gay clubs were openly operated up until the early 1930s. However, these gay clubs were known as pansy clubs, which pokes fun at the stereotypical femininity of gay men and plays into the homophobia of this community.

Labeling Homosexuality as an Illness

By 1935 in the United States, many laws were passed that were directly against homosexuality; these laws declared homosexuals of having a mental illness that needed to be cured. People of the LGBTQ+ community were diagnosed as having a disease and were then forced into treatment. This treatment included: castration, lobotomies, electroshock treatment, and pudic nerve surgery. These would take place in psychiatric institutions. Conversion therapy was even a part of the treatment. A German psychiatrist, Albert von Schrenck-Notzing, bragged that he had electrified a gay man into becoming straight. The treatment of this man was the beginning of the idea of conversion therapy, which is a set of pseudoscientific techniques that are used to alter the sexuality of those who are a part of the LGBTQ+ community to conform to societal expectations.[10] This included shocks being administered through electrodes that were implanted directly into the patient's brain. Psychiatrist Robert Galbraith Health would hire prostitutes or show heterosexual pornography to alter the patient's sexuality. Another form of conversion therapy is aversion therapy. This form of so-called therapy was based on the idea that individuals who are in the LGBTQ+ community would no longer experience their sexual desires if they were conditioned to have an aversion to it. Through this concept, patients were given chemicals that would induce vomiting while they were forced to look at photos of their same-sex partner. Sometimes electrical shocks were administered when being forced to look at gay

[10] Blakemore, E. (2018).

pornography. Sometimes these electrical shocks were administered to the patient's genitals too. Despite the decades of practicing conversion therapy on numerous people who are LGBT+, it can still be found today. Conversion therapy leads to irreversible psychological as well as self-hatred and shame. Conversion therapy can be found today, just with a different label. Although conversion therapy is technically illegal in the United States for minors, it still exists and continues to harm the people of this community. The person is never the one to initiate going to conversion therapy. Most oftentimes, it is the parents of the individual that will sign their child for this treatment in the hope of changing their sexuality, merely to conform to societal standards. It was fairly medically established that someone with a homosexual orientation had a mental disorder. The American Psychiatric Association even declared homosexuality as a psychiatric disorder. After the period when medicine agreed with this idea, religiously affiliated institutions started to take on the role of performing these 'therapies.' They were advertised as reparative therapy and the treatment ranged from talk therapy to exorcism. Individuals who were LGBTQ+ were told to pray for their heterosexuality or rather "pray the gay away," coached in the 'proper' gender roles that they should be fulfilling, and scolded that their sexual orientation is sinful and morally wrong. The way that homosexuality was viewed in the past was that it was a choice that the individual made and that it was wrong to do so.

This view of homosexuality is not exactly the case with how people view homosexuality in this current day and age. In 1962, Illinois became the first state to decriminalize private consensual sexual activity in same-sex couples, which was the first step toward homosexual liberation. In the late 1960s began the growth of liberation for the LGBTQ+ community in the United States. New organizations were beginning to be established, mainly based in New York City. This includes Gay Activists Alliance and Gay Liberation Front.

The LGBTQ+ Community as a Marginalized Group

The existence of inherently homophobic policies was still present, despite their beginning to be more liberation for the LGBTQ+ community. The "Don't Ask, Don't Tell" policy was enacted in 1993 in the United States military service. The policy was rooted in the idea that homosexual individuals should not enlist and serve in the military, but the way to get around this would be to refrain from discussing one's sexual orientation in general. In 1996 the Defense of Marriage Act denied any same-sex marriage as being recognized legally. It was not until 2008, that the state of California deemed this act as unconstitutional under the United States Constitution. The legalization of same-sex marriage only came when Barack Obama was the President.

The LGBTQ+ community has experienced a history that their safety and security in being represented fairly and equally has been waived. They had to live and still currently do live with the fears of hate crimes, being attacked physically or verbally for their sexuality or gender. Hate crimes still happen to this day. People still terrorize this marginalized community for a piece of their identity, something that cannot be chosen. In November of 2022, there was a shooting in Colorado Springs at a gay bar with five people killed and seventeen people wounded from this attack.[11] Club Q had a group of people that were usual at the bar and grew a tight-knit community. This community was targeted, harmed, and terrorized by a twenty-two-year-old man. He was faced with five charges of committing a bias-motivated crime that caused bodily injury and harm. The crime of hate led to an outcry that has shown that the LGBTQ+ community is strong and determined to continue to advocate for their group and show that this hate should not and will not be tolerated. The LGBTQ+ community has already dealt with tremendous

[11] Peipert, T., Bedayn, J., & Peterson, B. (2022, November 22).

amounts of adversity. The lack of acknowledgment from lawmakers and society as a whole for the right to be legally married to a same-sex partner isn't even the worst part of this community's history. They have dealt with hate, disgust, and neglect from our society.

The context and history of the LGBTQ+ community regarding society have shaped the way that medicine and medical professionals view people of this group. As mentioned before, medical procedures were done to 'convert' those who are perceived as sexual deviants to heterosexuality. Procedures, such as electroshock therapy and lobotomies, were medically approved and conducted on humans simply people to whom they are attracted. In an attempt to 'cure the gay,' some patients were forced to undergo a lobotomy. A lobotomy is a procedure done to treat psychiatric disorders or neurological disorders but sever connections in the prefrontal cortex. Epilepsy is a neurological disorder that was attempted to be treated with a lobotomy. The first problem with this procedure and thought process of providing treatment is that being homosexual doesn't need treatment. Homosexuality is not a neurological disorder or psychiatric disorder that needs to be treated and 'fixed,' despite it being treated as such.

Why is this History Significant?

The history of the LGBTQ+ community is important when trying to look forward and grow from the past. We often think about how we could let people treat others in a way that was fueled by hatred and personal beliefs. However, it's important to keep in mind that history is always changing and one day we may look back at the way that individuals in this community are being currently treated, within the scope of medicine and society as well. I present the historical context of the LGBTQ+ community to lay down the foundation to build my argument

that there are still tendencies and implications in medical practice that demonstrate old ways of homophobic and transphobic thinking.

CHAPTER TWO: PSYCHOLOGICAL IMPACT OF HOMOPHOBIC AND TRANSPHOBIC STIGMAS IN HEALTHCARE

Stigmas that LGBTQ+ Youth Encounter in Healthcare

The healthcare system in the United States, and throughout the whole world, is made up of human beings. Human beings are implicitly biased by nature, whether it is intentional or not. People carry biases with them throughout their daily lives and can sometimes let their biases control the way that they view and inevitably treat people. Cognitive bias is a psychological term that describes a systematic pattern of deviation from rational or so-called normal judgment. This can also be referred to as a subjective reality for that person's perception.[12] Framing biases in this way can help create the image that they can change the way a person perceives a specific race, sexuality, gender, or other groups of people, and can inaccurately pass judgments. Implicit biases are the attitudes or stereotypes that impact personal understanding as well as unconscious actions. Stereotypes are preconceived ideas and thoughts that allow us to assign specific characteristics to a specific group.

The LGBTQ+ community faces many stereotypes in day-to-day day life. Through media and other forms of entertainment, stereotypes of the queer community have been maintained. These stereotypes can sometimes have negative connotations that can negatively impact that community and can stem from homophobic or transphobic ideals. Stereotypes of the LGBTQ+ community include possibly unintentional stereotypes and biases from healthcare professionals that are providing them with treatment. Despite some of these physicians not even being homophobic or transphobic morally, sometimes these stereotypes and biases can find ways to

[12] O'Sullivan, E. D., & Schofield, S. J. (2018).

come out through the way that they speak and act with these patients. People who are a part of the LGBTQ+ community often face judgments of disapproval as well as heteronormative disapproval. This disapproval is oftentimes not consciously done by the medical professional but can still impact the patient in a harmful way. The way that a physician may speak or imply something to a patient can be seen as heteronormative and therefore can make them aware of the stigmas that they have towards that person and community.

Psychology plays a major role in how stigmas, stereotypes, and awareness of these stigmas and stereotypes can affect a person's emotions. Stigma consciousness refers to the extent to which groups of people who are specifically stereotyped focus on their stereotype status and how others' perceptions of them affect their life experiences[13]. It has been observed that those who experience stigma consciousness and think about individuals perceiving them have changes in behavior because these stigmas influence how they act. Higher stigma consciousness is associated with lower levels of well-being and health satisfaction, according to the individual.[14] Concerning sexual orientation, stigma consciousness is related to symptoms of depression and overall lower levels of mental health well-being.[15] These negative mental health impacts can be related to transgender teenagers having the highest rate of suicide out of any other group of individuals. Also, teenagers who identify as part of the LGBTQ+ community are about four times more likely to attempt suicide compared to their peers. According to The Trevor Project's 2022 National Survey on LGBTQ Youth Mental Health, 45% of LGBTQ youth seriously considered attempting suicide in the past year, and this included more than half of the nonbinary and transgender youth. Since facing these stigmas, heteronormativity and cisnormativity, and

[13] Pinel, E.C., Warner, L.R., Chua, P.-P. (2005).
[14] Gurr, T., Jungbauer-Gans, M. (2013).
[15] Berghe, W. V., Dewaele, A., Cox, N., & Vincke, J. (2010).

stigma consciousness, these youth members of the LGBTQ+ community are more likely to avoid stereotype-relevant situations, especially in these situations where the stereotypes may be confirmed. This can create a poor relationship between queer youth and physicians and, on a greater scale, medicine as a whole.

Although heteronormative communication may not be intentional by medical professionals, the stereotypes and stigmas can still be displayed to the patient. Individual physicians and healthcare professionals do not have complete control of health disparities in terms of wide-scale and structural barriers that queer patients may face, but their interactions with each patient can contribute to the disparities in medical care. The first form of health disparities for individuals who are LGBTQ+ is the avoidance of healthcare in general.[16][17][18] Referring back to the fact that patients who experience stigma consciousness tend to avoid situations where they can be stereotyped and could confirm the stereotypes. Data has shown that members of the LGB community are at a greater risk for developing mental health problems as serious as cancer because of their avoidance.[19][20][21] Not only are there health disparities for the entire LGBTQ+ group, but there are health disparities more specifically for LGBTQ+ youth. The inconsistency of presence could be detrimental to the proper education of young patients who require learning about how to take care of their bodies and maintain their health. Those who don't identify as heterosexual will most likely need to be educated on safe sexual relations and how to protect themselves against sexually transmitted diseases and other things that are related

[16] Harrison, A., & Silenzio, V. (1996).
[17] Heck, J. E., Sell, R. L., & Gorin, S. S. (2006).
[18] Krehely, J. (2009).
[19]Bränström, R., & van der Star, A. (2013).
[20] Dean, L., Meyer, I. H., Robinson, K., Sell, R. L., Sember, R., Silenzio, V. M. B., . . . Xavier, J. (2000).
[21] Robertson, R. (1998).

to STDs. Sex education in schools is very minimal in most schools across the United States. This usually includes forms of protection, how to obtain and use these forms of protection, and other topics related to conception and pregnancy. Schools almost always fail to mention any education that would be beneficial to LGBTQ+ youth. Therefore, the relationship between the pediatrician and the patient is vital to the well-being of that patient and their sexual safety and health. Another way that contributes to the disparity between the healthcare of heterosexual and cisgender individuals and LBGTQ+ individuals is the assumptions that doctors can make regarding their patient's sexual orientation and gender. When physicians make assumptions of heterosexuality and cisgender, this communication can lead to the patient's feelings of invisibility, lack of trust in the physician, and fears of disregarding non-disclosure agreements.[22] Again, a lack of trust and confidence in treatment by their pediatrician develops because of the fear that their sexual orientation and gender can be disclosed to the patient's parents, against their wishes. This will create barriers that the individual will have to face for the rest of their life, including access to and quality of healthcare. Additionally, fears of violations of non-disclosure agreements by physicians have been seen to relate to worsening psychological health after a one-year follow-up appointment, according to Durso and Meyer.[23] Other than nonverbal ways, healthcare professionals can project heteronormativity and cisnormativity on a patient through the way that they word questions or answer questions that a patient may have. It is first always assumed that the patient is cisgender and heterosexual with specific phrases that physicians use to ask questions about sexual intercourse. Asking a young patient if she is sexually active and she responds yes, and the pediatrician follows up with the question: are you worried about contraception? This question implies heteronormative ideals that the female patient is having

[22] Röndahl, G., Innala, S., & Carlsson, M. (2006).
[23] Durso, L., & Meyer, I. H. (2013).

sexual intercourse with someone who has a penis that can produce semen that can go on to possibly impregnate her. Many assumptions and generalizations had to be made to quickly jump to that follow-up question. First, the physician had to assume that the individual is heterosexual and has sexual relations with the opposite sex, which is male. Then, the physician had to assume that the male that the patient was having sexual intercourse with is a cisgender male who has a penis and can produce semen. Transgender men are born with uteruses and vaginas, which is the female sex anatomy. Some transgender men undergo surgery that is known as genital reconstructive surgery which can reform the genitals of that individual into a penis. Despite the complexity of this surgery, transgender men cannot produce semen and sperm that can be used to possibly make a zygote and lead to pregnancy. Many heteronormative and cisnormative assumptions are made by healthcare professionals that can impact the relationship between queer patients and those physicians. Although these set questions and protocols have been in place for many decades for pediatric healthcare, the manner of these questions needs to be reevaluated and changed, based on the negative impacts that have been observed in LGBTQ+ youth.[24]

Medicine Reinforces Heteronormativity and Cisnormativity

Heteronormativity and cisnormativity are often conveyed by a physician or medical professional through their language and the way that they communicate with the patient. The form of communication can either be verbal or nonverbally, but those societal standards are expressed. Heteronormativity can be conveyed through conversations or even through medical forms that patients must fill out, through the assumption that the patient lives with the opposite sex. On most medical paperwork, there is a question that asks about marital status. There are

[24] Utamsingh, P. D., Richman, L. S., Martin, J. L., Lattanner, M. R., & Chaikind, J. R. (2016).

three choices: single, divorced, and married. The choices don't give space for those who are same-sex partners but haven't gotten the privilege of marriage or other circumstances that play out the way that heterosexual couples would experience. Intake forms also reinforce the concept of heteronormativity by assuming that the terms "intercourse" and "vaginal intercourse" are interchangeable. Vaginal intercourse is defined as sexual activity that involves the insertion of the penis into the vagina.[25] The general term sexual intercourse is defined as the sexual contact and activity between individuals, typically involving penetration. In the case of sexual intercourse, homosexual sexual activity can be under this category because penetration can occur between two men with penises. This would refer to anal intercourse. The joining of the two terms as if they have the same definition, implies that they should be the same thing. Therefore, heteronormative sexual relations are enforced.[26] Another example of heteronormativity being expressed on patient intake forms is the distinct differentiation between sexual intercourse and the use of "objects during sex." Again, this shows that the use of sexual toys during intercourse differentiates the sexual act and becomes its category.[27]

Oftentimes when adolescent patients visit their pediatrician, it is common practice to discuss sexual health. According to the Clinician's Guide to Sexual History Taking prepared by the California Department of Public Health and the California STD/HIV Prevention Training Center in 2011, clinicians have a set guide that they should follow to receive the correct information needed to help prevent sexually transmitted diseases and maintain sexual health. The information would be useful for risk-reduction education and counseling if needed. For teens and adolescents, clinicians and physicians are instructed to incorporate questions of sexual history

[25] Parenthood, P. (2023).

[26] Goins, E. S., & Pye, D. (2013).

[27] Goins, E. S., & Pye, D. (2013).

with a broader range of questions. The way that this would typically happen is, the physician would ask the patient's parents and anyone else to leave the room so that the patient has privacy to answer the questions honestly. The physician is then supposed to state that anything that the physician and patient will discuss will remain confidential and will not be discussed with the patient's parents without permission. Then the protocol would be to ask questions that try to address possible issues related to home life, school, drug or alcohol use, and smoking. After this, sexual history is then addressed. The five "P's" guide the conversation, and these are Partners, sexual practices, Past STDs, Pregnancy history and plans, and Protection from STDs. The first questions would be to address and determine the number and gender of a patient's sexual partners. After this, a question about their partner's risk factors, such as a history of STDs, other partners, and injection drug use, should be asked. Then, sexual practices should be addressed. The patient is asked if they practice safe sex, typically meaning if a condom is being used the Clinician's Guide, states an example of how the physician should state their phrases. This example is: "I am going to be more specific about the kind of sex you may have been having over the last year so I understand your risks for STDs." The specification is the differentiation of what kind of sexual activity the patient is taking part in neither vaginal, anal, or oral sex. Then the physicians should ask about the patient's personal STD history, pregnancy plans if the patient or patient's partner were to get pregnant, and then what the patient does to protect themself from STDs.[28]

Although there is a physician's guide that is set forth by official departments of public health, there are still physicians and medical professionals that veer from this template. Not only can this personal questioning stray from the professional model, but this divergence can lead to

[28] *CA-STD A Clinician's Guide to Sexual History Taking*. California Department of Public Health. (2011, May).

the use of language that implies heteronormative and cisnormative assumptions that can be harmful to the patient. This harm can be felt through the direct impact on the patient's emotions, but it can also lead to a negative impact on the patient's subconscious and mental health.

Psychological Factors that Impact the LGBTQ+ Community

As mentioned earlier, individuals of the LGBTQ+ community have to encounter several heteronormative and cisnormative questions that most likely imply that being cisgender or heterosexual is the standard. With treatment like this from a medical professional, a well-educated adult, or an adolescent who has to deal with this is likely to develop feelings of invisibility and increased levels of stress. There are multiple psychological explanations and theories that can be linked to the statistics that show that LGBTQ+ youth and more specifically transgender youth have the highest rates of attempted suicide out of any other group in the United States.

In psychological science, there is a framework that is called minority stress theory. This theory describes that members of stigmatized minority groups face high levels of stress compared to those who are not members of stigmatized groups. This increase in stress levels can be caused by a few factors, including low socioeconomic status or poor social support. More factors that are more understood and their impacts are more understood are interpersonal prejudice and discrimination. For those who are in the LGBTQ+ community, it's very common to experience poor social support, whether that be from family, friends, or even strangers that one may encounter during a normal day. Being someone with a sexual orientation that is of minority eventually becomes a health risk for that individual because of this minority stress

model.[29] The idea that being heterosexual is the norm and standard, implies that those who are in the LGBTQ+ community are going against the dominant values of society and therefore cause conflict in social environments. These feelings that they are going against a specific code of values can lead to experiences of stress by minority group members. Not only do people who are queer experience internal conflict with their identity and sexual orientation but they can also be faced with hostility from external factors. The LGBTQ+ community has encountered decades of homophobia, harassment, maltreatment, discrimination, and hostility. All of these can either directly lead to an increase in stress or can influence feelings of internal homophobia and hatred that can increase levels of stress. With the growth of internalized homophobia, an individual can begin to expect rejection or prejudice in certain situations, which can cause the person to learn stigmas about themself or their community. This leads to avoidance of situations in which they believe they will encounter prejudice or rejection and this directly translates to healthcare. When a queer patient is stressed because they are part of a marginalized and stigmatized group, they will begin to avoid appointments and interactions with medical professionals that may have benefitted themself and their health because of stress and fear. This stress theory helps to provide insight into why there are health disparities between people of the LGBTQ+ community and those who are not in our country. The minority stress theory helps to create a framework that allows the impact of homophobia as a sociological paradigm to lead to the stress of a marginalized group, leaving this group disadvantaged and experiencing disparities in medical care.

A sector of the minority stress theory that helps to provide insight into a specific part of the LGBTQ+ is the significant relationship that was found between certain health risks and

[29] Dentato, M. P. (2012, April 1).

mental health. A specific example of this is the stressed risk of HIV among gay and bisexual men who are having same-sex sexual activity. HIV is also known as human immunodeficiency virus and it damages the immune system, which then interferes with the person's body's capacity and ability to fight disease and infection. It is typically spread through fluid contact with someone who is infected with HIV. These fluids include blood, semen, or vaginal fluids. HIV is commonly associated with AIDS, which is also known as acquired immunodeficiency syndrome. These two are commonly associated together because HIV causes AIDS. There is no cure for HIV or AIDS, but there are medications that can help control the infection and slow down or prevent the disease from progressing in the body. In 1981, the first reports of HIV/AIDS were recorded in the United States; this was the beginning of the HIV/AIDS epidemic. Since the beginning of this epidemic, about 84.2 million people have been infected with HIV and about 40.1 million people have died from it.[30] Along with the declaration that this virus and disease was part of a greater epidemic came hysteria throughout the country. The *New York Times* was the first to publish records for the public that stated that a rare cancer was being found in 41 homosexuals.[31] With the start of this epidemic and the spread of HIV/AIDS throughout the United States, began a new wave of homophobia. The HIV epidemic has always been connected negatively to the LGBTQ+ community, and more specifically homosexual men and men who have sex with men. The spread of this virus and AIDS was blamed almost entirely on the homosexual community and eventually led to homophobic thoughts, acts, and tendencies. Another thing to keep in mind is that HIV and AIDS treatment and prevention are both part of medical care. Referring back to the idea that those who are in the LGBTQ+ community may have feelings of distrust and invisibility in the healthcare system because of heteronormative and

[30] World Health Organization. (2022).
[31] Jolly, N. (2017, March 9).

cisnormative dialogue can explain why the health disparities negatively impact the treatment and prevention of HIV/AIDS. Some may not know if they have HIV and some may have a late diagnosis because of inequity of access to medical services. With a later diagnosis, HIV is harder to treat and can already be developing into AIDS. It has been found that there is a link between personal experiences of oppression and homophobia with the internalization of homophobia by the individual. There has also been found that there is a link between higher rates of internalized homophobia and taking sexual and health risks, such as having unprotected sex.[32] They can also take risks by having sex with multiple partners, which can put them more at risk for infection with HIV. It's not a coincidence that gay and bisexual men have the highest rates of HIV/AIDS throughout the United States. HIV can be transmitted through multiple different fluids that are not exclusive to men. Although there is increased visibility and social acceptance of homosexuality, we still live in a society that values heterosexuality and provides unintentional privileges to those who identify as heterosexual. The social structures that are unequal to gay and bisexual men perpetuate the HIV epidemic and other health conditions and diseases. There is a disproportionate effect of HIV/AIDS on the gay male community. Those who have HIV often always face stigmas and even those who do not have HIV but are gay men deal with the potential of seroconversion, which is when specific antibodies are developed in the blood resulting from an infection or vaccination. The psychological distress that non-heterosexual men experience, related to the HIV/AIDS epidemic, can cause worsening of mental health as well as an increase in risky behaviors. The ostracization of this specific community just because the virus and disease are more prominent leads to the stigmatization of that group. The stigmas that these

[32] Rosario, M., Hunter, J., Maguen, S., Gwadz, M., & Smith, R. (2001).

individuals of the group encounter can cause poor mental health, distrust, and avoidance of medical care, and therefore perpetuate the cycle that marginalized groups cannot escape from.

Another psychological science concept that applies to the LGBTQ+ community and how people are negatively affected is known as stigma consciousness. This is defined as the extent to which specific individuals who are stereotyped because of their identity or community that they are a part of are focused on their stereotyped status and believe that it permeates through all of their life experiences. This social psychology term helps to demonstrate that those who are in a marginalized group are aware of their status and they feel as though those who are not in that group see them as that stereotype. They become more vigilant and observant of signs of prejudice. This can be directly related to individuals who are LGBTQ+.

Analysis of Heteronormative Practitioner-Patient Interactions and Effects Study

Poja Dushyant Utamsingh, Laura Smart Richman, Julie Martin, Micah Lattanner, and Jeremy Ross Chaikind conducted and published a study in 2015 with the Department of Psychology and Neuroscience of Duke University. In this study, their goal was to determine if having a heteronormative or non-heteronormative interaction with a physician can lead to a lack of trust of the physician, and therefore result in health implications.[33] They carried this experiment out by randomly assigning LGB participants, meaning lesbian, gay, and bisexual, to read either heteronormative or non-heteronormative vignettes of a practitioner-patient interaction. After this, they were then asked how much health-related information they would disclose to the practitioner as well as their level of trust. The results provided evidence that LGB folks are more likely to choose to not disclose health-relevant information to a physician or

[33] Utamsingh, P. D., Richman, L. S., Martin, J. L., Lattanner, M. R., & Chaikind, J. R. (2016).

practitioner that conveys heteronormativity through their language and interactions. Through this lack of information that is relevant to health and wellness, there is a development of health disparities between this group and those who identify as heterosexual. This study shows the impact of a physician's communication style and language choice on a patient's decisions and overall feelings about the interaction, physicians, and medicine as a whole.

Reddit: Sharing Shared Harmful Medical Experiences

Reddit.com is a social network with a discussion structure framed by forums that started up in 2005. Reddit users, "Redditors," can create communities based on a topic, which is known as a "subreddit." This allowed individuals to create communities where they can speak with people who have similar interests. In subreddits, people share links, images, and GIFs that are relevant to that specific group's topic and add to the conversation of the group. The forum operates by having the top-voted submissions rise to the top of the page or the front of the page of the subreddit.

Reddit has become a space for individuals to share their personal experiences and stories with those in a specific subreddit that can relate to the topic. More specifically, it has become a space for people to share their bad experiences in a medical setting as a member of the LGBTQ+ community. Some posts that discuss these experiences are often titled the truth that the individual is going through. Just a handful of Reddit posts that have caught my attention were titled "Dealing with doctors as a trans person sucks," "Misgendering at Doctor's Office (Vent)," and "What do I do if my doctor is homophobic?" Each post is a personal account of an experience that was worth sharing or ranting about to a community that will understand and empathize with that Redditor. Luckily, I was able to access these vulnerable posts sharing

frustrations that many people are unaware of, simply because they don't need to be conscious of these issues.

I found a multitude of stories of experiences of transgender individuals who have had problems with medical professionals. Subreddit r/asktransgender was a community created to express feelings of invisibility, frustration, and invalidation as a person who is transgender. User I_Guess_Im_The_Gay opens up about a troublesome experience regarding going to an endocrinologist after eleven years of being on informed consent. The individual got a referral from the clinic that was associated with her insurance and then eventually received a phone call.[34] This is how the patient recalls being spoken to:

> Endo: Hey is this so and so?
>
> Me: Yes. Hi.
>
> Endo: We just want to confirm that you have everything when you come in so we aren't Wasting any time with this.
>
> Me: Not sure what you mean. Like medical records?
>
> Endo: No. Letters from a psych confirming you are ready to do this? Make sure you want to move forward with everything. Etc. We don't want you to show up and waste time if you don't have everything you need. We need [to] make sure you want to do this.

The individual then goes on to explain to readers that she has had bottom surgery and has been on estradiol, commonly given to transgender women, for eleven years. She is also legally female on all the documentation and medical records. However, the endocrinologist on the phone spoke

[34] I_Guess_Im_The_Gay. (2022). *Dealing with doctors as a trans person sucks. stewing on this for a few days now. sorry for ranting.* Reddit. Retrieved from https://www.reddit.com/r/asktransgender/comments/u5jcl7/dealing_with_doctors_as_a_trans_person_sucks/

to her as though to question her true intentions of transitioning and hormone treatment. She also recalls that the endocrinologist's office ran a male hormone panel on this patient, despite undergoing hormone therapy for numerous years. A seemingly innocent interaction is significant. Redditor I_Guess_Im_The_Gay ended her post with the admission:

> Anyways sorry for ranting. Just needed to get it out because this shit was messing me up. Looking forward to a lifetime of this shit. I avoid doctors because I am generally anxious about this exact thing and sure enough, it happened again.

In another post in the r/asktransgender subreddit, user fuckmylife333 recounts a 'humiliating' experience at a doctor's office that she had been going to for a decade.[35] The individual explains that she was feeling sick so she went to an outpatient clinic that was only two miles away from her house. She had just recently legally changed her full name as well as legally changed her gender on all of her legal documents. When she goes to the clinic, she informs the people in the office that she already has been recorded as an existing patient but under a different name than the new driver's license that she just handed to them. She showed that she still had the same social security number and birthday as the patient with the record in the system. The nurse pulls up the existing records with a different name but then says that they cannot change the records and are not currently accepting new patients. After the individual had outed herself as a transgender woman, the nurses would not stop misgendering her, using he/him/his pronouns. Despite the patient correcting them at least twice about what her pronouns were and the fact that the nurses originally referred to her with she/her/hers pronouns before she had to out herself as transgender, the nurses continued to use the wrong pronouns. After about an hour of sitting in the

[35] fuckmylife333. (2016).

clinic's office, the nurses concluded that the computer system did not allow for the changes to medical records that should be possible for people who are transgender. She recalls her emotions:

They had no problem with [using the correct pronouns] before I outed myself, and of all places, a doctor's office should NOT be the place where this is a problem. It's completely demoralizing… upon disclosing my medical history as a trans woman, I was repeatedly misgendered and denied service at a place I've been going to for over 10 years. I feel less than human.

Another experience of misgendering at a doctor's office was posted by user MsMoon88 on a FTM subreddit. FTM is an abbreviation of female to male, which indicates transitioning from female to male. This encounter is similar to fuckmylife333's experience where they were both misgendered in a medical setting. However, MsMoon88's misgendering was not initiated by the computer system that the medical office used. The patient identifies as non-binary and was also going through transitioning from female to male. The patient portal had gender options that were listed separately from biological sex, which they were happy about. There was also an option to put transgender male, which the patient chose. In their story, they discuss how the people working in the office, lab tech, and even the doctor misgendered them, even though they had prefaced what their pronouns are and that they are a transgender man. Although the patient portal allowed for inclusivity for the patient, this inclusivity did not translate to the actual interactions that occurred. They state:

…while I appreciate the inclusiveness of their charting system, they need to do culturally competent training for their staff and doctors. Or hell, at the very least, train them to read the

patient profile before they deal with them. I know that I will have to continue to advocate for myself and will have to teach people how to deal with me moving forward. I just hope they get their shit together before my appointment in October.[36]

MsMoon88's Reddit post elicited many responses from the FTM community. User Berko1572 wrote:

> Good on you for writing that email. You might consider noting that by having inclusive forms, but staff who are unable to use my pronouns given via said forms correctly, this can cause patient harm– while *you* may continue to get healthcare, others may not at all… Sadly, I see that MOST places that "fix" their forms (non-LGBT specific clinics that is) do so without doing training with front-facing staff…These systems need to be proactive, not reactive, and it should not be incumbent on patients to point this out.

A post that was a personal encounter at a doctor's office that demonstrated heteronormativity being reinforced by a medical professional was posted on the subreddit r/actuallesbians. User gyntaway posted that she had just gone to a new patient appointment and filled out patient information paperwork.[37] During a conversation with her doctor, she was asked if she was married, to which she replied yes. Later in the conversation, the doctor asked if there was any chance that the patient could be patient, and she replied no. The doctor then responded by asking how the patient knew with assurance and the patient replied that she doesn't do the kind of thing that could lead to pregnancy. At the end of the conversation, the doctor made the assumption and asked the patient if her husband would be coming to pick her up from the

[36] MsMoon88. (2022).
[37] gyntaway. (2017).

appointment. The Redditor confides in the readers of her post that she isn't someone who has a problem with coming out as gay if she is asked, but she usually doesn't give out that information without someone asking. The feelings of vulnerability and fear of rejection become amplified because she has some undiagnosed health issues and doesn't want to open herself up to inadequate healthcare if her doctor is homophobic or has biases toward people who are gay. She states:

I have a hard time coming out to doctors without being asked [because] I have some undiagnosed health issues, and I don't want to open myself up to inadequate health care if my doctor doesn't really like queer people and they decide to passively omit some diagnosis options. I want to have some surefire indication that they're cool with gay people…if they ask whether you have sex with men or women, it's usually an indicator that they're gay-friendly.

Although it may seem as though these interactions between medical professionals and patients are brief and harmless, they harm the emotions of the patients. Members of the LGBTQ+ community are already aware of the stigmas that exist toward their group. When these stigmas and stereotypes are presented in even slight ways, such as using the wrong pronouns or assuming the gender of a patient's partner, they still cause harm. Just by looking at a few examples of unpleasant experiences and encounters of LGBTQ+ patients and their physicians, the impact becomes clear.

CHAPTER THREE: OVERMEDICALIZATION OF ADOLESCENTS' SEXUAL ORIENTATION

Medical Imperialism and Social Control

The term over-medicalization refers to the occurrence of when more medical care and intervention are applied to a health condition that doesn't necessarily need more treatment. The overmedicalization of health conditions has begun to be more and more popular as financial motives are moving to the frontline. The purpose of the introduction of medicalization is to develop the concept that medicine is trying to gain more control over every aspect of one's life, and more specifically conditions that deviate from what has been set as the standard. Through this authority, medicine can have social control over patients and the aspects that are "out of the norm."

Women's health often gets medicalized in this day and age. This includes asking pre-teen and young teen females if they have gotten their menstrual cycle, or period, yet. It is common practice for health care professionals, such as pediatricians, to ask questions regarding periods to any girl, or female-born individual, when they come in for a check-up appointment. Sometimes this even involves the individual's parents being present in the room. This can be seen as nothing more than the parent or guardian being in the room with their underage child, but asking this question can be very personal for someone so young and trying to understand what is happening in their body. More so-called conditions have been observed to be overly treated, including obesity, mental illnesses and disorders, alcoholism, addiction, and sexual practices. All of those stated have begun to fall under the jurisdiction of medicine. There are some problems but also some positives that result from medicine treating more conditions. Obesity, for example, is a

chronic condition that describes when someone's body mass index is thirty or higher. Although this condition itself isn't harmful, it can lead to other conditions that are detrimental to the body's health and well-being. This includes high blood pressure, heart disease, and stroke. Obesity is also associated with type II diabetes and even some cancers. Despite obesity needing to be treated to help prevent other diseases and conditions, it is as of recently that obesity has been recognized to require medical attention. Mental illnesses and disorders are another category of conditions that has seen an increased amount of medical attention and treatment. While it is groundbreaking that mental disorders are now being recognized as medical conditions and more treatments are becoming more accessible and available for patients, it should also be analyzed to the extent of how the medical field as a whole and pharmacology have benefitted from the introduction of medication as a form of treatment. With more discoveries of science and exactly how medication helps with balancing chemicals in the brain, it is known that medication is effective and sometimes necessary for a patient to get better, in terms of their mental illness or illnesses. However, there is speculation as to whether or not medication for mental disorders is overprescribed now, and with the motivation to just make more money. Similar to mental disorders, alcoholism, and addiction are disorders that are biological and medical intervention helps the patient recover.

The emergence of the medical field and medical professions began when there became a separation between religion and medicine. This began in the 1970s and it came about when human issues were beginning to move into medical jurisdiction.[38] The faith in science was beginning to grow at that time as well as the prestigious titles that physicians and other medical

[38] Conrad, Peter. "Medicalization and Social Control." (1990).

professionals were receiving. This secularization allowed the shift of the main ideology to move from religion to medicine.

There are many reasons why there is a sort of "medical imperialism" when it comes to explaining why medicalization has occurred throughout history. The way that our society is structured allows for the medical field and medical professionals to have a monopoly on this so-called industry. This exclusive control of medical treatments and services has allowed professional dominance to grow. No one else is qualified for or able to provide any medical knowledge and treatments. Anything that was deemed to be labeled under the categories of health and wellness and illness was then able to be under the jurisdiction of medical professionals only. Since medicine is rapidly evolving right now, medicine's role in the individual's life changes. However, it has become clear that medicine has taken authority over many human conditions, and some are not exactly problematic conditions.

The Medicalization of Conditions and Disorders

It is still up for debate as to the purpose of the increase of medicalization of conditions, preventative vaccinations, and treatment of psychological disorders. Some believe that the increase is due to the advancement of medicine. According to Pawluch in 1983 pediatricians have been able to adapt their practices and how they carry out treatments to better the health of their patients[39]. Behavioral problems that parents or pediatricians noticed started to move under the domain of pediatrics, despite it technically being a health issue. Now known as "behavioral pediatrics," this enabled pediatrics to become more involved in the psychological development of the patients and later be included in conversations if problems arise. Through the emergence

[39] Pawluch, D. 1983.

and development of behavioral pediatrics, the medicalization of multiple aspects of a child's life, including behavior and psychosocial disorders, has been able to grow. It has now reached a point where pediatricians have involvement in many aspects of a patient's life.

On the other hand, sexual orientation and sexual activity are medicalized, but there doesn't seem to be a need for this intervention. Sexual orientation isn't a health condition that needs to be treated; it's a person's identification of which gender or gender that they are sexually attracted to. This is not something that needs to involve physicians or any sort of healthcare professional. The only thing that is important for a healthcare professional to know about your sexual orientation is if it pertains to sexual activity. Physicians should not know a patient's sexual orientation unless the individual is sexually active. With that in mind, why do pediatricians ask their patients if they are sexually active? This brings up questions of sexuality because with the answer to this question comes another question about if the patient is using protection and is worried about contraception. Contraception is only possible between female-born and male-born sexual intercourse. Therefore, if the patient responds that they aren't using protection but are not worried about contraception, this can lead to the physician concluding that this individual is having same-sex relations or intercourse. A lack of trust can develop between young patients with their pediatrician if these questions are being asked and they are not comfortable sharing anything related to sexuality and sexual activity. Keeping in mind that physicians can start asking patients at a very young age, starting in their teenage years. This structure of trust is very important and vital to build, for the sake of the patient's relationship with doctors and general medicine in the future. The main purpose for a physician to ask these questions in the first place is to ensure the health of the patient, which includes proper sexual education. Although most schools across the country have some sort of health class that reviews

sexual education and how to use sexual protection, including condoms, contraceptives, and dental dams, it is still important for the individual to learn more about their body and how to protect themself from sexually transmitted diseases and contraception from their pediatrician. With a lack of trust in a doctor, the patient may be apprehensive to listen to this sexual education and advice and then asking these sensitive questions would just be counteractive. It's also important to note the age of the patients that are being asked these introspective questions. Around the age that questions of menstruation start to get mentioned for someone who is born female is when questions of sexual orientation and sexual activity are later asked. While a child is growing and experiencing quite a few awkward stages, trying to understand their growing and changing bodies that appear because of puberty, they are also questioned about their sexual activity and then inherently asked about their sexuality. In the state of having very delicate self-esteem and self-perception, these questions can almost induce harm. Although it is very quick and easy to lie in the case that the patient doesn't want to disclose any information about their sexual orientation, just the act of having an adult ask questions that could lead to conclusions being made about that person's identity can cause self-reflection and almost unintentional coercion to out themselves to an adult figure. This adult figure also has the power to disclose the importance of the child to the parent or guardian, not without breaking confidentiality agreements but rules haven't stopped people before. A person's sexual orientation is a complete private matter and the only involvement a doctor should have about a patient's sexuality is only when there needs to be proper education regarding sexual intercourse related to that sexuality.

There is an aspect of social control when it comes to overmedicalization. The idea of social control is to have authority over anyone or anything that deviates from what is considered to be the norm in society. With that being said, illness is seen as deviance, and medical treatment

is seen to be the way that social control is carried out.[40] According to Conrad and Schneider, the most power that is obtained through social control is through the ability to define and diagnose specific behaviors and symptoms. With the authority of defining human behavior, this type of power begins to only be attainable if you are a physician.[41] Conrad differentiated three types of medical social control. These included: medical ideology, collaboration, and technology. A fourth category can be added to these, which is medical surveillance. Through medical surveillance, all human behaviors and conditions can be watched or surveilled by medical professionals through a medical gaze. Through this gaze, physicians can state that a specific condition or act should be intervened with medicine in some sort of way, whether it's on a small or large scale. This sociological perspective can be seen playing out in our society today, through the medicalization of menstruation, childbirth, menopause, and mental illness.

Deviating from the "Standard"

The sociology theory of medicalization of deviance is the idea that anything that deviates from the norm is considered bad and therefore a sick behavior that needs medical intervention. This includes the examples mentioned earlier, even acne treatment has now been medicalized despite it not being an actual health condition that puts the health of the individual at risk for health disparities. This sociological term gives medicine as a whole the jurisdictional power to control the lives of many people who are not technically sick or in need of treatment. Non-medical aspects of one's life can now be considered in medical terms, including disorders and illnesses. Even aging has now become medicalized and held under the control of medical professionals, although aging is a biological process of nature that everyone is experiencing. This

[40] Parsons, T. 1951.
[41] Conrad, P., Schneider, J. 1980a.

sheds light on the idea that as a society, we are seeking out what is considered to not be normative and trying to fix these behaviors and conditions. Although medicine is always evolving and science is making more discoveries daily that leads to the conclusion that medicalizing some conditions such as obesity, mental illness, and addiction is helpful, it also makes you wonder how our society responds to deviance. So then what is the reason for the medicalization of sexual orientation? Sexuality shouldn't have a so-called norm. What is normal? Heterosexuality? Even regarding gender: is cis-gender considered to be normal? There doesn't seem to be a need for physicians to know a child's sexual orientation, especially if they report no sexual activity. If medicine is following this sociological theory that any 'condition' that veers from the norm of society needs to be intervened with medical attention and treatment, then what is that saying about homosexuality, bisexuality, asexuality, or anything else that isn't heterosexuality? Is their sexuality a condition that needs treatment? There are societal implications that the medicalization of sexual orientation is revealing. Medicine and societal institutions are trying to attain social control and authority through this medicalization. These practices of sexual medicalization have become normalized and lead to no questioning done on the patient's part as to if it's wrong that they are being asked these questions. Especially for patients who are around the ages of twelve to fifteen, pediatricians most likely face no resistance to the questions that they are asking because they believe in the morality of their physician. After all, they are educated adults.

There are different degrees of medicalization of conditions, where some are fully under the jurisdiction of medicine, and some are only minimally medicalized. The medicalization of certain conditions has been very beneficial for overall health and well-being in our society throughout decades. The advancement of medicine has lengthened life expectancy and the

quality of life has greatly improved. The growth of medicine has allowed for more readily available treatments and interventions as well as more options for support from medical professionals. Medical insurance now exists and helps to cover the expenses of treatment when they are needed by the patient. Overall, medicine has made huge steps towards advancing and improvements that have benefited our society. Despite the positives of the increased scope of medicine, some consequences affect the individual. Although medical interventions in our current day and age are most often accurate and efficacious, they still carry negatives that can be unnecessary. In terms of conditions that are health-related, the process of medicalization can decontextualize social problems and therefore place them under medical control. An example of this is that domestic abuse has partially been medicalized. The treatment for this medicalized condition would typically be therapy, while it also distracts from the greater societal issue of patriarchal foundations and inequality between men and women. In terms of conditions that are not health-related, such as sexual orientation, the intervention of medical professionals in this domain can be harmful in other ways. Although homosexuality is an example of demedicalization in American society, pediatricians are somehow still involved with their patients' sexualities. The demedicalization of homosexuality was only achieved through years of organized movements to challenge the medical definitions that had been put into place. It took numerous years for the American Psychiatric Association to finally vote that homosexuality was no longer defined as a mental disorder. This goes to show how difficult it can be to go against medical authority, and this issue has not been completely solved yet. This is one issue that remains to be addressed and continues to be problematic for the growth of our society.

CHAPTER FOUR: THE BIOLOGICAL SUPPORT OF TRANSGENDER AND NON-BINARY INDIVIDUALS

Transgender, non-binary, and gender-nonconforming individuals are not completely socially accepted because of the expression of their gender or lack thereof. The society that we live in uses the binary system of sexes, which can be proven to be invalid, to base the structure of gender. Some individuals are born with ambiguous characteristics that do not allow them to fit into one of the genders of the binary system.

The Flawed Structure of the Gender Binary System and Its Consequences

The gender binary system was created as a Western concept that was put upon many other cultures throughout colonization periods. While other civilizations, cultures, and religions have believed that there are multiple gender identities, the Western idea that there are only two, female and male, has remained. The Bugis people of Indonesia recognized that there are five genders[42]. These included: trans woman, trans man, cis woman, cis man, and gender transcendent. In the year 1990, the term 'two-spirited' was created by Indigenous People to label the identity of someone who plays mixed gender roles. The Indigenous North American Peoples created a blanket term for one who expresses and performs functions attributed to that of a man and woman. This can also be related to sexual orientation, gender expression, and gender identity. Certain cultures have created a third gender category in the past, which negates the binary system that was created by Westerners. In pre-colonial times, the Zapotec community, located in Mexico, recognized this third gender party as 'Muxe.' They even celebrated their

[42] "Nonbinary History - out & Equal."

identity and existence as well as their significance to their community. In Ndongo society, which is modern-day Angola, there was a separate caste for this third gender group. This caste was called the 'Chibados.' Chibados[43] were free to express their sexuality and gender identity, and often even held positions of spiritual power, which shows their significance to the community. The discussion of a third gender can even be found in Egyptian hieroglyphics, this category is called 'Sekhet.' There isn't much more clarity on their significance in Egyptian culture, but it is known that they believed that there exists a man, a woman, and third gender. What can be taken away from these many cultures and societies from as far back as 2000 BCE, is that the ideals of more genders than the basic binary system is nothing new. Western civilizations created the gender binary system, based on religious beliefs, and proceeded to spread this concept with the countries that they colonized while condemning the idea of the existence of more than two genders.

The gender binary system is a social system built on cultural belief that creates a classification of only two genders, in the expression masculinity and femininity. Along with this system, there is a set expectation that one should follow the cultural standards of how to dress, how to act, what pronouns to use, sexual orientation, and more simply based on the sex that they were assigned at birth. This assignment at birth is based on the external genitalia that the individual has. With this system only having two categories, this leaves no room for straying away from being only masculine or only feminine, in the eyes of society. Gender binarism creates an institutionalized power dynamic that can lead to discrimination and harassment of those who do not fit into one of the two categories. People of the LGBTQ+ community often fall victim to the gender binary system, whether they are gay, transgender, or another identity.

[43] "Nonbinary History - out & Equal."

Through the expression of their sexuality or gender identity, queer people tend to not fit into one distinct group. As a consequence of their nonconformity, they face societal prejudice and inequity that is undeserved.

Individuals that do not fit into the gender binary system of man and woman endure numerous negatives. The first and most prominent effect is the feeling of a lack of self-identity. If I'm not suitable for the male or female categories, then where do I belong? The gender binary system reinforces that they are not valid in their feelings of not belonging. For people who are transgender or non-binary, there seems to be no group to be a part of except for outcasts. With this ideal set into place, it leaves room for other people to question the validity of transgender and non-binary individuals' identities. This can and almost always does lead to homophobia, ostracization, discrimination, and eventually isolation. Not only are people from an outside perspective questioning this community's identity, but also individuals that are a part of this community tend to have feelings of internalized homophobia. Because this system is so socialized and institutionalized, the concept of needing to fit into a gender category becomes ingrained in our minds. Many feelings of self-questioning and self-doubt arise. People of this community face discrimination in many different areas throughout their lives, including in the workplace, institutionally, from strangers, and even from their friends and family. Considering the self-uncertainty along with the unhuman-like treatment from external factors, transgender and non-binary individuals have very high rates of suicide and mental health issues. Data indicates that 82% of transgender individuals have considered taking their own life and 40% of transgender individuals have attempted[44]. Suicidality is the highest in transgender youth. This community also faces a lack of access to proper medical care. With the societal reinforcement of

[44] Austin, A., Craig, S. L., D'Souza, S., & McInroy, L. B. (2022).

the gender binary system, individuals that do not fit into a specific category deal with ostracization and discrimination. This system allows for restricting self-expression and it eventually plays a role in the person's overall health.

Not only does the gender binary system affect people of the LGBTQ+ community, but it also negatively impacts individuals who can fit into one of the two gender categories.[45] While one can identify as a man or woman, they may find themselves acting more masculine or more feminine than they think they should be as someone of a certain gender. The gender binary harms those who identify as male, despite the perception that men entirely benefit from patriarchal societies. One major harmful effect of this system is the concept of toxic masculinity. Toxic masculinity is the socialization of men to have stereotypical behaviors that involve aggression, violence, and unemotional habits. This includes the inability to express their emotions in ways that are not with anger. The gender binary system creates stereotypes that depict how the two groups should behave. Maleness tends to go along with the suppression of emotions. Oftentimes, men are not given the time and space to express their emotions, especially if they involve sadness. Boys are taught that they need to be strong and tough, which subconsciously creates the idea that they aren't allowed to show emotions that show their so-called weakness. Men are looked down upon for crying, for letting emotions overwhelm them, and even for showing their devotion to a partner. The term simp was coined to describe a guy that is overly desperate for women or a specific woman. This goes to show that men are not allowed to show any other emotion other than anger, because they will be ridiculed for doing so, even by their friends. Men also face the expectation of being independent and self-sufficient. This can be related to being self-reliant emotionally and socially. Compared to women, men

[45] *How the gender binary is bad for your health: Heal plus NM*. HEAL PLUS NM | New Mexico's LGBTQ Health Advocacy Organization. (2017, November 7).

report that they face internal struggles when it comes to reaching out for help and feeling connected to others. Both expectations created by the gender binary system negatively affect the mental health of men. Suppressing emotions and emotional challenges through poor coping mechanisms is how the usage of violence comes into play. Stereotypes teach men that they should always fight violence with violence, which creates false norms that reinforce poor tools for processing emotions. With all these stereotypes and expectations to meet, males grow to struggle with mental health and have no healthy outlets or room to express their feelings. This contributes to suicidality in men compared to women; males are four times more likely to take their own lives and they represent almost 78% of suicides. Without the ability to express and communicate their emotions, they must turn to other outlets, such as drugs and violence. Substance abuse of alcohol and drugs is a common pathway to go down for males. They are more likely to start using drugs at a younger age and they tend to develop habits of binge drinking, having more than five drinks in a short period of time. Men also partake in gun violence and are 98% of gun deaths in the United States. Women also face harmful stereotypes that are created from the gender binary. They often deal with specific gender roles and ideals created by patriarchy. Females undergo disempowerment socially, sexually, and emotionally because of the gender role that women are weaker and lesser than males. The wage gap between men and women in the United States has yet to be completely addressed and fixed. Women had to fight for the respect of men in multiple fields of academics and labor because their purpose is thought to be staying home, cooking, cleaning, and taking care of children. Women face undesirable hyper-sexualization because they are seen as being used by men as an object of sex while needing to please and meet the desires of these men. There are also unachievable beauty standards that are driven by what a man looks for in a woman. These are often unattainable,

expensive, and unrealistic, but women are still held to these standards and their worth depends on them. Females face microaggressions rooted in the praise of males, which will lead to internalized self-hatred. Because of these forms of oppression, women have higher rates of anxiety and depression. They also struggle with eating disorders due to the beauty standards created to be desirable to men. Women also fall victim to sexual violence at a disproportionate amount compared to men. With the gender binary system, even men and women are negatively impacted by the stereotypes and standards created.

The Significance of Intersex People in the Discussion of Gender

Intersex individuals are described as people born with characteristics that do not fit into typical binary ideals. These characteristics can include sexual reproductive anatomy internally, external genitalia, or hormones that are related to sexual reproduction. Some can be born with both testicular and ovarian tissues, an enlarged clitoris and no vaginal opening, a notably small peni,s and a divided scrotum that looks as though it's developing into a labia or other ambiguous genitalia. About one out of 2,000 babies are born with genitalia that isn't considered to be standard. When intersex people are born, it can only sometimes be noticed right away. Due to the institutionalized homophobia and discomfort of not fitting into the gender binary, doctors will perform surgery to alter the baby's genitalia to look more like a penis or more like a vagina. This decision is obviously without the consent of the individual, as they have just been born. It shows that society is very uncomfortable with things that cannot be given a label. Even parents who have an undying love for their child feel the societal pressure to have a baby that can fit into one of the gender binaries. They can become stressed about the baby's atypical genital appearance

and agree to the altering surgical procedure. Other times, it can only be identified when the person is going through puberty or even as late as discovering that they are infertile as an adult.

The surgery that intersex people undergo when they are very young can create life-long harm to the individual. Oftentimes, they grow up feeling like they do not completely feel like the sex that they were assigned at birth. This is because they were given sex and gender that didn't match who they exactly are biological. They were born without fitting into the male or female categories but were forced to go into one. The doctor decided what their genitalia should be, and from that point, their sex was determined. It's common for inaccurate gender assignments to occur, especially when it was simply decided for them. Along with that, it's also common for intersex children to be lied to about their identity. Referring to the societal pressure on parents, they can find it worthy to keep the truth of their child's identity a secret. Not only are the surgeries done on intersex people emotionally damaging to self-image and identity, but also they can result in physical damage. They can lead to the outcome of scar tissue, loss of sexual sensation, and even sterilization.[46] Because of the shame that our society instills in people who don't or can't conform to the gender binary system, intersex people are forced to undergo unwanted and unconsented surgery that is irreversible and may cause permanent damage.

The procedures and surgeries performed on intersex people violate medical ethics. With the consideration that the procedures are unnecessary because they are not tending to a problem that needs to be fixed, it's unethical to conduct. This goes to show that our society and the structure that we base it on subconsciously teaches us that anyone outside of the distinguished norms needs to be changed to fit into these norms. If this change doesn't occur, then shame and ostracization are to be expected to follow. The reason that performing these procedures is

[46] Cohen, Cathren. "Surgeries on Intersex Infants Are Bad Medicine."

unethical is not because the rationale behind it is wrong, but because there can be no consent given by the patient. These genitalia-altering surgeries are done when the individual is two years of age or younger. Informed consent is the permission of care agreed upon by the patient after communication with a medical provider. The provider needs to present the competent patient with accurate information about the medical treatment that they could be receiving. This goes alongside the bioethical principle of autonomy. In medical ethics, autonomy is expressed when the person has the right to make informed decisions about their medical care. Although our medical care system has concluded that people under the age of eighteen can't advocate for themselves and make medical decisions, it is still unethical to carry out procedures that can be emotionally and physically damaging for the entirety of that individual's life without their consent. This medical autonomy includes when the treatment decision contradicts what the medical provider believes is the correct course of action. With that being said, physicians try to persuade the parents to believe that these genitalia-altering procedures are what is morally and medically right for the child. While medical providers say that these surgeries will be beneficial because the child won't have to grow up with atypical genitalia and deal with the psychological trauma that can go along with that, they fail to mention that the person will go on to face other psychological struggles. Self-questioning and doubtful thoughts arise. Some struggle with self-acceptance with the gender that they were assigned at birth. Physicians also perform these procedures based on the idea that without changing the genitalia to appear 'normal,' that individual will not go on to have a normal life involving sexual partners. Without the disclosure of all the repercussions and the true reasoning behind this procedure, informed consent can never be given. Alternative treatment plans should be offered along with the associated risks of this surgery because of its lack of medical necessity while also creating harm. Framing this procedure

as ‘corrective’ inherently suggests that there was something wrong to begin with.[47] The issue is that the procedure is not because of medical necessity but rather conforming to the heteronormative and power structures reinforced by the gender binary system.

Along with individuals being born with ambiguous genitalia fitting into the umbrella category of intersex people, some people are born with different chromosomes that are not the standard XX and XY pairings. For example, Klinefelter Syndrome is when assigned males at birth are born with an extra X chromosome, resulting in XXY chromosomes. This syndrome isn’t inherited but rather a genetic mutation or error that randomly occurs. Those who are born with this condition experience lower levels of testosterone compared to someone born with just XY chromosomes. They also experience reduced muscle mass, facial hair, body hair, and the enlargement of breast tissue. Along with this, people with Klinefelter syndrome tend to deal with infertility due to low levels of sperm count or even no sperm at all. This trisomic anomaly occurs in about one out of 600 live births.[48] Another condition that involves a chromosomal error is Turner syndrome. This is a disorder that affects females because they are only born with one X chromosome; the other chromosome is either missing or incomplete. Symptoms of this condition include delayed puberty, infertility, short stature, and sometimes learning disabilities. They can have abnormalities with the development of their reproductive organs and loss of ovarian function, which coincides with slower puberty and maturation[49]. This condition occurs in about one out of 2,500 newborn females but would be seen at a more frequent rate if the data included pregnancies that didn’t reach full term. Almost one-half of people with Turner syndrome suffer from a heart defect or heart condition, involving abnormalities related to the aorta or aortic valve.

[47] Cohen, Cathren. “Surgeries on Intersex Infants Are Bad Medicine.”
[48] “Klinefelter Syndrome.”
[49] “Turner Syndrome: Medlineplus Genetics.”

Having XX or XY chromosomes is the only outcome that naturally occurs. In addition to Klinefelter and Turner Syndrome, other combinations of chromosomes result in biological presentations that do not perfectly align with the gender binary system.

Taking into consideration that there are naturally occurring biological instances of individuals that do not belong in the gender binary, why do we continue to use this structure of organization? Non-binary and transgender people along with people who are not born with the XX or XY chromosomes struggle with receiving societal and medical validation, despite the science that supports their experience and emotions. People who are born intersex are confronted with shame, secrecy, and oftentimes unwanted genitalia surgery that will impact them for their lives. The societal need for humans to categorize everything, such as gender and sexuality, creates more harm than good as a collective. The binary system of gender negatively affects those who do not fall under the categories of male and female, but it hinders the experience of males and females as well. We create more destruction for the sake of achieving simplified social interactions and maintaining order. Despite the acknowledgment of varying morphology of reproductive anatomy and varying development of internal anatomy, our society still tries to place people into boxes and reject those who won't or can't fit into these boxes.

CONCLUSION

The basis of this thesis is that stigmas and stereotypes are being conveyed through language and communication used in medical settings to patients who are young, vulnerable, and susceptible to these ideals. For someone who is old enough to understand and try to navigate their sexuality, but young enough to feel inferior and get overpowered by adults with authority, it's important to be aware of how they are being spoken to. Power dynamics and power structures that are societally embedded were revealed throughout this paper and emphasized through the analysis of these different relationships. Through the use of the framework of *Critical Theory* and *Symbolic Interaction Theory*, I can shed light on the societal problems that seep into medical treatment and care for LGBTQ+ youth, leading to this marginalized group experiencing mental health disparities.

One major change that needs to be done for these disparities to vanish is to change the medical education system and training for all doctors, nurses, medical techs, and more. Wittenberg and Gerber conducted a study in 2009 that focused on improving sexual health curricula in medical schools.[50] They analyzed how this improvement in education affected patients as well as students. Similar to a personal account by redditoRedditoray, they found that most are comfortable receiving sexual health information when it is initiated by their provider. This was about 45.1% of the participant's responses.[51] The researchers also found that the majority of the medical students that were a part of their study felt that learning about taking the sexual history of a patient is important, but they feel as though they are adequately trained and

[50] Wittenberg, A., & Gerber, J. (2009).
[51] Wittenberg, A., & Gerber, J. (2009).

educated to do so.[52] The lack of training along with the lack of confidence to ask patients about sexual history culminated in the wrong language being used. Therefore, the sexual health curriculum in medical schools and other health training should be modified so that it increases the medical students' experience and confidence. They should be undergoing more scenarios where they have to address someone that strays from the "standard" heterosexual sexual activity to learn how to approach these situations.

According to Liang, Gardner, Walker, and Safer's survey of medical students at Boston University in 2017, they found that medical students felt that their knowledge of LGBTQ+ populations and more specifically transgender and intersex health is deficient when compared to heterosexual and cisgender groups.[53] These surveys were based on self-assessed knowledge and attitudes and showed that these medical students felt as though they lack the knowledge about transgender health that they should have to provide proper care. They also found that students who identified themselves as LGBTQ+ reported much more significant knowledge and comfort with LGBTQ+ health, compared to those who didn't identify as such.[54] Another study conducted in 2018 found that despite the Association of American Medical Colleges publishing medical education competencies to guide them through undergraduate medical education, 76.7% of students still felt a level of incompetence in treating gender minority patients.[55] A majority of the participants reported feelings of insufficient preparation to properly treat someone who identifies as a gender minority, whether that is transgender, intersex, nonbinary, etc. To make changes so that medical students, who will eventually be treating LGBTQ+ adolescent patients, feel

[52] Wittenberg, A., & Gerber, J. (2009).
[53] Liang, J. J., Gardner, I. H., Walker, J. A., & Safer, J. D. (2017).
[54] Liang, J. J., Gardner, I. H., Walker, J. A., & Safer, J. D. (2017).
[55] Zelin, N. S., Hastings, C., Beaulieu-Jones, B. R., Scott, C., Rodriguez-Villa, A., Duarte, C., Calahan, C., & Adami, A. J. (2018).

educated and trained enough to provide competent care, the medical curriculum needs to continue to expand. Through increased education, training, and exposure to properly treating a patient who is LGBTQ+, positive changes to stigma and power in these clinical relationships will occur.

Power structures will always exist throughout society. Unfortunately, there is no way to eliminate them. However, there are tangible changes that can be made that can balance the dynamics that reinforce stigmas and stereotypes. For those who are marginalized for a piece of their identity, it becomes the easier choice to avoid environments where they may be stereotyped. Interactions between physicians and LGBTQ+ patients can be harmful to the patient because of hidden and implicit biases that the physician may have toward this group. Although these biases can simply be from a lack of knowledge and training, they can still negatively impact the individual and lead to avoidance down the road. Through avoidance of the medicine as a whole or through not disclosing health-relevant information because of a lack of trust, health disparities become apparent in the LGBTQ+ population. So when asked if medical treatment is truly equal, it's important to acknowledge that everyone's differences in identity make us who we are; we should be treated accordingly.

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