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IN THIS ISSUE

LGBTQ+ Health

In 1952, homosexuality was classified as a sociopathic personality disorder. It was declassified as a mental illness in 1973, but discrimination was still rampant.

The first known HIV case was in 1959 in what is now the Democratic Republic of the Congo (DRC) and was called the Belgian Congo. Even the earliest names for the set of conditions were discriminatory—the prevalent name prior to 1982 was Gay-Related Immune Deficiency (GRID),[1] and it was not until 1982 that the CDC formally adopted the acronym AIDS, for Acquired Immune Deficiency Syndrome (check out this interactive timeline). By this time, around 300,000 HIV infections had already been recorded and over 10,000 individuals had died of AIDS.

The first US cases were detected in 1981; a New York Times article on July 3, 1981 noted "a rare cancer in 41 homosexuals"[2] (Kaposi's sarcoma). Misinformation about HIV transmission was rampant, and due to these and other factors, even some healthcare providers refused care for AIDS patients in the 1980s.[3]

Although we are better informed about the health care needs of the LGBTQ+ communities now, disparities still exist. Recent political and legislative changes at the federal level have introduced fear and uncertainty into the delivery of care for this population. It is worth mentioning the historic, critical role played by gay rights activists, such as those who founded the Gay Men's Health Crisis (GMHC) network in New York in 1982, and those who supported the Whitman-Walker Clinic in Washington, DC. Incidentally, WWC was supported by DC government funds at its inception, and was housed in a church basement for the first several years.

The Third Annual National Survey on the State of LGBTQ Health reports that fear of stigma and institutional distrust remain major barriers to care for LGBTQ+ communities, and threats to gender-affirming care are decreasing access for LGBTQ+ populations.[4] LGBTQ+ individuals are being diagnosed with depression and/or anxiety (90%), substance use (39%), gender dysphoria (36%) and suicidal ideation (35%) at alarming rates, and mental health issues are one of the three most significant barriers to LGBTQ+ patients accessing healthcare (19%).[4]

Fifty-one percent (51%) of LGBTQ+ service providers have considered leaving their jobs in the last six months, and the LGBTQ+ healthcare workforce is experiencing levels of burnout driven by political volatility, increased workloads, and unstable funding.[4]

As of May 2025, Delaware has 1,112 psychiatrists, 1,044 professional counselors of mental health, and 77 marriage and family therapists to provide services for 1.05 million Delawareans,[5] not to mention the bevy of institutions, providers, and resources illuminated in this issue of the Journal and beyond. Addressing the disparities in LGBTQ+ health care is crucial for achieving health equity in Delaware, and ensuring the well-being of these—and all—Delawareans.

We heartily thank our Guest Editors, Christopher Moore and Dr. Anna Filip for curating this issue and bringing to light the many health care focus areas and resources for this community.

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Guest Editors

Honoring Voices, Advancing Equity

Christopher Moore, B.A.
Interim Executive Director, AIDS Delaware

Anna Filip, M.D.
Family Physician, ChristianaCare

We are honored to serve as guest editors for this special issue of the *Delaware Journal of Public Health*, dedicated to LGBTQIA+ health equity. As a physician and public health leader and a nonprofit executive rooted in advocacy, storytelling, and HIV services, we share a deep commitment to lifting up the voices and experiences too often sidelined in health care and public discourse.

This issue arrives at a critical time. Across the country and here in Delaware, LGBTQIA+ individuals face escalating threats to their health, safety, and rights. And yet—despite legislative setbacks, systemic underfunding, and persistent stigma—we see courage. We see revolution. We see people rising to meet this moment with care, clarity, and urgency.

From the opening pages, our contributors help us understand the broader landscape of rights, retrenchment, and resistance. Lieutenant Governor Kyle Evans Gay offers a compelling reflection on the role of equity in public health leadership. Mike Brickner draws powerful parallels between the legal rollback of reproductive rights and the potential erosion of LGBTQIA+ protections in our post-Skrmetti world. Dr. Suzan Abdallah reminds us that prevention is more than a strategy—it is an act of resistance, especially when health equity efforts are under attack. Sharon Morgan shows us what happens when funding is stripped away from the most vulnerable, especially in under-resourced areas like Sussex County.

We then turn our attention to young people—those navigating identity, family, and survival in systems not built for them. Rebecca McColl, Erin Nescott, Dr. Eric Layland, and colleagues offer a rare and necessary multi-perspective analysis of LGBTQIA+ youth homelessness in Delaware. That same commitment to intersectional data and compassionate care shines through in Dr. Layland's research team's work on mental health and substance use disparities among SOGI-diverse youth. Stephen Raskauskas brings policy into focus with a clear-eyed look at the urgency of protecting access to gender-affirming care for Delaware youth.

Care—how it's delivered, who it's designed for, and whether it heals or harms—is at the center of the next set of contributions. Dr. Sarah Matthews guides us through the deeply human and often invisible challenges faced by LGBTQIA+ older adults at the end of life. Alex Waad and Tylisha Johnson unpack the practical and ethical considerations of collecting sexual orientation and gender identity (SOGI) data in healthcare settings, while Dr. Catherine Dukes calls on providers to get more comfortable talking openly about sex—not just as a topic, but as an essential element of clinical care. In another vital contribution, Dr. Brett Herb examines how chest masculinization surgery can dramatically improve quality of life for transmasculine individuals, grounding clinical choices in personal and psychological impact.

Of course, no conversation about LGBTQIA+ health is complete without confronting the trauma so many endure—and the paths to healing that must be made available. Karla Fleshman brings this to life through a powerful narrative on dissociation as a response to systemic bullying, paired with an original poem that both mourns and dares to imagine. Elise Mora writes with clarity and compassion about the psychological damage caused by anti-LGBTQ legislation, especially among people living with HIV. And in one of the issue's most sobering pieces, Noah Duckett and Julissa Coriano trace the devastating legacy of forced and involuntary sterilization—revealing how that legacy still echoes in the present day.

Even as we sit with these heavy truths, we are reminded that change is possible—and already underway. April Lyons-Alls, Dr. Zowie Barnes, Noah Duckett, Emily Nardone, and Nena Rapposelli offer a replicable and community-informed blueprint for building gender-affirming care programs, grounded in the lived experience and practices of Planned Parenthood of Delaware. And Talena Queen closes the issue with a call to care for those doing the work: a deeply resonant piece on burnout, recovery, and sustaining the workforce needed to make equity real.

Together, these contributions offer more than just research and reflection. They offer a roadmap. They challenge us to confront the systems and stories that shape LGBTQIA+ health — and to build something better. We are deeply grateful to the *Delaware Journal of Public Health* for creating space for this critical work, and to every contributor who brought their wisdom, vulnerability, and vision to these pages.

To our readers: thank you for engaging. May these articles inform your work, provoke your thinking, and remind you that equity isn't a notion — it's a practice, a principle, and a promise we must continue to fight for.

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HIGHLIGHTS FROM
The NATION'S HEALTH
A PUBLICATION OF THE AMERICAN PUBLIC HEALTH ASSOCIATION

July 2025

The Nation's Health headlines
Online-only news from The Nation's Health newspaper

Weight-loss drugs providing hope for some, but not for all
Sophia Meador
The Nation's Health July 2025, 55 (5) 1-14;

Health officials keeping watchful eye on H5N1 mutations in US
Mark Barna
The Nation's Health July 2025, 55 (5) 1-10;

White House budget would further hurt US public health system
Natalie McGill
The Nation's Health July 2025, 55 (5) 1-6;

Scientific journals facing political interference, cuts
Kim Krisberg
The Nation's Health July 2025, 55 (5) 1-8;

Q&A with Michael Osterholm: Vaccine Integrity Project to serve as trusted voice on science
Sophia Meador
The Nation's Health July 2025, 55 (5) 5;

Better leadership, coordination may improve newborn screenings
Natalie McGill
The Nation's Health July 2025, 55 (5) 7;

WHO global agreement supports pandemic preparedness, equity
Mark Barna
The Nation's Health July 2025, 55 (5) 11;

For the healthiest milk, make sure it's not 'raw'
Teddi Nicolaus
The Nation's Health July 2025, 55 (5) 16;

Newsmakers: July 2025
Sophia Meador
The Nation's Health July 2025, 55 (5) e5;

Equity in Public Health

Kyle Evans Gay
Lieutenant Governor, State of Delaware; Former State Senator, 5th District

When we talk about equity in public health, we are talking about more than just access to care. We are talking about dignity. We are talking about whether people feel seen and heard when they describe their pain. About whether they can walk into a doctor's office and feel safe, supported, and respected, regardless of who they are, who they love, or how they identify.

In Delaware, we've made meaningful progress toward building a healthcare system that is more equitable and responsive to the needs of all residents, from Claymont to Delmar. But equity is not a destination. It is a daily practice that requires ongoing commitment and care. This is especially true when it comes to supporting our LGBTQIA+ neighbors.

As a mother, a policymaker, and your Lt. Governor, I carry this responsibility with both urgency and deep respect. My work on behalf of the LGBTQIA+ community is not just a policy priority. It is deeply personal. It is shaped by conversations with young people seeking affirming care, and by listening to trans-identified Delawareans who have expressed fears about their safety. It is guided by a belief that public service means showing up, especially for those who have historically been left out or overlooked.

I also carry the privilege of holding public office with deep humility. Serving as both a legislator and now Lt. Governor has given me a platform, and I do not take that for granted. I view this role as an opportunity to help amplify voices that have too often gone unheard and to ensure those voices help shape the policies that affect their lives.

During my time in the State Senate, I was proud to sponsor and support legislation that expanded protections for LGBTQIA+ individuals. That includes laws which made it easier for individuals to change their name and ensure that gender-affirming care is protected and respected. I also co-sponsored the Gender Identity Nondiscrimination Act, and joined advocates fighting to increase access to housing, mental health support, and essential services for LGBTQIA+ communities across our state.

Still, we know that legislation alone cannot create equity. An inclusive public health system must reflect the lived experiences of the people it serves, and data from the Centers for Disease Control supports this: LGBTQ+ youth are more than four times as likely to attempt suicide as their peers. Nearly one in six trans individuals has experienced homelessness. LGBTQ+ adults, especially people of color, face higher rates of chronic illness, substance use, and delayed care, often as a result of negative past experiences with healthcare providers.

These disparities are not inevitable. They are the result of systems which haven't evolved to meet the needs of LGBTQIA+ individuals. Often, these systems operate on outdated assumptions, unintentionally reinforcing exclusion, misinformation, and stigma. Fortunately, systems can evolve — and they must.

Equity in public health means placing LGBTQIA+ voices at the center of decision-making. It means making sure every provider, from school-based clinics to major hospitals, is trained to deliver culturally competent, affirming care. It means gathering inclusive data, investing in targeted services, and backing our values with the resources to make them real.

Equity also means creating a society where people can live without fear. Across the country, we have seen a rise in harmful rhetoric and legislation targeting LGBTQ+ individuals, particularly trans youth. These actions create uncertainty and distress in communities that already face disproportionate challenges. In Delaware, we are committed to a different path.

Our state should always be a place where every person, no matter their gender identity or sexual orientation, knows they are safe, welcome, and valued. I have said it before and I will say it again. Health care is a human right. That includes gender-affirming care.

When we support LGBTQIA+ people in accessing the care they need, whether it is PrEP to prevent HIV, therapy for mental health, hormone treatment, or simply a doctor who listens without judgment, we are doing more than treating illness. We are affirming people's humanity. We are building trust. And we are creating a public health system that leaves no one behind.

Throughout my career, I've been proud to champion access and integrity in public service, whether through my work on the Behavioral Health Consortium, my advocacy for reproductive freedom, or my support for evidence-based policymaking. A guiding question across all of this work is simple: Who gets to be well?

Equity invites us to look beyond general statistics and pay attention to the people most at risk of being left out. For LGBTQIA+ Delawareans, that means continuing to expand nondiscrimination protections, offering training for healthcare professionals in inclusive care, and supporting community-based organizations that have earned trust through decades of advocacy. Community-based advocacy groups and HIV service organizations are already doing the work, and they deserve our partnership and support.

This is not just a moral imperative. It is a public health priority. When LGBTQIA+ people are treated with respect, health outcomes improve. When they are embraced by their communities, families become stronger. When they are protected by law, all of us benefit from a more just and compassionate state.

I am proud to live in a Delaware that believes in this work and shows up for it every day. But I also know that progress is never guaranteed. It depends on our willingness to listen, to act, and to care for one another.

To every LGBTQIA+ Delawarean: Your health, your safety, and your dignity matter. You are an essential part of our communities, and your wellbeing is a priority. I remain committed to building a public health system that reflects your needs, protects your rights, and ensures you are valued every step of the way.

The Lieutenant Governor's team may be contacted at lginfo@delaware.gov.

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Strengthening the Argument for Telemedicine

Fotarisman Zaluchu
Universitas Sumatera Utara

The COVID-19 pandemic has further highlighted the efforts of healthcare service institutions to adapt in order to save those in need. In their article titled "Improving Postpartum Follow-Up with Telehealth: Did the Pandemic Nudge Us in a Better Direction?", the authors conclude that the use of telemedicine has had a significant impact on attendance at post-delivery visits. The authors also outline several limitations of their study, including the limited sample size. As a direction for future research, they suggest that comparing telehealth visits between 2020 and 2022 would be an interesting topic of study, along with exploring the difference in new pregnancy visits within two years of the studied delivery.

From a future research perspective, I believe the authors could further explore a qualitative approach. They may dig into the experiences of telemedicine users to assess how they interact with and perceive this service. Notably, this paper lacks an adequate explanation of how telemedicine was implemented, as the authors do not provide such details. As a result, the potential for replication becomes ambiguous if other studies wish to use this research as a reference.

However, numerous studies have demonstrated that user experiences significantly influence the decision to adopt new behaviors. These experiences are also closely related to other factors, including education and occupation. If the authors wish to explore this further, they may uncover whether the use of telemedicine was driven by fear of the COVID-19 virus or by respondents' genuine preference for it. By drawing qualitative reflections, we may identify aspects that warrant further investigation in future, more comprehensive research.

Another important aspect to consider is that the willingness to visit healthcare facilities is closely related to a mother's parity. Based on our field experience, primiparous women tend to be more inclined to seek healthcare services. Their curiosity and sensitivity to health issues are often higher. Investigating this aspect could be a highly valuable future research direction that would further enrich this paper.

AUTHOR RESPONSE

These comments are valid, and we are pleased to draw attention to this topic, and appreciate your making the time to comment, as well as read the DJPH.

Is Our Post-*Skrmetti* World Like a Post-*Dobbs* World? Lessons from the Fight for Reproductive Rights

Mike Brickner, M.A.
Executive Director, ACLU of Delaware

ABSTRACT

In June 2025, the U.S. Supreme Court ruled that Tennessee's ban on gender affirming care for minors can stand, as it did not constitute sex discrimination. This meant that the decision of whether to protect or restrict gender affirming care for minors is a decision left up to individual states, similar to how the court ruled in the landmark Dobbs decision. What lessons can transgender advocates take from the fight for reproductive rights, and how can transgender rights advance despite a flurry of attacks?

On Wednesday, June 18, 2025, the U.S. Supreme Court issued its ruling in *US v Skrmetti*,[1] a case out of Tennessee which tested whether states could ban gender-affirming care for minors. In a highly controversial 6-3 decision, the Court found that Tennessee's ban could remain in effect, leaving over 100,000 transgender minors in 25 states without meaningful access to gender-affirming care.[2]

The Court's decision was gut-wrenching, as families across the country have relied on gender-affirming care to provide support to transgender children as they navigate understanding and actualizing their gender identity. *Skrmetti* does not ban gender-affirming care for young people nationally, but rather leaves those decisions up to each individual state. For people who have followed recent Supreme Court decisions, this patchwork of access echoes the court's ruling in *Dobbs v. Jackson Women's Health Organization*,[3] the 2022 case that struck down nearly 50 years of jurisprudence that held people had a constitutional right to access abortion. Similarly, *Dobbs* put the question of abortion back to the states, meaning that several states immediately moved to ban abortion, while others sought to protect and expand access.

There are differences between a post-*Skrmetti* and post-*Dobbs* world. While the decision to allow bans on gender-affirming care for minors is devastating and will have real life consequences, it did not undo other hard-won advances in transgender rights, such as non-discrimination protections in employment, housing, and public accommodations, nor did the Court bless bans on gender-affirming care for adults. As a result, transgender rights advocates are not starting from the same floor that reproductive rights advocates did after *Roe v. Wade* was overturned.

Post-*Dobbs,* many in the reproductive rights movement reassessed the strategies that had led to the overturning of *Roe,* and there are several lessons that are relevant to the current fight for transgender rights. While the path to secure full equality for transgender Americans is likely to be long and fraught, we can learn from the social movements that preceded to mitigate harm, grow grassroots support, and guarantee rights.

WHAT THE *SKRMETTI* DECISION SAYS

Despite several advancements in LGBTQ+ rights over the past two decades, the United States is experiencing a significant pushback led both by the federal government and conservative state legislatures. Since 2000, LGBTQ+ rights advocates were able to strike down harmful laws such as "Don't Ask, Don't Tell"[4] and the Defense of Marriage Act,[5] while also winning decisions in the U.S. Supreme Court on marriage equality[6] and recognition that LGBTQ+ people are protected by sex discrimination laws.[7] However, over the past few years, more state legislatures have introduced and enacted anti-LGBTQ+ laws. Currently, the ACLU is tracking 598 such laws that have been introduced in 2025 alone.[8]

As a culmination of the past years of attacks on the LGBTQ+ community, the election of Donald Trump in 2024 saw new federal threats. Upon taking office, he immediately rescinded much of the Biden administration's guidance to protect LGBTQ+ people in schools, healthcare, and prisons, and then issued executive orders ranging from declaring there were "only two sexes" to banning federal grant recipients from discussing gender identity or sexual orientation in their programming.[9] The ACLU has filed lawsuits against many of these actions and are prevailing thus far in the vast majority of them.

This tidal wave of anti-LGBTQ+ laws and executive orders has disproportionately targeted the transgender community, which has often been ostracized and maligned with more vitriol than their LGB counterparts.[10] Even within the LGBTQ+ community, there has been a long-documented tension between people fighting for acceptance of sexual orientation and gender identity, with transgender advocates having been marginalized in past advocacy campaigns.[11] While there have been significant steps to build solidarity and trust amongst the LGBTQ+ community members, these past wounds continue to play out in advocacy circles.

The Tennessee law banning gender-affirming care for minors was challenged by the ACLU and Lambda Legal in April 2023. Two months later, a federal district court judge in Tennessee agreed that the law was likely unconstitutional and blocked its enforcement, but the state appealed. In July 2023, the Sixth Circuit Court of Appeals reversed the judge's decision and allowed the state to move forward. The ACLU and Lambda Legal appealed to the U.S. Supreme Court, and they accepted the case in June 2024.[12]

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At the heart of the case against Tennessee's law was the claim that it constituted sex discrimination. According to the law, minors cannot access medications for gender-affirming care. For instance, a transgender boy who wished to take testosterone could not do so. However, Tennessee law does not ban a cisgender boy from taking testosterone for another medical condition that does not relate to gender dysphoria. The attorneys for the Tennessee families and practitioners who challenged the law stated this was clearly sex discrimination because the young people were banned from accessing this treatment solely because of their status as transgender people—i.e. their sex.

In legal challenges involving accusations of discrimination, there are various levels of judicial review that courts may be required to provide as to whether a law is viable. If a court finds that the law poses some sort of harm based off a protected class, such as sex, race, national origin, disability, or religion, then they apply what is known as strict scrutiny, which is a very high bar for the government to meet to justify the law. However, if the court finds that there is not one of these fundamental rights at stake, they can apply a rational basis review, which is a much lower bar for the government to meet and they are generally granted wide discretion.

In the U.S. Supreme Court's 6-3 decision, Chief Justice John Roberts asserted that Tennessee's law did not discriminate based off sex because both transgender and cisgender children were forbidden from accessing these treatments for gender-affirming care. This ignores the fact that cisgender children would never attempt to access these treatments for gender-affirming care because it is not necessary for them. It also ignores that cisgender children can have treatments such as hormone therapy that correspond to their gender assigned at birth, but transgender children cannot have hormone therapy that corresponds to their gender identity.

Instead, Chief Justice Roberts said that the laws discriminated based off age and the reason the person wanted to access the therapies. Neither of these are protected classes, which meant that the Court could apply the rational basis review that is highly deferential to government. Based off that classification, the Court found that Tennessee's law could remain in place.

The impact of the *Skrmetti* decision is substantial. Gender-affirming care is supported by nearly every major medical organization,[13] and transgender people report that it greatly benefits their mental health.[14] With young people in many states unable to receive this care, they may suffer significant harm to their mental health, or their families could be forced to relocate to another state to obtain care.

Importantly, the *Skrmetti* decision does not impact availability of gender-affirming care to adults, nor does it reverse other legal and legislative protections that transgender people have won in recent years.

In Delaware, gender-affirming care is available to minors. In June 2025, Governor Matt Meyer signed Executive Order #11 that extended the state's existing shield laws to gender-affirming care.[15] Shield laws are those that ensure both patients and providers are protected against investigations or criminalization from law enforcement in other states or federally for healthcare received in Delaware. The Delaware General Assembly voted to codify those protections by passage of House Bill 205, which awaits the Governor's signature.[16]

While gender-affirming care remains legal in Delaware, its availability may be impacted by actions in other states or by the federal government. In its first months, the Trump administration has targeted organizations that support transgender people, meaning that organizations have faced potential loss of funding, investigations, and potential legal challenges.[17] These attacks are meant to persuade these institutions to no longer support gender-affirming care, which can make access for the transgender community a right on paper, but not reality. Similarly, bans on gender-affirming care in other states increases the cost and burden for families seeking care, and can put an overall strain on the medical systems meant to support them.[18] For advocates of reproductive rights, these challenges are nearly identical to those that patients and providers experienced in the lead up to the *Dobbs* decision, and especially post-*Roe.*

CONNECTING THE STRUGGLE FOR TRANS RIGHTS AND REPRODUCTIVE RIGHTS

Make no mistake—reproductive rights and transgender rights are closely aligned and we cannot win one without the other. Both issues have the same core value: that every person should have full control over their own bodily autonomy, and that the government cannot tell someone how to live their life. While this might seem like a remarkably libertarian worldview, conservative political forces have tried to control and diminish Americans' right to control their own bodies. If both issues have the same core values, they also have the same core forces animating their opposition, namely patriarchy and Americans' rigid adherence to Victorian gender norms.

If these two issues are intertwined, then we must take lessons from the movement for reproductive rights that can help to inform and strengthen advocates' strategy to secure transgender peoples' full rights and equality.

DRIVING THE "WEDGE"

When *Roe v. Wade* was decided, it marked a watershed in American democracy where pregnant people could fully make decisions about when and how they gave birth. Almost immediately, opponents of abortion rights began its attack. While some advocates started with attempting to reverse the U.S. Supreme Court's decision immediately, the anti-abortion movement largely shifted to a strategy of slowly chipping away at *Roe.* Opponents of abortion recognized that they would likely not succeed in overturning the landmark *Roe* decision immediately, but if they found holes that they could exploit, they could erode both legal protections and public support for abortion rights.[19]

The easiest way for anti-abortion activists to attack abortion rights was to focus on issues that divided traditional supporters of abortion. In the decades following the nationwide recognition of a right to abortion, opponents typically focused their attacks on three key issues:

- Who was having an abortion?
- Why were they having an abortion?
- Was abortion really safe?

If we examine each of these lines of attacks, we can see some clear patterns emerge.

In terms of who was having an abortion, there were various ways anti-abortion activists focused their attack. First, they often pushed abortion bans or maze-like regulations on minors who wished to have an abortion.[20] By focusing on young people, this provided an insidious way for anti-abortion activists to prey on a vulnerable group of people with little political capital or influence, and undermine the core value that all people should have autonomy over their own bodies. Another group that anti-abortion activists targeted was the Black community by quoting some founders of the reproductive rights movement who espoused racist beliefs that flirted with or directly connected to eugenics. This public media campaign preyed on many Black Americans' well-founded fear of the medical community, given the United States' long history of experimentation and punitive use of sterilization, to undermine trust in institutions that provided reproductive healthcare.[21] Finally, anti-abortion activists would routinely utilize people who expressed regret over their own abortion to advocate for limitations and bans on abortion care. By utilizing these people to speak about their own regret, advocates were able to create doubt in Americans' minds that abortion care was a positive experience, despite the vast majority of people who have received an abortion reporting that it was an empowering, affirming experience.[22]

Why people have an abortion was also a common discussion point that was used by anti-abortion activists. For many years, most opponents of abortion would affirm that there could be "good" reasons for terminating a pregnancy, such as saving the life or health of the pregnant person and instances of rape or incest. However, they would also frequently invoke people who would have multiple abortions, or have abortions later in their pregnancy. These tropes would cast these people as simply "using abortion for birth control" or that they waited so long to have an abortion because they were lazy or indecisive,[23] despite the fact that research shows most later abortions happen because of access issues, health concerns over the fetus or pregnant person, or because of domestic abuse or incest.[24]

Finally, anti-abortion activists targeted abortion providers by enacting Targeted Regulations Against Providers or TRAP laws. These laws placed unnecessary and burdensome regulations on abortion providers that made it extremely difficult to provide care to patients. For example, abortion clinics would need to have transfer agreements with local hospitals, but other ambulatory clinics that perform other types of outpatient surgeries were not required to have such agreements. Opponents of abortion cast these TRAP laws as ways to protect abortion patients; however, abortion is one of the safest medical procedures with extremely low complication rates.[25] Instead, these laws created increasing doubt in the public that abortions were safe and that providers were professional and well-trained.

HOW ELECTED LEADERS RESPONDED TO ATTACKS AND WHAT WE CAN LEARN

For decades, abortion rights became a third rail of American politics. While the Democratic Party generally supported abortion rights, there was frequently room for anti-abortion Democrats to become elected officials, and it was infrequent for abortion rights to be proactively brought up by Democratic elected officials in campaigns. Restrictions on abortion rights were passed with Democratic support in many states. Abortion advocacy organizations such as Planned Parenthood, ACLU, NARAL, and other groups were included in the progressive ecosystem, but abortion advocacy would often be marginalized and deprioritized in progressive organizing spaces.

When people did speak about abortion publicly, it was often heavily scripted and controlled by tightly polled talking points. Much of the time, advocates were taught to utilize language that avoided using the word abortion, and sought to distance advocates from some of the very groups of people who needed abortion care that anti-abortion activists attacked. For instance, the slogan, "Safe, legal, and rare" become a rallying cry for many abortion advocates throughout the 80s, 90s, and 2000s.[26] However, casting abortion as something that should only happen rarely implicitly creates stigma for the procedure and alienates people who may need to access multiple abortions. This messaging buys into the trope that opponents promoted that suggests abortion is shameful and something people should avoid.

In addition, the people chosen to be storytellers about their abortion care were generally people who had harrowing stories to tell. They had a life and death medical condition, or their much-wanted pregnancy was not viable, or they were a survivor of rape or incest. To be clear, these stories are incredibly important to the overall tapestry of reasons why a person may get an abortion, but those stories were told at the expense of also telling the stories that were more mundane or at the margins. It was less frequent to hear from the person who simply knew they did not want to be a parent now, and decided to get an abortion. Stories that centered young people, low-income people, or other marginalized identities were even rarer. Prioritizing the stories of people who had sympathetic circumstances may have had some short-term utility because members of the public who were undecided on their support for abortion, or only had soft support would find these storytellers compelling. However, it traded this short-term gain for the long-term problem of portraying abortion as something one had to be worthy to access. It also stifled many people from sharing their personal abortion story with their social circles because they did not have one of the special circumstances that averted stigma.

The attacks anti-abortion activists waged should sound familiar to anyone following the struggle for transgender rights. The past several years have seen relentless attacks on the rights of young people to access gender-affirming care, similar to attacks on young peoples' right to access an abortion. Anti-transgender activists have repeatedly elevated the stories of the people who have "detransitioned" and regretted getting gender-affirming care, despite them constituting a very small minority of those who have received care.[27] These attacks on young people and the utilization of those who regretted receiving gender-affirming care has been combined to portray those who do seek to transition as doing so as part of some sort of fad, or because of social pressure from their peers. Neither of those reasons are supported by the testimonies of transgender people, but instead seek to undermine their ability to make decisions for themselves. Finally, the anti-transgender movement has begun to weaponize radical parts of the medical community to cast doubt on the safety and effectiveness of gender-affirming care, despite existing research, the testimonies of transgender people, and nearly every major medical association all supporting this life-saving healthcare.

If we can acknowledge that the anti-transgender playbook is remarkably similar to the anti-abortion playbook, then we must also resist making the same mistakes again. In the wake of *Skrmetti,* some pundits and elected officials have charged that transgender advocates have gone too far in their push for equality, and need to create a bigger tent of people who will support their cause. This pragmatic approach is not without some merit, as we must recognize that many Americans may not fully understand transgender rights issues, and the barrage of anti-transgender attacks have caused some to retreat from their support. But if we are to create a big tent, we have to do so effectively and in a way that will allow supporters to move the tent closer to justice, rather than further away, as we saw with abortion access.

Creating a big tent that can be used to move people to greater support of transgender rights can be done in a few ways. First, we must always lead with values that unite supporters. Abortion advocates were too often playing defense and taking too long to explain why their opponents were wrong about their assertions, which brought us further away from connecting with the underlying values that would win broad support. By focusing on the core values of autonomy, freedom, and privacy, advocates can assert powerful values that will unite voters, while also avoiding alienating members of the transgender community that opponents attempt to target.

Storytelling is also a critical part of winning public support. One of the traditions of the LGBTQ+ community is National Coming Out Day, which sees members celebrate when they formally affirmed their LGBTQ+ status with friends and family.[28] Oftentimes, it proved to be an important moment for the social circle of the person because they may not have known an out LGBTQ+ person, or had negative views of LGBTQ+ people. Once they knew someone they loved who was LGBTQ+, it helped to break down barriers and stigma against them. Outing oneself in more public ways comes with risk for transgender people, who rank among those most vulnerable to be attacked in hate crimes. However, for those who are comfortable to disclose their stories, these can be some of the most powerful tools towards combatting transphobia. Beyond trans people themselves, their loved ones can also be powerful messengers. In telling their stories, they need not be traumatizing or dramatic, but stories of everyday life can be highly effective in allowing others to identify with and better understand transgender people.

THREATS AND OPPORTUNITIES FOR TRANSGENDER RIGHTS

The *Skrmetti* and *Dobbs* decisions illustrate that we cannot rely on the courts alone to protect our rights: we must work to secure them in the legislature and with the public. In particular, the reproductive rights movement illustrates why we must have an affirmative, compelling vision for the future beyond simply protecting the status quo. While defending *Roe* from challenges was a worthy goal, it does not inspire activism, and it leaves advocates in a defensive position where they are constantly fending off attempts to undermine their rights. Instead, transgender advocates must take a lesson from the post-*Dobbs* abortion rights community and center their advocacy on clear values and a vision for the future that unites their base and brings in others. It has been thrilling to see ballot initiatives on reproductive rights succeed in various states, and that advocates have mostly used messaging that is abortion-forward and abortion-positive.

Many of the threats that face the transgender community are directly tied to reproductive rights. Beyond the use of shield laws, like Delaware's, states should consider significant reforms to digital privacy laws that can leave both transgender people and those seeking abortion care vulnerable. Reverse warrants are a novel tool that allow law enforcement to serve warrants to tech companies requesting information on people who use their services to access information about healthcare. For instance, a law enforcement officer could ask a cell phone carrier to produce records of anyone who was within a certain distance of an abortion clinic or gender-affirming care provider on certain dates, or they could request an internet provider send them data on anyone who searched for information on any of those healthcare services. These controversial methods are the subject of litigation, but states like Delaware can ban their use now rather than wait for the federal courts to invalidate their use.

Access to gender-affirming care mirrors the problems that have plagued abortion providers for years. As care becomes banned or threatened in various states and the federal government restricts funding, clinics in states that permit gender-affirming care will become stretched to accommodate the need and low-income people will also struggle to pay for care. In the wake of *Dobbs*, states like Oregon created a Reproductive Healthcare Equity Fund, which provides dollars to abortion providers and funds to ensure patients can retain access. Transgender advocates and their allies should adopt these same strategies to leverage state and private resources to cover potential gaps in coverage.

Lastly, now is not the time to abandon the courts. While the federal courts may have a mixed record on transgender rights, there will be cases that they will continue to rule in favor of transgender people. Most importantly, many states have parts of their constitutions that can also be used to affirm and expand the rights of transgender people in deeply meaningful ways. We must fight for freedom and equality on all fields in order to achieve victory, and we have tools to do just that.

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- Medicaid and our workforce – challenges and opportunities
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Prevention is Resistance: Upholding LGBTQIA+ Health Equity in the Era of Retrenchment

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INTRODUCTION: A PUBLIC HEALTH INFLECTION POINT

In Delaware and across the nation, LGBTQIA+ communities stand at a dangerous crossroads. Just as decades of advocacy, research, and public health programming have begun to bear fruit—increased access to PrEP, more affirming healthcare spaces, and youth-led movements demanding visibility—those very gains are now under threat. Federal HIV prevention funding is uncertain. State and local programs are bracing for cuts. And amidst it all, anti-LGBTQIA+ rhetoric and policy initiatives are proliferating.

Yet within this volatility lies an undeniable truth: prevention is not simply a public health tool. It is an act of resistance, of solidarity, and of care.

As someone who has worked in Delaware's public health sector for nearly a decade, I have seen firsthand what happens when systems invest in people, and what happens when they don't. In this moment, we must treat community-rooted prevention work not as a luxury, but as a lifeline.

BEYOND THE METRICS: HUMANIZING PREVENTION WORK

At the Delaware HIV Consortium, we see the impact of affirming prevention work every day. We see it in the young trans woman who, after months of missed appointments and instability, makes the difficult decision to cross state lines in search of a better life and finally starts PrEP with a provider who sees her fully. We see it in the outreach worker providing free testing and distributing harm reduction kits beyond the typical work hours, offering support and information in moments when it matters most. We sense it in the relief of a client when they hear that HIV prevention services can be free, anonymous, and judgment free.

This is the type of care that cannot be captured solely by epidemiological graphs or budget line items. It is messy. It is labor-intensive. And it is undoubtedly essential.

THE IMPACT OF RETRENCHMENT: WHEN CUTS COMPOUND INEQUITY

The current wave of federal-level instability, including delayed FY2025 awards, CDC reductions in force, and proposed eliminations of key prevention funding, has sent shockwaves through organizations like ours. For communities already marginalized because of their race, gender identity, immigration status, housing insecurity, or criminal justice involvement, these funding cuts do not represent mere bureaucratic shifts. They are a direct hit to access, to safety, and in many cases, to survival.

Delaware, like many states, has seen rising HIV and STI rates, particularly among young LGBTQIA+ individuals, Black and Brown communities, and people who inject drugs. These trends are not coincidental; they are the predictable outcomes of system-level disinvestment and policy regression. When the safety net is shredded, those furthest from power fall first.

INTERSECTIONALITY IS THE WORK

Too often, public health discussions treat LGBTQIA+ health as a silo. But the truth is, prevention work, when done right, cuts across systems. HIV prevention is a gateway to mental health support, care referrals, food assistance, legal aid, and more. A peer navigator offering a safer sex kit might also be the first person a youth confides in about suicidal ideation or domestic violence in their home.

This is why the integration of trauma-informed care, gender-affirming practices, and anti-racist frameworks is not optional. It is what makes programs effective, especially in high-burden zip codes and among historically excluded populations. It is how we build trust in systems that have historically failed LGBTQIA+ communities.

DELAWARE'S COMMITMENT TO AFFIRMING CARE

Despite national backsliding, Delaware has taken steps to reaffirm its commitment to health equity. One powerful example came in June 2025, when Governor Mathew Meyer signed Executive Order #11, affirming the state's unwavering support for access to gender-affirming care and the rights of providers who deliver it. In doing so, Delaware sent a strong message: in this state, your identity does not diminish your right to health, and your healthcare provider will not face persecution for offering medically necessary, affirming care.

This Executive Order wasn't just symbolic. It builds upon a foundation of inclusive policy, protects providers from out-of-state legal interference, and reinforces the principle that equitable care is a public good. In a climate where even basic protections are being stripped away elsewhere, Delaware's stance is both reassuring and necessary.

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POLICY, POWER, AND THE ROLE OF PUBLIC HEALTH PRACTITIONERS

Public health should not be a political act. The erosion of LGBTQIA+ protections, the criminalization of gender-affirming care, and the undermining of reproductive rights all have direct and measurable impacts on health outcomes. As practitioners, we must be prepared to speak not just as clinicians or administrators, but as resolute advocates.

We must challenge policymakers who cut prevention funding while lamenting rising HIV rates. We must resist narratives that suggest LGBTQIA+ health disparities are inevitable rather than constructed. And we must support a new generation of public health leaders, many of whom are queer, trans, and BIPOC, who are reimagining what public health can and should be.

A CALL TO ACTION: CENTERING COMMUNITY, RECLAIMING PREVENTION

We are at a critical juncture. The choices we make now will reverberate for decades. Will we allow our prevention infrastructure to erode under political pressure? Or will we invest boldly in the community-based models that have already proven effective?

To truly advance LGBTQIA+ health equity in Delaware, we must:

- Fund and expand trauma-informed, culturally competent HIV prevention programs.
- Strengthen mental health services and suicide prevention efforts tailored for LGBTQIA+ youth.
- Protect and scale harm reduction initiatives, particularly for people who use drugs and justice-involved populations.
- Engage directly with trans and nonbinary community leaders to co-design services.
- Advocate relentlessly for sustained and increased funding at the state and federal level.

Public health cannot be separated from the social conditions in which people live and love. Prevention is about more than avoiding disease; it is about affirming the right to exist safely and with dignity.

To those on the frontlines, navigators, educators, testers, advocates, know this: your work is not invisible. It is revolutionary. And even in the face of austerity, it must endure.

Because prevention is not a program. It is a promise that every person, regardless of who they are or where they come from, has the right to protect their health.

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The Impact of Current and Proposed Funding Cuts on the LGBTQ+ Communities in Delaware, with a Focus on Sussex County

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ABSTRACT

In spite of the apparent tolerance in Delaware for those who identify as LGBTQ+, these communities still face enormous challenges related to visibility, acceptance, and fair access and treatment across healthcare and social settings. These challenges will undoubtedly be exacerbated by current federal budget cuts, although the extent to which the degradation of rights won will become permanent remains unknown.

INTRODUCTION

This year, SafeHome.org ranked Delaware as one of the eight safest states for LGBTQ+ individuals, maintaining its position as the third best in the nation.[1] The authors noted the State's zero reported hate crimes based or sexual or gender orientation; its 45 pro-equality laws; and its 2025 inclusion of LGBTQ+ history in school curricula as reasons for the high ranking. Quite an advancement, considering sodomy laws that once levied penalties of death or forced sterilization were not officially removed from the books until 1973.[2]

LGBTQ+ LANDSCAPE IN DELAWARE AND SUSSEX COUNTY

The disaggregated data for Delaware and particularly Sussex County is soft. However, as of 2023, 7.5% of adults living in Delaware identified as LGBT, with one in six young adults (18-24) representing the highest adult age group and the percentages decreasing as the age increases.[3] Of these adults, 35% stated they were child rearing, the 4th largest state percentage of LGBT individuals with children.[4] An estimated 22% of 8th graders and 28% of 11th graders considered themselves part of the LGBTQ communities.[5] The majority of youth and adults identified as Caucasian--62% and 58%, respectively--with Black/African American the next highest identified ethnicity, with around 15% for both youth and adults.[3,6] On average those in the LGBT communities in Delaware tend to be two times more likely to have income below $24,000 or be unemployed, to experience food insecurity, and to lack health insurance.[4]

While no direct statistics reflect similar data for Sussex County, most overall surveys conservatively suggest the county follows state trends.[6–8] Moreover, both the state and Sussex County continue to see growing support and visibility for the LGBTQ communities. Since the 1960's, Rehoboth Beach in Sussex County has been a welcome port for the out and proud communities. Although early on most social events were discreet and private, Rehoboth and the surrounding areas now boast an extensive gay-owned business sector, a vibrant entertainment scene, all while maintaining a family-oriented beach destination profile.[9]

HEALTHCARE CHALLENGES

Delaware is ranked 18th in the country for clinical care, to include access to care, quality of care, and access to preventative clinical services.[10] However, the state comes in last among all states related to primary care practitioner (PCP) access.[11] Several factors contribute to these somewhat conflicting rankings. First, Delaware hospital systems consistently score well, particularly in areas such as low 30-day readmissions, hospital acquired infections, and avoidable emergency room admissions.[12] The abysmal PCP access in Delaware, however, reflects not only the current national PCP shortage, but lower state reimbursement rates and burgeoning population growth. This is particularly true for Sussex County, which is the fastest growing county in the state and reflects over a quarter of the state's population.[11] Between 2020 and 2024, the county saw a 14.5% increase in population and just less than one-third of all residents are over the age of 65.[13] An estimated 177 additional PCPs are needed right now just to meet basic standard of care for the county.[14]

For the LGBTQ+ communities, the lack of healthcare infrastructure exacerbates existing health disparities. Across all states, health disparities between ethnic groups have been well documented. Black and American Indian and Alaska Natives (AIAN) tend to die younger than their Caucasian and Hispanic counterparts, often from treatable conditions or preventable outcomes in care delivery.[15] The COVID-19 pandemic disproportionately and adversely impacted Black, Hispanic, and AIAN individuals, with a marked decline in life expectancy since 2020 for these groups compared to their Caucasian counterparts.[16]

Several factors drive healthcare racial and ethnic disparities. For example, minority communities tend to have higher crime and poverty rates, more pollution, and less access to quality and affordable healthcare, all which amplifies healthcare disparities. These minorities tend to also be uninsured or underinsured, leading to higher numbers being treated in hospital settings for diseases that could easily be managed in outpatient settings.[16] Policy makers also share the burden for healthcare disparities. For instance, ten states that did not expand Medicaid under the Affordable Care Act have some of the highest racial and ethnic disparities for healthcare benchmarks.[17]

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Nationwide, the intersection of race and sexual orientation can magnify health disparities. Those who identify as LGBT are twice as likely to have experienced homelessness, and this holds steady across all ethnicities. About 65% of LGBT adults versus about 40% of non-LGBT adults state they have been discriminated against by a healthcare provider in the past year. For those that are of lower income, younger, or female, the incidences of discrimination increase. Black and Hispanic LGBT adults report greater frequency of discrimination from healthcare providers than their peers. Over half of LGBT individuals report frequent episodes of anxiety in meeting activities of daily living, and a third report feeling lonely or depressed. On a positive note, LGBT individuals who have strong support networks tend to have more mental health resilience.[18]

LGBTQ+ youth and seniors can be particularly vulnerable to the factors underlying health disparities. With the improvement of human immunodeficiency virus (HIV) medications, HIV+ individuals are living longer, potentially better-quality lives. However, elders have faced a lifetime of discrimination and for self-preservation have long hidden their sexual orientation and avoided needed care. Consequently, seniors tend to have a higher rate of disabilities and chronic diseases than their non-LGBTQ+ peers.[19] Seniors also tend to be more isolated and distanced from family members, leading to mental health and substance abuse issues. For example, elder females who identify as LGBTQ+ report a higher incidence of smoking and binge drinking.[19] LGBTQ+ youth are twice as likely to report being bullied and about three times more likely to acknowledge being forced to have sexual contact. Compared to their heterosexual peers, they are also markedly more likely to feel hopeless, misuse prescription medication or use illicit substances, and report suicidal tendencies.[20]

Delaware fares better than other states related to health disparities, although data are lacking in several benchmarks.[16,21]Caucasian Delawareans scored in the 85th percentile nationally on benchmarks covering healthcare access, healthcare quality, and healthcare outcomes. Hispanics in Delaware, however, score in the 32nd percentile, with all other ethnic groups falling somewhere in between.[16] Sussex County is 80% Caucasian, with the next highest ethnic group represented by Blacks at 11%. That said, the county has a middle of the road diversity index, suggesting any given community will have representation from at least 2 ethnic groups. In addition, despite a 12% unemployment rate, the county scores 5/10 on the deprivation index, suggesting residents have a limited resilience to those factors which would increase the risk of poor health outcomes.[22]

Current data on health disparities faced by Delawarean seniors and youth are lacking, but anecdotal surveys support aspects of national trends. In 2016, CAMP Rehoboth, a nonprofit LGBTQ+ service organization located in Sussex County, through a grant from the Delaware General Assembly, launched a survey to quantify the health needs of LGBTQ+ adults in Sussex County over the age of 50. Sixty-five percent of respondents saw a PCP for one or more chronic health conditions in the previous two years, with one fifth stating their inability to engage in healthcare due to a lack of competent health specialists in the area. Respondents considered accessibility a bigger issue than discrimination in healthcare delivery, but this may also reflect that the respondents were primarily White and more affluent. Over half acknowledged they are struggling with mental health issues, with 44% admitting drinking more weekly than the national average.[23]

For LGBTQ+ youth, the 2024 Trevor Project Survey reports that in Delaware, 58% of respondents reported discrimination in the past year and 18% felt threatened because of their sexual orientation. Mental health issues included 67% feeling anxious, 52% feeling depressed, and 37% considering suicide in the previous year. That said, 48% considered home and school as affirming spaces.[6]

OTHER SOCIOECONOMIC ISSUES FACING THE LGBTQ+ COMMUNITIES

The income and wealth data of the LGBTQ+ communities nationwide are not homogenous and reflects nuances within the different groups, as well as reflect previously mentioned racial disparities. For example, same sex couples tend to have a higher median income than their hetero-counterparts, presumably because both parties are more likely to work full time in same sex arrangements.[24] If simply comparing LGBT people to cis-straight people, poverty levels are estimated to be 17% and 12%, respectively. However, when the data is parsed, transgender individuals and bisexual cis women have even higher poverty rates: 21% and 20%, respectively. In addition, 25% of LGBT people of color (POC) reported being at or below the poverty level. Conversely, gay cis men had a lower estimated poverty rate than straight cis people, at 10%.[25]

Regarding home ownership, 71% straight and cis individuals claim owning a home, as opposed to 50% of those identifying as lesbian, gay, bisexual, or queer. That percentage drops to 47%, however, for those identifying as transgender or nonbinary. For Black and Hispanic LGBTQ+ individuals, home ownership is even less: 41% and 33%, respectively.[24]

Because of poverty, the LGBTQ+ communities are also more likely to use federal assistance programs than their hetro-counterparts. For example, regardless of category, across the board, LGBTQ+ individuals were more likely to use the Supplemental Nutrition Assistance Program (SNAP), with highest need for LGBTQ+ POC and those disabled. The same is true for using Medicaid, unemployment benefits, and housing allowances; again, with the highest percentage of use for LGBTQ+ POC and those disabled.[26] As mentioned earlier, those in the LGBT communities in Delaware tend to be two times more likely to have income below $24,000 or be unemployed, to experience food insecurity, and to lack health insurance.[4]

A wage gap also exists for those in the LGBTQ+ communities. One study estimates the wage gap between LGBTQ+ college graduates and non-LGBTQ+ graduates was 12% after one year and up to 22% after 10 years.[27] For every dollar a cis-gender worker earns, on average, someone in the LGBTQ+ communities earns 90 cents. Like with other socioeconomic data, however, the percent earned varies by race and sex, and gender identity. For example, LGBTQ+ white workers make 97¢; LGBTQ+ Latin workers, 90¢; Blacks, 80¢; and Native Americans, 70¢. Ironically, LGBTQ+ Asians make the full $1.00. By gender, LGBTQ+ men make 96¢; women, 87¢; non-binary or genderfluid, 70¢; trans-men, 70¢; and, trans women, 60¢.[28]

IMPACT OF CURRENT TRUMP ADMINISTRATION POLICIES

In 2023, The Heritage Foundation published Project 2025's "Mandate for Leadership: The Conservative Promise," a hawkish thinktank blueprint for a like-minded administration to start on day one in office to dismantle what the authors' view as the perils of the "Administrative State."[29] Within its 30 chapters, the Mandate spells out concrete policy recommendations across all aspects of government centered on four broad themes: 1) restore the family as the center of American life; 2) return self-governance to the people by undoing the administrative state; 3) defend our nation's borders and sovereignty; and, 4) secure a person's right to live freely.[29]

The alarming speed and surgical precision with which the current Trump administration has issued Executive orders has caused chaos at international, national, and state and local levels. As of June 19, 2025, the President had signed 164 Executive orders, the most by any President within his first 100 days in office.[30,31] Although the President has disavowed any association with the Mandate, in at least 37 of his Executive orders the language mirrored that of the Project 2025 playbook.[32] Moreover, several of Trump's key cabinet and administrative members are architects of the Mandate. These include Russell Vought, the Office of Management and Budget (OMB) head; Peter Navarro, Senior Counselor and Director of Trade and Manufacturing Policy; Tom Homan, Trump's Border czar; and, Brendan Carr, Federal Communications Commission (FCC) chairman.[33]

An initial Executive order and one with international implications is Trump's January order putting a 90 day pause on all foreign funds.[30] Although the language did not specifically target the LGBTQ+ communities, the impact this has had on the U.S. Agency for International Development (USAID) efforts, particularly in its execution of the President's Emergency Plan for AIDS Relief (PEPFAR) will impact international communities dealing with the human immunodeficiency virus (HIV) for generations. Launched in 2003, no single effort has focused as much national attention and resources on the eradication of HIV worldwide as PEPFAR. In its 20 years, the program is attributed for saving over 26 million lives and providing much needed medication in the prevention and treatment of HIV.[34] PEPFAR received a limited waiver in February, to include HIV testing; the care and prevention of mother-to-child transmission (PMTCT); and, pre-exposure prophylaxis (PrEP) medication, but only for pregnant and breastfeeding women. Even with the waiver, current program staff is having difficulty continuing services and getting paid.[35] Perhaps more disconcerting is the adverse impact this Executive order has had on USAID and eerily echoes Project 2025's call to erase the organization's diversity, equity, and inclusion (DEI) and "bullying LGBTQ+ agenda."[29]

Through May, the Trump administration has also canceled over 660 National Institutes of Health (NIH) research grants, worth over $800 million. Nearly half of the studies focused on the LGBTQ+ populations, to include HIV prevention & treatment, youth suicide, and cancer, with an emphasis on the LGBTQ+ populations as they age.[36] Moreover, the current administration has taken several steps to link continued federal funding to dismantling DEI initiatives, as well as issued broadly worded memorandum to cut federal funds to any non-government organization whose intent and actions "undermine the national interest."[37]

The Trump administration's war on DEI, while not specifically mentioning LGBTQ+ communities, ultimately impacts them. By removing DEI policy efforts, addressing unique health related challenges faced by these communities will likely prove more challenging.[37] Several of the Executive orders, however, are a direct assault on the LGBTQ+ communities. The administration has rescinded several previous Executive orders amended over time that have expanded original discrimination protections based on religion, race, sex, and origin and now include sexual orientation and gender identity. In addition, the Office of Federal Contract Compliance Programs (OFCCP), Department of Labor has been instructed to not take any actions that would ensure diversity or equal opportunity in federal contracting. As a result, an estimated 100,000 LGBTQ+ federal employees or contractors and an additional 14,000 transgender individuals are in danger of losing federal discrimination protections.[37,38]

The current administration's specific efforts to obliterate the transgender community is particularly onerous, given that the community represents about 1.4% of the population.[39] An Executive order has been issued that attempts to define sex as strictly male or female.[40] Based on that, the administration issued another order forbidding current and future members of the Armed Forces—those currently in basic training, service academies or Reserve Officer Training Corps (ROTC)—who identify as transgender from serving.[41] In addition, several Executive orders and clarifying memos through the federal health departments strictly forbid any type of gender affirming care and limits any attempt to collect data on sexual orientation and gender identity (SOGI) through federally funded programs.[37]

In Delaware, $38 million in previously funded Congressional grants to the Delaware Department of Health and Social Services (DHSS) is being withdrawn. The grants were specifically allocated to support community health workers, immunizations, control of emerging infectious diseases, mental health and substance use disorder prevention and treatment, and research into health disparities.[42] Such cuts only exacerbate already meager state resources. Last year, the Delaware HIV Advocacy Coalition highlighted that HIV prevention federal funding had already dropped in the state by 64%, while HIV infections had risen by 10%.[43] In Sussex County, CAMP Rehoboth's Communications Director Matty Brown had already voiced concern the deleterious impact of previous federal cuts could have to county HIV monitoring efforts, noting HIV disproportionately effects Blacks, the LGBTQ+ communities, and those who inject illicit drugs.[44] Dozens of non-profits across the state who rely heavily on federal funding have voiced their concerns over the negative impact current administration's strong arm tactics will have in providing much needed healthcare, housing, and youth support services.[45]

President Trump's 2026 "skinny budget" proposal for fiscal year 2026 is only expected to exacerbate current undermining of social and healthcare support for the LGBTQ+ communities. The administration wishes to decrease non-defense discretionary spending by 23% from 2025 levels, while increasing Defense spending by 10% and Homeland Security spending by 65%. The Bill specifically calls out the slashing to DEI federal policies, research, and education as the primary means by which these budget priorities can be accomplished.[46] A Human Rights Campaign analysis of the skinny budget suggests total fiscal impact on the LGBTQ+ populations could reach as high as $2.67 billion.[47] The analysis points out that the Ryan White HIV/AIDS

education component could lose $74 million and the Centers for Disease Control and Prevention (CDC) might lose stand-alone funding for sexually transmitted disease prevention, viral hepatitis, and HIV programs. In addition, the CDC is expected to remove mandates for LGBTQ+ health priorities. The Substance Abuse and Mental Health Services Administration (SAMHSA) would lose support for harm reduction and mental health programs for the LGBTQ+ communities, and the NIH would be expected to eliminate any "radical gender" research. Other Departments, such as Justice, Housing and Urban Development, and the Small Business Administration would also be expected to cut grants and programs in support of LBTQ+ initiatives.[47]

Bear in mind that the skinny budget is not the One, Big, Beautiful Bill Act, which is estimated to make steep cuts to Medicaid and SNAP benefits.[48] Both have or could place severe constraints on Delaware's ability to meet the needs of its most vulnerable. The Delaware Healthcare Association represents six nonprofit health care systems and has already raised red flags over what Medicaid cuts would mean for the state. According to the Association over 230,000 Delawareans use Medicaid. Cuts to the health insurance program would not only put lives at stake but would place an even deeper strain on Delaware's overburdened health personnel and facilities.[49] Much of the CDC's efforts toward HIV prevention and treatment, to include PrEP medication and HIV testing, are executed at the state and local levels. State officials fear desired budgetary cuts will decimate what is left of existing HIV programs.[50] Finally, the Food Bank of Delaware has already said it can no longer provide 900,000 meals due to Trump policies.[51] Further cuts to federal food supplements would only further stretch the Food Bank's meager resources.

THE FIGHT BACK

Since 1978, the GLBTQ Legal Advocates & Defenders (GLAD Law) has been fighting in the courts for the rights of the LGBTQ+ communities and those with HIV.[52] In the weeks following the Trump's administration flurry of Executive orders, GLAD Law filed several petitions arguing that many of the orders were discriminatory, unconstitutional, or outside the scope of the Executive Branch.[53] They are not alone. Lawsuits have also been filed by the American Civil Liberties Union (ACLU), Lambda Legal, and several states' Attorneys General offices. As of late June, 298 cases are currently active, including 9 suits brought by the Trump administration challenging state or local law.[53,54] Thus far, 39 cases have been dismissed or appealed; 18 suits ending in a summary judgement or permanent injunction; 10 Supreme Court stays or vacating of lower court rulings; and 1 Supreme Court affirmation of a lower court ruling.[54] Here in Delaware, Attorney General (AG) Kathy Jennings and 21 other AGs sued the administration over NIH research grants and funding cuts, underscoring the deleterious effects the cuts would have on critical support to underserved communities. This includes legal action to block the cut of the $38 million to the DHSS.[42,55] Delaware has had a fair share of non-discriminatory laws on its books for decades, to include explicit protections for individuals on the basis of sexual orientation and gender identity in key areas, such as marriage, healthcare delivery, employment, and housing.[7] State representatives and officials have also joined in the ACLU Firewall, a national plan to take concrete steps to protect vulnerable populations and reproductive rights and ensure due process for all.[56]

CONCLUSION

Delaware has enjoyed a national reputation as being a welcoming environment for the LGBTQ+ communities. However, the Trump administration's swift and calculating efforts to undermine what it calls the "Administrative state," mirroring the Project 2025 Playbook, seriously threatens the health and welfare of these communities. Legal action against the actions has been equally swift. Unfortunately, court actions take time. Moreover, legislative codifying of administrative intent will undoubtedly reverse years of hard-fought rights won by the LGBTQ+ communities. To the extent to which these reversals are permanent are yet to be seen.

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Provider Perspectives on LGBTQ+ Youth Homelessness in Delaware

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ABSTRACT

Objective: This article details the results of focus groups with providers who work with LGBTQ+ youth experiencing or at risk of experiencing homelessness in Delaware. **Methods:** Researchers interviewed 16 service providers in four focus groups held between May 24, 2023 and June 5, 2023. Providers included housing support specialists, social workers, community health workers, school counselors, mental health care providers, and other community-service-based practitioners. Data were collected through semi-structured interviews conducted via Zoom, and the authors utilized inductive coding to identify emerging themes. **Results:** Throughout Delaware, there are limited housing and public health supports in place for LGBTQ+ youth experiencing homelessness. Even when services are available, LGBTQ+ young people may have difficulty accessing them due to age restrictions, shelter segregation by sex or gender, or safety concerns. Providers working with this population face challenges including limited funding and staff, and a lack of specialized training. Changes at the local and state level—including increased funding, enhanced access to specialized training, and greater inclusivity on administrative forms—are important first steps to ensuring providers can adequately provide services to LGBTQ+ youth experiencing homelessness. **Conclusions:** LGBTQ+ youth are more likely to experience homelessness than their cisgender and heterosexual peers and yet face greater barriers to housing services throughout Delaware. The unique needs of this population necessitate specialized services and programs to ensure all young people have access to basic needs such as housing. **Policy Implications:** The provider perspectives in this paper offer a firsthand account of the challenges of serving this population and opportunities for improvement in policy creation and program administration.

INTRODUCTION

More than one in four lesbian, gay, bisexual, transgender, queer, or questioning (LGBTQ+) youth report experiencing housing instability or homelessness at some point in their lives.[1] LGBTQ+ youth are not only more likely to experience homelessness[2,3] than their straight or cisgender peers, they are also at a greater risk of mistreatment and exploitation while they are unhoused.[4] Due to age constraints, young people under 18 experiencing homelessness may not qualify for certain services for adults, creating a barrier to services. Moreover, those in the LGBTQ+ community may feel unsafe or unwelcome at group shelters or those separated by sex or gender. Therefore, the unique housing and administrative needs of this population necessitate specialized services on a state and national level.

Delaware currently has several methods in place to quantify homelessness throughout the state. These include the Point-in-Time (PIT) count, which counts the number of unhoused individuals on a single night in January,[5] and the McKinney-Vento Homeless Assistance Act, which tracks the number of students in the state experiencing homelessness during each school year.[6] However, it is unclear how accurate these methods are in capturing the true incidence of homelessness—let alone youth homelessness—in the state, and there is limited data on unhoused LGBTQ+ youth specifically. Thus, additional work is necessary to understand the population characteristics of LGBTQ+ youth experiencing homelessness and their needs.

To this end, previous research at the University of Delaware's Center for Community Research and Service laid out a plan for a multi-step process to understand LGBTQ+ youth homelessness in Delaware.[7] The research team first conducted a literature review of existing survey work around LGBTQ+ homelessness and the needs of the population. Then, the team conducted focus groups with service providers and individuals with lived experiences of being unhoused to assess how best to survey the number and needs of the unhoused youth population. This led to the creation of a survey and methodology to enumerate youth experiencing homelessness in Delaware. When viewed together, the data gathered in the outlined steps will provide a more comprehensive picture of LGBTQ+ youth homelessness in Delaware, enabling policymakers and program administrators to better meet the needs of this population. This paper explores key findings from the provider focus groups.

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RESEARCH DESIGN

This study employed a qualitative research design to explore participants' experiences and perspectives related to LGBTQ+ unhoused youth. A thematic analysis approach was used to identify, analyze, and interpret patterns of meaning within the data. Thematic analysis was chosen for its flexibility and its ability to provide rich, detailed, and complex accounts of qualitative data.[8]

METHODOLOGY & DATA COLLECTION

The research team utilized a purposive sampling method to identify Delaware-based service providers with expertise, experience, or relevant knowledge in housing support and services tailored to LGBTQ+ youth. Providers were identified by word-of-mouth recommendations from community and research partners, snowball sampling (asking identified participants to recommend others), and through strategic recruitment strategies (study investigators attended local trainings and workshops during the spring of 2023 to recruit interested youth service providers). A total of 50 service providers in Delaware were invited to participate in focus groups, including housing support specialists, social workers, community health workers, school counselors, mental health care providers, and other community-service-based practitioners. In total, 16 providers participated across four focus groups between May 24, 2023 and June 5, 2023.

Data were collected through semi-structured interviews conducted via Zoom. Focus groups lasted between 30 and 60 minutes and were audio and video recorded with participants' consent. The interview guide consisted of open-ended questions (*table 1*) designed to elicit in-depth narratives and reflections on participants' experiences with LGBTQ+ unhoused youth and needs. Probing questions were used to encourage elaboration and clarify responses.

Ethical approval for this study was obtained from the University of Delaware's Institutional Review Board. All participants provided informed consent prior to participation. They were assured of the confidentiality of their responses, their right to withdraw at any time, and the secure handling of their data.

DATA ANALYSIS

Interviews were transcribed using Otter.AI Pro and checked by members of the study team for consistency. Initial thematic analysis of the focus groups involved (1) familiarization with the data, (2) generation of initial codes, (3) searching for themes, (4) reviewing themes, and (5) defining and naming themes.[8] Data were coded using Dedoose version 9.0.90. Coding was inductive, allowing themes to emerge from the data rather than being pre-determined.

Authors one and two performed the initial coding and analysis of the focus group transcripts. The last author reviewed identified codes and refined emerging themes, ensuring rigor and intercoder reliability.

RESULTS

Ten overarching themes were identified from service provider focus groups, including: hiding in plain sight; familial, cultural and community factors; safety concerns, risks, and consequences; coming into contact with unaccompanied youth; services, referrals, and available resources; shuffling youth between services; barriers to youth accessing housing and social supports; barriers to service providers; administrative barriers and data needs; and reducing barriers.

HIDING IN PLAIN SIGHT

Youth experiencing homelessness are a hidden population. According to providers, unaccompanied youth often "couch surf" or reside with friends and family versus staying out in the open. When such arrangements fall through or are unavailable, young people under the age of 18 are often not eligible for adult services such as hotel vouchers due to their age. As a result, when they do not have access to temporary housing with family or friends, they will often stay in cars, unoccupied buildings, wooded areas, parks, or other public places.

Table 1. Interview Guide Questions for LGBTQ+ and Unhoused Youth Service Providers

1. How does your organization come in contact with LGBTQ+ youth?
2. What specialized services for LGBTQ+ youth do you provide?
2a. How are staff trained specifically to work with this population?
3. In your opinion, what are barriers LGBTQ+ youth face when accessing housing and other forms of support?
3a. What are barriers to making sure unhoused LGBTQ+ youth know your services are available?
4. When youth do not access housing supports where do they go?
5. How does your organization define experiences of homelessness?
6. As a provider or community leader, what are major gaps that you see in services provided to unhoused LGBTQ+ youth in your local areas?
6a. What are major gaps broadly in Delaware?
6b. Rural/ suburban/ urban (geography)w
7. What would your organization need to better reach and serve LGBTQ+ youth?
8. What do you think is most important to know about the LGBTQ+ youth that you seek to serve?
9. Is there anything today that you wanted to discuss that we did not get a chance to?
10. Who else should we be talking with about this?

FAMILIAL, CULTURAL, AND COMMUNITY FACTORS

For some LGBTQ+ youth experiencing homelessness, familial circumstances such as parental job loss have led to them being unhoused. Others become unhoused when their sexual orientation or gender identity is incompatible with their current living situation. Providers noted that many LGBTQ+ youth experience familial, cultural, or community stigma related to their identity. Cultural factors, including Black spiritualism, Latino machismo, and Christian beliefs, can all contribute to perceived or actual stigma or conflict for LGBTQ+ youth. Individuals living in these environments who do not conform to a heteronormative sexual or gender identity may be forced to leave home or elect to leave because of fear of rejection or stigmatization.

SAFETY CONCERNS, RISKS, AND CONSEQUENCES

Providers noted that unaccompanied youth of all sexual and gender identities experience extreme threats to their safety and well-being including violence, participation in risky behaviors, and increased prevalence of mental health issues. LGBTQ+ youth specifically were noted as being at an increased risk of sexual violence or trafficking when compared to their straight, cisgender peers. Unhoused youth who reside outside are also at risk of exposure to the elements and extreme weather. These negative experiences can have far-reaching consequences; providers have seen unhoused youth experience early incarceration and introduction to the criminal justice system.

COMING INTO CONTACT WITH UNACCOMPANIED YOUTH

Service providers revealed a variety of ways in which they encounter unaccompanied youth. Some young people reach out to services in an official capacity, by walking into housing support or social welfare offices, contacting school counselors, or by accessing informational resources online or through the state library system. Others learn about available services through their social network by word of mouth, social media, or internet forums. Outreach is another important component to contacting unaccompanied youth, and service providers may encounter this population by meeting them where they are staying, including outdoors or in public places.

SERVICES, REFERRALS, AND AVAILABLE RESOURCES

Teachers, school counselors, mental health providers or therapists, and outreach professionals all serve as conduits to specialized services. Often, providers say, housing support services and LGBTQ+ support groups work together to ensure youth have access to services. PFLAG, Charlie Health, the Gay-Straight Alliance, 21st Century Learning Community Center programs, and the Community Partner Support Unit (CPSU) were all mentioned as groups that can help young people connect to the services they need.

Specific to Delaware, providers noted that unaccompanied youth are often referred to the "Life Lines" program at West End Neighborhood House. Because there are limited specialized providers in the state, some youths are also referred to external organizations, such as the Attic Youth Center or Mazzoni Center, both in Philadelphia.

SHUFFLING YOUTH BETWEEN SERVICES

Because there are limited LGBTQ+-specific housing resources in Delaware, when service providers do not have the resources to assist LGBTQ+ youth, they often contact an organization that may be more familiar with resources such as one of the support organizations listed above. The support organization is then tasked with finding accommodations, services, and resources that match the needs of the youth. This can result in unhoused youth being shuffled among multiple services in order to find one or several that can meet their needs.

Providers noted that often, when the available services in Delaware are unable to meet the needs of unhoused youth, alternative measures can be employed. These may include placing youth with friends or family or transporting them to larger, more specialized organizations in neighboring cities or states.

BARRIERS TO YOUTH ACCESSING HOUSING AND SOCIAL SUPPORTS

While there are many ways in which unaccompanied youth come into contact with housing services, providers also discussed the significant barriers many youths encounter that may prevent them from accessing or receiving services. Providers stated that age was a substantial barrier, as unaccompanied minors often need parental consent to access services like shelters and motel vouchers. Limited public transportation in Delaware poses challenges for young people who do not have access to a vehicle, particularly for those in the state's more rural areas. Safety concerns may hinder an individual's willingness to stay in shelters or other communal housing, and for youth who identify as transgender or nonbinary, gender-segregated accommodations in shelters pose additional risks. There are a limited number of LGBTQ+ specific housing and mental health providers throughout the state, and religious or moral agendas may prevent certain shelters or groups from offering services specifically catering to the LGBTQ+ community. Even when services are readily available, youth who lack medical insurance or Medicaid may be unable to access them.

BARRIERS TO SERVICE PROVIDERS

The restrictions at temporary shelters, which are often segregated by sex (male or female) or group (families or individuals) make it challenging to place unaccompanied youth, especially those who may identify as trans or nonbinary. Although shelters receiving federal funding are obligated to follow equal access rules, many still struggle to accommodate all identities due to these restrictions. Even when certain services are available to teens and young adults, they may not meet the needs of this population. For instance, those over 18 may be eligible for services such as hotel or motel vouchers, but some of these organizations will not rent to teens or young adults.

Staffing and funding constraints are another major barrier to adequately serving this population, as many shelters and service providers do not have staff trained to specifically work with LGBTQ+ youth and lack the funding to provide such training. In schools, LGBTQ+ social support groups, such as the Gay Straight Alliance, are often only available in high schools, making it challenging for younger students to access the peer support and resources offered by these groups. Additionally, religious agendas and cultural stigmas may hinder schools and community organizations from adequately providing services to LGBTQ+ individuals.

ADMINISTRATIVE BARRIERS AND DATA NEEDS

Service providers often face administrative barriers when attempting to assist unaccompanied youth. Providers consistently cited the age of eligibility for services as a substantial barrier for those who leave home as minors. Administrative forms that use sex at birth rather than gender identity may deter transgender or nonbinary youth from seeking services. Additionally, some organizations' narrow definitions of homelessness that exclude temporary accommodations such as couch surfing or staying with friends may prevent some young people from being eligible for services.

REDUCING BARRIERS

Service providers discussed several ways to make access to services and the ability to provide services easier. Adding pronoun and gender identity questions on administrative forms and allowing respondents space to identify their gender correctly can increase inclusivity in service provision. Schools may reduce barriers by introducing more LGBTQ+ resources in elementary and middle schools, creating more peer support programs, and integrating LGBTQ+ supports into the McKinney-Vento Act. On the state level, focus group participants noted the importance of ensuring providers have appropriate training to work with LGBTQ+ youth populations, increasing funding for housing supports, and advocating for early emancipation to ensure minors can access certain housing services.

DISCUSSION

LGBTQ+ youth experiencing homelessness are a unique population that require intentional action to create inclusive policies and safe, welcoming spaces. Housing is a basic need for all people, and LGBTQ+ youth are at an increased risk of this need not being met. By interviewing individuals who provide services to this population, this research offers a unique perspective on the programmatic and policy-related needs of LGBTQ+ unhoused youth population in Delaware.

Throughout the focus groups, service providers emphasized the barriers facing unhoused LGBTQ+ youth. They noted the difficulty in reaching youth experiencing or at risk of homelessness and the dearth of services for unhoused LGBTQ+ youth in Delaware. Providers also discussed the challenges they face in serving these youths, including limited funding and staff, administrative restrictions, and a lack of specialized training.

Addressing LGBTQ+ youth homelessness requires a multi-pronged approach. Inclusivity on administrative forms is an important first step, as having the correct pronouns and gender identity on forms can help young people access the appropriate services. Since the school system is a frequent point of contact for young people at risk for homelessness, providers suggested increasing support programs in schools and integrating LGBTQ+ supports into the McKinney-Vento Act. Statewide, taking steps to ensure minors have access to services is key. To this end, providers discussed access to early emancipation to ensure minors can access adult housing services when appropriate, increasing funding for housing support programs, and expanding specialized training opportunities for providers.

PUBLIC HEALTH IMPLICATIONS

Unhoused young people—particularly those who identify as LGBTQ+—are a group that often experiences gaps in services due to the limited availability of specialized housing and public health programs in Delaware. Speaking with service providers who have firsthand experience working with this population creates a knowledge base regarding current services available and opportunities for improvement in service provision. Future research will focus on the analysis of the lived experience focus groups. In these, researchers spoke with members of the LGBTQ+ community who have experienced or been at risk of experiencing youth homelessness. Together, the integration of the lived experience and provider perspectives creates a comprehensive dataset that can be used to better serve the needs of this population.

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Mental Health and Substance Use Disparities by Sexual Orientation and Gender Identity Among Delaware Youth

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ABSTRACT

Objective: To investigate mental health and substance use disparities by sexual orientation and gender identity among Delaware youth. **Methods**: Data were from the Delaware School Surveys (DSS) administered to 8th and 11th graders (*n*=17,361; ages 12–17 years old) in 2022, 2023, and 2024. Frequency statistics were used to summarize sexual orientation and gender identity composition, including frequency of youth who were lesbian, gay, bisexual, transgender, and other minoritized sexual and gender identities (LGBT+). Using logistic regression, we tested associations between LGBT+ status and odds of reporting psychological distress, anxiety, underage drinking, cigarette smoking, vaping, marijuana use, and prescription drug misuse. **Results**: Around one in four (25–26%) Delaware youth identified as LGBT+, including 6–7% of youth who were transgender or nonbinary. Rates of lifetime mental health symptoms and underage substance use were elevated among LGBT+ youth for every health outcome. For 8th grade LGBT+ youth relative to cisgender heterosexual youth, odds were elevated by 269% for psychological distress, 276% for anxiety, 91% for drinking, 141% for cigarette smoking, 121% for vaping, 98% for marijuana use, and 86% for prescription drug misuse. In 11th grade LGBT+ youth relative to cisgender heterosexual youth, odds were elevated by 228% for psychological distress, 240% for anxiety, 33% for drinking, 71% for cigarette smoking, 51% for vaping, 57% for marijuana use, and 70% for prescription drug misuse. **Conclusions**: Mental health and substance use disparities between LGBT+ youth and cisgender heterosexual youth highlight an alarming public health crisis in Delaware. With growing numbers of youth identifying as LGBT+ and persistent health disparities, state policy and clinical practice must be attuned to the needs and lived experiences of LGBT+ youth to identify and eliminate drivers of these disparities. Schools, healthcare, and policy provide important avenues for intervention.

BACKGROUND

Mental health and substance use disparities between cisgender (individuals whose sex assigned at birth is congruent with their gender identity, e.g., a person whose sex assigned at birth was male and whose current gender identity is man) heterosexual youth and lesbian, gay, bisexual, transgender and other sexual and gender minoritized (LGBT+) youth are well-established in national data.[1] National and state level research shows higher rates of anxiety,[2] depression,[3] drinking,[4,5] smoking,[4,6] vaping,[7,8] marijuana use,[4,9] and prescription drug use[9] among LGBT+ youth relative to cisgender heterosexual youth. As mental health and substance use disparities have been widening,[10] the proportion of youth who identify as sexual and gender minority youth has also been increasing nationally,[11] pointing to even greater relevance and need for identifying mental and behavioral health challenges prevalent in this population. Increasing evidence of these disparities over the last decade and a growing LGBT+ youth population warrants Delaware-specific empirical examination of youth mental health and substance use disparities by sexual and gender identity. A focus on Delaware youth not only expands the existing evidence of LGBT+ health disparities established in other states, but more formally provides evidence of Delaware-specific LGBT+ youth disparities and invites alignment of state and local resources to address and eliminate these disparities.

MENTAL HEALTH AND SUBSTANCE USE DISPARITIES BETWEEN LGBT+ AND CISGENDER HETEROSEXUAL YOUTH

Over the last two decades, increasing national and state-level studies provide evidence of consistent mental health disparities between LGBT+ and cisgender heterosexual individuals. While the majority of this research has focused on adults, landmark national studies demonstrated higher levels of depression among lesbian, gay, and bisexual youth compared to heterosexual youth.[3,12] A systematic review of adolescent and adult mental health disparities by sexual identity revealed consistently elevated levels of depression and anxiety across national, state, and local

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research studies.[2] More recent studies provide evidence that these disparities have persisted into more contemporary cohorts of LGBT+ youth.[13] In addition, transgender and non-binary youth exhibit higher rates of depression and anxiety symptoms relative to cisgender heterosexual youth but also higher than cisgender sexual minority youth.[14] This within group differences suggest that while LGBT+ youth generally are at risk of worse mental health, there are some subgroups for whom mental health disparities are particularly alarming. These mental health disparities are often attributed to experiences of minority stress wherein dominant norms of cisgender heterosexuality are used to justify mistreatment of LGBT+ youth, resulting in an extra burden of identity-specific stress that is known to erode mental health.[15,16] Together, theoretical explanation and empirical evidence have consistently pointed to the stark mental health disparities between LGBT+ and cisgender heterosexual youth, yet little of this research has been conducted in Delaware.

Rates of underage substance use are also higher for LGBT+ youth compared to their cisgender heterosexual peers. Like with mental health, substance use disparities are more robustly established among adults, but growing research among adolescents extends this epidemiological research to find similar disparities among youth.[17] For example, in a California-based study of underage substance use, sexual minority youth had higher rates of drinking, cigarette smoking, and marijuana use relative to their heterosexual peers.[4] This research was later extended to examine differences by gender identity and found transgender youth had higher binge drinking rates than cisgender youth.[18] Regional research in the southeastern United States (US) demonstrated disparities in lifetime use of cigarettes, marijuana, prescription drugs, and both vaped tobacco and marijuana.[9] More recent studies also demonstrate these disparities persist into emerging types of substance use including vaping.[19] Emerging research including nonbinary and transgender youth provides new evidence of elevated substance use among these youth. For example, in a California-based study transgender youth were more likely to have used substances (e.g., alcohol, tobacco, marijuana, other drugs) than their cisgender peers.[20,21] Further still in a national study, nonbinary and genderqueer youth demonstrate greater odds of lifetime marijuana and cigarette use compared to their cisgender sexual minority peers.[22]

To date, there are few studies examining youth mental health and substance use disparities by sexual orientation and gender identity in Delaware. One notable exception used data from 2003 to 2007 to demonstrate prevalence of drinking and marijuana use was higher among sexual minority youth relevant to heterosexual youth.[23] Although this study provides important early evidence of these disparities, expansion of this research is necessary to (1) include transgender and nonbinary youth, (2) extend research to contemporary youth, (3) examine a broader array of substances and mental health.

THE EXPANDING LGBT+ POPULATION

Comparison of historical and contemporary surveys of youth reveals a seemingly expanding population of LGBT+ youth in the US and abroad. For example, in a Delaware study of sexual minority health using data from 2003-2007, around 5% of high school students identified as homosexual, bisexual, or questioning their sexual orientation.[23] In contrast, more recent national studies in the US found 12% of adolescents identified with a sexual identity other than heterosexual in 2019[13] and 20% of adolescents in 2021.[24] Scholars and community members point to an explanation in increased visibility, representation, and shifts in cultural acceptance facilitating more identity exploration, flexibility, and disclosure than permitted in prior generations, thereby contributing the appearance of an expanding LGBT+ population.[25] Transgender and nonbinary youth are estimated to comprise 1.4% of the US adolescent population,[26] however, prevalence of these identities may also be increasing and diversifying. Inclusion of diverse gender identity options in more recent state and national data allows researchers to more precisely estimate prevalence of transgender and non-binary identities in contemporary data sets. When paired with health disparities data, population estimates allow us to estimate both the magnitude of the disparities and how many young people may be affected. According to 2023 census data, an estimated 7.3% (n=75,538) of Delawareans (total population 1.3 million) are between the ages of 12 to 17 years old.[27,28] Yet it remains unclear how many of these youth are LGBT+ and to what degree they are experiencing elevated rates of mental health and underage substance use disparities.

CURRENT STUDY

The purpose of the current study was to investigate differences in mental health and substance use between LGBT+ youth and cisgender heterosexual youth in Delaware. To accomplish this objective, we first described how many youth identified as LGBT+. Then, mental health and substance use prevalence rates were compared among LGBT+ and cisgender heterosexual youth, separately in 8th grade and in 11th grade. Finally, we examined associations between LGBT+ status and mental health and substance use outcomes while accounting for racial and ethnic differences and potential change in prevalence across years. Based on prior research, we anticipated higher rates of mental health challenges and substance use among LGBT+ youth compared to cisgender heterosexual youth.

METHODS

Data were from the Delaware School Survey (DSS) that was administered annually to 8th and 11th grade students in the 2022-2024 period.[29,30] Surveys from 5th grade students were not included because gender identity was not collected in 5th grade. The DSS is funded by the Delaware Division of Substance Abuse and Mental Health and has been regularly administered for 26 years. We included 2022 to 2024 data for two reasons. First, the 2022 survey was the first year that responses to the question, "What is your gender?" were expanded to include non-binary. Second, 2022 was also the first year the question "Are you transgender?" was also included.

The DSS included students from all public, charter, and alternative schools that volunteered to be included. As such, it was not a probability sample but included schools from all three Delaware counties. The DSS aimed to provide prevalence estimates of students' substance use, other risk-taking behaviors, and mental health data. Following the COVID-19 pandemic, the DSS was converted to an online format, with an alternative option of completing the DSS using paper and pencil in a classroom setting. Surveys were conducted in both English and Spanish.

Passive parental/guardian consent via letter or email was used to obtain permission for students to participate in the survey. Parents/guardians who did not want their child(ren) to participate were allowed to submit an opt out form either electronically, by mail, or by calling the school. Students were allowed to refuse to participate in the survey at any time. Relatively few parents declined to have their child respond to the survey.

Because the current study analyzed 8th and 11th grade surveys across a three year period, it is unlikely that any data points were repeated from the same participants in more than one year or grade. Survey data from 2022, 2023, and 2024 were pooled, in 8th grade and 11th grade separately, to increase power for detecting differences in health outcomes with low prevalence and to maintain confidentiality of youth in demographic groups with lower prevalence (e.g., nonbinary youth).

MEASURES

All survey measures were identical in 8th grade and 11th grade.

Mental health. To measure psychological distress, participants answered the following question, "Do you ever feel sad, empty, hopeless, angry, or anxious," with response options of yes, no, or don't know. Don't know responses were coded missing, no responses were coded 0, and yes responses were coded 1. Participants who responded yes to the psychological distress question were then asked, "Over the past two weeks, how often have you felt very nervous or anxious?" Responses options were not at all, several days, over half the days, or nearly every day. To contrast students who experienced no anxiety versus those who experienced any anxiety, 'not at all' responses were coded 0 and all other responses were coded 1.

Substance use. Participants reported their lifetime frequency of alcohol drinking, e-cigarette vaping, and marijuana use on 7-point scales (6-point for vaping) with ordinal response options ranging from 0 times through 40 times or more (31 times or more for vaping). Specifically, participants reported how many times in their life they "had a drink (not just a few sips) of alcohol, beer, wine, liquor, or missed drinks," "used nicotine in an e-cigarette or other vaping device (tobacco or nicotine products only)," and "smoked marijuana (weed, pot, hash, blunts, dabs, wax)." Additionally, participants reported how many cigarettes they have smoked in their lifetime on a 7-point scale with ordinal response options ranging from none to 31 or more cigarettes. Due to skewness and to create variables reflecting any lifetime underage use of each substance, participants who reported never using a substance were coded 0 and participants who reported they had used a substance at least once were coded 1, on each respective substance. Participants also reported whether, in the prior year, they had taken each of 13 different prescription drugs (e.g., OxyContin/Oxycodone, Ritalin/Adderall, Xanax) without a doctor's prescription or differently than prescribed. Responses were recoded to reflect any past year prescription misuse coded as 0 and no misuse of any prescription drugs coded 1.

Sexual orientation and gender identity. Three questions were used to operationalize students' gender identity and sexual orientation. First, participants reported their sexual orientation by selecting the option that best described them from the options: heterosexual (straight), gay or lesbian, bisexual, other, or not sure. Students who responded heterosexual were coded as 0 and all other participants were coded as 1, indicating a sexual minority identity. Second, participants reported their gender by selecting from the following options: boy, girl, non-binary, and prefer to self-describe with write-in option. Write-in responses were coded as missing as they could not be validly reported as any one separate category. Third, participants responded to the question, "Are you transgender?" with the response options, "No, I am not transgender," "Yes, I am transgender," "I am not sure if I am transgender," and "I don't know what this question is asking." Participants who responded no were coded 0 and students who responded yes or that they were not sure were coded 1. Coding "not sure if transgender" participants as 1 reflected common practice applied to sexual orientation clustering wherein youth not sure of their sexual identity are grouped with sexual minority rather than heterosexual youth. Those who were not sure what the question was asking were coded missing. We created a new variable to contrast LGBT+ participants with cisgender heterosexual participants. Participants who (1) were identified as a sexual minority identity, (2) reported a non-binary gender, or (3) were identified as transgender were coded 1 for LGBT+ (all sexual and gender minorities) and participants who were heterosexual, boys or girls, and not transgender were coded 0 (cisgender heterosexual).

Covariates. To measure race and ethnicity, participants first selected the race group that best described them from the options: American Indian or Alaskan Native, Native Hawaiian or Pacific Islander, Asian, Black or African American, White, or Other (describe). Then participants reported whether they were Hispanic or Latino by selecting the option no or one of five Hispanic or Latino ethnic groups (e.g., Mexican/Mexican American/Chicano, Cuban/Cuban American). Race and Latino ethnicity responses were combined to create categories similar to typical census reporting groups: White/non-Latinx, Black/non-Latinx, Latinx/Any Race, and Other/non-Latinx (aggregated due to low subsample sizes). The reference category was White/non-Latinx. In addition, year of survey was also controlled in multivariate models, with 2022 used as the reference category.

ANALYSIS PLAN

To investigate mental health and substance use disparities by sexual orientation and gender identity among Delaware youth, analyses proceeded first through a descriptive stage and then through a series of between group comparisons. All analyses were completed with pooled samples across three years (2022, 2023, 2024) within 8th grade and 11th grade. Frequency statistics were used to describe the sexual and gender and identity composition of all 8th and 11th grade students who completed the DSS from 2022–2024. We described the total number of LGBT+ youth in 8th grade and 11th grade and then summarized disaggregated sexual orientations and gender identities.

Bivariate chi-squared tests were used to investigate whether prevalence of each mental health and substance use outcome differed significantly between LGBT+ and cisgender heterosexual youth in 8th grade and then again in 11th grade. Following bivariate tests, we used multivariable logistic regression to test associations between LGBT+ status and odds of each mental health and substance use outcome, adjusting for race and ethnicity and year of data collection. All analyses were run in SPSS (Version 29).

RESULTS

The total DSS sample pooled from 2022 to 2024 included 17,361 youth (8th grade *n*=9,181; 11th grade *n*=8,180). Sample demographic characteristics are summarized in *Table 1*. Approximately one in four youth identified as LGBT+ (8th grade: 24.5%; 11th grade: 26.1%). For sexual orientation, the majority of participants identified as straight/heterosexual with a marginally lower proportion in 11th grade compared to 8th grade (8th grade: 76.4%; 11th grade: 70.4%). The most common sexual minority identity was bisexual (8th grade: 9.2%; 11th grade: 11.9%) followed by other and not sure, and then gay or lesbian. The majority of participants were cisgender with 6-7% of participants identifying as transgender or nonbinary (8th grade: 6.6%; 11th grade: 6.0%). Regarding gender identity, boys composed 46.6-50.6% of the sample, with the majority being cisgender boys. Girls composed 47.4-51.1% of the samples, with the majority being cisgender girls. White/non-Latinx was the largest race and ethnicity subgroup (37.3%) followed by Latinx/Any race in 8th grade (24.5%) and Black/non-Latinx in 11th grade (26.2%), however, no single race and ethnicity group comprised a majority in either grade. Participant ages ranged from 12 to 19 years old. For 8th grade, the majority (55.6%) were 14 years old followed by 13 (41.2%). For 11th grade, the majority (56.2%) were 17 years old followed by 16 (38.4%).

Approximately two-thirds of youth in both 8th grade (61.2%) and 11th grade (64.7%) reported experiencing any lifetime psychological distress. Over 59.0% of 8th graders and 56.0% of 11th graders reported experiencing any anxiety in the past 2 weeks. Generally, rates of lifetime underage substance use were lower among 8th grade compared to 11th grade youth: drinking (19.9% vs. 38.1%), cigarette smoking (3.9% vs. 7.9%), vaping (12.3% vs. 20.7%), and marijuana use (9.9% vs. 25.7%). Prior year prescription misuse was reported by 8.8% of 8th grade participants and 7.3% of 11th grade participants.

ARE THERE DISPARITIES IN MENTAL HEALTH AND SUBSTANCE USE BETWEEN LGBT+ AND CISGENDER HETEROSEXUAL YOUTH?

Table 2 shows bivariate comparisons of mental health and substance use prevalence between LGBT+ and cisgender heterosexual youth in 8th and 11th grade. In both 8th and 11th grade, LGBT+ youth had significantly higher prevalence of every mental health and substance use outcome, relative to cisgender heterosexual youth. For example in 8th grade, 80.7% of LGBT+ youth reported feeling anxious compared to 50.7% of cisgender heterosexual youth. This pattern was replicated in 11th grade. As an example of substance disparities in 11th grade, 32.2% of LGBT+ youth reported ever using marijuana compared to 23.3% of cisgender heterosexual youth. This disparity was also apparent in 8th grade. In every case, the overall sample prevalence was pulled higher by higher prevalence of every outcome among LGBT+ youth.

Table 1. Demographic Sample Summary in 8th and 11th Grades

	8th Grade (*n*=9,181)		11th Grade (*n*=8,180)	
Demographic category	*n*	**Valid %**	*n*	**Valid %**
LGBT+ Status				
LGBT+	2,103	24.5	2,139	26.1
Cisgender Heterosexual	6,493	75.5	5,657	69.2
Missing	585		384	
Gender Modality				
Transgender and Nonbinary	568	6.6	492	6.0
Cisgender	8,081	93.4	7,344	89.8
Missing	532		344	
Gender Identity[a]				
Cisgender boy	4,091	49.0	3,453	45.5
Transgender boy	136	1.6	82	1.1
Cisgender girl	3,869	46.4	3,812	50.2
Transgender girl	87	1.0	63	0.8
Non-binary	163	2.0	177	2.3
Missing	835		593	
Sexual Orientation				
Straight/ Heterosexual	6,712	76.4	5,761	73.6
Bisexual	809	9.2	977	12.5
Gay/Lesbian	287	3.3	327	4.2
Other	458	5.2	414	5.3
Not sure	523	6.0	347	4.4
Missing	392		354	
Race				
While/non-Latinx	3,274	37.3	3,053	37.3
Black/non-Latinx	2,135	24.4	2,143	26.2
Other/non-Latinx	1,205	13.7	903	11.0
Latinx (Any Race)	2,152	24.5	1,739	21.3
Missing	415		342	

Note. All frequency percentages based on valid, non-missing data. [a]These percentages were obtained from a crosstabulation of transgender identity with gender identity; missingness gender identity reflects missingness from transgender status AND gender identity.

Table 2. Comparison of the Prevalence of Mental Health and Substance Use Outcomes between LGBT+ and Cisgender Heterosexual Youth

	8th Grade		11th Grade	
	LGBT+	Cisgender Heterosexual	LGBT+	Cisgender Heterosexual
Psychological Distress	82.1	55.1***	81.8	58.2***
Anxiety	80.7	50.7***	75.0	48.8***
Alcohol Drinking	28.4	16.9***	43.3	36.3***
Cigarette Smoking	6.6	3.0***	11.0	6.8***
Vaping	13.4	6.6***	26.0	18.8***
Marijuana Use	14.9	8.2***	32.3	23.3***
Prescription Drug Misuse	13.0	7.5***	10.4	6.4***

*Note. ***p<.001.*

IS LGBT+ STATUS ASSOCIATED WITH MENTAL HEALTH AND UNDERAGE SUBSTANCE USE?

Tables 3 and 4 show the results of logistic models testing the association of LGBT+ status with odds of mental health and substance use outcomes, adjusting for effects of race and ethnicity and data year. Results indicate that even after accounting differences by race and ethnicity and data year, LGBT+ youth were significantly more likely to report all mental health and substance use outcomes compared to cisgender heterosexual youth in both 8th and 11th grades.

Findings for mental health showed that LGBT+ youth in both 8th and 11th grades had significantly higher odds of experiencing psychological distress and past 2-week anxiety compared to cisgender heterosexual youth. Like the bivariate results, the relationships were not only highly significant, but the magnitude of the differences were very high. For example, the odds of experiencing anxiety or depression increased by over 220% for both 8th and 11th grade LGBT+ youth compared to cisgender heterosexual youth (to obtain the percentage change in the odds, the formula (((Exp(*B*)-1) X 100)) is used[31]). Similarly, the odds of experiencing anxiety in the past two weeks increased by over 240% for both 8th and 11th grade LGBT+ youth compared to cisgender heterosexual youth.

Although LGBT+ youth had higher odds of using every substance compared to cisgender heterosexual youth, the associations between LGBT+ status and odds of substance use were stronger in 8th grade than in 11th grade. In 8th grade, for LGBT+ youth odds of drinking were 91% higher, odds of cigarette smoking were 141% higher, odds of vaping were 121% higher, odds of marijuana use were 98% higher, and odds of prescription misuse (prior year) were 86% higher, relative to cisgender heterosexual youth. Associations were similar though smaller in magnitude in 11th grade. In 11th grade, for LGBT+ youth odds of drinking were 33% higher, odds of cigarette smoking were 71% higher, odds of vaping were 51% higher, odds of marijuana use were 57% higher, and odds of prescription misuse (prior year) were 70% higher, relative to cisgender heterosexual youth.

Table 3. Adjusted Logistic Regression Testing Associations between LGBT+ status and Mental Health and Substance Use in 8th Grade

	Psychological Distress		Anxiety		Alcohol Drinking		Cigarette Smoking		Vaping		Marijuana Use		Prescription Misuse	
	n=7,468		*n*=7,001		*n*=7,850		*n*=7,968		*n*=7,979		*n*=6,821		*n*=8,385	
	OR	SE	OR	SE	OR	SE	OR	SE	OR	SE	OR	SE	OR	SE
LGBT+	3.69***	.07	3.76***	.07	1.91***	.06	2.41***	.12	2.21***	.07	1.98***	.08	1.86***	.08
Race and Ethnicity														
Black/ non-Latinx	0.79***	.06	0.69***	.07	0.83*	.08	0.84	.17	1.28	.09	1.33**	.10	1.22	.10
Latinx/Any Race	0.83*	.06	0.82**	.07	1.30***	.07	1.31	.14	1.71***	.09	1.54***	.10	1.12	.10
Other Race/non-Latinx	1.11	.10	0.84*	.08	0.91	.09	0.91	.19	0.80	.12	1.04	.13	1.14	.12
Data Year														
2023	0.95	.06	0.69***	.06	0.93	.07	1.23	.15	1.25	.08	1.21	.09	0.94	.09
2024	0.79***	.06	0.63***	.07	0.84*	.08	2.78***	.14	1.27	.09	1.02	.10	1.43***	.10

*Note. Reference group for LGBT+ status was cisgender heterosexual youth. Reference group for race and ethnicity was White/non-Latinx and for data collection year was 2022. OR = odds ratio. SE = standard error. *p.<.05, **p.<.01, ***p.<.001. [a]Prescription misuse recall period is past year, in contrast to lifetime for all other substances.*

Table 4. Adjusted Logistic Regression Testing Associations between LGBT+ status and Mental Health and Substance Use in 11th Grade

	Psychological Distress		Anxiety		Alcohol Drinking		Cigarette Smoking		Vaping		Marijuana Use		Prescription Misuse	
	n=6,523		*n*=6,505		*n*=6,838		*n*=6,953		*n*=6,967		*n*=6,821		*n*=7,379	
	OR	SE	OR	SE	OR	SE	OR	SE	OR	SE	OR	SE	OR	SE
LGBT+	3.28***	.07	3.40***	.06	1.33***	.06	1.71***	.09	1.51***	.09	1.57***	.06	1.70***	.09
Race and Ethnicity														
Black/ non-Latinx	0.89	.07	0.77***	.07	0.51***	.06	0.34***	.13	0.66***	.13	0.96	.07	1.27*	.11
Latinx/Any Race	0.81*	.07	0.88	.07	0.70***	.07	0.58***	.12	0.85*	.12	0.82	.08	1.19	.12
Other Race/non-Latinx	0.99	.09	0.89	.09	0.59***	.09	0.49***	.17	0.65***	.17	0.66***	.10	1.13	.15
Data Year														
2023	0.95	.07	0.93	.07	1.00	.06	1.04	.14	1.07	.14	1.17*	.07	0.81	.11
2024	0.58***	.06	0.33***	.06	0.86*	.06	2.99***	.11	1.07	.11	0.83	.07	1.15	.10

*Note. Reference group for LGBT+ status was cisgender heterosexual youth. Reference group for race and ethnicity was White/non-Latinx and for data collection year was 2022. OR = odds ratio. SE = standard error. *p.<.05, **p.<.01, ***p.<.001. [a]Prescription misuse recall period is past year, in contrast to lifetime for all other substances.*

DISCUSSION

Increasing numbers of youth identifying as LGBT+ and persistent evidence of mental health and substance use disparities nationally together warranted investigation of these disparities among LGBT+ youth in Delaware. The current study makes several major contributions to our understanding of sexual orientation and gender identity health disparities in Delaware. First, results demonstrate a higher proportion of youth identifying as LGBT+ than in prior national and Delaware-based studies. Second, we provided evidence consistent with that found in other state and national studies showing LGBT+ youth in Delaware exhibit higher rates of mental health burdens and substance use than cisgender heterosexual youth. Third, when contrasting disparities in 8th and 11th grade, we uncovered greater disparities in 8th grade highlighting the early emergence of these disparities and need for early intervention. Together, results point to the urgent need for increased research investigation and expanded resource allocation to address alarming mental health and substance use disparities among LGBT+ youth in Delaware.

With one in four Delaware youth identifying as LGBT+, the health behaviors and needs of this population warrants increased health surveillance and attention in Delaware public health initiatives. Furthermore, more than one in twenty surveyed youth identified as transgender or nonbinary. Finding 25% of youth are LGBT+ in the current study contrasts with Button and colleagues' estimate that 5.3% of youth were identified as LGB in Delaware school-based surveys from 2003-2007.[23] Extrapolating results of the current study onto the most recent Delaware census estimates suggests that there may be between 18,000 to 20,000 LGBT+ youth living in Delaware (24.5%-26.1% × 75,538 youth ages 12-17 in Delaware).[27,28] Similarly, results of the current study suggest there may be as many as 4,500-5,000 transgender and nonbinary youth in Delaware (including youth who are still unsure whether they are transgender; 6.0%-6.6% × 75,538). Documenting the potential size of the Delaware LGBT+ youth population emphasizes the importance of ensuring adequate public health and school-based resources across the state for supporting the unique needs of LGBT+ youth. In particular, this highlights the growing need for transgender and nonbinary affirming healthcare and school policies. The seemingly high prevalence of LGBT+ youth mirrors and marginally exceeds national and international trends documenting the higher proportion of Generation Z youth identifying as part of the LGBT+ community,[24,32,33] often attributed to increased cultural acceptance and visibility of diverse sexual and gender identities.[34] Taken together, identifying the size of the LGBT+ youth population draws attention to the magnitude of disparities and urgency for public health response in Delaware.

This is one of the first studies of sexual orientation and gender identity youth disparities to use state-level data collected entirely after the most restrictive COVID19 pandemic lockdowns when mental health challenges among youth were acutely severe.[35] The results of the current study show sustained prevalence of psychological distress and anxiety 2-4 years after the beginning of the pandemic, with rates of mental health challenges for LGBT+ alarmingly higher than cisgender heterosexual youth. For cisgender heterosexual youth, half of youth reported feelings of anxiety in the prior two weeks. Although this rate alone is concerning, rates of psychological distress and current anxiety were even higher among LGBT+ youth with 75-80% of LGBT+ youth currently experiencing anxiety. These rates exceed national levels of psychological distress for LGBT+ youth. National data from the 2023 Youth Risk Behavior Survey found around 60% of LGBT+ youth reported persistent feelings of sadness or hopelessness in the past year and around 50% reporting poor mental health in the past month.[36] LGBT+ youth in Delaware appear to be faring worse in their mental health compared to cisgender heterosexual youth in Delaware and compared to LGBT+ youth nationally. Additionally, mental health disparities that emerged in the 8th grade data appear to generally be sustained through 11th grade; thereby suggesting that disparities between LGBT+ youth and cisgender heterosexual youth are well established by early adolescence and do not appear to improve by late adolescence. These results support the need for LGBT+ tailored mental health resources in both middle and high schools across the state. Expanded health surveillance into earlier adolescence and childhood will be necessary to identify when these disparities emerge and escalate.

Across all substances, LGBT+ youth in Delaware demonstrated elevated rates of lifetime use compared to cisgender heterosexual youth in both 8th and 11th grade. This means that, on average, by ages 13-14 years old, more LGBT+ youth are using substances relative to their heterosexual cisgender peers. Though differences in recall period prevents direct comparison, results of the current study did reiterate evidence of drinking and marijuana use sexual orientation disparities previously uncovered from 2003-2007.[23] When contrasted with national prevalence rates, Delaware youth substance use reported in the DSS appears to be lower than national averages.[37] However, when disaggregating by LGBT+ status in Delaware, LGBT+ substance use is more similar and, at times, exceeds national averages. The 2023 national rate for lifetime drinking in 8th grade was 20.1% of youth which is virtually equivalent to the 19.9% of all DSS youth in the current study. Among LGBT+ youth in Delaware, the percentage of 8th graders who ever drank was 28.4%, well above the national average. Of note, Delaware 8th grade LGBT+ youth drinking, cigarette smoking, and prescription misuse rates were above the national general youth averages and 11th grade LGBT+ drinking, cigarette smoking, marijuana use, prescription misuse were similar to national general youth averages.

When contrasting LGBT+ substance use disparities between 8th and 11th grade, it is apparent that disparities are generally larger in 8th grade than 11th grade. This suggests that disparities emerge earlier in adolescence and may narrow as youth age towards adulthood. Indeed, the magnitude of the disparity for every substance diminished, but remained significant in 11th grade. This is likely due to the overall increase in substance use across adolescence typically of this developmental period.[38] Thus, more cisgender heterosexual youth initiate substance use by 11th grade, but rates of lifetime use remain higher for LGBT+ youth. Disparities in 8th grade are especially pronounced for tobacco/nicotine smoking, including both cigarette and nicotine vaping. These Delaware results mirror studies of LGBT+ smoking in other states[39] and highlight the on-going need for culturally tailored smoking prevention and cessation education among LGBT+ youth[40] including during childhood and early adolescence. A particularly alarming finding is that rates of lifetime drinking, cigarette smoking, vaping, and prior year prescription misuse for LGBT+ 8th grade youth are more similar to 11th grade cisgender heterosexual youth than to 8th grade heterosexual youth. This means that the lifetime substance use patterns of LGBT+ youth in early and middle adolescence more closely resemble the substance use patterns of older adolescence. Given that early onset of substance use is a predictor of faster escalation to substance use disorder,[41] the elevated substance use for LGBT+ youth in 8th grade is particularly concerning.

LIMITATIONS AND FUTURE DIRECTIONS

The strengths of the current study must be interpreted within the limitations of the data and analyses. First, although the DSS includes a racially and ethnically diverse sample from all across the state, this is a non-probability sample. As such, prevalence of LGBT+ identities and magnitude of disparities cannot confirm the actual LGBT+ youth population size in the state and may not represent youth from schools who did not participate. Future research should attend to the specific health behaviors and needs of LGBT+ youth who are outside the school system as called for by scholars and community members previously.[42] Second, the DSS offers only a small number of options for gender and sexual identities which may limit some youth with other identities from selecting an appropriate box to reflect their LGBT+ identity. Adolescents today are more likely to identify with newer identity labels such as pansexual and queer[25] which are not in the DSS. Future iterations of the DSS and other youth health surveillance in Delaware and elsewhere should consider expanded, more inclusive sexual orientation and gender identity options. Third, because the DSS only assessed past year rather than lifetime misuse of prescription drugs, frequency of this outcome may be artificially deflated in contrast to all other substances measured at the lifetime level. Because rates of prescription drug use for LGBT+ youth in the current sample exceeded lifetime levels in national data, it is pertinent that we expand measurement and response to prescription drug misuse in Delaware. Fourth, it is difficult to contextualize the current results for transgender and nonbinary participants because prior research has often not collected gender identity, including in prior DSS and national youth surveys. Therefore, it is pertinent that state and national youth surveys continue to collect gender identity data among youth to continue accurate surveillance of transgender youth health and health disparities.

PUBLIC HEALTH IMPLICATIONS

Alarming mental health and substance use disparities together with evidence that one in four Delaware youth may identify as LGBT+ emphasize the urgent need for public health response. Although an extensive state-level needs assessment is warranted, we make the following recommendations for public health response. Without change to resource allocation and increased access to prevention and treatment services, LGBT+ youth will likely continue to exhibit higher levels of mental health burdens and early and higher rates of substance use. There are several potential avenues for promoting LGBT+ well-being and reducing negative health outcomes. Evidence from multiple intervention studies suggest schools can be effective sites for reducing LGBT+ mental health burdens when schools take "whole school" approaches wherein the dominant cisgender, heterosexual norms of the school environment are challenged and discrimination and marginalization of LGBT+ youth is addressed.[43] This requires response at the environmental, staff, curriculum, and policy levels. In addition to schools, clinical mental health and substance use interventions can play a key role in addressing stigma against LGBT+ youth and reduction of mental health and substance use burdens.[44,45] Targeted training for LGBT+ mental health providers can be implemented to improve competency and skills for serving LGBT+ individuals through culturally tailored LGBT+ clinical interventions.[46] Because disparities between LGBT+ and cisgender heterosexual youth are well-established by 8th grade, it is likely necessary to extend LGBT+ tailored school and clinical response beyond high schools to include middle and elementary schools. Relatedly, LGBT+ youth today are often coming out in late elementary school and middle school, pointing to the need for intervention and resources available to these youth and their families in Delaware.[25,33] In addition to school and clinical response, state level policy provides an opportunity for far reaching intervention impact. States with more policies that protect LGBT+ youth rights and fewer policies that restrict LGBT+ youth rights tend to exhibit better youth mental health

outcomes, on average.[47] Although Delaware has some policies in place to protect the well-being of LGBT+ youth, additional laws and protection could help address the vast mental health and substance use disparities uncovered in the current study. For example, Delaware does not have state-level policy naming sexual orientation and gender identity in anti-bullying laws and does not require state school curriculum to be LGBT+ inclusive.[48]

CONCLUSION

Significant disparities in mental health and substance use exist between LGBT+ youth and cisgender heterosexual youth in Delaware, underscoring an urgent public health crisis. Stark disparities in mental health and substance use emerge as early as 8th grade and persist into 11th grade. These disparities reflect and extend evidence of LGBT+ mental health and substance use disparities from two decades prior. Prevalence rates of LGBT+ youth are similar to and above national averages, even in 8th grade, signaling the need for early intervention. State-level policies, school strategies, and mental healthcare practice must be tailored to the unique needs and lived experiences of LGBT+ youth to eliminate disparities and prevent continuance of these disparities into future generations of Delaware youth.

FINANCIAL DISCLOSURE

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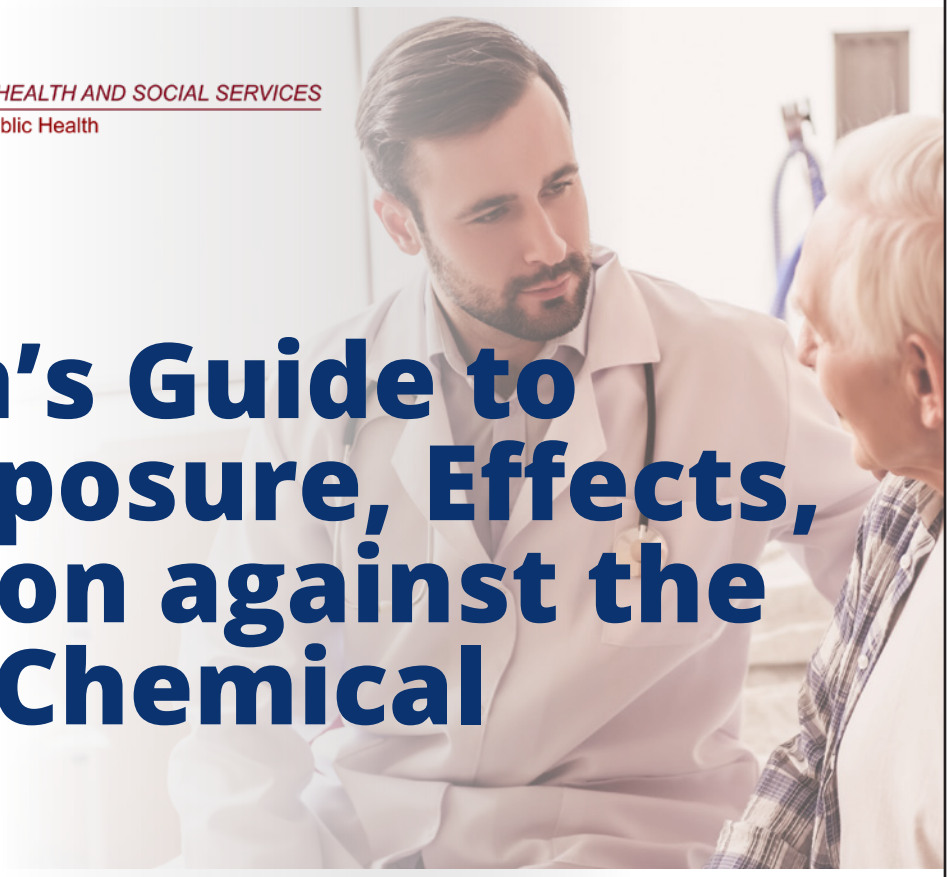

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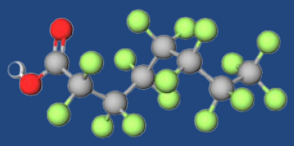

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The Policy and Public Health Implications of Protecting Gender-Affirming Care for Delaware Youth

Stephen Raskauskas, M.A.

ABSTRACT

Gender-affirming care (GAC) for youth is a medically necessary, evidence-based practice endorsed by major health organizations to support transgender and gender-diverse individuals. In Delaware, proposed legislation threatens to restrict access to GAC despite clear evidence that such care improves mental health outcomes and reduces suicide risk. This article outlines the components of GAC, examines the impact of legal and political threats, and argues for sustained protections to safeguard the health of Delaware's youth and public health systems.

INTRODUCTION

Gender-affirming care (GAC) for youth is a medically necessary and evidence-based approach that supports the mental, emotional, and physical well-being of transgender and gender-diverse individuals. In the current legislative climate, both nationally and within Delaware, these services are increasingly targeted by restrictive laws and policy proposals, many of which affect trans youth disproportionately. As healthcare professionals, policymakers, and public health institutions grapple with the future of GAC for youth, it is imperative to understand the components of this essential care, and the implications of protecting it for patients, care-providers, and institutions.

UNDERSTANDING GENDER-AFFIRMING CARE FOR YOUTH

According to the U.S. Department of Health and Human Services[1] and leading medical bodies such as the American Academy of Pediatrics,[2] the Endocrine Society,[3] and the American Medical Association,[4] gender-affirming care (GAC) is a crucial, evidence-based component of healthcare for transgender and gender-diverse individuals.

While GAC is tailored to each individual's needs and developmental stages, many healthcare providers and institutions follow the *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, Version 8* (SOC-8) issued by the World Professional Association for Transgender Health (WPATH).[5] For youth, SOC-8 outlines broad kinds of GAC, including:

Mental Health Support (All Ages).
Across all developmental stages for trans individuals, affirming mental health care is foundational. Providers support youth as they explore their identities, navigate family and school dynamics, and manage mental health conditions such as depression or anxiety, which occur at disproportionately high rates in this population.

Social Affirmation (Prepubescent Children).
For prepubescent children, interventions are typically non-medical. SOC-8 endorses social transition when appropriate, including changes in name, pronouns, hairstyle, and clothing.[5] Therapy for both the child and family is prioritized to foster understanding and resilience.

Puberty Blockers (Early Adolescents).
At the onset of puberty (Tanner stage 2), youth experiencing gender dysphoria may be eligible for reversible puberty suppression using gonadotropin-releasing hormone agonists (GnRHa).6 This intervention halts the development of unwanted secondary sex characteristics and provides additional time for gender identity exploration. GnRHa therapy is considered safe and effective when monitored by multidisciplinary specialists.

Hormone Therapy (Older Adolescents).
For some older adolescents – typically around age 16, but sometimes earlier under careful clinical oversight – gender-affirming hormone therapy (GAHT) may be initiated.[3] Eligibility requires persistent, well-documented gender dysphoria, mental health assessment, and the capacity to provide informed assent or consent with parental or guardian approval, depending on jurisdiction.

Surgical Interventions (Rare and Exceptional).
Genital surgeries are almost never performed on minors. In rare and exceptional cases, some adolescents may undergo chest (top) surgery if they have persistent gender dysphoria and meet rigorous clinical criteria. Genital surgeries are generally deferred until adulthood, except in cases of severe psychological distress and with multidisciplinary clinical and legal oversight.[3]

A significant source of opposition to gender-affirming care centers on exaggerated fears of irreversible surgeries, especially genital surgeries, on minors. Opponents often use inflammatory rhetoric such as "genital mutilation" to stoke public anxiety.

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However, this framing misrepresents clinical realities and risks obstructing access to vital care.

In truth, surgical interventions for minors are exceedingly rare and carefully regulated. The vast majority of gender-affirming treatments provided to youth involve reversible or partially reversible steps (social affirmation, puberty blockers, and hormone therapy) administered under strict clinical protocols.[5] Genital surgeries are reserved almost exclusively for legal adults, with exceptions requiring persistent, well-documented gender dysphoria, demonstrated emotional and cognitive maturity, multidisciplinary clinical support, thorough informed consent by the minor and guardians, and urgent medical necessity.[5]

GAC is not synonymous with surgery among any age group. Rather, GAC is a holistic approach that affirms a person's identity and supports their development within a compassionate, trauma-informed framework. Conflating rare surgical cases with all gender-affirming care fuels policies that undermine the lifesaving benefits of non-surgical care and contributes to stigma and misinformation. As a result, many young transgender and gender diverse individuals are denied or at risk of losing broad categories of care based on fear rather than evidence. Such blanket bans place youth at risk of worsened mental health outcomes, including increased suicidality.

Despite politicized narratives, gender-affirming care is neither rushed nor experimental. It is guided by well-established protocols, multiple layers of assessment, and continuous monitoring. Most interventions in minors are reversible or partially reversible, and all require comprehensive evaluation.

A growing body of research confirms that access to gender-affirming care improves mental health outcomes among transgender youth. Benefits include lower rates of depression and anxiety, reduced suicidality, and improved self-esteem.[7] Transgender teens who received puberty blockers were 70% less likely to experience suicidal ideation than those who desired but were denied access to such care.[8]

LEGAL AND LEGISLATIVE THREATS TO GENDER-AFFIRMING CARE FOR DELAWARE YOUTH

Delaware has long positioned itself as a champion for LGBTQ+ rights, including safeguarding the health and dignity of transgender youth. Since 2013, state law has prohibited discrimination based on gender identity across employment, housing, and public accommodations including healthcare.[9] A 2018 ban on conversion therapy for minors further reinforced the state's progressive stance.[10] In 2016 and 2020, the Delaware Department of Insurance declared that Medicaid and most private insurers must cover gender-affirming care.[11]

Despite these protections, access to GAC for minors in Delaware is increasingly threatened by legislative backlash, federal preemption, and potential legal challenges to state-level protections.

In 2025, during the first session of the 153rd General Assembly, legislators introduced Senate Bill 55 (SB 55), known as the Delaware Save Adolescents from Experimentation (SAFE) Act.[12] This bill proposes a broad prohibition on gender-affirming medical care for minors (including non-surgical treatments such as puberty blockers and hormone therapy) with narrow exceptions for intersex youth. It would also classify such care as "unprofessional conduct," potentially subjecting healthcare providers to licensure sanctions.

Earlier efforts, such as SB 315, similarly aimed to restrict public and private insurance coverage for gender transition procedures in minors and sought to label such practices as grounds for professional discipline.[13] These bills align with a national trend of legislation targeting trans healthcare under the guise of protecting children, despite being starkly at odds with guidance from leading medical organizations, including the American Academy of Pediatrics, American Medical Association, and World Professional Association for Transgender Health.

In response, Governor Matt Meyer issued Executive Order 11 on June 20, 2025, declaring Delaware a "shield state" for gender-affirming care. The order protects "any medically necessary healthcare or treatment consistent with current clinical standards of care prescribed by a licensed healthcare provider for the treatment of a condition related to the individual's gender identity and that is legal under Delaware law."[14]

EO 11 also prohibits Delaware agencies, contractors, and professional licensing boards from cooperating with out-of-state legal actions, including subpoenas, investigations, and extradition requests, targeting providers or recipients of gender-affirming care that is legal in Delaware. Furthermore, it instructs professional boards not to penalize licensed practitioners for delivering or referring gender-affirming care consistent with Delaware law, and protects any "individual who provided, received, inquired about, responded to, assisted with, or traveled to Delaware for gender-affirming care." The order also reinforces protections for the confidentiality of medical records involving GAC, shielding them from unauthorized disclosures in cross-jurisdictional proceedings.

While EO 11 positions Delaware among a handful of states actively protecting gender-affirming care, it is not immune to challenge. Under Delaware's constitutional structure, the General Assembly possesses multiple tools to challenge, override, or restrict the impact of the executive order.

The Assembly may pass legislation that directly contradicts or narrows the scope of EO 11. If the Governor vetoes such legislation, the Assembly can override the veto with a two-thirds vote in each chamber, thereby enacting the measure into law despite executive opposition. While courts primarily review the constitutionality of executive actions, the legislature can also authorize litigation challenging the executive order or enact laws that form the basis for judicial review, such as clarifying statutory limits on gubernatorial authority over healthcare policy. Lastly, Delaware lawmakers could introduce legislation to institutionalize a review process for executive orders, allowing the Assembly to vote to disapprove or repeal executive actions by statute.

These mechanisms highlight the fragility of EO 11's protections. They may be undone with shifts in legislative leadership or political priorities.

At the federal level, threats persist that threatened local protections. In January 2025, President Trump issued Executive Order 14187, barring federal funds—including grants and contracts—from entities that provide gender-affirming care

to anyone under 19.[15] This encompasses a vast range of institutions such as hospitals, clinics, schools, and community-based organizations.

Although two federal court cases, *PFLAG, Inc. v. Trump* and *Washington v. Trump*, resulted in preliminary injunctions, one nationwide and the other limited to four states, the legal landscape remains uncertain. Appeals are ongoing, and the threat of eventual enforcement looms over institutions and providers even in supportive states like Delaware.

Recently, H.R. 1, the so-called "One Big Beautiful Bill Act," sought to eliminate Medicaid and CHIP coverage for all gender-affirming care, regardless of age, and would have removed these services from the Affordable Care Act's essential health benefits. The restriction on gender-affirming care was removed not because of a shift in policy or pressure from advocacy groups, but due to a procedural roadblock: it violated the Byrd Rule, which prohibits including non-budgetary policy changes in reconciliation bills.[19]

Future federal bills, if passed, however, could preempt Delaware's current Medicaid coverage mandates and disrupt private insurance markets, effectively outlawing access to gender-affirming care even where it remains legal.

The interplay between federal hostility, state-level threats, and the tenuous nature of executive protections poses a serious risk. Hospitals may retreat from offering care. Insurers may drop coverage. Providers may hesitate to counsel families. Yet, delaying or denying care compounds mental health disparities and increases the risk of suicide, depression, and long-term harm.

LEGISLATIVE IMPACT ON DELAWAREANS: PATIENTS, PROVIDERS, AND PUBLIC HEALTH INSTITUTIONS

Legislative efforts to restrict GAC for youth place Delaware's most vulnerable populations at risk, and affect more than just patients. They jeopardize healthcare providers, institutions, and the state's public health infrastructure.

The Trevor Project's 2024 U.S. National Survey on the Mental Health of LGBTQ+ Young People reported alarming trends in Delaware: 69% of transgender and nonbinary youth in the state experienced symptoms of anxiety, 64% experienced symptoms of depression, and 45% seriously considered suicide in the previous year.[16] Furthermore, 42% of transgender and nonbinary young people reported that they or their family have considered leaving Delaware for another state because of LGBTQ+-related politics and laws.

The rollback of support services further compounds these risks. In June 2025, the federal administration discontinued the LGBTQ+-specific "Press 3" option on the 988 Suicide & Crisis Lifeline, eliminating a crucial pathway for affirming crisis intervention.[17] The rationale offered that all callers should be treated equally fails to account for the heightened and distinct mental health risks LGBTQ+ youth face, particularly in stigmatizing environments or when access to affirming care is blocked.

Healthcare providers and institutions face growing uncertainty. Facilities reliant on federal funds (e.g., Medicare, Medicaid, NIH grants) may face sanctions for continuing to provide GAC. Providers operating across state lines must navigate conflicting mandates, risking licensure and legal consequences.

Providers working across state lines are particularly vulnerable to conflicting mandates. In states like Delaware, they may be required or permitted to offer gender-affirming care, while neighboring states could penalize or prohibit the same services. Healthcare systems must therefore implement proactive compliance strategies: tracking law changes, ensuring internal legal review, and maintaining communication with staff and patients about shifting regulatory obligations.

Denying medically indicated gender-affirming care may constitute a form of medical neglect under accepted clinical standards. The legal and ethical landscape places providers in a difficult position: balancing the standard of care against external political and regulatory threats. Inaction, however, has measurable and detrimental consequences. When trans youth are denied care, emergency rooms and school systems often bear the burden. Increased rates of crisis mental health visits, absenteeism, and school dropout may increase with barriers to care. These consequences propagate into adulthood, contributing to elevated rates of homelessness, unemployment, and substance use.

From an economic standpoint, the cost of untreated gender dysphoria, including hospitalizations, suicide attempts, and chronic mental illness, far outweighs the costs associated with providing affirming care.

According to Executive Order 11 protecting GAC in Delaware, "Delaware is home to approximately 40,000 LGBTQ+ individuals aged 13 and older, representing about 4.5 percent of the state's population… an estimated 6,300 adults in Delaware identify as transgender, comprising approximately 0.82 percent of the adult population."

How many young transgender Delawareans might be affected by legislative changes which prevent access to GAC? According to the U.S. Census Bureau the Delaware population as of July 1, 2024 was 1,051,917, with 20.5% of the Delawareans under age 18, or 215,651 individuals.[18] Statistics on children, youth and families in Delaware from the Annie E. Casey Foundation and KIDS COUNT in Delaware estimate that 3% of youth within the state identify as transgender as of 2023, or approximately 6,470 individuals.

Recent legislative protections such as Executive Order 11 from the office of the Delaware Governor are important to safeguard the health and safety of transgender Delawareans, as well as care providers and institutions. However, to fully safeguard its citizens, and particularly youth, Delaware lawmakers must expand protections. Delawareans must maintain and expand mental health services to ensure sustained funding for LGBTQ+ crisis hotlines, school-based mental health counselors, and community partnerships. Institutions must counter misinformation on the safety and efficacy of gender-affirming care, and enact policies to create support inclusive school environments that include staff training and peer support programs to affirm trans students.

The data are unambiguous: gender-affirming care is life-saving and medically necessary. Legislative attempts to block access to such care jeopardize not only individual well-being but the stability of Delaware's public health infrastructure. At a time of growing national hostility, Delaware has both the opportunity and the responsibility to protect its youth, its care providers, and its institutions.

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Serious Illness and End of Life in LGBTQIA+ Older Adults

Sarah Matthews, M.D.
ChristianaCare

"He's my dad!" Mr. H's daughter fiercely reported in the family meeting. Mr. H was receiving mechanical ventilation in the Intensive Care Unit, unresponsive and unable to participate in the discussion. His health had declined sharply and this was his second intubation in three months. During this critical illness in his eighth decade of life, when no longer able to care for himself, Mr. H had come out to his daughter as a transgender man.

According to SAGE and the National Resource Center on LGBT Aging, there are greater than three million LGBTQIA+ adults over age 50 in the United States. These elders are twice as likely to be single and live alone, and four times less likely to have children. They are more likely to face poverty and homelessness, and to have poor physical and mental health.[1] LGBTQIA+ older adults face several unique health challenges, particularly as they encounter serious illness.

LEGAL SURROGATES FOR DECISION-MAKING

Mr. H's decision-making defaulted to his daughter as legal surrogate.

If a Delaware adult has neither medical decision-making capacity, nor a valid advance directive designating a power of attorney (POA) for healthcare, decision-making defaults to the legal surrogate per Delaware Code Title 16 Chapter 25. Until September 30, 2025, the Delaware surrogate hierarchy recognizes relatives by marriage or blood.[2] This can adversely impact LGBTQIA+ older adults by granting decision-making rights to family of origin who may not be as close as chosen support network. For those elders who are unmarried and childless, this hierarchy may allow more distant biological family members to make decisions, rather than unmarried partners, roommates, and close personal friends. After September 30, 2025, Delaware will adopt the Uniform Health Care Decisions Act (UHCDA) which updates the surrogate hierarchy. Additional parties recognized include any adult the individual has identified, cohabitants, adults who have exhibited special care and concern for the individual and are familiar with their personal values.[2] While imperfect, the updated surrogacy hierarchy is more inclusive of varying support structures.

ADVANCE CARE PLANNING

Mr. H did not have a completed advance directive or a DMOST form. He had never talked to his daughter or his healthcare team about his wishes.

Advance Care Planning (ACP) is "a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care."[3] Given the nuances of legal surrogate law, it is of paramount importance for LGBTQIA+ older adults to engage in ACP. Having high quality conversations about their wishes with loved ones and healthcare providers empowers elders to direct their own care. Advance directives should be offered to all adults; however they are essential to name a medical power of attorney when the preferred decision-maker does not match the state's legal surrogate hierarchy. For LGBTQIA+ patients, this may include unmarried partners, long-time roommates, close friends, and other chosen family. The upcoming legal change with the UHCDA is more inclusive, however it is still unwise to leave life-or-death decisions to a hierarchy which may not accurately represent one's preferred decision-maker. For LGBTQIA+ adults with serious illness or frailty, a Delaware Medical Orders for Scope of Treatment (DMOST) form is a standing medical order which can be signed to protect their end-of-life wishes across settings.[4] A DMOST can be signed either by the individual, or by their legal decision-maker if the individual lacks the capacity for medical decision-making.

LONG TERM CARE

Mr. H experienced mistreatment in skilled nursing facilities, misgendered by staff and left exposed in bed, too weak to cover himself up.

Some LGBTQIA+ older adults fear discrimination in long term care settings leading to the erasure of their identities.[5] Studies repeatedly find that LGBTQIA+ elders experience harassment in long term care, with caregivers refusing to use their preferred name or pronouns. Some LGBTQIA+ elders consider suicide to be preferable over long term care.[6] Greater staff training, as well as inclusive forms and policies, are needed to address this challenging situation. SAGECare has provided LGBTQ+ culturally sensitive staff development and training to over 1100 long term care facilities, hospices, and other organizations.[7] As clinicians we can advocate for organizations to earn such credentials and provide better care to LGBTQIA+ older adults.

GENDER-AFFIRMING CARE

Mr. H continued to receive testosterone injections every two weeks while critically ill, as well as a binder over his chest.

Gender-affirming care is just as important during serious illness and end of life. Typically, gender-affirming hormone therapy is maintained throughout life to provide masculinizing or feminizing effects as desired.[8] At end-of-life, it may be the person's wish to continue hormones even if the medication poses additional risk. Whenever possible, gender expression preferences of LGBTQIA+ elders should be honored. TRANSforming Choices Healthcare Decisions Starter Guide is an excellent resource for transgender, gender-diverse, and gender-expansive people to make choices about their healthcare including gender-affirming care.[9] Funeral directives are available to ensure that LGBTQIA+ elders' funeral wishes are followed, including name, pronouns, and presentation of the body.

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CONCLUSION

"We honor your dad's gender identity and acknowledge a lifetime of discrimination." The medical team continued to support Mr. H medically while conducting ongoing discussions with his daughter regarding goals of care. He was unable to be weaned from the ventilator and underwent tracheostomy and gastrostomy tube placement. Mr. H ultimately died several months later with his daughter at his side. Throughout his final critical illness, the medical team endeavored to provide respective and inclusive care. We honored him as a whole person, a dedicated father, and a proud man in his final chapter of life.

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If You Seek SOGI: Current State and Practical Implementation Considerations for Health Care Organizations Seeking to Collect Sexual Orientation and Gender Identity (SOGI) Data Domains

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ABSTRACT

As health care systems across the United States continue to grapple with a new health landscape changes brought from the COVID-19 pandemic, the need for robust and accurate data collection continues to be an ongoing need. While some national directives exist for health care organizations, the implementation of systematic sexual orientation and gender identity (SOGI) data domains for health care organizations is often a complex, interdisciplinary undertaking. The authors provide a current state status of national policies and best practices for SOGI data domain collection in health care environments, as well as practical considerations for health care organizations seeking to implement or expand their own collection of SOGI data domains. Due to the rapidly evolving landscape of socio and geopolitical changes around healthcare delivery in the United States, health care organizations may benefit from assessing their own current capabilities to collect and use SOGI data domains to support health equity for LGBTQIA2S+ patients and families.

INTRODUCTION

Since 1977, the United States Office of Budget and Management has outlined federal standards for collecting and reporting patient sociodemographic data, specifically race, ethnicity and language (REL).[1] The original 1977 Statistical Policy Directive No.15 was updated in 1997,[2] and again in 2024 to better reflect a growing and broader range of racial / ethnic identities within the United States.[3] Unfortunately, the same directives and systems of accountability are not available for data domains related to sexual orientation and gender identity (SOGI). SOGI data domains include their namesake components: sexual orientation and gender identity; in addition to additional domains such as name to use, pronouns, sex parameters for clinical use, as well as organ and surgical inventories.

While the United States healthcare system continues to morph and adapt to a care delivery system disruptions from the COVID-19 pandemic and subsequent aftermath, health care systems and health insurance payors alike recognize the need for robust and accurate data collection to ensure that trends and differences in population health disparities can be identified, tracked, and addressed.[4,5] Without the data infrastructure to adequately capture and leverage SOGI data domains, health care organizations and entities may not be best equipped to meet the unique health care needs of LGBTQIA+ patients and families.[6] This article explores current guidance for health care organizations seeking to collect and use SOGI data domains, as well and implementation considerations for health care organizations who currently collect, or seek to collect, SOGI data domains.

BACKGROUND OF COLLECTION OF SOGI DATA DOMAINS

In 2011, the National Institutes of Health published a landmark, and first of its kind, report on health considerations and disparities of LGBT(QIA2S+) individuals within the United States.[7] While the 2011 report brought new attention to disparities across LGBTQIA2S+ communities, it also tasked professional and academic communities to expand research agendas to address the growing biopsychosocial health needs of LGBTQIA2S+ individuals and families. However, it was not until 2016 that Centers for Medicare and Medicaid Services and the Office of the National Coordinator for Health Information Technology required electronic health records (EHR) programs that are certified for Meaningful Use to include sexual orientation and gender identity data domains.[8] Health care organizations were now tasked with addressing LGBT(QIA2S+) health disparities, as well as making sure their data infrastructure could manage sexual orientation and gender identity data domains.[9]

It was not until 2019 that HL7 International worked to create consistent health care terminology and system mapping for data to aid in greater consistency in accuracy in the collection and use of clinical sexual orientation and gender identity data domains.[10] With recommendations from The Fenway Institute,[11] and other LGBTQIA2S+ organizations across multiple countries, the HL7 Gender Harmony Project offered health care organizations and health insurance entities a consistent 'playbook' to follow in standardizing naming and data use mechanisms related to SOGI data domains.[12] Whereas the Institutes of Health 2011's report provided a roadmap for expanding LGBTQIA2S+ health equity,

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CMS's Meaningful Use requirements and HL7's infrastructure provided health care organizations with the 'how' to complement the IOH's 'why' for SOGI data collection.

In practice, the complete and accurate collection of SOGI data is crucial for the delivery of patient-centered care, in addition to organizational ability to bill and pay for health care services. While it is recognized that SOGI data domains are important to health care delivery, health care entities may find the implementation of standardized language and data collection mechanisms to be less than linear.[13,14] Major health care organizations across the United States, such as University of California Davis Health System,[15] the Children's Hospital of Colorado,[16] and others, have reported on their processes in expanding SOGI data collection at their respective institutions. However, implementation of SOGI data collection is often a personal process for organizations, requiring a great deal of institutional knowledge and agility in wrangling traditionally siloed departments into collaborative working groups.

PRACTICAL CONSIDERATIONS FOR IMPLEMENTATION OF SOGI DATA COLLECTION

Given the complexity of health care systems and the many information technology applications they employ, our team recognizes that equity in data collection is a journey, and not a destination. This is to say: there are always opportunities to make data collection more equitable, and to not let 'perfection' get in the way of progress. With how many programs and downstream systems that health care organizations use across the patient care continuum, it is unlikely that a 'perfect time' will arise begin or expand SOGI data domains. We offer three practical considerations for health care organizations seeking to expand and enhance their collection of SOGI data domains.

INTER/INTRA-SYSTEM OPERABILITY

Expansion of telehealth services since the onset of the COVID-19 pandemic have ushered in a new era of digital health interventions. For LGBTQIA2S+ communities in particular, digital health and telehealth services offer expanded access to affirming healthcare providers for LGBTQIA2S+ patients and families who may otherwise not be able to access affirming services due to geographic or transportation barriers.[17] Unfortunately, there is a lack of standardization across digital health applications and vendors in how SOGI data is collected and used. For example, while a healthcare system's central electronic health system may be able to collect multiple dimensions of SOGI data, downstream applications may not. In practice, this may look like a patient's affirming name appearing within the electronic health record, but that information not relaying to a downstream remote patient monitoring system and a patient seeing their non-affirming / deadname displayed. Fragmentation in care experiences such as this may contribute to known avoidance in health care engagement across LGBTQIA2S+ patients and families.[18]

In practice, organizations seeking to create data collection plans that account for system inter/interoperability, may want to engage in on-going discussions with existing and future vendors regarding their data collection capabilities around SOGI data domains. With current applications or vendors, health care organizations may want to ask about existing SOGI data domains that are supported by the platform, as well as future considerations or timelines for the implementation or expansion of SOGI data domains. This may mean existing application package upgrades or working directly with the vendor (or other clients of the vendor) to identify and implement SOGI data domain solutions.

PATIENT DATA SAFETY & PRIVACY

As with any other sensitive, identifiable information, SOGI data domains are first and foremost protected health information (PHI). Legislative and executive orders from the 47th US Presidential administration have shifted the SOGI data collection landscape, in comparison to the significant guidance provided by the Biden administration[19] for the collection of SOGI data domains. Nonetheless, health care organizations such as the National Committee for Quality Assurance (NCQA) outline robust data privacy protection procedures as part of their Health Equity accreditation programs.[20] Data safety and privacy protection around SOGI data domains not only includes the safe, respectful and accurate collection of SOGI data domains, but also how those data are stored and shared – patient-facing and health care provider-facing.

For health care systems, a close collaboration between system legal entities and information technology entities will be vital to building safety, sustainable SOGI data collection domains. Whereas system information technology entities will have a strong understanding of data collection systems and architectures, system legal entities will have a strong understanding of data protection and privacy laws and standards. For example, a health system's information technology entities may be able to guide a SOGI data collection working group as to the available data fields to accommodate SOGI data domains – such as how many fields are pre-built by the EHR software, and if custom-built data fields and response options may be available. In practice, it is the dialogue between legal and information technology entities that will help the organization strike the balance between patient-centered methods and robust legal and privacy protections.

MULTI-AUDIENCE COMMUNICATION PLANNING

There is well-documented evidence of the interpersonal challenges that may occur during collection of patient demographic data.[21] Whereas LGBTQIA+ patients may be hesitant to disclose their LGBTQIA2S+ identity within a healthcare setting, health care staff tasked with collecting SOGI data may feel uncomfortable or unprepared for collecting these data.[21,22] Subsequently, it is important to communicate to patients and healthcare team members the relevance of SOGI data to their respective care and scopes of practice. For health care staff, SOGI data may be displayed or used in a variety of clinical contexts, such as USPST preventative screening recommendations,[23] pharmacological and medication-based recommendations,[24] medical equipment settings,[25,26] and imaging procedures and precautions.[27] For patients, there may not yet be shared understanding of why SOGI data is collected, and how that information is used to inform the delivery of patient-centered care.[22]

For health care organizations, it is not simply a matter of if their EHR can collect, store, and query SOGI data domains. Organizations must also take into consideration how health care staff are trained to appropriately solicit and maintain the privacy of SOGI data domains. A robust, multimodal communication plan can equip healthcare providers, as well as patients and families with the context necessary to interact with SOGI data domains. The Fenway Institute's 2020 "Ready, Set, Go! Guidelines and Tips For Collecting Patient Data on Sexual Orientation and Gender Identity (SOGI)" guide provides patient-centered verbiage for collecting SOGI data from patients at multiple points of care (ex: face-to-face with healthcare providers versus through an asynchronous patient check-in software).[11] Focusing on specific guidance for healthcare providers around how we ask for SOGI data can help ensure patients feel heard and safe when sharing sensitive information. Standardized language can be integrated at various patient touchpoints, including registration forms, in-person contact and within the patient's EHR.

Targeting specific guidance for health care providers around soliciting SOGI data domains can ensure that patients feel safe when sharing this potentially sensitive information. Standardized guidance on language and its delivery can be included in various points, such as patient registration forms at check in, or face-to-face contact with the patient once in their clinical encounter. This includes using inclusive language and offering patient education on why this data is being collected along with training staff on how to respond appropriately to questions and concerns. Standardized methods can help an organization build trust with LGBTQIA2S+ patients and families, as well as reduce the risk of poor patient experiences.

LIMITATIONS & FUTURE CONSIDERATIONS

Given the rapidly evolving landscape for LGBTQIA2S+ health equity within the United States within just the first few months of its tenure,[28] there is a great deal of uncertainty as to how the remainder of the 47th US Presidential administration may affect LGBTQIA2S+ health equity. However, this does not mean that hope and efforts around more robust and comprehensive data collection to support LGBTQIA2S+ health equity should cease, but rather that they may need to adapt.

While EHRs are used to collect and store patient information, many were not designed to collect, store, and use SOGI data domains. Organizations may need to update or adapt their systems to include expanded SOGI data domains. This may involve creating new data collection fields or modifying existing fields to collect SOGI data domains meaningfully. For some, this can be a lengthy and costly process, requiring considerable effort from information systems workforce. However, the long-term benefits include more accurate data collection, improved patient experience, and opportunities to identify and address health dipartites.

CONCLUSION

A wide array of health care organizations, health insurance entities, and community-based health organizations may find value in standardized collection of relevant SOGI data domains. However, determining which SOGI data domains may be organizationally necessary, and how to go about collecting those necessary data domains is often less than simple. For health care organizations with the desire to implement the collection of SOGI data domains, there are some resources and guidelines available to assist in implementation. Unfortunately, even with the assistance of the limited resources available to organizations, the standardized and systematic collection of SOGI data domains for identifying and addressing LGBTQIA2S+ health disparities is far from reality. Due to fragmentations across large health care systems and the information technology applications they use to support their operations, implementation of collection of SOGI data domains can be an onerous, but incredibly vital, undertaking. The authors provide three implementation recommendations for health care organizations seeking to begin or expand their journey in seeking SOGI data domains. As the United States health care system continues to change and adapt through turbulent socio and geopolitical times, the collection of SOGI data domains should remain a priority for those organizations seeking to support health equity for LGBTQIA2S+ communities.

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Talking about S-E-X in Healthcare Settings: Let's Get Clinical

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ABSTRACT

Sexual health is a foundational aspect of health and wellbeing, yet many healthcare and mental health providers avoid conversations about sex with their patients. This article explores how inadequate training and systemic discomfort around sexuality lead to missed diagnoses, invalidation, and harm—especially for LGBTQIA+ individuals and other sexually marginalized communities. Drawing from clinical experience and current research, the author outlines how silence around sexual concerns can deepen shame, perpetuate inequities, and drive patients away from care. This article offers practical, affirming strategies for initiating these essential conversations and encourages clinicians to reflect on their own values, biases, and knowledge gaps. This work calls on all healthcare professionals to normalize discussions of sexuality as routine, respectful, and integral to care—not peripheral.

INTRODUCTION

As a sex educator with 25 years of experience and the founder of a group practice that centers sex therapy, relationship therapy, and psychotherapy for sexually marginalized communities, I've seen firsthand the harm that occurs when healthcare professionals are not adequately trained in the full spectrum of human sexuality. This includes the diverse sexual behaviors, expressions, identities, and orientations across the LGBTQIA+ spectrum and beyond. Too often, queer, trans, nonbinary, intersex, and asexual clients—along with those exploring kink, polyamory, or sex work—suffer in silence because we as providers haven't opened the door to ask even the most basic of sexual health questions. When we fail to approach sexual health with curiosity, respect, and clinical competence, we risk misdiagnosing, mistreating, or simply overlooking what matters most to our clients.

These harms aren't always driven by malice or willful ignorance. Many happen in the blind spots of our own limited training, especially when sexuality is treated as peripheral instead of integral to health and well-being. Here in Delaware, harm happens every day when providers ignore or inadequately address sexuality, or when they treat sexual concerns through the narrow lens of their own values rather than from a foundation of evidence-based, sex-positive, LGBTQIA+ affirming care.

So let's crawl beneath the (fact)sheets together and ask the hard questions: Why is this happening? What can we do differently? And how do we continue to grow as clinicians and caregivers to better serve the diverse sexual health needs of all our clients?

TO MY FELLOW HEALTHCARE PROVIDERS

To my fellow healthcare providers, I have a true story to share with you. I know of a 19-year-old college student in Delaware who sought help from a local therapist. She was feeling depressed and insecure about her sexuality and experiencing some challenges in her sexual functioning, so she believed. She made the brave decision to seek therapy, picked out a therapist, and went to her first few appointments, sharing information about her life, her difficulties, and her worries. As she continued with therapy appointments, she noticed that her sexual concerns were being overlooked, ignored. When she eventually asked about when and how the sexual issues might start to be addressed, she was told that the sexual challenges weren't her "*real*" issue, and that she had "control issues," and that's the work that she needed to do. She felt deep shame about that response and stopped asking. She continued with that therapist for a while longer, believing the therapist must be right, after all. And the sexual challenges persisted. That college student eventually stopped therapy, actually feeling quite a bit worse than when she entered, no surprise, especially since her presenting problems had been categorically neglected and invalidated. Further, the clinician had done harm by not only disregarding the presenting problem, but also by creating more shame by ignoring it and judging it ("you just have control issues"), and also failing to refer out to a trained sex therapist when the clinician clearly had no training in treating sexual concerns. So, what happened to that patient? Well, 30 years later, she went on to write the words you're reading in this article right now. Nice to meet you.

WHY AREN'T CONVERSATIONS HAPPENING? LACK OF TRAINING IN HEALTHCARE AND MENTAL HEALTHCARE INSTITUTIONS IS SYSTEMIC.

A trend in the lack of knowledge in our healthcare providers is systemic, originating in the universities and organizations that train doctors, nurses, and therapists. These institutions typically don't value sexuality and sexual diversity. Academic programs that train doctors, nurses, therapists (psychologists, counselors, social workers and marriage and family therapists) and other healthcare providers do not offer typically comprehensive coursework that covers sexual diversity, sexual function, and treating sexual concerns and dysfunctions[1] or how to competently serve sexually marginalized populations like lesbian, gay, bisexual, transgender and queer (LGBTQ+) members. One study found that the average amount of education medical schools require in sexuality education is only 3-10 hours total over the course of four years.[2] That's only a half to barely over a full day of education. And regarding the mental health field, while it would make sense for potential clients to assume competence around sexuality in their psychotherapists, surveys show that few psychology and counseling programs "offer comprehensive training in sexuality… sex therapy, sexual expression" and more.[3]

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WHY AREN'T CONVERSATIONS HAPPENING BETWEEN PROVIDER AND PATIENT? IT'S BECAUSE YOU'RE NOT ASKING. BUT, YOUR PATIENT IS WAITING FOR YOU TO OPEN THE DOOR.

Here's what we know about the lack of discussing sex and sexuality with your patients: at the very least, we as providers are missing so much vital information and at worst we are doing harm.[4] A common mistake many providers make is assuming that your patient is going to bring up sexual concerns spontaneously without you asking. Nope. More often, your patient is hoping you'll ask. They are waiting because they are wondering if you are a safe, open, nonjudgmental space for them to share their sexual concerns. They are looking to see if you're going to ask them first, and if you will be comfortable talking about sex with them. Unfortunately, your silence is probably telling them all they need to know. A study from researchers at the University of Chicago found that while almost two-thirds of OB-GYNs regularly asked about their patients sexual activity, this only skimmed the superficial surface, and most did not ask follow up questions nor inquire about orientation nor identity. Just 40 percent of OB-GYNs noted that they assessed for sexual problems or dysfunctions, less than 29 percent regularly asked about sexual satisfaction, and only 28 percent confirmed their patients' sexual orientation (LGBTQ).[5]

However, we know that in general, your clients want to be asked. One research survey revealed that 99% of patients who had presented for regular gynecologic care reported at least one sexual concern.[6] Of those who reported concerns, these were the most common reported:

- Lack of interest in sex (87%),
- Challenges with orgasm (83%), and
- Painful sex (72%).

In another large international study of 27,000 mixed-gender study participants, the results showed that over 50% reported at least one sexual problem/concern.[7] However, only 19% of those had sought out a health provider or care for that concern, and only 9% had a health provider who had asked them about their sexual health in the prior three years.[1]

Please start to ask yourself these questions with compassion and curiosity: If you're not bringing up questions about sex and sexuality with your patients, is it because you're not comfortable doing so? Is it because you don't know where to start? Keep reading, we will get there together.

HOW DO I START TALKING ABOUT SEX/ SEXUALITY WITH MY PATIENTS? (PREREQUISITES).

These recommendations can be pre-requisites, but I want you to think of these as co-requisites, meaning you can get started with asking your patients right away if they have any sexual concerns or if they have anything about their sexuality they would like to discuss with you. But when you do, make sure you are ready to respond nonjudgmentally, able to offer support and resources, especially to LGBTQ-welcoming and friendly services, and refer out if you are not comfortable and competent in treating any concerns they bring up.

Here are the other prerequisites and corequisites for competently addressing other areas of your patient's sexuality, the most powerful (and fun) one first: work on your own sexuality. Yes, really. Read sex books and listen to sexuality education podcasts and watch sexuality education videos and attend sexuality workshops and conferences. You will probably have a WONDERFUL time. Learn about your own pleasure and connect more deeply with your body's capacity for relaxation, pleasure, and sensuality. Get more practice talking with your partners about sex, deepening your understanding about your own sexuality, and as you do, you will get more comfortable talking with your patients about their unique sexualities. As you learn about your sexuality, you'll deepen your understanding of how bodies work regarding sexual desire, arousal and orgasm, how our thoughts and values influence our sexual connections, how cultural shame can impact our ability to experience pleasure, and how your values influence how you approach your work with clients, all of these being critical insights how you address sexual issues with clients. Read that again. Last but not least, commit to lifelong learning by attending trainings and conferences and by joining professional sexuality associations like the American Association of Sexuality Educators, Counselors, and Therapists (AASECT.org), the Society for Sex Therapy and Research (sstarnet.org), International Society for the Study of Women's Sexual Health (isswsh.org), the Association of Black Sexologists and Clinicians (theabsc.com) and World Professional Association for Transgender Health (wpath.org) to name just a few. See more here: https://www.aasect.org/related-organizations.

HOW DO I START TALKING ABOUT SEX / SEXUALITY WITH MY PATIENTS? (DOING THE WORK)

If you're in any healthcare or mental healthcare setting, you can open the door to normalize talking about sex and sexuality by saying something like: "I believe it's important to normalize talking about sexual health and sexuality as a critical part of each person's life, so I ask routine questions about sex and sexuality of all my patients." Tell your patients that most people have sexual questions or concerns about sexuality and this is a judgment-free zone. But, take this to heart: if you say this, you must mean it. Don't promise this and then judge your clients for LGBTQ identities, or sharing with you that they are ethically non-monogamous, or into consensual kink, or participating in consensual sex-work. It is such a harmful experience when providers promise a "judgment-free zone," and then patients are met with judgment and shamed by the doctor or therapist who promised safety. When I start asking questions about sexual health and sexuality, I always share with my patients that if there's anything they don't feel comfortable answering, just to let me know or say "I pass." This makes your interactions very consent-based. I always give my clients the 'right to pass' on any question, just in case they're very uncomfortable or tempted to minimize something or make something up to protect any sensitive information.

If You're a Healthcare Provider

One model you can use to guide your sex questions is with a Sex History Risk Assessment using the 5 P's recommended from the

CDC website,[8] but in truth, I recommend adding two more P's to that sex history list. As a medical professional, you'll want to open the door and ask about:

1. Partners (genders, orientation),
2. Practices (sexual behaviors),
3. Past history of STDs,
4. Protection from STDs and unplanned pregnancy, and
5. Pregnancy plans.[8]

But here's where as a sex educator, a sex therapist and a sexologist, I'm begging you to go further, I need you to add two more Ps to your medical sex history risk assessment:

6. Pleasure and
7. unwanted Pain.

Ask if sex is pleasurable for them and if they have any concerns about their sexual functioning. Ask if they experience unwanted pain during sex. These last two questions are critical because typically patients will not bring concerns about sexual functioning (pleasure) up unless asked, and far too many people minimize and normalize pain associated with sex, and this is often missed in regular routine care unless directly asked point blank. Please, ask.

If You're a Mental Healthcare Provider

Start the conversation about sex, orientation, gender, partners, and expression from the first appointment. As a sex therapist, I have had so many patients who find me and our center because of our expertise with sexuality, sex therapy, and working with sexually-marginalized populations. So many of our clients describe leaving their previous therapists, who were otherwise a good fit, because they just hit a wall where they couldn't move forward as the therapist either wasn't comfortable discussing sexuality, or couldn't treat any sexual concerns. Other patients come to me after experiencing years without mental health care after an experience of harm with a therapist. Common examples of harm include therapists who insisted that the patient's interest in kink could only be a result of trauma (it's not), therapists who judged and shamed clients for doing chosen and consensual sex work (sex work is real work), therapists who spent the client's time (and money) having the client educate *them* on sexual orientation and gender identity instead of doing their own work on their own time, therapists who told clients that all porn use is addictive (absolutely false and not based in science), and therapists who insist that any relationship structure that isn't monogamous is indicative of attachment problems or commitment issues (absolutely not). Whew.

If your clients are making consensual choices, stay curious. Don't judge. Read everything you can. I'll include a brief reading list at the end of this article to get you started. Commit yourself to being sex-positive, inclusive, intersectional, trauma-informed, and anti-racist. All of these have deep connections and intersections.

So where to start asking? Your patient's sexuality is an inherent, critical part of who they are, just like every other piece of their life. Even if your patient's sexuality wasn't part of their list of presenting concerns, it's important to cover sexuality and sexual health questions starting at the intake. It's fundamental to know about sexual orientation, sexual attraction, gender orientation, pronouns, gender expression, partner or partners, and ask them to tell you if there's anything important for you to know about their sexuality. Ask them if there's anything about their sexuality that they think they might want to discuss in therapy. If the answer is no, let them know that the door is always open for sexuality to be discussed in therapy anytime. If it's couples therapy, ask about the couples' sexual life and what it is like for each of them. Ask them if they have anything they'd like to discuss about their sexual life, and if the concerns bringing them to seek couples' therapy have also affected their sex life (likely, they have).

TREATING CLIENT'S SEXUAL CONCERNS & REFERRING OUT.

Working with and supporting client's sexual concerns is an amazing creative and delightful magical area of work. However, if you do not have the training and education to treat the client and their presenting sexual concern, please consult, get training and/or refer out to competent sexually-trained professionals. Expand your training, your education and your professional network in order to help your patients get the most sex positive and comprehensive and supportive care they can get. Believe your client. Believe your client's experience of pain, and support your client in their goals. Do not, please, do not tell your clients to have a glass of wine or other alcoholic drink to relax before sex which 20% of medical providers do when, according to one study, women share they have pain with sex.[6]

WHAT ARE YOU GOING TO DO TOMORROW?

In closing, you're still reading this article so I still at least somewhat have your attention. What are you going to do with this information? Let me close with a "Call to Action." Please do one thing, maybe three.

1. Buy one of the sexuality books I recommend on the accompanying list.
2. Commit to starting to ask every patient about their sex life.
3. Commit to adding LGBTQ resources to your referral network.
4. Join AASECT.
5. Become a certified sex therapist.
6. Become a specialized sexual health provider.

Jump in with me! Let's get clinical.

TO THE PATIENT: TIME TO ASK WHAT'S UP DOC? IS SEX MISSING FROM YOUR HEALTHCARE CONVERSATION? TIME TO BRING IT UP.

First and foremost, you are 100% normal. Sexual concerns and worries are normal and common, uncertainty about optimal sexual functioning is normal, you are normal. I often validate my clients by telling them, 'no one grows up in this culture with their sexuality unscathed.' It's common to feel unsure, or have worries or insecurities. And while sexual shame as a result of a repressive culture is normative (common), it's not helpful and you don't deserve to feel that way. And you certainly don't deserve to have

your sexuality, your identity, your sexual interests, orientation, gender, behaviors, expressions in any way shamed, judged, or ignored by your medical providers. If any of these have happened, please advocate for yourself if you think it might help or find a provider who can serve you better. You deserve great care!

So how do you get started with having your sexual health and sexuality included in healthcare? First of all, if you have noticed that you are not getting asked about your sex life in routine healthcare, or your mental health care, it's a great time for you to bring it up. You can ask your provider if knowing about your sexual health and sexuality important for them to know. Ask them and then wait for them to answer. Their answer may tell you a lot. Are they warm and open and inviting and curious with a resounding yes? Do they seem uncomfortable? If you bring up a sexual concern, notice if your provider listens, gets curious, supports you, believes you, and wants to get you answers, treatment and resources. Or, do you leave their office feeling not believed or invalidated? I want to share a case of a recent study of patients with sexual pain disorders who had attempted to access medical help had disheartening findings.

Research participants reported that they found about 34% of their providers to be supportive, 32% they noted were "belittling," 31% did not believe the patient, over 41% had been told to "just relax more", and over 20% of patients had been told by their medical providers to "drink alcohol" as a recommendation. What's more, just under 40% of these patients noted that they were "made to feel crazy" and most (around 53%) considered ceasing care due to these experiences.[9] It's important to emphasize that this study was only able to capture patients who continued with treatment, and not the scores of patients who gave up on treatment after experiences just likes these. If you are feeling less than confident and supported by your provider, find another provider. Supportive, competent, compassionate sex-positive well-trained providers are here in Delaware.

Pleasure is your birthright and advocating for your sexual health, sexual rights, dignity and respect needs to be a given. Please check out my recommended reading list to get you started or continue your path of sexual wellness & joy.

READING LIST

- Black Girls' Guide To Couples' Intimacy; Dr. Lexx Brown-James
- Come as You Are: The Surprising New Science that Will Transform Your Sex Life; Emily Nagoski, PhD
- Come Together: The Science (and Art!) of Creating Lasting Sexual Connections; Emily Nagoski, PhD
- Gender Magic: Live Shamelessly, Reclaim Your Joy, & Step Into Your Most Authentic Self; Rae McDaniel
- Good Sex: Stories, Science, and Strategies for Sexual Liberation; Candice Nicole Hargons, PhD
- Naked at Our Age: Talking Out Loud About Senior Sex; Joan Price
- With Sprinkles on Top: Everything Vanilla People and Their Kinky Partners Need to Know to Communicate, Explore, and Connect; Stefani Goerlich

Dr. Dukes may be contacted at cat@thecentercd.com.

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Improvement in Quality of Life in Transmasculine Individuals After Chest Masculinization Surgery

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ABSTRACT

Many transgender masculine individuals experience gender dysphoria, including body dysphoria. Body dysphoria is the experience that our body does not align with our gender identification. For many of these individuals, their chest is an area of body dysphoria. Subsequently, many seek out a surgical masculinization of their chest, or what is commonly called "top surgery" to reduce the dysphoria. This systemic review aims to evaluate the current literature on changes in quality of life in trans masculine individuals after top surgery. APA PsychArticles, APA PsycInfo, PubMed, Scopus, Web of Science, and ProQuest Dissertations & Theses Global were the databases utilized for this search. Chaining was also used as the literature is sparse concerning this subject. There was no date range, and exclusions were minimal due to the sparsity of literature. The search produced 8 articles that could be used for this review. All of the studies that utilized proper data analysis found statistically significant evidence that top surgery results in improved body image or body congruence. The studies that included psychological wellbeing or psychological symptomology as a form of quality of life found statistically significant improvement in those areas. All studies found that the majority of participants felt more satisfied with their chests than dissatisfied. Based on the above studies, there is evidence that quality of life does improve for trans masculine individuals who receive top surgery. These studies imply that the gender affirming model of care of transgender individuals is a viable model to use for the treatment of body dysphoria. More studies in this area need to be conducted on this topic in order to validate these findings.

INTRODUCTION

Gender Dysphoria is a marked incongruence between one's assigned gender at birth and their experienced gender, causing significant emotional distress and impairment in many functioning areas, such as school, work, and social relationships.[1] These individuals describe themselves as transgender or as a different gender than they were assigned at birth.

A 2016 systemic review found that self-reported transgender identities ranged from 100 to 700 per 100,000 people, or 0.1% to .07%.[2] However, these percentages are probably on the low end as the number of people verbalizing that they identify as transgender is increasing with no sign that it is leveling off.[3]

The 2015 U.S. Transgender Survey, completed by the National Center for Transgender Equality[4,5] found that 39% of respondents experienced severe psychological distress in the month before completing the survey, compared to only 5% of the U.S. population. Additionally, 40% of trans identifying individuals attempt suicide at some point in their lifetime, compared to only 4.6% in the U.S. population.

Quality of life can be defined as a person's perception of their own well-being and functioning. This can include a person's psychological, physical, and social functioning.[6] Transgender individuals have a significantly lower quality of life than cisgender males and cisgender females.[7–9]

Body incongruence, or body dysphoria, is a common issue for most individuals with gender dysphoria. Transgender individuals assigned female at birth, who identify on the masculine end of the gender continuum or identify as males, often experience significant chest dysphoria. "Top surgery" is the number one surgery transmasculine individuals seek to reduce their body dysphoria. Until this surgery is available to them, they often bind their chest. Body image itself is a predictor of quality of life. A study by Navir, et al. found that body image was closely aligned with Quality of Life (QoL) when measured by the World Health Organization (WHO) QoL short form.[10]

Transmasculine individuals "bind" their chest to reduce their body dysphoria. Additionally, they bind to reduce their social dysphoria, with the hope of being gendered correctly in public.[11] Individuals may use such garments as elastic bandages, athletic or neoprene products, manufactured binders, or duct tape. Often, transmasculine individuals will layer more than one binding item in the hopes of flattening their chest as much as possible. Binding can cause pain and skin, musculoskeletal, neurological, gastrointestinal, and respiratory symptoms and damage.[12]

As stated earlier, chest dysphoria is a common experience for transmasculine individuals.[13] Many seek masculinization chest contouring to abate this dysphoria and improve their quality of life. The purpose of this rapid systemic review is to evaluate the research regarding change in quality of life in transmasculine individuals following top surgery.

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THEORETICAL UNDERSTANDING AND BACKGROUND OF THE BIOPSYCHOSOCIAL PROBLEM

The etiology of the transgender and gender diverse identity can be understood through a biological lens. One theory considers the timing of processes during the gestational period. The sexual differentiation of the genitals occurs during the first trimester of pregnancy, while the sexualization of the brain begins in the second trimester. These processes may work independently of each other, perhaps allowing for the incongruence of genitals and gender identity.[14] One study surmised that endocrine disruptors might play a role in forming a transgender identity[15]; however, more research in this area is vital before stating there is a correlation. Finally, genetics may play a role in the development of a transgender identity. The Diagnostic and Statistical Manual of Mental Disorders[1] indicates there is evidence for some heritability. There is a higher incidence of transgender identity between monozygotic same-sex twins than dizygotic same-sex twins.

The psychological lens of Gender Dysphoria purports that the incongruence of a person's body and gender identity causes emotional distress and impairment in critical functioning areas. However, evidence suggests that distress also originates from the social stigma associated with cisnormative societal expectations[16] and discrimination.[17] Facing the fear of this discrimination sets the stage for social dysphoria, where the individual worries they will be gendered incorrectly. In transmasculine people, their female chest is the "tell" to strangers that they were assigned female at birth. When this person is misgendered, they experience emotional distress.[13] Subsequently, body dysphoria and social dysphoria can be linked, indicating the importance of utilizing a psychological and sociological lens when viewing this problem.

It makes sense then that chest masculinization surgery or "top surgery" will help reduce both body dysphoria and social dysphoria. It is possible that with the reduction of those two symptoms, the person will have an improvement in many aspects of their life.

The Diagnostic and Statistical Manual of Mental Health Disorders clarifies that gender dysphoria is not a mental illness.[1] It is the distress accommodating the dysphoria that is the psychological concern. Subsequently, the World Professional Association of Transgender Health (WPATH) suggests using a gender-affirming approach to managing and reducing the illness.[18] It is suggested that by following the WPATH Standards of Care (SOC) for treatment, individuals will receive the behavioral health and medical services they need to relieve their gender dysphoria, thereby improving their quality of life. One gender affirming treatment for gender dysphoria is "top surgery" or chest masculinization surgery.[18]

SEARCH METHODOLOGY

As transgender research is a newer field, the search needed to remain as open as possible to ensure no material was missed. Subsequently, inclusion criteria included age 18 and up, any location, no time limits on when the studies were completed, and both peer reviewed and gray literature. The search terms used were, "Top Surgery" OR "chest masculinization surgery" AND "quality of life" for title, abstract, and key words. Exclusions included individuals assigned male at birth and individuals under the age of 18.

Databases used were APA PsychArticles, APA PsycInfo, PubMed, Scopus, Web of Science, and ProQuest Dissertations & Theses Global. The International Journal of Transgender Health was also searched for articles. Cochrane Library and Campbell Collaboration were searched using various search words, including the ones above, to ensure a recent systemic review had not been completed on the topic. Chaining from the bibliographies were also used in the search.

The initial search produced 72 articles through the database searches. There were 14 duplicates. 20 articles were found through chaining, leaving 78 articles to screen for title and abstract review. 46 articles were excluded using title search and abstract review, leaving 32 articles for full article review. 24 of those articles were excluded for not meeting criteria, leaving 8 articles to meeting the criteria to be a part of the literature review. Examples of reasons why some articles were excluded include some participants were under the age of 18, articles that did not separate out data of transfeminine surgeries and transmasculine top surgery, and one article that compared change in quality of life after chest masculinization between transmasculine individuals and cisgender males (*figure 1*).

DATA EXTRACTION

Pertinent data was extracted from the literature and placed in *table 1*. The table states the author(s), aim of the study, design, sample size, measures used, and primary findings. All of the p values in the table are of statistical significance.

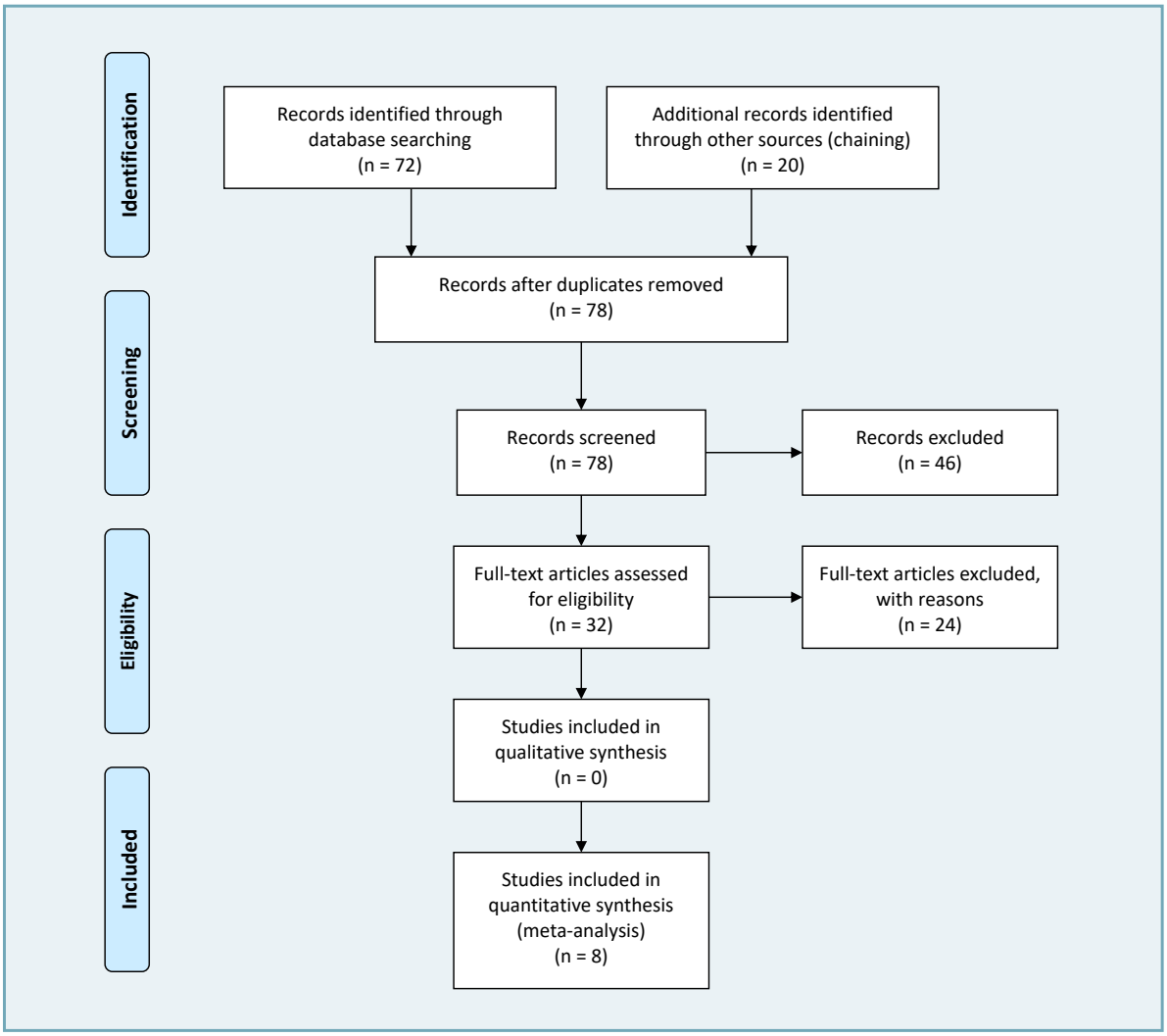
LITERATURE REVIEW

The studies below are organized according to the strength and rigorousness of the study. All of the studies were quasi-experimental studies. The JBI Critical Appraisal Quasi-Experimental Studies was applied to all articles.

Davis and Meier conducted a cross-sectional, mixed methods study.[6] The qualitative portion of the study assessed changes in mood and sexuality since beginning gender -affirming hormone treatment (GAHT). The quantitative study compared the emotional and body satisfaction changes in transmasculine people in three different stages of transition. The first group had not had any medically affirming transition treatment, the second group was taking GAHT, and the third group was taking GAHT and had top surgery.

Two hundred and eight (208) trans masculine people participated in the study. It was a 98-question written survey. Purposive sampling included the internet, two transgender listservs, chain referral, and San Francisco community events. Individuals took the test with pencil and paper or online. The questionnaires included the Beck Anxiety Index (BAI), the Beck Depression Inventory (BAI-II), the Snell Clinical Anger Scale (CAS), and a novel 10 question Likert scale to determine Body Dissatisfaction. The BAI and BDI-II were found to have excellent internal reliability. Both the CAS and the Body Dissatisfaction scale were determined to have good internal reliability. No validity data was provided. The authors used appropriate statistics to answer the main research questions. The key variables were defined and measured clearly.

Figure 1. PRISMA 2009 Flow Diagram



Both the transmasculine people who were on GAHT (n= 46) and the GAHT/ top surgery (n=72) group were statistically significantly less depressed ($p < .001$), less angry ($p < .001$), less anxious ($p < .001$), and had less body dissatisfaction ($p < .001$) than the no treatment group (n=78). As expected, the GAHT/ top surgery group (n=72) reported statistically significant less body dissatisfaction than the GAHT group (n=46) ($p < .001$). The authors tested for internal consistency which was found to be consistent and the key variables were operationalized clearly. One clear strength of this study is that it had larger than usual number of participants for studies of this type.

Klassen, et al. conducted a cross-sectional study using the BODY-Q chest module to assess improved satisfaction with body, psychological wellbeing, and quality of life.[19] The study was conducted at the Department of Plastic, Reconstructive and Hand Surgery at the Center of Expertise on Dysphoria of the VU University Medical Center, Amsterdam. The preoperative group was recruited when they first approached the Center for surgery. The postoperative group were recruited at one of their postoperative visits. One hundred and one (101) persons participated in total. There were 50 preoperative participants and 51 postoperative participants. Preoperative participants scored statistically significantly lower than postoperative participants in satisfaction of their chest, nipples, and body ($p <0.0001$) and statistically significantly higher on psychological symptoms ($p=.05$).

The key variables were operationalized and specified clearly in the study. The chest and nipple scales of the BODY-Q module were developed and validated for trans masculine people; the other BODY-Q scales did not include trans people in its development. The authors used appropriate statistics to answer the main research question.

One limitation of this study that it is a cross sectional design. The study would be improved if the scales were given pre- and post-surgery with the same individual. Additionally, the small sample size and the anxiety and depression items were not validated measuring tools. One strength of this study is that the two of the scales in the BODY-Q module were validated for transmasculine people.

Van de Grift et al. conducted a quasi-experimental study of the associations of dissatisfaction with surgery and quality of life.[20] The study was conducted within the European Network on the Investigation of Gender Incongruence (ENIGI). Participants were from gender treatment clinics from Amsterdam (the Netherlands), Ghent (Belgium), and Hamburg (Germany). Forty-nine (49) postoperative transmasculine individuals completed the study. Scales included the Utrecht Gender Dysphoria Scale (UGDS), the Symptom Checklist 90-R (SCL-90), the Satisfaction With Life Scale (SWLS), the Subjective Happiness Scale (SHS), and the Cantril Ladder (CL).

Ninety-four percent (94%) of the participants were satisfied with their outcomes. The satisfied group had statistically significantly lower SCL-90 scores (p=.05) statistically significantly higher SHS scores (p=.04), and were trending in that same direction for the CL, as the dissatisfied group. The reasons given for dissatisfaction was aesthetic concerns, complications, or general treatment dissatisfaction. Notably, the dissatisfied individuals had higher levels of psychological symptoms and life dissatisfaction preoperatively. Although this group had a lower level of gender dysphoria than the satisfied group, their gender dysphoria was higher prior to surgery.

The variables were clearly defined in the study. There was no reliability or validity data provided on the measures. There was a non-probabilistic sample selection method. A proper statistical analysis was completed, including descriptive statistics. Selection bias was one of the limitations of the study as individuals with lower education were underrepresented.

Poudrier et al. completed a quasi-experimental, mixed methods study by sending an anonymous online survey to 81 transmasculine individuals who were postoperative patients (of at least 3 months duration) from New York University Langone Health.[21] Fifty-eight (58) respondents participated. Quality of life,

Table 1. Description of Studies Included within the Literature Review

Author/ Date	Aim of Study	Design	Sample Size	Measures Used	Primary Findings
Davis & Meier (2014)	Assess effects of chest reconstruction with/without testosterone on MH/QoL	Quasi-experimental	N=208	BAI, BAI-II, CAS, novel Likert scale	Improved mental health, less body dissatisfaction for GAHT and GAHT/Top surgery groups. (p < .0001) GAHT/Top surgery group had less body dissatisfaction than GAHT group (p < .001)
van de Grift et al. (2018)	Body Image and QoL after top surgery	Quasi-experimental (exploratory)	N=101 Preop=50 Postop=51	BODY-Q	Pre-op scored significantly lower on satisfaction of chest, nipples, and body (p < .0001) Pre-op scored higher on psychiatric symptoms (p=.05, statistically significant)
van de Grift et al (2017)	Asses QoL, gender dysphoria, psych sxs after gender affirming surgeries (top)	Quasi-experimental	N = 49	UGDS SCL-90 SWLS SHS CL	94% satisfied with outcome. Satisfied group had lower SCL-90 scores (p=.05) and higher SHS scores (p=.04) (both statistically significant)
Poudrier et al. (2018)	Assess QoL after top surgery	Quasi-experimental (Mixed methods)	N = 58	Modified BREAST-Q	Improved QoL and sexual confidence (p < .0001) 86% reported improvement in MH symptoms associated with GD
Argarwal et al. (2018)	Assess QoL, satisfaction, body image after chest wall masculinization	Quasi-experimental	N = 42	BREAST-Q BUT-A	BREAST Q = improvement in all domains (p < .0001) BUT-A = Global Severity Index (cuts across all domains) improvement (p< .0001)
Kraemer et al. (2008)	Assess improvement of body image after surgery	Quasi-experimental	N = 15 Preop=7 Postop=8	FBeK	Improvement in all 3 body image areas Stat. significance with accentuation of body image (p< 0.001)
Black et al. (2020)	Assess patient satisfaction ("joy") after chest masculinization	Quasi-experimental	N=50	IBM Watson Linguistic "Tone Analyzer"	Mean value medium strength of joy for Original Post **Original post** Mean ±SD 0.74±0.13 Range= 0.55-1.0 **Post** Mean ±SD 0.81± 0.13 Range =0.58-0.99 Responders presented with more joy than the original poster
Nelson et al. (2007)	Assess patient satisfaction, surgical outcome, psychological morbidity	Quasi-experimental	N = 12	Non-valid novel survey	N= 8 very satisfied patients N= 3 satisfied patients N = 1 unsatisfied patient

mental health, satisfaction of surgical outcome, sexual confidence, and perceptions around "the role of top surgery in gender transition" were assessed.

Although not validated with transmasculine individuals, the measurement used in this study was the BREAST-Q, which is a validated questionnaire for use with cisgender females after cosmetic or reconstructive breast surgery. The measurement has two domains broken down into three matrixes each. The domains are Quality of Life and Satisfaction.[22] For this study, modified questions were created from three of the matrixes to better assess the psychosocial needs of transmasculine individuals. There is no information on what matrixes were used, which is a limitation of this study.

Only 30% of participants scored as satisfied on any of the preoperative measures. Postoperatively, quality of life and sexual confidence had statistically significant improvement ($p<0.001$) in all domains of the modified BREAST-Q measurement. Additionally, 86% of these postoperative individuals indicated improvement in mental health symptoms associated with gender dysphoria. The key variables were defined and clearly measured in the study. No reliability of the data is provided and the tool used was not a validated measure. A non-probabilistic sample selection was used. Appropriate statistics were used to answer the research question.

Agarwal, et al. conducted a prospective study assessing quality of life after chest wall masculinization utilizing the BREAST-Q and Body Uneasiness Test.[23] Both measurements have been validated with cisgender women, but not with transmasculine individuals. It does make sense that these are the measurements used for this population due to no other options being available. Together they assess body image, general well-being, and quality of life factors.[23,24] No reliability data was provided. A non-probabilistic sample selection was used. There were 87 eligible patients, with 42 deciding to participate in the surgery. The participants had top surgery with Dr. Cori Agarwal between April 2015-June 2016. The questionnaires were given before surgery and given six months after surgery.

The domains assessed with the BREAST-Q survey were physical well-being, psychosocial well-being, sexual satisfaction, and breast satisfaction. The BREAST-Q evaluation produced statistically significant improvement in all 4 domains. Physical well-being scores improved from 65.3±13.7 preoperatively to 80.3±11.8 postoperatively ($p<0.0001$). Psychosocial well-being improved significantly from 31.3±14.2 preoperatively to 78.9±15.9 postoperatively ($p<0.0001$). Preoperative scores for sexual satisfaction were 30.7±20.9 with an improved score of 71.4±19.2 <p0.0001) postoperatively. Lastly, chest satisfaction scores improved from preoperative values averaging 17.4± 14.0 with postoperative averages at 85.0±11.7 ($p<0.0001$).

Appropriate statistics were used in order to answer the research question. Statistically, significant improvement was seen in all domains in the BUT-A questionnaire. The Global Severity Index (a cumulative measure of all domains) decreased from 2.68±.73 preoperatively to 1.20± 0.68 postoperatively ($p<0.0001$). The most noteworthy domain for quality of life, body image concerns, decreased from 3.49±0.84 to 1.33± 0.77 ($p<0.0001$) after surgery.

Problems with the study included the lack of generalizability to other transmasculine individuals who have had this surgery. Only one surgeon completed the surgeries. Dr. Agarwal has been performing these surgeries for over 15 years, which is a much more extended period than most top surgeons in the United States. This variable should be taken into account when noting the significant improvement in chest satisfaction of the participants. This domain points to the aesthetics of the work. With that said, it needs to be noted that other studies have had similar findings.

Limitations in the study include selection bias in those who had an interest in taking the survey, the small cohort size, and the lack of racial diversity of the group (88% of the participants were white). As stated earlier, neither the BREAST-Q, nor the BUT-A are validated scales to use with this population. An additional concern is that the second questionnaire was completed after only 6 months. It is not known if after a more extended period of time if the participants would continue to experience this same improved quality of life.

Kraemer et al. conducted a quasi-experimental study comparing the feelings associated with body image in preoperative transgender individuals versus postoperative transgender individuals.[25] Although both transmasculine and transfeminine individuals were used in this study, they were compared separately. The participants were from the University Hospital of Zurich, which is a gender affirmation clinic in Switzerland. The sample was non-probabilistic and were previous / and current patients of the institution. The sample sizes were small for the transmasculine group, with 7 preoperative participants and 8 post operative participants, which is one limitation of this study. The study used a validated body image instrument called the Fragebogen zur Beurteilung des eigenen Körpers (FBeK). The authors tested for internal consistency which was found to be consistent and the key variables were operationalized clearly.

The scales assessed insecurity/concern, attractiveness/ self-confidence, and accentuation of body appearance. The transmasculine postoperative group scored higher in all three areas in body image than the preoperative group. However, the only score of statistical significance was the accentuation of body appearance ($p = <0.001$). The authors noted that this might have been due to the small sample size, which is a significant limitation of this study.

Black, et al. completed a quasi-experimental study using linguistic analyzing technology using social media posts to assess feelings of "joy" after one has trans masculine top surgery.[13] The researchers used an IBM Watson tone analyzer which rated the presence of joy on a continuous scale of 0 – 1. The researchers used the social media APP Instagram, to assess 50 subcutaneous mastectomy postoperative results. An encrypted password-protected folder was used for the data. Hashtags used were #topsurgery, #transisbeautiful, #transispowerful, #transqueer, #transman, and #transgender. The original post and the responding comments were analyzed through the IBM Watson Linguistic "Tone Analyzer." This tool uses linguistic analysis to detect emotional and language tones in text. The "view JSON" setting was selected to allow joy analysis on a continuous scale. An additional part of the study was the use of 3 gender-affirming plastic surgeons to rate the aesthetic quality of the top surgeries.

Joy was analyzed on a scale of 0 – 1. The postoperative individuals' level of joy had a mean value of .74 (±0.13 with a range of .55-1.0). The level of joy was reported to be of medium strength. Interestingly, the individuals who commented on the

original post had higher levels of joy than the postoperative person themselves. The mean value was 0.81 (±0.13 with range of 0,58 – 0.99) for the responders, which is a sign of emotional support among trans community members. Interestingly, the surgeons regarded the aesthetic quality of the work as only average (5.3 on a 1-10 scale, with a range of 2.8 to 8.5 out of 10). It seems the patients themselves found the results to be more appealing than 3 experienced surgeons.

Based on the information given on the linguistic analyzer, the appropriate statistics were used. However, validity nor reliability of the tool were provided. Selection bias is one limitation of the study, as patients are more likely to post photos of their surgical results if they are pleased with them. Additionally, the joy analyzer was not able to assess the positive emoticons in the posts, which is clear limitation of using this analyzer.

Nelson, et al. conducted a 5-year retrospective review evaluating 12 patients to assess surgical outcome, patient satisfaction, and psychological morbidity after top surgery.[26] The mean follow up period was 10 months, with a range of 2-23 months. The study was conducted through a postal questionnaire sent to 17 patients after their procedure (non-probabilistic sampling).

Twelve individuals returned the form. The invalidated questionnaire was created by the author and reviewed by the "sexual problems psychiatrist." There was no information on the reliability or validity of the questionnaire. Questions included how the participants experienced their nipple positioning, sensation, and scaring. Quality of life questions included asking if the patient felt more confident in their body since having the surgery. Ten of the twelve participants stated that they felt "much more confident" in their body since the operation, while two felt "a little more confident." Eight patients stated they were "very satisfied" with the surgery, three were "satisfied" and one was "unsatisfied." The article stated that all patients felt that the surgery had a positive impact on their lives. There was no statistical analysis completed, which is a significant limitation of the study. An additional limitation of the study is that participants completed the questionnaire at varying times after their surgery, affecting comparison among the group, as there is a "honeymoon period" for one year postoperatively.[27]

SYNTHESIS OF FINDINGS

Gender dysphoria, specifically body dysphoria, is a well-documented problem for transmasculine individuals. All of the studies above showed statistically significant improvement in some area of quality of life except for two studies that did not provide proper data analysis.[13,26] All of the studies that utilized proper data analysis found statistically significant evidence that top surgery results in improved body image or body congruence (Agarwal, et al. 2018; Davis & Meier, 2014; Poudrier et al. 2019; van de Grift, 2017, 2018). The studies that included psychological wellbeing or psychological symptomology as a form of quality of life found statistically significant improvement in those areas.[6,20,21,23,28] All of the studies that asked about chest satisfaction found that the majority of participants felt more satisfied with their chests than dissatisfied. Although Black et al. states there is a correlation between "joy" and quality of life, no measurements were used to show this correlation.[13]

There was a significant number of limitations across studies. All the studies suffered from small sample sizes, which is common for transgender research. Davis and Meier did have 200 participants which is on the higher end for transgender research studies and they also tested for internal consistency.[6] Moreover, the majority of their measures were validated measures for the general population, including trans people. Additionally, in some ways, this study having a group of individuals who had no gender-affirming care could be seen as having a control group. However, this study, along with the others, were all quasi-experimental, had a non-probabilistic sample selection method, and suffered from a lack of diversity in race and socioeconomic class.

All the studies were in keeping with the theoretical gender affirmation model and the studies that did comment on the steps participants took before receiving medical treatment were steps in keeping with the WPATH Standards of Care. Several studies indicated the importance of improving aesthetic treatment outcomes for this surgery even though studies show the patients are satisfied with the work.

IMPLICATIONS AND RECOMMENDATIONS

As stated earlier, research into trans healthcare and the transgender and gender diverse population is a newer field. Subsequently, research studies and the sample sizes in those studies are small. Although all of these studies were quasi-experimental, 6 out of 8 studies did proper data analysis. All of those produced statistically significant evidence that top surgery does improve some areas of quality of life in trans masculine individuals. Moreover, all of the studies showed that more participants were satisfied with their chest than dissatisfied. These positive outcomes indicate that the gender affirming model for treatment recommended by WPATH followed by behavioral health and medical care providers is reasonable in its approach. We are moving in the right direction.

As more people publicly identify as a different sex than they were assigned at birth, more people are seeking medical transition. Within the United States, we are seeing more access to these treatments through medical coverage. Although academic literature does not yet show this, a larger number of transmasculine individuals are getting top surgery as they no longer must pay out of pocket for the surgery. Many states require that employers no longer have blanket exclusions of trans healthcare. This gives transgender people room to appeal denials of medically necessary transition related surgeries. In the past, the only means for transmasculine individuals to acquire this surgery was to pay out of pocket. However, it is not known how long the trend of private insurance paying for gender -affirming surgeries will continue as we see changes in coverage based on the changing political landscape of the United States.

Fortunately, the number of surgeons who are providing this surgery is expanding across the U.S. With the increase in surgeries being completed, and with more surgeons conducting these studies, we should see an increase in research on top surgery outcomes, including studies on postoperative quality of life.

A review of the literature shows that quantitative studies are being conducted on top surgery outcomes. It would be helpful if qualitative studies were completed in order to capture the subjective feelings of the participant. However, since qualitative studies are vulnerable to research bias, and reduces applicability, mixed methods studies would be a good choice to increase our knowledge in the area of quality of life after top surgery.

This rapid systemic review presented the available literature to date on quality of life after top surgery. The outcomes of these studies show a correlation between an improvement in quality of life and top surgery.

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FOCUS
Collaborating to find solutions for childhood obesity and related health issues

PROFILE
Dr. Courtney Choy builds health infrastructure in Samoa

Q & A
Josh Rosenthal, PhD: Fogarty past and present

NEWS
Smartphone-sized CRISPR test uses blood and saliva to rapidly diagnose TB

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Global Health Matters

FOGARTY INTERNATIONAL CENTER

A participant in the research of Columbia University's Dr. Ayesha Sania.

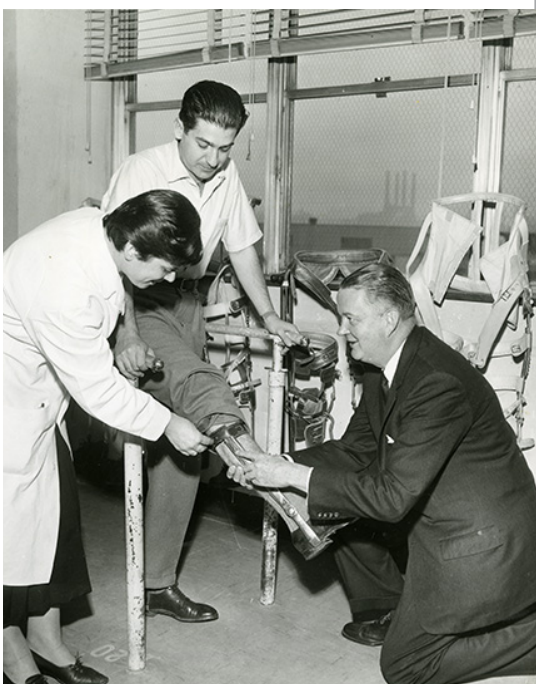
MAY/JUNE 2025 | ISSUE 3

TELLING OUR STORY

How America and the World Benefits

FROM GLOBAL HEALTH RESEARCH COLLABORATION

Fogarty has supported over 8,500 scientists from 132 countries, many of whom now hold senior positions in academia, government, and public health institutions around the world.



IN HIS 1959 NEW YORK TIMES ARTICLE, "The Universal Republic," Dr. Howard A. Rusk praised Congressman John E. Fogarty's "Health for Peace" bill, which would create within NIH a new "National Institute of International Medical Research" with an annual appropriation of $50 million. Writing during the Cold War, Rusk argued that science could serve as neutral ground for collaboration across ideological divides and that Fogarty's legislation exemplified this principle. By supporting medical research abroad, the bill recognized that disease knows no borders and that American health and security are strengthened through global engagement. More than six decades later, that insight remains profoundly relevant.

Several new Fogarty resources illustrate why global health research is not only an act of scientific solidarity but also a strategic investment in the health and well-being of the American public. These online materials offer updated evidence, data, and case studies that demonstrate how Fogarty's work and NIH's global research enterprise more broadly support U.S. health priorities, strengthen the domestic research ecosystem, and enhance our readiness for emerging health threats. As the Acting Director of the Fogarty International Center, I'm pleased to share them with you.

The web page, "Fogarty's Impact in the United States," describes how our international collaborations directly benefit Americans. Benefits include developing low-cost diagnostics for early cancer detection, testing interventions to prevent Alzheimer's disease in highest-risk populations abroad, and bringing a novel treatment for a life-threatening pediatric condition developed in Africa back to the United States. The page reports metrics from fiscal year 2024 showing that 77% of

Fogarty's 488 grants involved U.S. individuals or institutions. These awards supported research and training programs that contributed to nearly 1,400 publications and strengthened global research capacity in ways that amplify the U.S. scientific enterprise.

Another new resource, "Fogarty's Impact: Facts, Numbers, and Stories," offers a more comprehensive look at the Center's contributions over time. Since its founding in 1968, Fogarty has supported over 8,500 scientists from 132 countries, many of whom now hold senior positions in academia, government, and public health institutions around the world. Through sustained investment in people and partnerships, we have helped build the infrastructure for global discovery science and enabled U.S. scientists and institutions to remain at the cutting edge of international research. To further support communication efforts, we also released five new two-page fact sheets, each summarizing a key aspect of Fogarty's impact. These printable documents highlight the Center's role in researching non-communicable diseases, addressing childhood obesity in the Americas, using technology and innovation to improve health care, and, importantly, advancing bioethics research capacity. They offer concise, non-technical language supported by visuals and data.

An additional resource broadens the lens to the full NIH enterprise. "How Global Scientific Advances Can Benefit the American Public" provides examples across the NIH that highlight how global research collaborations improve health outcomes in the U.S. The page describes how studies of diseases like cervical cancer, malaria, and COVID-19, conducted through international partnerships, have produced tools, data, and insights that directly informed U.S. prevention and treatment strategies. These collaborations have also supported drug discovery, improved diagnostics, and developed scalable care models that benefit underserved populations in America.

Together, these web resources and fact sheets underscore a core principle of Fogarty's work: The health of Americans is inseparable from the health of the world. This is not a new concept, but it has become more salient in recent years. From global pandemics to chronic disease trends and weather-related health threats, many of the most pressing challenges we face today demand scientific cooperation that crosses national borders.

As all government programs are being scrutinized to increase their efficiency and impact, it is important to articulate clearly how global engagement serves national interests. I encourage our community to review these new web pages, share them, and reflect on what they reveal: that the United States benefits scientifically, economically, and in terms of public health when it leads in global health research.

Global Health Matters

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profile

Dr. Courtney Choy works with a community health worker in Samoa.

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BUILDING HEALTH INFRASTRUCTURE TO PREVENT CHILDHOOD OBESITY AND RELATED DISEASES IN SAMOA

For families in the Pacific region, cardiometabolic diseases, such as diabetes, diseases of the heart, kidneys and liver, and stroke, are the leading cause of premature and preventable deaths. Dr. Courtney Choy, a two-time Fogarty Fellow and postdoctoral fellow at the Yale School of Public Health, studies chronic diseases including obesity, diabetes, cancer and hypertension in Samoa, a small Pacific Island nation with a rich culture and a high prevalence of chronic diseases. She seeks to understand both risk factors and protective factors to help prevent obesity and related cardiometabolic conditions.

For 10 years, Choy has been engaged with the Ola Tuputupua'e ("Growing Up") study. "The project has evolved into a longitudinal observational cohort that is uniquely situated to understand child growth and development." She follows a cohort made up of Samoan children and their primary caregivers, who entered the study in 2015 at ages 2 to 4 years old, and studies what healthy growth and development look like for children, what factors are associated with good and with poor health, and how the health of families is changing. "How can we best make sure that children are well-positioned to be at the most minimal risk of developing obesity, which is connected very much to other chronic diseases and conditions later in the life course?"

Choy has seen these children enter school and start to become their own people, and, as she learns more about their lives, she's begun to think about ways to better support their health and well-being over time. "As scientists, we tend to focus on the things putting them at risk, yet they are still

Photos courtesy of Courtney Choy

very resilient." She hopes that eventually her team will be able to track health across the life course and across generations, and that her work will lead to better programs and interventions.

Current programs and interventions are not enough and what is needed is not only research, but a translation of the data into action and solutions that bridge services, not only in public health, but across education, judicial systems, commerce, industry, agriculture, communication, and information technology, Choy says. "I love the work that I do because every day we're always thinking not only about public health but also sharing knowledge with each other so that there can be greater capacity to address the high and rising burden of chronic diseases. That's a big part of what Fogarty taught me."

Dr. Courtney Choy assists the community in measuring children for her study.

Choy says that her fellowship with Fogarty led to her work being highlighted in the community, on the radio and in the local newspaper, as well as in publications in several peer-reviewed journals. She's given presentations at international meetings and received an NIH "Pathway to Independence" award. Her work has been used to improve school nutrition and health promotion in Samoa, to better understand the burden of disease, to identify opportunities to intervene, and to encourage healthier lifestyles for children. The fellowship was tailored to her specific career interests and helped her build networks and collaborations to achieve real impact. The fellowship also gave her time for development as an individual and public health professional, with an exceptional mentorship team, strong community partnerships and pathways to move her work forward. "I think those individuals who have that passion, drive, and are willing to listen, learn, and work collaboratively have the best experiences as a Fogarty fellow. It's that open mindset that allows someone to also have an open heart and bring in not only their lived experiences and knowledge but also be able to engage in a way that creates this beautiful synergy of work."

Student trainees weigh and measure children for Dr. Courtney Choy's study.

While Choy conducts research in the Blue Pacific Continent, a heavy burden of chronic disease also exists in the U.S. and worldwide. "We've all seen how a child affected by obesity and these related chronic diseases may have a harder time paying attention in school, their energy level changes to the point where it impacts their activity, engagement, and even their social skills." Choy believes that we have a responsibility to do better and serve our communities by working together to sustain programs that address the needs of different communities in the U.S. and worldwide.

"That's part of what makes America great. We've always risen to the challenge of doing better than what's been done before."

"HOW CAN WE BEST MAKE SURE THAT CHILDREN ARE WELL-POSITIONED TO BE AT THE MOST MINIMAL RISK OF DEVELOPING OBESITY?"

Courtney Choy, NCD Epidemiologist working with Asian & Pacific communities.

COLLABORATING TO FIND SOLUTIONS FOR

CHILDHOOD OBESITY

AND RELATED HEALTH ISSUES

OUR WORLD IS EXPERIENCING A CRISIS: CHILDHOOD OBESITY IS INCREASING AT ALARMING RATES ACROSS THE GLOBE

FOCUS

RISING RATES OF CHILDHOOD OBESITY MATTER BECAUSE IT AFFECTS BOTH CURRENT AND LIFELONG HEALTH OUTCOMES. Children with obesity are more likely than their normal weight peers to develop type 2 diabetes, heart disease, depression and other non-communicable diseases. And, as overweight children mature into adults, their risk of chronic illness (and premature death) also exceeds that of peers.

Fogarty funds research projects in the U.S. and abroad that aim to produce evidence-based interventions and develop innovative strategies to stem this tide of rising rates. Opportunities to learn through collaboration have already produced positive results. The U.S. Fogarty's Global Health Reciprocal Innovation project implemented Colombia's Open Streets program (Ciclovía), which promotes physical activity, in New Orleans, Atlanta, Los Angeles and the District of Columbia. And Fogarty's Cross-Border Collaborative Awards on Childhood Obesity have provided training and mentorship to over 20 junior researchers, mostly in the U.S.

Read about two Fogarty-supported researchers—Dr. Ayesha Sania of Columbia University and Dr. Abby King of Stanford University—whose collaborative work aims to elucidate and prevent childhood obesity and related health issues.

SLEEP HEALTH STUDY IN BANGLADESH PROVIDES A NUANCED UNDERSTANDING OF CHILDHOOD OBESITY

BANGLADESH, A DENSELY POPULATED, LOWER-MIDDLE-INCOME COUNTRY IN SOUTH ASIA, IS HOME TO APPROXIMATELY 170 MILLION PEOPLE. "When we think about the children of Bangladesh, we usually think of stunting," says Dr. Ayesha Sania, an assistant professor at Columbia University Irving Medical Center. (Stunting is impaired childhood growth and development due to poor nutrition.) "Yet Bangladesh has a dual burden of malnutrition—this means a high rate of stunting (though this is decreasing)—while obesity among children is increasing at a concerning pace."

Sania is examining sleep health as it relates to cognitive development and obesity in Bangladeshi children for her Fogarty International Research Scientist Development Award project. She notes that, between 2003 and 2015, childhood obesity in Bangladesh more than doubled from 3.6% to 7.9%, while recent reports indicate that approximately 14% of children between ages 4 and 7 are obese. Similar striking shifts over relatively short periods can be seen in many low- and middle- income countries (LMICs).

"These changes reflect the broader lifestyle transitions happening in many LMICs," says Sania.

Urgency required

As swift urbanization occurs in many LMICs, socioeconomic differences widen. "Urban families often live in small, densely packed apartments with limited or no space for children to play or be physically active," says Sania. Meanwhile, processed foods, fast food, and high-calorie snacks increasingly replace home-cooked meals. Kids are spending more time on screens, which not only reduces opportunities for physical activity but also interferes with sleep. "Meta-analyses have shown that short sleep duration is associated with increased obesity risk in children."

One of the child participants in Dr Sania's sleep health study in Bangladesh.

Courtesy of Ayesha Sania

Sania explains that shorter sleep duration disturbs the metabolic hormones—such as leptin, insulin and cortisol—as well as the growth hormones, and these then disrupt metabolic regulation resulting in higher obesity rates. "We also hypothesize a bidirectional relatioship between executive function and obesity," says Sania. (Executive function, which includes self-control, cognitive flexibility, and working

Courtesy of Ayesha Sania

Child study participant sleeps wearing an actigraphy watch to detect and record patterns in his sleep-wake cycle.

memory, begins to emerge around age 3 and then rapidly develops through age 6.) On the one hand, a child cannot stop eating due to poor executive function (poor impulse control), while, on the other hand, elevated hormones induced by obesity are modifying brain activity resulting in poor executive function.

"This complex interplay between sleep, executive function, and obesity could help us understand childhood obesity in a more nuanced way," says Sania.

Childhood sleep deficits

Preliminary data for Sania's Fogarty project show that roughly 40% of preschool children in Bangladesh slept less than what WHO recommends for the age group. Across all LMICs, emerging data highlight similar trends favoring later bedtimes and shorter nighttime sleep for children. "It's a big problem, yet also a big opportunity where we can make a change," says Sania. Research in high-income settings suggests that several features influence and predict sleep, including individual factors (such as screen time and physical activity), interpersonal factors (including maternal depression and parental stress), and family and social factors (socioeconomic status and household crowding). "However, we still don't fully understand how these factors play out in LMICs where the context is quite different."

Her study of children in Bangladesh relies on wearable devices (actigraphy watches) to collect sleep data that "will deepen our understanding of the relationship between sleep health (and other lifestyle factors including physical activity and diet), executive function, and obesity risk," says Sania. Her team also plans to adapt and evaluate a sleep promotion intervention tailored to the local context. Overall, she hopes to gain valuable knowledge about preschool children in Bangladesh, while creating a pipeline of knowledge on which the scientific community can build.

As of May, Sania's team had enrolled 256 of its 300 target participants and processed 140 actigraphy readouts. In 2024 the team faced delays due to political instability, yet things are running smoothly now primarily thanks to her Bangladesh mentor, Dr. Shams El Arifeen, and his team.

Benefits for Americans

When we sleep, where we sleep, and how we sleep may be cultural, but the biological aspects of sleep health, including the relationship between sleep, executive function, and obesity risk, are universal, says Sania. Insights gained from her study will be "broadly applicable, especially for children in similar sociocultural contexts, such as those in South Asia and even in the U.S." Children living in poor neighborhoods and small apartments, whether in New York or Dhaka, lead similar lives, she adds. "Many solutions developed in one context have been successfully adapted to others. For instance, one of my mentors has brought an intervention developed in LMICs to the U.S."

"I CARRY LESSONS FROM EVERY CONTEXT INTO MY CURRENT WORK, AND THAT MOSAIC OF EXPERIENCES INFORMS AND INSPIRES ME, ENABLING ME TO SUPPORT POPULATIONS FACING SIMILAR CHALLENGES ANYWHERE ON THE GLOBE."

"Science often transcends borders," says Sania, whose research spans the U.S., South Africa, Tanzania, and Bangladesh. "If the intervention proves feasible, then we hope to study its impact in a larger randomized trial."

A family begins the enrollment process for Dr. Sania's sleep health study.

Courtesy of Ayesha Sania

OUR VOICE HELPS CITIZEN SCIENTISTS—AGES 7 TO 100—ADDRESS CHILDHOOD HEALTH

Childhood obesity is familiar research territory for Abby King, PhD, a professor of epidemiology and population health at Stanford Medicine. How researchers interrogate common health issues is crucial. "A lot of my research (I'm a clinical psychologist by training) started out on the very individual and group level of intervention, but then I got really frustrated because treating people is not what I wanted to do—I wanted to prevent what was going on to begin with!"

She developed a socioecological framework as her guiding principle when designing interventions. This approach, which considers both social and ecological factors while examining the processes that influence them, also informed her work as scientific co-chair of the Fogarty-led special issue in Obesity Reviews, Childhood Obesity Prevention Across Borders: The Promise of US-Latin American Research Collaboration. In that publication, she fused research done in Latin America with research done in the U.S.

These days King is most passionate about Our Voice (Nuestra Voz), an initiative that "turns everybody into citizen scientists who then collect meaningful health-related data for their own communities." To guide novices through the Our Voice process, King's lab developed the Discovery Tool, a multilingual app that is currently "in 14 languages and counting."

Discovering empowerment

Anyone can learn the app in just minutes and use it to identify and understand the barriers to healthy behavior in their neighborhood, school, workplace or wherever they wish to study, says King. Take, for example, a group of neighbors who want to examine barriers to accessing healthier foods, including how easy or difficult it is to walk in their community. Using the Discovery Tool, these citizen scientists would first collect data and then interpret this information together. Next, they'd prioritize issues, and, in a facilitated process, present their research and possible solutions to "community decision-makers and policymakers—the people who really hold the reins of change."

"We've had citizen scientists as young as 7 years old all the way up to 100," says King. "Some of our best work in Mexico and Colombia focuses on intergenerational citizen scientists—abuelos and abuelas walking around with their grandchildren, each seeing things differently yet sharing their differences."

Student works with the Discovery tool.

Our Voice performs equally well in the U.S.—elementary school students in Daly City, California, who wanted

> "We've had citizen scientists as young as 7 years old all the way up to 100."

An Our Voice citizen scientist decides which issues to prioritize for a presentation.

Photos courtesy of the Our Voice Pozon team

Photo courtesy of Abby King

Students in Daly City, California, present their work that was part of the Our Voice initiative to the city council.

to know, *How can we make it easier to walk or bike to school?*, turned to the Discovery Tool to collect data on dangerous and difficult conditions preventing these healthy activities. Next, the children, who were backed by their county's Department of Education and other community partners, discussed and prioritized issues. Finally, they presented their work to the city council, made suggestions and asked for help. "Now, if it had been a scientist, people would have applauded politely," says King. Instead, the council responded enthusiastically.

"You need to grab people's hearts and kids can do that."

Scientific connection

"What I bring to Our Voice is the inclusion of artificial intelligence (AI) into the process," says Eduardo de la Vega, a Fogarty-funded post-doc in Abby's lab. Once participants reach the sharing and discussion phase of the process, they can use the Stanford version of chatGPT to help form solutions, he explains. For example, a group of teens in El Pozón, an impoverished area in Cartagena, Colombia, wanted to fix road- and building-related holes that had become pools of stagnant water attracting dengue-carrying mosquitoes. Iterating their proposed solution of filling the holes with cement or sand, the AI steered them toward the use of a cement lid as a temporary solution that would not interfere with future construction plans. The AI capabilities of Photoshop also generated new images from one of the teen's existing photos to reveal how the repaired holes might look in the future. "By interacting with AI, citizen scientists improve their solutions and make them more feasible."

Community engagement efforts also benefitted from de la Vega's attention. "In many places you cannot just invite major players or those holding formal offices to stakeholder meetings." To extend the political reach of citizen scientists, he incorporated social network analysis into the process to help identify those capable of mobilizing change. "Other relevant systems or people, such as NGOs working in the area or community leaders, may be doing similar work. If you don't do a rigorous search, you may miss the very people who are most likely to make solutions happen."

Global Influences

Sadly, childhood obesity is a crisis that trespasses all borders. Humans weren't built for so much abundance, but for hunting food, seeking food, burning calories, says King.

As an engineer-psychologist, de la Vega also emphasizes the impact of the environment on human development. "If you improve the environment, you don't have to try to change or heal the individual so much—improving the environment is a population-level intervention." Given that childhood obesity is a shared, global problem, international collaboration is appropriate as it leads to shared knowledge, he says, adding that, when focusing on a universal issue, U.S. research dollars go farthest in more affordable countries. "What you do with $1 in the U.S., you can do 10 times in Colombia." How Latino populations like to solve problems is similar whether they live in the U.S. or in Latin America, he notes. "A lot of knowledge from Colombia about culturally sensitive approaches to improving health for Latino population can translate to the U.S."

American voices

King's lab has now completed Our Voice projects in more than 25 countries plus "18 U.S. states and counting." Community-engagement doesn't just empower residents, it empowers scientists, she says. "With participatory research you see the community impacts immediately." Effects are also lasting. A U.S. study found that end-of-year walking/biking to school was significantly higher when schools added Our Voice to a standard Safe-Routes-to-School curriculum (compared to when schools did not).

Recently, King and her colleagues spoke to West Virginia transit officials about helping them make statewide changes intended to increase children's activity levels and so improve overall health. "Our voice is remote and accessible," says King. "To work with children is just unbelievable—they're so excited to have a voice."

"IF YOU DON'T DO A RIGOROUS SEARCH, YOU MAY MISS THE VERY PEOPLE WHO ARE MOST LIKELY TO MAKE SOLUTIONS HAPPEN."

Josh Rosenthal, PhD

Q&A

Fogarty past & present

Joshua Rosenthal, a senior scientist in Fogarty's Division of Epidemiology and Population Studies, retired on March 31. After completing a PhD in Botany at the University of California, Berkeley, he conducted his post-doctoral research in Entomology and then joined Fogarty as an AAAS Science and Diplomacy Fellow in 1994. Over the course of his career at Fogarty, he served as a program officer, deputy director and interim director of the Division of International Training and Research, and interim deputy director of the Center.

What are you most proud of about your time at Fogarty?

After an exciting 30 years that's difficult to say. Because Fogarty is such a creative place full of dedicated people willing to take risks, I've had the opportunity to do lots of things—biodiversity-based drug discovery, ecology of infectious diseases, international training and research in environmental health, household air pollution, implementation science, and climate health. In terms of scientific impact, perhaps our creation of the Ecology and Evolution of Infectious Diseases program with the National Science Foundation and several NIH institutes has been among the most transformative, and I am thrilled that this 25 year old partnership with multiple agencies has continued to this day.

How did you get involved with the GeoHealth hubs?

The Environmental Training Research and Environmental Occupational Health Research program was a very traditional toxicology and epidemiology-focused program doing valuable work training scientists in LMICs. But the projects were small and at the end of a grant, these individually trained scientists were left disconnected in disparate places around the world. It wasn't clear that we'd produced any institutional impact. Christine Jessup and I wanted to develop a program that was better networked, more institutionally based and more transdisciplinary. We came up with this notion of hubs that would link to multiple institutions in the U.S. and abroad. To build-out each hub, we gave a research grant and a training grant in parallel within a networked environment. It's still too early to know, but some of those projects have already generated follow-on investments from Canadian and European organizations and other parts of the NIH, so I hope the science and the capacity that's been created will have longstanding impact.

What is the connection between American health and global health?

Most people in the U.S. don't pay attention to health conditions outside the country. Occasionally, epidemics like those of HIV/AIDS, Ebola or COVID raise awareness, but we tend to think of those problems as "overseas," until they threaten us. But today we are so connected that every health challenge and discovery in the developing world has either direct or indirect applications to health in the U.S., whether they're related to infectious or chronic diseases, or environmental in origin.

The U.S. is still the strongest country in the world scientifically, yet it's necessary to work with those who have expertise and deep knowledge about topics and environments that are less familiar here. These partnerships expand our own capacity to deal with problems that are here today and/or will be in the future. And when our partners are better scientists we are better as well.

For example, most people have forgotten that malaria was once endemic in the U.S., and now, once again, we have transmission of both malaria and dengue in the U.S. Because we have spent years investing in the study of malaria and dengue overseas, we've learned a lot about the biology of those diseases and how to manage them. The chance that they'll be able to embed themselves and become major health problems here are much lower because we understand how to reduce exposures, how to control the vectors, how to treat the diseases or vaccinate against them—all due to the extensive, painstaking work we've done overseas.

Smartphone-sized CRISPR-based device uses blood and saliva to rapidly diagnose TB

An estimated 10 million people, including more than a million children, develop tuberculosis each year. Roughly half of all infected children go undiagnosed or unreported. Several reasons contribute to the high number of untested and untreated patients.

To test for tuberculosis (TB), the World Health Organization recommends either an interferon-gamma release assay (IGRA, a type of blood test) or a tuberculin skin test (TST), which requires a shallow injection beneath the skin. IGRA requires specialized facilities and trained staff, consequently the skin test is more commonly used in low resource settings. Yet, there's a major drawback to the skin test; results are read two to three days later, so a patient must return to a healthcare provider or clinic, which in low resource settings may be far from home and difficult to access.

One other reason for the high numbers of undiagnosed children is "the IGRA and TST can only confirm that a patient has been infected with *Mtb*, they cannot distinguish latent TB infection from active TB," says Dr. Tony Hu, a distinguished professor of biochemistry and molecular biology, biomedical engineering, and microbiology at Tulane University. *(Mtb* or *mycobacterium tuberculosis* is a species of bacteria that causes tuberculosis; a latent TB infection means a person lacks symptoms but has a small number of living, inactive germs in their body, while active TB means a person has both symptoms and many active germs in their body.) High numbers of undiagnosed cases, then, are also a result of the current, limited active TB testing capabilities, which require "expensive, bulky equipment not suitable for point-of-care testing," explains Hu.

To remedy this, Hu and his team developed a new assay that specifically and quickly tests for active disease, diagnosing patients with either symptomatic or asymptomatic TB. Its reagents, based on the CRISPR DNA-editing technology, can identify *Mtb* DNA in either sputum (mucus produced in the lungs and airways that may be coughed up), blood or saliva samples. Use of blood and saliva is key: Children (and many people living with HIV) often cannot produce sputum, so saliva or blood is much easier to obtain. The smartphone-sized, battery-powered device is also economical, costing less than $800, with each assay totaling less than $3. Most importantly, it delivers accurate TB diagnoses in under an hour.

For all these reasons, Hu and his team are hopeful that their TB testing device will contribute to improved rates of diagnosis across the globe. Their research, published in *Science Translational Medicine*, was supported by the National Institute of Allergy and Infectious Diseases, the National Institute of Neurological Disorders and Stroke, the Eunice Kennedy Shriver National Institute of Child Health and Human Development, and other funders.

Accuracy & availability

A test's accuracy is determined by its sensitivity and specificity.

Dr. Tony Hu in his lab at Tulane University

Photo courtesy of Tulane University

Sensitivity refers to a diagnostic test's ability to correctly identify patients with a disease, while specificity refers to a test's ability to identify people without the disease. Using saliva samples from 15 TB positive and 15 TB negative patients, the test (known as LIT-TB) achieved 73% sensitivity and 100% specificity. Overall, sputum testing had perfect sensitivity (100%) and 90% specificity. "LIT-TB clinical testing had slightly lower sensitivity using saliva and blood compared to sputum, but both non-sputum sample types displayed higher specificity than sputum," explained Hu. "The device performed similarly in saliva, blood, and sputum when combining sensitivity and specificity metrics." The team is working to improve sensitivity related to saliva and blood samples, given how important these options are when testing children and patients living with HIV.

Though the new test is not yet commercially available, "Tulane is negotiating with some industry partners to manufacture and bring the LIT-TB test to market, including IntelliGenome," says Hu. "Our point-of-care device is the next step in addressing TB diagnostic needs," says Hu. Going forward, his team is pursuing additional CRISPR-based assays and clinical tools.

Shattering consequences of tuberculous meningitis described in new study

Dr. Karen du Preez

Photo courtesy of Karen du Preez

An estimated 10 million people, including more than a million children, develop tuberculosis each year. Young children, who have immature immune systems, are more likely to develop disseminated disease. Disseminated TB results when the immune system cannot control the spread of TB-causing bacteria and then cannot prevent the bacteria from growing in places like the central nervous system (in the case of TB meningitis).

Deadly when untreated, TB meningitis often causes death or disability even when treated. A Fogarty-funded study published in *The Lancet Global Health* provides first-ever estimates of TB meningitis incidence, morbidity, and mortality in children.

Understudied scourge

"Working as a clinician in a high TB burden setting and seeing the devastating effects of TB meningitis on children and their families motivated me to do our study," says Dr. Karen du Preez of South Africa's Desmond Tutu Tuberculosis Centre, Stellenbosch University. She and her team created a mathematical model and analyzed the literature to assess the number of children up to age 14 affected by TB meningitis in 2019. They estimate 24,000 children developed the disease, most of them younger than 5 years old, while approximately half were diagnosed and treated. Among these children, TB meningitis resulted in 16,100 deaths in 2019 and had a case-fatality rate of 67%, higher than the estimated 19% overall tuberculosis mortality in children that year.

Identification, diagnosis and treatment of the disease can be thorny, says Dr. Alexander Kay, who oversees clinical care at Baylor College of Medicine's TB Centre of Excellence in Mbabane, Eswatini. "The initial symptoms of TB meningitis, which include fever, headache, and nausea or vomiting, overlap with common childhood illnesses." Knowledge of a child's exposure to TB would be helpful, but busy clinics are not always capable of recording patient histories. If a clinician suspects TB meningitis, a diagnosis typically requires cerebrospinal fluid tests and brain imaging, which are unavailable in many settings. For these reasons, children frequently become lost to care before receiving a diagnosis. Among those diagnosed, the duration of therapy is long plus children with TB meningitis often require neurosurgical care to prevent a build-up of fluid in the brain. Unable to swallow medication by mouth, children sometimes require the placement of nasogastric tubes. "In children who survive, the degree of disability can be profound."

"TB meningitis can impact anyone, but mostly it impacts those without a voice," says Kay, who did not contribute to the du Preez study. This includes "infants who have yet to speak" and those "without access to the care needed to prevent or treat TB meningitis," particularly people with suppressed immune systems (due to medication or diseases like HIV).

Eliminate TB

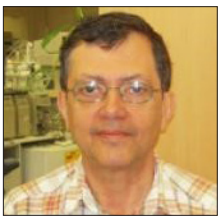
Kay believes awareness of this study is crucial for clinicians. If they understood how many children are affected and that this is a "fatal condition without treatment, it may spur them to initiate more diagnostic evaluations or start treatment early while working towards a definitive diagnosis." Early detection can be achieved by robust case tracing programs to evaluate everyone with a recent TB exposure. "And ensuring that the Bacillus Calmette–Guérin (BCG) vaccine is given to all eligible newborns in countries where this vaccine is recommended can help reduce their risk of TB meningitis."

Though most children impacted by TB meningitis are born in Africa or South-East Asia, Kay says the study findings also benefit American children. "Every year there are U.S. families whose children die or have lifelong disability resulting from this condition. Unless we eliminate TB, children will continue to suffer from TB meningitis. And until TB is eliminated, investing in research to improve diagnosis and treatment is absolutely needed to avoid devastating outcomes."

"TB MENINGITIS CAN IMPACT ANYONE, BUT MOSTLY IT IMPACTS THOSE WITHOUT A VOICE."

people

Community



NAS welcomes NIAID's Jose Ribeiro and David Lawrence Sacks
The National Academy of Sciences (NAS) has selected two National Institutes of Health scientists for membership in recognition of their achievements in original research. José M.C. Ribeiro, MD, PhD, is chief, vector biology section, National Institutes of Allergy and Infectious Diseases (NIAID), whose research explores the biochemical and pharmacological diversity found in the salivary glands of blood feeding insects and ticks.

David Lawrence Sacks, PhD, is senior staff fellow, laboratory of parasitic diseases, NIAID, whose research focuses on the immunology and cell biology of leishmanial infections and the biology of *Leishmania* parasites within hosts and sand-fly vectors. This research may have indirect relevance to both tuberculosis and malaria. Previously, he studied immune suppression in African trypanosomiasis (sleeping sickness).

Reed Tuckson receives 2025 Elizabeth Fries Health Education Award
Reed V. Tuckson, MD, FACP, received the 2025 Elizabeth Fries Health Education Award, which is managed by the CDC Foundation and recognizes a leader who makes significant contributions to health education and promotion through program development, policy, advocacy or research. He is Managing Director of Tuckson Health Connections, LLC, an organization dedicated to promoting health and preventing disease through data analytics, care delivery, telehealth and biotech.

Global health experts rank among TIME 100 most influential people
Time Magazine's 100 Most Influential People of 2025 list includes several global health experts. Among those honored are Dr. Christian Happi, a Fogarty grantee who helped build the African Centre of Excellence for Genomics of Infectious Diseases to educate future generations of African scientists. His use of genomics technologies for early diagnosis and confirmation of Ebola virus disease helped contain the spread of disease in Nigeria during the Ebola epidemic of 2013-2016.

Wesley Sundquist, PhD, and Tomas Cihlar, PhD, a biochemist at University of Utah and a virologist at biopharmaceutical Gilead, respectively, were also named by *Time.* They transformed an antiviral treatment, lenacapavir, into a twice-a-year therapy to prevent HIV infection. Sundquist laid the groundwork by studying an HIV protein, the capsid, which creates a protective shell around the virus' genome. After visiting his lab, Cihlar worked on these discoveries to extend the effect of the drug over six months.

Another expert on *Time's* list is Ismahane Elouafi, PhD, former chief scientist at the U.N. Food and Agriculture Organization and now Executive Managing Director of CGIAR, a global agricultural research partnership. Her work in sub-Saharan Africa and South Asia helps millions of farmers grow stronger crops and restore damaged soil, which helps make the global food supply more reliable and protects natural resources, thus improving human health.

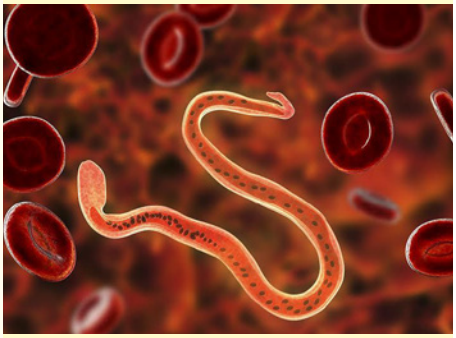
Global HEALTH Briefs

NYU scientists link heart disease deaths to chemicals in plastics

Daily exposure to phthalates, chemicals used to make plastic items, could be linked to more than 356,000 global deaths from heart disease in 2018 alone, a new analysis from NYU Langone Health / NYU Grossman School of Medicine shows. Phthalates are found in cosmetics, detergents, solvents, bug repellants and other products; when broken down into microscopic particles and ingested, they increase the risk of various conditions, including obesity, diabetes and cancer. These chemicals are in widespread use globally, yet the Middle East, South Asia, East Asia, and the Pacific bear about three-fourths of total deaths. In their analysis, the authors estimated that exposure to one type of phthalate, Di(2-ethylhexyl) phthlate or DEHP, contributed to 356,238 deaths, which is more than 13% of all global deaths from heart disease in 2018 among men and women ages 55 through 64. The National Institute of Environmental Health Sciences and the National Institute of Diabetes and Digestive and Kidney Diseases funded this work.

Intervention reduces harmful emissions from brick kilns in Bangladesh

Researchers at Boston University School of Public Health, Stanford University and other institutes developed a strategy for reducing emissions caused by brick manufacturing, an industry that is central to economies in South Asia. Brick manufacturing releases carbon dioxide (CO_2), fine particulate matter (PM2.5), and other contaminants into the environment, thus posing a threat to human health in many low- and middle-income countries. The intervention, which consists of educational resources, training, and technical support, promotes changes that prioritize practicality and profit. Introduced during the 2022-2023 season, the intervention was adopted by 65% of kiln owners and was associated with a 23% reduction in energy use and a 20% reduction in CO_2 and PM2.5 emissions alongside substantial savings in coal costs and higher-quality bricks. Returning the following season, the researchers found adoption had not only sustained but increased. Their findings are published in *Science*.



New anti-parasitic effectively treats lymphatic filariasis

A clinical trial in Cote d'Ivoire, led by researchers at Washington University School of Medicine in St. Louis, showed that moxidectin—a new, anti-parasitic drug approved to treat river blindness—is more effective against lymphatic filariasis (elephantiasis) than the drugs currently in use. Annually, millions of individuals worldwide are infected by the parasitic worms that cause lymphatic filariasis, a disease that leads to severe swelling and deformities of the limbs and genitals. The researchers, who collaborated with the Centre Suisse de Recherches Scientifique, believe fewer rounds of moxidectin will be needed to treat infections (compared to currently used drugs), so its use could accelerate elimination of lymphatic filariasis. Findings of the study, funded by The Bill & Melinda Gates Foundation, are published in *The Lancet Infectious Diseases.*

Global Virus Network seeks to tackle emerging virus threats

The 2025 Global Virus Network (GVN) Regional Meeting: Caribbean and Latin America convened scientists, public health experts and government officials in Kingston, Jamaica for a two-day summit focused on collaboration to bolster viral surveillance, diagnostics, vaccine research and pandemic preparedness across Latin America and the Caribbean. Former Fogarty Advisory Board Member Dr. Sten Vermund, who is also GVN chief medical officer, discussed vaccinology in his presentation. Meanwhile, longtime NIH Grantee Dr. Gene Morse, a SUNY Distinguished Professor at the University of Buffalo, praised Fogarty's Global Infectious Disease Research Training program and called for more support from industry and foundations for capacity-building programs in low- and middle- income countries.

SCAN
TO READ MORE

FUNDINGNEWS

On behalf of the Fogarty International Center at the U.S. National Institutes of Health (NIH), the following funding opportunities, notices and announcements may be of interest to those working in the field of global health research.

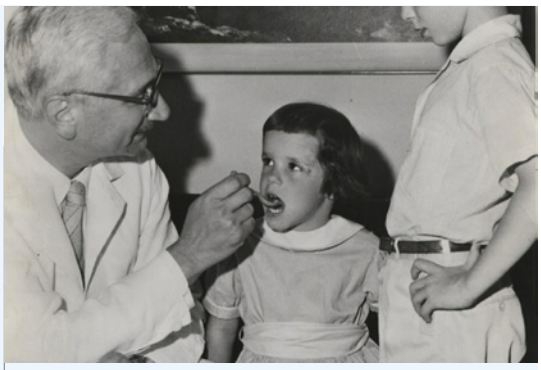
Funding Announcement	Deadline	Details
Global Infectious Disease Research Training Program D43 Clinical Trial Optional	August 6, 2025	https://go.nih.gov/Gqp2oel
HIV-associated Non-Communicable Diseases Research at Low- and Middle- Income Country Institutions R21 Clinical Trial Optional	December 8, 2025	https://go.nih.gov/3jZlVL8
Interventions for Stigma Reduction to Improve HIV/AIDS Prevention, Treatment and Care in Low- and Middle- Income Countries R01 Clinical Trial Optional	December 22, 2025	https://go.nih.gov/9yc65e2

A key period in Fogarty's history burnished the reputation of the NIH... and the U.S.

When World War II ended, the nations of Europe were devastated, their populations starving. In 1948, the U.S. implemented the European Recovery Program—popularly known as the "Marshall Plan"—to provide financial and material assistance in Western Europe. A decade later, NIH launched its own version of the Marshall Plan, the International Research Fellowship (IRF) program, to strengthen European capacity to conduct biomedical research. In 1968, management of this program was transferred to the newly established Fogarty International Center.

IRF aimed to develop a cadre of foreign investigators who trained at American universities and NIH before returning to Europe's academic centers. The program's American mentors included renowned scientists and future Nobel laureates Drs. Christian Anfinson, Julius Axelrod, David Baltimore, Baruj Benacerraf, Arthur Kornberg, and Severo Ochoa. Following the program, most IRF fellows pursued careers in research, teaching or administration in Europe, often maintaining close ties with their U.S. colleagues. Over three decades, IRF trained more than 2,500 scientists from 55 countries.

In 1969, Fogarty founded the Scholars in Residence, or SIR, program to foster international collaboration. Dr. Ken Bridbord, senior scientist emeritus at Fogarty, noted that the SIR program was "driven by NIH's desire to bring the best and brightest to NIH to collaborate with its intramural scientists." At any given time, half a dozen internationally recognized scientists lived in Stone House on the NIH campus, where they held seminars, wrote books, and collaborated with NIH colleagues. Fogarty's SIR program hosted more than 200 scientists, including Dr. Margaret Mead and Nobel prize winners Drs. Daniel Bovet, Rita Levi-Montalcini, Sir Hans Krebs and Ragnar Granit.



Dr. Albert Sabin, who developed an oral polio vaccine, worked at Fogarty in the 1980s.

NIH Fogarty

Advancing Science for Global Health

Fogarty International Center
National Institutes of Health
31 Center Drive
Bethesda, MD 20892

The Role of Dissociation in Surviving Severe, Systemic Bullying: A Reflective Narrative for EMDR Therapists (and Trauma-Responsive Clinicians Serving LGBTQ+ Folx)

Reverend Karla Fleshman, L.C.S.W., M.Div.

ABSTRACT

The LGBTQ+ Community is experiencing a very organized, legislative effort to stop, block, and halt medical and mental health services at both the state and federal levels of government, and yet LGBTQ+ people experience higher rates of PTSD, warranting an imperative need for access to these services. This article will focus on how repetitive, systemic bullying often leads to complex trauma and dissociative experiences for survival, and how an integrative, culturally responsible therapeutic approach is necessary for EMDR trained therapists (and trauma-responsive clinicians).

COMPLEX PTSD AS LIVED EXPERIENCE: GROWING UP GAY IN GETTYSBURG, PA

It is easier for me now to close my eyes; and remember.

It is easier for me to remember, in part, because I am no longer alone. *I feel safe enough to process the trauma*, but make no mistake, it is not an easy time to remember. It is not an easy time to remember because the current political/social climate is like an extreme case of severe bullying that is both traumatizing and RE-traumatizing for many people within the LGBTQ+ community. The ACLU is tracking almost 600 anti-LGBTQ+ legislative bills as of June 2025, and the website TransLegislation.com has recorded over 940 bills introduced just this year

There was a time I lived without the memories of extreme bullying, having successfully blocked them from my prefrontal cortex so that I could focus enough just to graduate and get the hell out of Gettysburg to start a new life. I grew up in a town and at a time when being seen as a member of the LGBTQ+ community made one a target.

The trauma experienced by systemic oppression leads to masking one's sexual orientation and/or gender identity for years,[1] which often leads to the risk of increased social isolation (particularly among family, peer, or community support for fear of rejection) and dissociative experiences as adaptive tools for survival. This level of isolation magnifies and exacerbates negative narratives of self in addition to social isolation. It is arguably the strongest and most reliable predictor of suicidal ideation, suicide attempts, and lethal suicidal behavior among samples varying in age, nationality, and clinical severity.[2] In *Our Epidemic of Loneliness and Isolation: The U.S. Surgeon General's Advisory on the Healing Effects of Social Connection and Community*, Surgeon General Dr. Murthy refers to scientific research saying, "About one in two adults in America reported experiencing loneliness" with LGBTQ+ individuals identified as having higher risk."[3]

I recall the spring of 1986. I can see the black rotary phone. I see my hand picking up the receiver to answer the call. I hear a male voice on the other end call me a dyke before also declaring that I would end up like Craig if I wasn't careful. Craig's body was found a few days earlier after being declared missing for several months. He was murdered. The severe bullying I was experiencing during my senior year of high school began when I was in 5th grade and had only escalated over the years.

Funny, not funny, is that my situation isn't a "one-off" or "an anomaly;" and without knowing for certain through news articles or Tik-Toks, I know for certain that many of our nation's LGBTQ+ plus kiddos, young adults and those of us who escaped our childhood bullies years earlier are experiencing trauma/re-traumatization, as well as engaging in all kinds of means to distract and dissociate–in both adaptive and maladaptive ways–from our current cultural climate.

WHO WAS NEX? WHO IS NEX.T?

When I first heard about Nex Benedict's death in February 2024, I just knew it would be labeled death by suicide, and yet the actual cause was external to Nex.

The death of Nex Benedict represents countless numbers of kiddos who lose hope in a country, a community, a school, and yes, even and especially in their homes. These are spaces where they are subjected to narratives of **conditional** love, being unwanted just because of who they are, and being told they will go to hell if they do not change their ways. Nex ***was*** loved by their family, yet it wasn't enough to save them from the adverse impact of severe, relentless bullying because of who they were.

Calls are surfacing to reintroduce conversion therapy under new aliases, such as gender exploratory therapy. Lawmakers and branches of our federal government are using the fear of legal action and/or pulling federal dollars from state services offered by medical/mental health providers who follow evidence-based,

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culturally responsible, and legal gender-affirming care. This will lead to more trauma, more dissociative measures to survive the onslaught, and more lives lost because of ignorance and fear.

One of the worst traumas to experience and the most challenging to heal with is attachment-based trauma. This type of trauma includes what should ***never*** have happened to a person, as well as what ***never*** got to happen. Thomas Zimmerman, author of EMDR With Complex Trauma, succinctly outlines the developmental costs of attachment wounding, which leads to complex PTSD[4]:

1. A child not getting their needs met was wounding, and
2. The child is often blamed by the caregiver for having those needs, which leads to more wounding
3. The child has to develop coping strategies to survive those unmet needs, which is also wounding
4. A child, because of points 1-3, is probably missing a lot of the implicit learning (adaptive information/ resourcing) that getting their needs met would have provided.

Humans are incredibly resilient, and our brains are amazingly adaptive to all kinds of environments. We are wired for survival, and so when the environment (caregivers/culture/community) doesn't provide all that would be wonderful to develop the mind, body, energy/spirit, and emotion to the fullest potential, we will modify and adapt to survive.

THE FOUR SELVES

What follows is one possible way to explore creative adaptability, by engaging how the brain has different "selves" that process and interpret the environment from the framework of being LGBTQ. (Though, make no mistake, every human has the four selves!)

Conceptual Self

LGBTQ+ newborns are more often than not born into heterosexual/cisgender homes in which they are groomed for certain gender roles, beginning with gender reveal parties that announce what family/society expects of them while developing in utero. The creation of the conceptual self may begin before birth as a developing fetus hears parents talk to them, and perhaps tells them what they will be when they grow up!

I once had a client who identified as transgender say to me, "I think the first time I dissociated was sex assigned at birth." I believe them.

The conceptual self refers to our cognitive understanding of who we are - the mental models, beliefs, and narratives we construct about our identity. The *conceptual self is initially largely language-based and socially constructed*, involving both how we see ourselves and how we believe others see us. It is the stories people tell us about ourselves, and the stories we are told we need to align with. For example, many little children are told that *boys play with trucks and girls play with dolls* in our binary construction of gender.

Somatic Self

While the LGBTQ+ kiddo is growing up in a culture/community that centers the cisgender/heterosexual experience, their *somatic self never stops talking* with them. The somatic self is our embodied, physical sense of being. It encompasses our awareness of bodily sensations, physical boundaries, and the felt sense of inhabiting our body.

This includes: proprioception (awareness of body position), interoception (awareness of internal bodily signals like heartbeat or hunger), and the general sense of physical presence in space. The somatic self is largely pre-cognitive and immediate - it's how we know where our body ends and the world begins, and how we feel grounded in physical reality…*or not.*

Diane Ehrensaft in her book *Gender Creative Child*, encourages the reader to move from the socially constructed gender binary narrative to a more gender-expansive understanding, which she calls the gender spectrum. She speaks about the "Gender web [which] proposes that gender is a three-dimensional construction and that all children weave their gender web based on three major threads: nature, nurture, and culture–to arrive at the gender that is 'me.'[5]

She unpacks *Nature* as chromosomes, hormones, hormone receptors, gonads, primary sex characteristics, secondary sex characteristics, brain, and mind; and *Nurture* as socialization practices and intimate relationships (usually housed in the family, the school, peer relationships, and religious and community institutions), while *Culture* is society's values, ethics, laws, theories, and practices; and declares:

> *Gender creativity is children's use of fanciful thinking, perseverance, fortitude, and finesse to incorporate the world around them into their inner psych and their gender as they know it and want it to be.*

Like artists with thread and loom, children possess inherent creativity to weave their authentic gender identity and sexual orientation through exploring possibilities. When the caregivers function as supportive witnesses, holding space for this creative process and reflecting emerging expressions back to the child, secure attachment develops. Unfortunately, many LGBTQ+ children lack this experience because parents often replicate their upbringing, perpetuating intergenerational trauma.

The Thinking Self

LGBTQ+ children often experience early conflict between their somatic self and conceptual self within cisgender/heterosexual culture. Their thinking self assumes control, attempting to solve the distress by disconnecting from authentic body narratives about identity and attraction. This thinking self—our internal narrator and decision-maker—may become like a drill sergeant forcing the somatic self to conform to dominant cultural expectations. They do this by incorporating dissociative tools to mask as successful assimilation for as long as the thinking self can enforce the forced narrative.

The LGBTQ+ thinking self dissociates from authenticity, working overtime to compartmentalize somatic experience and align with conceptual expectations for caregiver and community approval. This creates a disconnection from the body's wisdom about true identity and love.

The Observational Self

The observational self is the capacity to witness our experience without complete identification, noticing thoughts, emotions, and sensations without being consumed. This awareness cultivated through mindfulness practices provides meta-cognition and continuity, allowing us to float above cultural narratives and recognize: *I am different from the stories told about me, and I feel called to walk a path that has not been presented to me.*

Dissociation is contextually adaptive or maladaptive. The observational self's separation from dominant, constricting narratives allows young people to explore their inner sense of being, asking, "Who am I?" This is when LGBTQ+ youth find a voice to name their truth and seek their tribe.

LGBTQ+ children are born into isolation, raised by cisgender/heterosexual caregivers subscribing to binary narratives, while hearing from politicians, principals, and preachers that they are not enough. This attachment-based trauma occurs within a community; therefore, healing requires affirming the community. LGBTQ+ people need their tribe—family of choice–with a DNA connection being bonus points. Finding our people means finding affirmation, unconditional love, and encouragement to live authentically.

DELAWARE: AN AFFIRMING STATE; AND YET...

Delaware is becoming a destination state for LGBTQ+ persons and families. Parents are deciding to relocate to a state that will support their LGB and especially TQ+ children. If one were to research the legal protections for LGBTQ+ folx in Delaware, one would see the First State ranks as one of the safest places to be if LGBTQ+; and yet the Gay Lesbian Straight Education Network (GLSEN) published the findings of the 2021 National School Climate Survey demonstrating Delaware schools do not feel safe for most LGBTQ+ secondary students.[6] The 2024 results are not yet available.

The 2021 National School Climate Survey State Snapshot for Delaware includes the following details:

In Delaware, transgender and nonbinary students in particular experienced gender-based discrimination, specifically being prevented from: using their chosen name or pronouns (40%), using the bathroom that aligns with their gender (25%), using the locker room that aligns with their gender (30%), wearing clothing deemed "inappropriate" based on gender (12%), and playing on the school sports team that was consistent with their gender (19%).

I recently led an ethics training through the NASW Delaware/NASW West Virginia chapter, comparing the statistics of both states in the 2021 National School Climate Survey. You'd think the Delaware percentage rates would be a lot better in all categories (*Table 1*). They *are* better, but not as strong as one would hope, and I believe the reason is that: *"You can change laws. However, it is not until you change hearts that real cultural shifts may occur."*

TRAUMA NARRATIVES FOR LGBTQ+ CHILDREN: GROWING UP QUEER/TRANSGENDER IN AMERICA

When parents struggle to support their queer children, I often say: "I'm sorry our culture made no space for your family and that you live with fear for your child's safety. I appreciate you're here learning to embody unconditional love." Most parents of transgender children are cisgender—they never questioned their gender identity because their birth assignment matched their inner knowing.

The gender binary is socially constructed; characteristics and roles associated with male/female are culturally created, not inherently biological. What "masculine" or "feminine" means is learned through social interaction, not determined by assigned sex.

Pause and consider: "How do you know your gender identity? How did you learn what it meant to be the gender matching your assigned sex? How did you know who you were attracted to?" Our binary culture promoting cisgender/heterosexual norms means most never examine major identity aspects.

> *However, when we challenge binaries of any kind, we expose assumptions that uphold them as culturally and historically contingent, rather than as ostensibly universal and "natural." When we deconstruct binaries that limit a people's way of being in the world, we open up possibilities for a proliferation of identities." Gender Binary is inextricably tied to the discourse of patriarchy, which dictates ideas of "normal" masculinity and femininity, particularly in regard to social power, authority and privilege. (p.17, p.39)*[7]

Most LGBTQ+ kiddos, simply grow up with cisgender/heterosexual parents who never had a thought that maybe the newborn they were holding would be queer or transgender (it just never crossed their minds as a possibility); however, we queer folx don't get random glitter bombs dropped on us by some celestial being converting us into rainbow fabulousness. In the immortal words of Saint Lady Gaga, we are simply "born this way!"

Table 1. Delaware vs. West Virginia: LGBTQ+ School Climate Comparison

Category	Delaware	West Virginia
Hearing Homophobic Remarks	92% of students reported hearing them frequently or often	97% of students reported hearing them frequently or often
Feeling Unsafe Due to Sexual Orientation	60% of students felt unsafe	70% of students felt unsafe
Verbal Harassment (Sexual Orientation)	65% of students experienced it	75% of students experienced it
Access to LGBTQ +-Inclusive Curriculum	25% of students had access	15% of students had access
Presence of GSA (Gender & Sexuality Alliance)	40% of students reported having one at their school	20% of students reported having one at their school

Instead, the trauma narratives of growing up LGBTQ+ in the American landscape may be best understood this way[8]:

- Knowing at a young age you are different before knowing the words LGBTQ+
- Pretending to be who you aren't, trying to fit into the socially constructed binary narratives
- Because messages from family and community highlight your existence as flawed based on who you are and who you like/love
- Left without a safe enough mentor or coach to counter this cisgender/heterosexual norm self-hatred and shame begin to grow within the inner psyche; and
- The child is left alone, fearing abandonment by those they long to be loved by, often leaving them with a glaring choice to dissociate from who they are to survive.

Therapeutic endeavors involving LGBTQ clients—particularly Transgender and Gender Expansive individuals—requires addressing the trauma of growing up Queer in the U.S., within a framework that deconstructs systems of oppression including but not limited to: race/ethnicity, gender, sexuality, neurodiversity, disability, class, body size, religion, and colonialism. A clinician must pay attention to where they land on the Wheel of Power and Privilege, created by Sylvia Duckwork, with their clients from an intersectional framework to be most effective in cultivating a holistic therapeutic alliance for the trauma healing journey.

THE ADAPTIVE ARCHITECTURE OF SURVIVAL: DISSOCIATIVE RESILIENCE IN LGBTQ+ DEVELOPMENT

The dissociative continuum, originally conceptualized by Pierre Janet,[9] is explored further by both the work of Fisher[10] and Marich,[11] with the latter incorporating lived experiences from the global community into the clinical narrative. Dissociation is a complex neurobiological response that shifts from an adaptive resource to a crucial survival strategy based on environmental demands. For LGBTQ+ individuals navigating identity development in heteronormative systems, dissociation may often serve as a balancing act between authenticity and safety.

At the gentler end of the continuum, young LGBTQ+ individuals may practice being present without full engagement, allowing their consciousness to retreat during discussions about traditional family structures or heterosexual relationships. This response helps them maintain psychological integrity and safe connections.

As external pressures, such as bullying, increase, Fisher's idea of "going away but staying present" may emerge. Here, dissociation becomes creative adaptation; for instance, a transgender adolescent might feel their consciousness hovering outside their body during stressful events at school or home. Similarly, questioning youth may mentally disengage during conversations about dating, preserving crucial family ties while retreating to safe internal spaces.

At the more complex end of the continuum, LGBTQ+ individuals may have encountered rejection, conversion attempts, or violence. In these situations, dissociation may lead to and/or be a contributing factor to the emergence of multiple self-states. Each self-state reflects different aspects of creativity that come into existence as an act of love to protect the person.

This internal dynamic allows the person to navigate the painful choice between authenticity and safety. Dissociation serves as an adaptive response, whether it occurs unconsciously, consciously, or both. This response honors the resilience and creativity that LGBTQ+ individuals exhibit in preserving their humanity. They do this within oppressive environments that demand conformity, all while continuing to seek connection.

LGBTQ+ individuals are at increased risk for experiencing intersectional trauma, including yet not limited to socioeconomic marginalization, racial discrimination, and ableism. These compounding trauma exposures can amplify psychological distress and heighten reliance on dissociative coping mechanisms.

AN INTEGRATIVE APPROACH TO EMDR FOR LGBTQ+ FOLX

Transitions Delaware has a service philosophy that believes that mental health care is a collaborative journey between therapist and client. Our practice is grounded in trauma-informed, identity-affirming approaches that recognize the impact of minority stress while celebrating the resilience and strength of the LGBTQ+ community. We commit to meeting each client where they are, honoring their lived experiences, and supporting them in achieving their mental health goals.

This practice philosophy reflects my personal values and professional ethics over the last 35 years, providing clinical care and community training, raising the baseline for culturally responsible LGBTQ+ healthcare across the aging spectrum. I prioritize helping providers' hearts become more open, kind, compassionate, and responsible rather than simply prescribing best practices supported by policies and procedures. The "why?" matters as much as the "how?" for lasting change to take hold and become the new normal.

This principle of responsible clinical care centered in cultural responsibility matters with Eye Movement Desensitization and Reprocessing (EMDR), too, as a wonderful treatment modality for working with LGBTQ+ folx who have experienced trauma, especially complex trauma; and like all treatment models works best from an integrative, collaborative framework.

Interweaving Modalities

Integrating EMDR with narrative therapy, Internal Family Systems, somatic interventions, and mindfulness cultivates holistic trauma treatment addressing cognitive, emotional, somatic, and existential dimensions. During preparation, narrative exploration identifies problem stories while parts work acknowledges trauma-carrying aspects of Self-states (Parts)/Ego states (parts). Somatic awareness and mindfulness strengthen dual awareness and distress tolerance for effective processing while also cultivating opportunities for System Mapping and increased internal communication among Parts of the System.

The processing phase enriches bilateral stimulation by facilitating memory integration, internal parts communication, nervous system awareness, and mindful witnessing. Somatic techniques maintain optimal arousal while Parts/parts work honors internal complexity without pathologizing protection. Post-processing integration uses narrative re-authoring to weave experiences into empowering life stories with input from different Parts/parts.

This model effectively treats complex trauma's fragmentation across multiple domains. Combining EMDR's processing efficiency with modalities addressing meaning-making, internal coherence, embodied healing, and present-moment awareness offers comprehensive recovery, honoring trauma's complexity and human resilience.

The Narrative Approach: Client-Centered/PRIDE-Centered

Narrative therapy treats LGBTQ+ persons with complex trauma by separating authentic identity from harmful societal narratives and internalized stigma. Clinicians strengthen outcomes by intentionally reframing stories from shame-centered to pride-centered narratives. For example, transforming "I'm broken because I'm gay" (negative/shame) to "I courageously live authentically despite adversity" (positive/pride), or shifting "My transition makes me abnormal" to "My transition reflects my strength and self-knowledge." This same principle applies to persons living with strong dissociative experiences that align more with Self-states than Ego states, with the therapist either celebrating or welcoming all Parts (self-states) and all parts (ego states).

The Disorder is Not the Client: Decentering the Medical Model

As language shapes culture and culture shapes language, clinicians must reframe shame narratives away from the medical model's disease-centered, "expert-driven" approach that pathologizes normal client experiences while elevating provider authority over lived experience. Rather than post-traumatic stress *disorder* or dissociative identity *disorder*, reframe to post-trauma responses and dissociative identity experiences.

This approach helps clients distinguish their authentic selves from discrimination and rejection, reducing shame by affirming that clients did nothing wrong and are not wrong for who they are. The disorder belongs not to the person in your office, but to the systems, communities, and individuals who cultivated the traumatic events.

This collaborative, non-pathologizing stance validates LGBTQ+ identity and dissociative experiences while addressing discrimination, minority stress, and trauma's impact, enabling clients to integrate experiences into coherent, empowering narratives that honor both identity and recovery.

Welcome All P/parts of the Client into Therapy: Acknowledging the Dissociative Spectrum

I once had a Plural Transtastic client say to me regarding their headmates, *claiming space in the external world is too often rare, yet so validating*. Coming out and being affirmed matters for LGBTQ+ folx; and it matters for LGBTQ+ folx who are plural, too, where every Part of them is welcomed and invited into the healing narrative.

Ego states (or "little 'p' parts") are flexible, context-dependent shifts in how we show up, often blending naturally in response to relationships or environments. For example, your "work self" might emerge in meetings—more confident and composed—while a call from a critical parent might draw out a younger, more defensive self. These shifts are usually smooth, like adjusting the volume on different aspects of identity to feel safe or effective in the moment. Whereas Self-states (or "big 'P' Parts")—also known as Headmates, Insiders, or System Members—are more distinct and are often, yet not exclusively, rooted in trauma or attachment disruptions. The DSM recognizes both endogenic and traumagenic formation of Parts. Unlike ego states, these Parts often have clearer boundaries, unique roles, preferences, and memories, as well as dis/likes from what will help in grounding to what is their favorite color or ice cream flavor. They may switch or remain present simultaneously, with varying levels of awareness of each other.

During all Eight Phases of EMDR, a therapist is encouraged to welcome all P/parts into the therapeutic alliance. Where ego state work focuses on fostering fluid integration and co-consciousness, self-state work involves recognizing and engaging each Part as a distinct entity, intending to build respectful internal dialogue and coordination that I like to frame as "integrative collaboration" among the headmates, partnered with a mantra "all of you(s) are stronger together."

The Layers of Identity: Transgender, ADHD, Autism, Aphantasia, Complex PTSD, Ehlers-Danlos Syndrome, and PCOS

When working with anyone in the LGBTQ+ community, especially transgender folx, please be aware that certain "complementary" diagnoses often will present at the start of care or during your therapeutic work together. A comprehensive bio-psycho-social is highly encouraged.

Beware of Flooding Out the CNS (Central Nervous System): Widen the Window of Tolerance

In EMDR (and other forms of trauma processing treatment modalities), flooding the nervous system happens when the therapist moves too quickly to process the trauma narratives with clients who have a narrow window of tolerance. A resource to understand how different Parts may be having different experience with tolerance is called The Wheel of Tolerance by Katarina Lundgren.[12] Complex trauma involves attachment breaches, and so it matters greatly for the therapist to take time to connect with every P/part presenting for therapy to cultivate opportunities for attachment repair. Additionally, each P/part may be resourced by different tools from the mindfulness and/or DBT toolbox. Working with the client to foster inner communication and collaboration to learn what tools each P/part will want to use for staying in the window of tolerance matters greatly. Slow and steady is fast when addressing complex PTSD.

BRINGING IT ALL TOGETHER: THE POWER OF COMMUNITY IN HEALING WITH COMPLEX PTSD

I am still turning my gaze toward the positive energy and radiant hope felt the moment I watched Governor Matt Meyer sign Executive Order #11 on Friday, June 20th at Camp Rehoboth, making Delaware the latest state (joining at least 14 other states and Washington, DC) in providing legal refuge for individuals seeking and providing gender-affirming care, with the order explicitly protecting information of both patients and providers. Thank you, Governor!

At the moment of the signing, I realized I left out a deep sigh along with unspoken worries held in my body centering around unanswerable questions on how I would keep Transitions

Delaware clients and clinicians as safe as possible during this unprecedented time in our nation. It feels really good to know that our state government is elevating our visibility and protection rather than trying to erase us from the community, which leads me to encourage you, the reader, to consider the following.

Healing with complex PTSD often involves the release of the deep, long-held, unspoken (and even unrealized) trauma from earlier times in our lives. The journey of recovery becomes more complicated when the environment is riddled with retraumatizing experiences. The daily headlines of doom may block the illumination of the two truths we, as LGBTQ+ people, are experiencing.

1. Our safety and freedom as equal citizens in this great country are under attack, ***and***
2. We are not alone in the energy and effort to create a more perfect union in which we are seen and celebrated as LGBTQ+ people.

We have a community. We have allies.

If you identify as cisgender and/or heterosexual, please keep checking in and supporting your LGBTQ+ family, friends, and neighbors. Members of the LGBTQ+ community may not be aware of how the daily onslaught of attacks is impacting their central nervous system, and connecting with people who are kind and caring is some of the best healing medicine around.

If you identify as a member of the LGBTQ+ community, please remember to find your people! It can feel overwhelming, and easy for app-based analytics to flood your social media feed with negative narratives that crowd out voices reminding you that you belong, you matter, you are beautiful, you are important!

I wish to close with the words of two pioneering activists, trans liberation trailblazers, and foundational figures in the modern LGBTQ+ rights movement in the United States:

> *We have to be visible. We should not be ashamed of who we are. I'm tired of living with labels. I just want to be who I am. I am Sylvia Rivera. ~ Sylvia Rivera*
>
> *No pride for some of us without liberation for all of us. History isn't something you look back at and say it was inevitable…It happens because people make decisions that are sometimes very impulsive and of the moment, but those moments are cumulative realities. ~ Marsha P Johnson*

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Who was Nex? Who is Nex.T?

Reverend Karla Fleshman, L.C.S.W., M.Div.

It is the start of a new school year.

Nex lived in Oklahoma. They were 16, identified nonbinary, and their pronouns were He/They.

Who is Nex.t?

The Trevor Project reports that 90% of queer youth have been negatively impacted by our nation's politics.[1]

In Oklahoma, State Senator Tom Woods, when referring to the Queer community, is recorded as saying, I represent a constituency that doesn't want that filth in Oklahoma.

Who is Nex?

So far, 13 states ban transgender people from using public bathrooms and facilities according to their gender identity.[2]

In Oklahoma, where Nex lived, there is a 2022 state ban requiring transgender people use the bathroom in schools K-12 that aligns with their sex assigned at birth.

Who is Nex.t?

23% of LGBTQ+ young people reported that they have been physically threatened or harmed in the past year due to either their sexual orientation or gender identity.[1]

On February 7 2024 Nex Benedict was involved in a physical altercation in the girls' restroom at the Owasso High School. They didn't want Nex in that bathroom…or their school…or their community

Who is Nex?

28% of transgender and nonbinary young people reported that they have been physically threatened or harmed in the past year due to their gender identity.[3]

Nex's family reportedly said that bullying started after LGBTQ+ policies began to take effect at the state level.

Who is Nex.t?

So far, 26 of these United States have banned gender affirming care, including Oklahoma.

They say that the injuries Nex sustained the day before their death - injuries to their head, neck, torso, and limbs by three fellow students - were not lethal

Who is Nex?

LGBTQ+ young people report lower rates of attempting suicide when they have access to affirming spaces and communities.

Oklahoma State Superintendent of Public Instruction, Ryan Walters following the death of 16 year old Nex Benedict is recorded as saying, "To make sure that all individuals are safe in a school, we want every student to be protected…that means we're not going to lie to students. And we're not going to push a gender ideology."

Who is Nex.t?

Transgender and nonbinary young people who had access to gender-affirming clothing, gender-neutral bathrooms at school, and had their pronouns respected by the people they lived with had lower rates of attempting suicide compared to those who did not.

Nex was just a kid who grew up in a country, a state, a community, a school that made it clear they weren't wanted, nor protected. The coroner's report ruled Nex engaged in self-harm to end their life…the beating the day before, according to the coroner, was not lethal.

Who is Nex.t?

In Delaware, 43% of LGBTQ+ students reported discriminatory policies or practices at their school, 40% of transgender and nonbinary students were prevented from using their name or pronouns, 25% were prevented from using the bathroom that aligned with their gender identity, 47% experienced verbal harassment, and 9% experienced physical assault.[4]

We shouldn't be asking who's next, but if we don't improve on these statistics by way of sound policies, appropriately trained adults in our schools and communities, offering gender and sexuality alliances to our students, it won't be long until we have an answer the question.

Who was Nex.t!

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DSAMH

Naloxone Access Training

Register at delaware-dsamh.eventbrite.com

New Castle County:

Appoquinimink Community Library
2nd Thursday of each month
Training: 11:00am-12:00pm
POD:12:00pm- 1:00pm

Bear Public Library
4th Monday of each month
Training: 5:00pm- 6:00pm
POD: 6:00pm-7:00pm

Claymont Public Library
1st Wednesday of each month
Training: 11:00am-12:00pm
POD:12:00pm- 1:00pm

Rt. 9 Library and Innovation Center
4th Friday of each month
Training: 11:00am-12:00pm
POD:12:00pm- 1:00pm

Kent County:

Dover Public Library
3rd Saturday each month
Training: 2:00pm - 3:00pm
POD: 3:00pm - 4:00pm

4th Thursday Each Month
Training: 5:00pm - 6:00pm
POD: 6:00pm - 7:00pm

Harrington Public Library
1st Tuesday each month
Training: 12:00pm - 1:00pm
POD: 1:00pm - 2:00pm

James Wiliams State Service Center
2nd Tuesday of each month
Training: 11:00am-12:00pm
POD:12:00pm- 1:00pm

Sussex County:

Georgetown Public Library
1st Tuesday each month
Training: 3:00pm - 4:00pm
POD: 4:00pm - 5:00pm

Laurel State Service Center
1st Monday each month
Training: 12:00am - 12:00pm
POD: 12:00pm - 1:00pm

Lewes Public Library
2nd Saturday each month
Training: 12:00pm - 1:00pm
POD: 1:00pm - 2:00pm

Upon completion of training you are eligible to receive a FREE Opioid Rescue Kit.

What is Narcan

Narcan (Naloxone) is a medication that is effective in reversing the effects of an opioid overdose in an individual.

Learning Objectives:

- Recognize and effectively respond to an opioid overdose
- What Naloxone is, how to store it & to administer
  Relevant laws and legislation around Naloxone, including the statewide standing order

Training:
Classroom-style. This is the most informative training for any member of the public offering an in depth presentation to a small group in 30-45 minutes with plenty of time for questions and answers.

POD (Point of Distribution):
This training is best for returning trainees, or those who have used their Naloxone kit previously. Only requires a few minutes per person.

Any questions should be directed to the DSAMH Naloxone Support Team: **Narcan.Train@delaware.gov** or **(302) 255-2777**

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Substance Abuse and Mental Health

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Legislation as Trauma: The Mental Health Toll of Anti-LGBTQ Policy on Clients in HIV Care

Elise Mora, L.C.S.W.
AIDS Delaware

ABSTRACT

The recent surge in anti-LGBTQ+ legislation across the United States has far-reaching consequences that extend beyond civil rights, posing a significant but underrecognized threat to public mental health—particularly for LGBTQ+ individuals living with or at risk for HIV. This article explores how such legislation operates as a form of structural trauma, exacerbating minority stress, anticipatory grief, and psychological distress among clients in HIV care. Drawing on clinical experience, trauma-informed practice, and existing literature, it demonstrates how discriminatory policies compromise mental health, disrupt care engagement, and deepen medical mistrust. Through composite case vignettes and evidence-based analysis, the article highlights the role of the mental health clinician as both a therapeutic and systemic advocate. It concludes with urgent recommendations for culturally competent care, trauma-informed public health systems, and policy advocacy to resist harm and promote resilience among LGBTQ+ populations. Ultimately, the piece calls for a unified public health response that affirms identity, fosters healing, and safeguards the dignity and well-being of marginalized communities.

INTRODUCTION

Across the United States, a surge of anti-LGBTQ+ legislation has redefined the landscape of rights, visibility, and safety for lesbian, gay, bisexual, transgender, and queer individuals. From laws targeting access to gender-affirming healthcare and participation in sports to restrictions on inclusive curricula in schools, these policies have rapidly evolved from political talking points to lived realities. Although much attention has been paid to the legal and civil rights implications of these developments, the impact on mental health has received comparatively less attention in public health discourse. For individuals whose identities are shaped by multiple intersecting forms of marginalization, the resulting impact has been especially profound, often manifesting as significant psychological and emotional trauma.

For LGBTQ+ individuals living with or at risk for HIV, the stakes are very high. The interconnection of stigma, healthcare discrimination, and fear of legal repercussions can create a toxic psychosocial environment that directly undermines engagement in care, medication adherence, and overall wellness. In my role as a Licensed Clinical Social Worker (LCSW) at an HIV service organization, I witness the psychological toll this legislative hostility inflicts on my clients. These are not abstract policy debates; they are flashpoints for real-world trauma, anxiety, and despair.

Even when such laws are not passed, their mere proposal or discussion in the public sphere can incite fear, retraumatize clients who have histories of marginalization, and reinforce a sense of otherness and vulnerability. Many of my clients have referenced feeling dehumanized as they have engaged in and bore witness to political discourse, largely after they listen to transphobic and homophobic justification for anti-LGBTQ+ policies, spewed by people that are not a part of the LGBTQ+ community. This phenomenon functions as a chronic trigger for many LGBTQ+ individuals, activating hypervigilance, depression, and isolation. These mental health effects are not only detrimental in their own right but also complicate efforts in HIV prevention and care. As a nation, making progress in those areas requires trust, community engagement, and psychological resilience.

This article explores the complex ways anti-LGBTQ+ legislation serves as a form of structural trauma, shaping the mental health outcomes of clients engaged in HIV services. Drawing from clinical experience, relevant literature, and trauma-informed practice, I aim to outline the urgent need for culturally competent, affirming mental health care, and to situate the mental health clinician as a critical ally in both individual healing and systemic advocacy.

THE PSYCHOLOGICAL IMPACT OF ANTI-LGBTQ+ LEGISLATION

The psychological consequences of anti-LGBTQ+ legislation are profound and far-reaching, often functioning as *structural violence* that perpetuates trauma and distress.[1] Structural violence is a "form of violence wherein social structures or social institutions harm people by preventing them from meeting their basic needs." There is an insidious lethality; structural violence leads to unnecessary harm and even death through disparities, and it often goes unrecognized as it is woven into the fabric of systems and institutions. When laws or policies invalidate identity, restrict access to care, or encourage social exclusion, they send a powerful message to LGBTQ+ individuals: you are not safe here. For those already managing minority stress (the chronic psychological strain caused by stigma, discrimination, and marginalization) these messages compound an already heavy burden.

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MINORITY STRESS AND LEGISLATIVE HARM

Minority Stress Theory, originally conceptualized by Dr. Ilan Meyer, posits that LGBTQ+ individuals experience chronic stress as a result of their marginalized status in society.[2] This stress is not simply the result of isolated incidents of prejudice. It is cumulative, occurring across a person's lifespan and at multiple levels: interpersonal, institutional, and structural. Anti-LGBTQ+ laws exemplify this structural level of oppression, reinforcing the idea that LGBTQ+ identities are less valid or even nefarious.

These policies trigger and reinforce internalized stigma, displayed by feelings of shame, guilt, or self-hatred that individuals may carry as a result of societal rejection. For clients, this can manifest as persistent self-doubt, low self-esteem, or even suicidal ideation. In my clinical work, I have seen clients experience significant spikes in anxiety and depressive symptoms in response to news of legislation targeting gender-affirming healthcare or banning LGBTQ+-inclusive books in schools. Even clients who are not directly affected by a particular law still feel its reverberations, particularly when the legislation is accompanied by hostile public discourse.

ANTICIPATORY GRIEF AND HYPERVIGILANCE

Another psychological phenomenon I frequently observe is *anticipatory grief*. This is defined as the mourning of future losses that have not yet occurred.[3] Many LGBTQ+ clients fear that rights they've fought for (such as marriage equality or gender recognition) will be stripped away. They grieve the potential future where their children may be unsafe at school, or where they may be denied medical care. This form of grief, while often invisible, takes a measurable toll on mental health and day-to-day functioning.

Clients also describe a heightened sense of vigilance in public spaces, healthcare settings, and workplaces. Hypervigilance, which is a common response to trauma, results from a learned need to scan environments for signs of danger or rejection. It interferes with the ability to relax, to feel joy, and to focus on long-term goals. Over time, this psychological state can lead to burnout, substance use, and social withdrawal.

YOUTH AND THE MENTAL HEALTH CRISIS

Among LGBTQ+ youth, the mental health consequences of anti-LGBTQ+ legislation are even more acute. The Trevor Project's 2023 National Survey on LGBTQ Youth Mental Health found that 86% of transgender and nonbinary youth reported that recent debates about anti-trans bills negatively impacted their mental health.[4] The constant political scrutiny and dehumanization contribute to rising rates of anxiety, depression, and suicidal ideation in an already vulnerable population.

For young people navigating identity formation, these policies don't just limit access to affirming care or education; they fundamentally disrupt the process of self-acceptance. They create environments where it is unsafe to be authentic, to seek help, or to trust adults and institutions. These mental health harms are not incidental. They are predictable outcomes of policy decisions made without regard for public health, and seemingly with the direct and willful intention of causing harm to LGBTQ+ people and communities.

IMPACTS ON CLIENTS IN HIV CARE

For LGBTQ+ individuals engaged in HIV prevention, treatment, and supportive services, the effects of homophobic and transphobic legislation are not just psychological – they are clinically, medically, and societally significant. Stigma and stress linked to identity-related discrimination create direct barriers to engagement in HIV care and prevention. These barriers compound existing social determinants of health such as poverty, racism, unstable housing, and limited access to transportation, making it more difficult for individuals to stay connected to lifesaving services.

Stigma and Disengagement from Care

Clients often come to HIV care already carrying complex trauma histories. They report experiences of family rejection, bullying, homelessness, and intimate partner violence with tragic frequency. When these lived experiences are then validated by state-sanctioned discrimination in the form of legislation, they reinforce deeply internalized beliefs about unworthiness and danger. This undermines the therapeutic alliance that providers work so hard to establish.

In my work, I have witnessed clients abruptly disengage from therapy or medical appointments following high-profile legislative developments. For example, one client, a Black gay man living with HIV, stopped coming to sessions after his home state passed a law banning LGBTQ+ education in schools. Though the law did not affect him directly, he described feeling "erased" and "hunted," expressing a belief that "they don't want people like me to exist." This sense of erasure can quickly lead to hopelessness, which then impairs motivation to remain adherent to antiretroviral therapy (ART) or attend follow-up visits.

Even clients who remain in care may do so warily, carrying skepticism that their providers are truly safe allies. For transgender and nonbinary clients, this is especially acute. When anti-trans legislation dominates the media, it becomes harder to trust that healthcare spaces will honor pronouns, provide appropriate medical interventions, or even treat them with respect. This apprehension isn't paranoia; it's a rational response to systemic harm.

Medical Mistrust and Cultural Disconnection

Medical mistrust among LGBTQ+ populations, particularly among LGBTQ+ people of color, is well-documented. It is rooted in a history of pathologization, exclusion, and neglect by healthcare systems, including the early years of the HIV epidemic. Anti-LGBTQ+ laws reinforce this mistrust by signaling that discrimination is not only tolerated but codified. This makes the task of re-establishing trust in healthcare settings an uphill battle.

Clients often question whether their providers will be required to follow laws that discriminate, or whether services they depend on will be cut, such as housing referrals, hormone therapy, or LGBTQ-specific support groups. Even the suggestion that these supports might be compromised can cause clients to preemptively withdraw. For those engaged in prevention programs such as PrEP navigation or syringe exchange services, this can lead to increased risk of HIV acquisition.

Intersectionality and Compounded Risk

The impact of anti-LGBTQ+ laws is not felt equally. Individuals who hold multiple marginalized identities are especially vulnerable to falling through the cracks of HIV care systems. For example, being Black or Latinx, low-income, disabled, undocumented, or a survivor of the criminal legal system means experiencing much more stress and adversity accessing medical care and supportive services. Anti-LGBTQ+ legislation rarely exists in a vacuum; it often coexists with efforts to restrict reproductive rights, criminalize homelessness, or defund public health services.

Transgender women of color, who already experience some of the highest rates of HIV incidence and violence, face disproportionate harm when gender-affirming healthcare is restricted. Their mental health suffers not only due to the trauma of systemic erasure but because their very survival strategies, such as accessing hormones or engaging in sex work, are further criminalized.

As a mental health clinician, I see how these compounded layers of oppression create a sense of fatalism. When a client believes their future is unsafe, uncertain, or unsanctioned by society, their ability to engage in consistent, preventive health behavior naturally declines. What is needed is a structural response that affirms identity, validates experience, and actively resists harm.

THE ROLE OF THE MENTAL HEALTH CLINICIAN

In the face of growing legislative hostility, mental health clinicians occupy a critical position in the continuum of HIV care. We are often among the first to witness the emotional fallout of anti-LGBTQ+ policies and it is a core function of the work we do to help clients process and survive it. The clinician's role extends beyond symptom management. We are also advocates, cultural brokers, and stabilizing forces in systems that are chaotic and exclusionary.

Providing Affirming, Trauma-Informed Care

At a minimum, affirming care means recognizing LGBTQ+ identities not as clinical problems but as valid and integral parts of the human experience. In practice, this includes using correct names and pronouns, understanding the diverse experiences within LGBTQ+ communities, and acknowledging how systemic oppression contributes to distress. It involves believing our clients when they describe the very real harm they have experienced as a result of vilification of their respective identities.

For clients living with or at risk for HIV, affirming care also requires understanding how HIV stigma intersects with other stigmas related to gender, sexuality, race, and class. Trauma-informed care in this context means not only treating trauma symptoms, but preventing retraumatization by creating a therapeutic space rooted in choice, safety, trustworthiness, collaboration, and empowerment.[5] It means anticipating that many LGBTQ+ clients have been harmed by institutions and may enter care guarded, skeptical, or ashamed.

As clinicians, we help clients reframe this distress not as a personal deficit but as a logical reaction to systemic injustice. This can be a powerful intervention in and of itself. For example, validating that a client's anxiety in medical settings is a reasonable response to transphobic laws and past discrimination helps shift the focus from "what's wrong with you?" to "what's happened to you?" which is a cornerstone of trauma-informed practice.

Clinical Interventions That Support Resilience

Mental health clinicians can deploy a range of interventions to support LGBTQ+ clients navigating the stress of hostile policy environments:

- Psychoeducation: Helping clients understand the connection between systemic oppression and mental health symptoms reduces self-blame and increases empowerment.
- Narrative therapy: Encouraging clients to author their own stories in resistance to dominant, oppressive narratives fosters identity pride and psychological integration.
- Cognitive-behavioral strategies: Teaching grounding techniques, cognitive reframing, and emotion regulation skills can mitigate the impact of chronic stress and help clients maintain engagement in care.
- Harm reduction approaches: Acknowledging the realities of clients' coping strategies (including substance use or sex work) without judgment allows for more honest therapeutic relationships and supports realistic goal setting.

Importantly, clinicians should also recognize when systemic issues, and not individual pathology, are at the root of a client's distress. We are not solely responsible for changing unjust laws, but we are responsible for reducing the harm those laws inflict.

Advocacy and Systemic Engagement

Mental health clinicians cannot afford to remain neutral in the face of anti-LGBTQ+ legislation. Silence can be interpreted by clients as complicity. Advocacy within and beyond the clinical setting is part of our ethical responsibility to uphold client dignity and reduce harm.

Clinicians can:

- Advocate within healthcare systems for LGBTQ+ inclusive policies, such as gender-affirming forms, inclusive intake procedures, and anti-discrimination training.
- Partner with community organizations that support LGBTQ+ health, housing, and legal advocacy to create holistic care ecosystems.
- Engage in public discourse by writing op-eds, giving talks, or testifying about the mental health impacts of anti-LGBTQ+ policy. Bring clinical expertise into the policy arena.
- Train colleagues and future professionals in affirming, anti-oppressive practice.

These actions communicate to clients that they are not alone and that their mental health providers are active allies. In environments where the law may not protect them, knowing that their clinician will stand up for them and their community can be a lifeline.

CASE VIGNETTES

To illustrate the lived realities of clients navigating the dual pressures of HIV and anti-LGBTQ+ stigma, the following composite vignettes demonstrate how legislation can act as both a psychological and practical barrier to care. All names and identifying details have been changed to protect client confidentiality.

Vignette 1: *Marisol – "I'm Just Tired of Fighting for Everything"*

Marisol is a 27-year-old transgender Latina woman receiving PrEP and gender-affirming hormone therapy through an HIV prevention program. After Texas passed legislation restricting access to gender-affirming care for youth, she began experiencing depressive episodes and expressed fears that adults would be next.

Though she was not a minor, Marisol's care was provided through a public health initiative funded partially by state dollars. She worried aloud that her hormone access could be next: "They're starting with kids because they think people won't fight as hard for them. But we're all on the chopping block."

Marisol's mental health symptoms exacerbated, and she began using methamphetamines more regularly, something she had previously avoided for over a year. In a one-on-one therapy session, she admitted, "I know it's not safe, but it numbs everything. I'm just tired of fighting for everything—my identity, my healthcare, my safety." Her experience underscores how legislative attacks erode hope, particularly for transgender women of color, and how hopelessness can reintroduce risk behaviors that increase HIV vulnerability.

Vignette 2: *Darius – "What's the Point of Staying on Meds If They Don't Want Me Alive?"*

Darius is a 21-year-old nonbinary person recently diagnosed with HIV. They were initially highly motivated to engage in care, attend support groups, and begin antiretroviral therapy (ART). However, after their home state introduced legislation criminalizing gender-affirming healthcare for youth and mandating that school counselors report students exploring gender identity, Darius became withdrawn and distrustful.

Though legally an adult, they had only recently aged out of a school system that had already been unsupportive. The new law, and the social discourse surrounding it, reopened old wounds. "It just feels like they're legislating my disappearance," they said during a session. "What's the point of staying on meds if they don't want me alive anyway?"

Darius began missing doses of ART, stating that it felt futile. They described dreams about being detained or forcibly outed, symptoms of reactivated trauma that had been dormant. Through sustained therapeutic work that validated their fears while reinforcing their right to exist and thrive, Darius was eventually able to reengage with their care plan, but the emotional impact remained lasting.

These individual accounts illustrate how policy can operate as a form of chronic trauma—one that seeps into clients' bodies, identities, and care routines. For mental health clinicians and HIV care providers, understanding these dynamics is essential to offering responsive and affirming care.

COMMUNITY AND POLICY RECOMMENDATIONS

To address the multifaceted harm that anti-LGBTQ+ legislation inflicts on mental health, especially within HIV care settings, public health professionals must engage in proactive, coordinated strategies at both the clinical and policy levels. The impact of these laws is not inevitable; it is the result of choices made by institutions and leaders. Similarly, healing and resilience can be cultivated through systems that choose equity, affirmation, and accountability.

1. Strengthen LGBTQ+ Cultural Competence in Healthcare Settings

Many clients disengage from HIV services not because they reject care, but because they do not feel safe or respected. Every public health organization, from state departments to local clinics, must invest in LGBTQ+ cultural competency training across all staff roles. This includes:

- Training in trauma-informed, identity-affirming language and practices.
- Regular review of intake forms, signage, and marketing materials to ensure they are inclusive.
- Hiring and retaining LGBTQ+ staff, especially those who reflect the communities served.

Affirming care is not an optional service enhancement. It is a foundational element of effective HIV prevention and treatment.

2. Invest in Mental Health Services as Core HIV Infrastructure

Mental health must be understood as integral to HIV care. Chronic stress, stigma, and trauma directly affect medication adherence, sexual health decision-making, and engagement with prevention services. Funding structures, especially Ryan White and CDC-backed initiatives, should explicitly support embedded mental health services within HIV clinics and community-based organizations.

Models of integrated care that include therapists, case managers, and peer navigators working collaboratively have demonstrated success in improving retention in care and mental health outcomes.[6] These models should be scaled and supported.

3. Build Trauma-Informed Public Health Systems

Trauma-informed principles can be extended from the clinic to the systemic level. Public health departments should:

- Create feedback loops with LGBTQ+ community members to ensure services are meeting needs.
- Respond rapidly to changes in the legislative landscape that may affect LGBTQ+ residents.
- Develop messaging and outreach that actively counters stigma and misinformation.

When public health institutions act swiftly to affirm LGBTQ+ people during times of political hostility, they send a powerful counter-narrative of safety and belonging.

4. Promote Protective Legislation and Challenge Harmful Laws

Mental health and HIV care professionals have a vital role in public policy. Their voices lend clinical and moral authority to advocacy efforts. Recommendations include:

- Supporting nondiscrimination ordinances and inclusive health policies at the local and state levels.
- Opposing legislation that targets LGBTQ+ healthcare, education, or expression.
- Providing testimony, public comments, or letters to legislators about the impact of anti-LGBTQ+ policies on clients.

Professional organizations (including NASW, APA, and APHA) should also continue issuing statements and policy briefs that educate lawmakers and the public about the consequences of discriminatory laws.

5. Resource and Uplift LGBTQ+ Community-Based Organizations

LGBTQ+ community organizations are often the first and most trusted responders when clients are in crisis. These groups provide culturally specific support, legal advocacy, crisis intervention, and affirming social spaces. Yet they are frequently underfunded and overextended.

Public health systems must:

- Fund these organizations sustainably, not just through short-term grants.
- Partner with them in program design, not just service delivery.
- Defer to their expertise in engaging hard-to-reach populations.

In moments of legislative crisis, these organizations often serve as lifelines. Supporting them is both a moral and a strategic imperative.

CONCLUSION

Anti-LGBTQ+ legislation does more than deny rights. It commits violence and it enacts trauma. For LGBTQ+ individuals, especially those living with or vulnerable to HIV, these laws represent a form of systemic violence that deepens psychological distress, undermines care engagement, and fractures trust in institutions. They are not abstract policy disputes; they are lived realities that manifest as anxiety attacks, substance use relapses, depressive episodes, and interrupted treatment adherence.

Mental health clinicians working within HIV care systems are uniquely positioned to bear witness to these impacts and respond with care that is trauma-informed, affirming, and justice-oriented. Yet we cannot work in isolation. Healing in the face of structural harm requires collective action: from healthcare systems that affirm identity, to policymakers who reject bigotry, to communities that rally around their most marginalized members.

If public health is to serve all people, it must actively resist policies that endanger some. This moment calls on clinicians, advocates, researchers, and public health leaders to speak plainly about the damage being done and to act boldly to protect the mental health and dignity of LGBTQ+ people.

The question is not only how we care for our clients in the therapy room, but how we help build a world where that care is no longer needed to survive injustice.

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It Never Stopped: The Continued Violation of Forced, Coerced, and Involuntary Sterilization

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ABSTRACT

From the Buggery laws of 1533, to the hundreds of years of medical experiments taking advantage of already historically oppressed communities throughout the world, to the current anti-Trans laws and policies that are bombarding the nation today, reproductive autonomy has long been treated as a privilege as opposed to an inalienable right. The notion of reproductive freedom should be uncompromisable but it has not been fully realized due to the fostering and the legitimizing of coercive systems that keep marginalized communities oppressed, perpetuate violations to a person's body, and that prevent individuals from asserting themselves as the experts of their lives. While self-declaration, reproductive autonomy, and clear informed consent should always be the highest standard, we continue to see that these basic human rights are simply not afforded to all. This paper explores the history of coerced, forced, and involuntary sterilization, globally and in the United States, as a means of population control through criminalized punishment, "cures" to gynecological issues, and the gatekeeping of bodily autonomy, with a call to attention on how this practice has and continues to impact persons of color, the poor, and the LGBTQIA+ community. The authors of this paper aim to shift the oppressive standards that currently exist towards self-declaration, reproductive and sexual autonomy, and self-advocacy as a means to combat the harm of coerced sterilization and its intentional practice in medicine and policies. The clinical considerations provided intend to challenge the reader to examine their own actions as a possible "conspirator" to the passive eugenic practices that lead to sterilization by default, as outlined by the authors.

INTRODUCTION

In September 2020, alarming details emerged from the Irwin County Detention Center in Georgia outlining the mistreatment of immigrant detainees under ICE custody. In a report issued by Project South, The Institute for the Elimination of Poverty & Genocide, a complaint was filed on behalf of the detained immigrants held at the Irwin County Detention Center, citing lack of proper access to language translation, medical neglect, unsanitary conditions, safety issues, and other human rights abuses and violations.[1] One of the biggest red flags brought forward by the complaint was the alarming rate of hysterectomies that were being performed of the women under ICE custody.

Project South conducted several interviews with immigrant detainees who reported undergoing medical procedures without a clear understanding as to why the procedure needed to be done.[1] Initially, the women were experiencing issues with heavy periods, cramping, or other gynecological concerns. According to detainee interviews, many women did not receive proper education and information from the doctor and the medical staff and were not able to properly consent to medical treatment. Additionally, detainees reported that there were no Spanish speaking medical staff available to explain and clarify the doctor's orders; instead, medical staff resorted to using improper Spanish translation measures such as Google Translate to communicate with the detainees.

Horrifically, the recent ICE detention story is just a continuation of a long history of forced, coerced sterilization, intrusive gynecological practices, and "medically necessary" procedures that still exist in this country and globally.[2] Eugenics, the practice of selective reproduction, has been used since the beginning of the 1900s to control and limit certain communities deemed undesirable.[3]

HISTORY OF STERILIZATION IN THE UNITED STATES

The arrival of the 20th century marked the beginning of forced reproductive sterilization all over the world.[2] The main purpose of this government-imposed tactic was for population control while other governments used sterilization to prevent those considered socially unsatisfactory from reproducing.[3] Indiana became the first state to adopt involuntary sterilization statutes in 1907; from 1907-1939, 30 states followed with their own sterilization laws.[2]

In the South, sterilization was used as a means of racial control and as a way to break the dependency of residents on welfare.[4] Up until 1977, nearly 7,600 individuals were sterilized in North Carolina; the vast majority were Black.[4,5] For various reasons, Black youths as young as ten years old were deemed and declared unfit to be parents, according to state records.[4,6] In order to aggressively promote the sterilization agenda, the government used tactics such as threats of losing welfare benefits and other assistance provided by the state if sterilization consent forms were not signed.[4,5]

In the United States, sterilization was used for depopulation but it was also heavily used to prevent those considered to be

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"retarded and insane" from reproducing.[2] Labeled "feebleminded," individuals who were mentally and physically differently-abled were subjected to sterilization in order to remove the option of family planning.[7] Although sterilization of these communities still occurs today, new guidelines have been created by human interest groups such as The World Health Organization in order to lobby for the best interest of the person.

As an effort to reduce immigration in California, Mexican men and women were sterilized at a significantly higher rate than non-Latinos between 1920-1945.[8] According to accounts from several California eugenics programs, Mexican women were classified as "hyperfertile, inadequate mothers, criminally inclined, and more prone to feeblemindedness" therefore, sterilization was justified in order to control the spread of these undesirable qualities.

Forced sterilization was a key tactic of government funded assimilation campaigns that targeted Indigenous and Native communities throughout the 19th and 20th centuries.[9] Native women describe coercion and non-consensual surgical sterilization; chemical sterilization, such as ingestion of radioactive iodine, was often administered on a daily basis. Between 1970 and 1976 alone, it is estimated that over 3,400 Native women had been sterilized, forced to abort, or received "medically necessary" hysterectomies; some reservations reported a sterilization rate of 80% or higher.[10] Additionally, the creation of residential schools in the 1800s saw the forcible removal of Native children from their families and their land, as an attempt to force children to assimilate into White society.[9] Upon reaching puberty, administrators of the residential schools were given the right to sterilize any Native student that was under their care.[9]

GLOBAL CASES OF STERILIZATION

All over Latin America, women and men have been reproductively violated in order to comply with their government's strategy to eliminate poverty by limiting family size.[11] As a tactic, many governments began to limit access to forms of birth control as a way to promote a more permanent solution in the way of sterilization.[11] Additionally, there is evidence that many governments developed financial incentives that were awarded to health care workers for every woman they brought in for sterilization. These types of claims have also been made in Honduras, Mexico, Guatemala, Argentina, and other Spanish-speaking countries.[12]

In recent years, the government of Peru launched an investigation based on claims that 300,000 women were subjected to forced sterilization under the ten-year reign of former president Alberto Fujimori.[11] It had been reported that poor, uneducated women were lured into medical offices with promise of free medical checkups; once the women were on the examination table, the medical staff allegedly restrained the women, anesthetized them, and then performed the tubal ligation.

For over two decades, Puerto Rico had the highest rate of coerced sterilization in the world.[13] It was determined that by 1954, 16% of the women on the island had been sterilized and that "no other country-industrialized or developing had sterilization ever achieved such popularity."[14] Research and studies have concluded that the reason sterilization was so popular on the island was due to the adamant encouragement, persistence, and coercion of the American physicians who practiced on the island.[13,14]

In parts of Africa, there have been thousands of cases of involuntary sterilization occurring with women living with HIV/AIDS.[15] Based on presumptions, miseducation, and stereotyping, the African government pursued sterilization as a method of preventing the transmission of the virus to unborn children. Without proper information and consultation, women have reported being forced to sign consent forms under coercion and duress.

Adopting American ideology on the matter, perhaps the biggest proponents of sterilization were the German Nazi leaders.[3] Known as Rassenhygiene, or racial hygiene, Nazi German doctors performed involuntary sterilization for the sake of eradicating the inferior from society. Medical documentation accounted for the sterilization of 400,000 men and women but scholars believe the numbers are much higher[3,16]; it had been argued that "as many as 10-15 percent of the population were defected and ought to be sterilized.[16] Feeling that surgical sterilization was too slow of a process for mass efforts, the Nazis experimented with medicinal methods that would allow sterilization via ingestion or injection.[16]

"MEDICALLY NECESSARY" HYSTERECTOMIES

The "medically necessary" hysterectomy is one of the most controversial medical procedures performed around the world, with physicians suggesting that 90% of hysterectomies are unnecessary and that other option should be explored.[17] Recently, The Guardian released an expose bringing to light that sugar cane workers in India are being coerced into having hysterectomies as a remedy to painful periods[18]; in Sweden, a case has been launched to investigate the misdiagnosis of 33 women who had unnecessary hysterectomies.[19]

According to Yale Medicine, approximately 500,000 hysterectomies are performed in the United States every year; hysterectomies are the second most common surgery for women in the US.[20] Medical recommendations for hysterectomies include abnormal bleeding, gynecological cancers, and unmanageable pain from fibroids, cysts, or endometriosis. The two most common types of hysterectomies are the total hysterectomy and the radical hysterectomy. Both types of procedures are considered common treatments to address gynecological concerns; the radical hysterectomy is the full removal of all reproductive organs such as the uterus, ovaries, fallopian tubes, and cervix.

INVOLUNTARY STERILIZATION FOR THE LGBTQIA+ COMMUNITY

Targeted as far back as the Buggery Laws of 1533 in Britain, cisgender gay men were a group within the LGBTQIA community that underwent involuntary sterilization through the criminalization of consensual homosexual sex.[21] Chemical castration has been used as a permanent punishment for those engaging in criminal same sex interactions.[22] Through the administration of hormones and medications to block testosterone, the purpose of chemical castration aims to decrease the desire of sex and cause impotence. Often resulting in infertility, chemical castration also impacts sperm production, known as azoospermia.

One of the most well-known cases of chemical castration of a gay man was that of Dr. Alan Turing, the British mathematician who in 1952 was prosecuted criminally for engaging in homosexual acts.[23] Turing was forced to choose between a prison term or chemical castration and chose the latter. The effects and impact of the chemical castration left Turing ostracized and isolated, he developed breasts due to the hormonal treatments, and he experienced severe depression. In 1954, Turing died by suicide. Homosexual activity was decriminalized in England and Wales in 1967.[21] In 2009, the British government publicly accepted wrongdoing, apologized to Dr. Alan Turing for his abhorrent mistreatment, and posthumously recognized Turing's accomplishments and contributions as a codebreaker during WWII.[23] Turing was issued a posthumous pardon in 2017 under the Disregards and Pardons Scheme, which serves to grant expungements to those convicted under laws criminalizing same sex activity.

In addition to chemical castration, jail time was also used as a means to deter and punish homosexuality.[21] Jail terms varied up to life in prison, included fines, and other consequences such as registering as a sex offender. It is estimated that 49,000 persons were found guilty under Buggery Laws in the UK, one being playwright, novelist, and poet Oscar Wilde.[21,24] After two very public trials, Wilde was found guilty of gross indecency under British law in 1895 and was sentenced to two years in prison.[24] After completing his sentence, Wilde fled to France where he lived freely as homosexuality was decriminalized there in 1791.[24,25]

Across the United States, and many parts of the world, Trans individuals are forced to undergo required reproductive procedures in order for their gender to be legally recognized.[26] Up until 1987, the American Psychological Association (APA) considered gender and sexual orientation variance a mental illness in its Diagnostic and Statistical Manual of Mental Disorders (DSM); therefore, for those who identified as LGBTQ, sterilization was justified under those criteria.[27] Currently in the US, there are nine states that actively mirror coercive sterilization against Transgender and gender non-conforming individuals by requiring sterilization as part of the medical transition process.[26] Several other states require proof of gender medical transition which includes hormone replacement therapy in order to change the sex markers on a birth certificate.

Adopting America's lead, other countries followed in enacting laws sterilizing LGBTQ-identified individuals.[28,29] Japan and Finland also required sterilization before an individual is able to legally and medically transition.[28,29] Recognizing that a person is entitled to reproductive autonomy, both countries dropped this requirement in 2023.[30] Up until 2014, Denmark required sterilization in order to change gender markers but now only requires a six month reflection period before moving forward with legal transition.[31] Worldwide, self-declaration recognition is now being called for as the ultimate standard for legally affirming one's gender.[32]

Undeniably, the intersex community has had an extensive history of medical abuse, specifically medical professionals making unilateral reproductive decisions on behalf of the patient.[33] One of the early pioneers of this practice was Dr. John Money who was considered to be the eminent expert in human sexuality and the treatment of intersex medical cases.[34] As noted in his most famous gender reassignment case of the twins referred to as John and Joan, Money believed that gender identity was malleable and that it was possible to shape gender via consistent environmental cues.[35] While this patient was not intersex, Money's extensive publication and press around the case formed the basis for what continue to be the standard medical and psychological approaches to treating intersex patients. Money's theories of malleable gender identity were disproven when fellow sexologist, Dr. Milton Diamond, published a follow up to the John/Joan case.[36] Diamond reported that Money's theories and practice were not only erroneous but absolutely damaging to the patient's emotional and psychological wellbeing. In the case of John/Joan, both patients died by suicide in 2002 and 2004.[37] It is estimated that Money attended to dozens of intersex patients, experimenting on them with his misguided theories of malleable gender identity which essentially altered the course of their lives.[36] Globally, organizations such as the World Association for Transgender Health (WPATH) and the United Nations Human Rights Council, have issued best practices guidelines for working with the intersex community, primarily focusing on the ending of non-consensual medical procedures.[35] In January 2025, the U.S. Department of Health and Human Services released the Advancing Health Equity for Intersex Individuals.[38]

STERILIZATION BY DEFAULT

Perhaps the most pervasive form of sterilization among Transgender individuals is the surrendering of fertility based on assumption, lack of information, and lack of access to alternative options. While there is no longer a widespread culture of medical providers intentionally pushing sterilization onto Transgender patients, there are several aspects of the medical transition process that contribute to sterilization by default. Currently, there are no standardized guidelines regarding fertility preservation education or options counseling when working with Transgender patients. As so, this leaves many providers to assume the patient's wants or needs based on their own preconceived ideas around the patient's medical transition goals.[39]

In assuming that a patient is not interested in fertility preservation, or prioritizing patient education only around Hormone Replacement Therapy (HRT) instead of the full scope of medical transitioning, patients are often left learning about time sensitive fertility preservation medical options too late, if at all. In a 2023 study focusing on fertility preservation education for Transgender patients, between 37.5 and 51% of adult Transgender respondents reported that they would have been interested and opted in for fertility preservation had they been given the education and resources before starting HRT or having surgery.[40] While 58% of respondents reported receiving adequate fertility options counseling, 42% of respondents reported receiving inadequate education or no education at all.[41] Instead, patients are often learning about preservation options after initiating HRT and fertility has been impacted, leaving them with the decision to temporarily stop their medical transition or accept the loss of their fertility.

Even in cases when proper patient education is given, patients still might feel hesitant to focus on fertility preservation if it contradicts other transition-related goals. Engaging in fertility preservation delays starting HRT and scheduling Gender Affirming Surgery, and in many states delays the ability to

complete the legal transition process. Transgender men wishing to preserve their eggs typically need to engage in estrogen therapy and an intense fertility medication regimen.[41] Also taking into consideration that treatments take place at fertility clinics which often aesthetically center on motherhood, these combined factors may trigger increased feelings of dysphoria.

One of the largest barriers to autonomy in the fertility preservation process is the significant financial burden of this care. Fertility preservation is rarely covered by medical insurance plans, requiring patients to pay for the initial costs of the preservation process, as well as the long-term fees related to storage, and the costs related to initiating the conception process. When faced with the reality of paying for the costs associated with continuing medical transitioning or fertility preservation, many give up hope of becoming parents. By refusing to cover the costs associated with this process, insurance companies are effectively making the determination to sterilize Transgender individuals and that can be viewed as a form of eugenics.

REPRODUCTIVE TRAUMA SUPPORT

There is a dearth of qualitative and quantitative studies investigating the emotional impact of post-sterilization experiences. The body of research that does exist tends to focus on medical measures of pain and healing while ignoring emotional impact of depression, loss of fertility, shifts in sexual identity, bodily agency, and sense of self.[42] In addition to the aforementioned issues, patients who have undergone a hysterectomy have reported changes in libido, weaker orgasms, loss of interest in masturbation and sex, difference in sexual sensation, and feeling disconnected from their partner.[43] We imagine the same is true of all individuals who have gone through reproductively invasive procedures.

As expected, medical practitioners are most likely strictly prioritizing the medical aspect of the procedure and not the emotional and sexual impact of the patient's new post sterilization reality.[44] Education around expectations typically stops at medical aftercare instructions, while therapy is rarely recommended or mentioned. If existent at all, most support groups, literature, discussion, or even therapeutic approaches focus on the concepts of cancer survivorship, not so much reproductive trauma.

For many clients, the experience of reproductive intrusiveness is likely to be viewed as a medical trauma, therefore, clinical treatment should be viewed through a trauma-focused lens. Clinicians should be prepared to treat clients using the lens of grief therapy to address loss of autonomy, the changing of identity, the feelings surrounding the function of their body, and their sexual identity and satisfaction. Clinicians should consider working to balance themes of empowerment and a patient's reclamation of their body and life while giving space for exploration of grief, loss, and even self-blame or doubt. Healing from the trauma of an intrusive reproductive practice may impact intimate relationships, mistrusts of medical providers, and the ability to connect with one's own body in a healthy and fulfilling way.[43,45] Concerns regarding post-procedural sexual function and satisfaction may arise, causing feelings of inadequacy, anxiety, and depression; fears of both emotional and physical discomfort surrounding intercourse post procedure are very common.[43]

In essence, broader multidisciplinary conversations are needed between sexuality and medical providers to address the holistic impact of medical procedures on clients. Recommendations for pre and post procedure counseling should be required in order to respond to a client's non-medical questions, concerns, and expectations. Oncosexology is a discipline of sex therapy that focuses specifically on the sexual wellness and intimacy of cancer patients, which includes hysterectomies; this lens may still be helpful in helping others who are navigating a post-sterilization reality. Clinicians should become familiar with the modalities used in the branches of sexology that focus on chronic illness, oncology, and gynecological issues, as these are best suited to address the impact of medical procedures on a client's sexuality.

Finally, validating, normalizing, and encouraging a client's right to question a medical professional's opinion is a significant way of empowering a client. Recognizing the need to expand their fullest informed consent, explicitly understanding the impact on all aspects of their procedure - the medical, emotional, physical, and sexual - is crucial in establishing reproductive agency. Moreover, identifying gaps in the patient's knowledge will contribute to creating a personalized care plan that will increase their cognizance. Motivating the client to work collaboratively with their medical team to achieve the most optimum outcome for their situation is paramount.

PROFESSIONAL CONSIDERATIONS

Throughout 2025, the United States has seen a relentless attack on reproductive health and gender affirming care. Laws and policies are being introduced to criminalize those exercising their reproductive rights.[46] Medical professionals are under threat of jail time, loss of license to practice, and the withholding of federal funds if they continue to provide affirming care. The Trans community is experiencing the stripping of access to HRT and the legal transition process. The advancements made to secure reproductive autonomy, self-declaration of identity, and freedom of gender expression are all being gutted on a daily basis. In spite of these risks, professionals have an ethical and moral obligation to continue providing comprehensive gender affirming care and reproductive care.

As we broaden our understanding of experiences with intrusive reproductive procedures, a series of moral and ethical questions arise:

- Why do we continue to be denied reproductive anatomy?
- Are medical recommendations grounded in what is actually best for the patient or are drastic reproductive procedures simply being performed as the first and only intervention as opposed to a last resort?
- Historically, why do reproductive organs continue to be viewed as expendable by the medical profession and not as an extension of one's holistic identity?
- Why do we have to choose between our gender identity and our sexual identity? What further fundamental changes need to take place in order for these two distinct entities to be disentangled?
- Finally, are we contributing to eugenics by not engaging in the full disclosure of the medical consequences for all reproductive procedures, especially for procedures that have irreversible consequences?

According to renowned physician Dr. James E. Bowman, the concept of eugenics speaks to "genetic inequality" and can be viewed as two pronged: active eugenics and passive eugenics.[47] Bowman defines active eugenics as the act of encouraging or discouraging reproductive capabilities amongst certain groups, while passive eugenics is seen as policies and laws that do the same. In both cases, lack of reproductive advocacy, the lack of fully transparent informed consent in patient care, and the oppression of reproductive autonomy can all be seen as fostering eugenics.

Without exception, the reproductive potential of all individuals must be respected. The consequences of being forced or coerced into decisions that lack full information and transparency not only violate human rights but the trauma imposed upon someone who has had no informed decision over their own body is beyond negligent and the repercussions can be felt for years, impacting every part of their lives. The right to gender identity and expression, and the right to sexual reproductive autonomy, are basic human rights. Being forced to renounce one's reproductive abilities based on misinformation, lack of information, or even the assumptions of a medical provider, violates this right. Case in point, based on the statistics provided, it appears that hysterectomies have been and continue to be used as a frontline treatment to solve gynecological issues.[20] By presenting a hysterectomy as the foremost intervention, the patient is denied the agency over their own body and reproductive future. This can be viewed as a form of eugenics as medical professionals may be acting as "conspirators in health care inequality" by influencing clients to surrender their fertility abilities.[47]

Recognizing that Trangender and intersex individuals must have a say in retaining their fertility potential is of the most paramount importance. What prevents Trans individuals from fully exercising their sexual and reproductive rights are not only found in the regulation of laws and policies but also within societal expectations and norms that have been created.[48] The thought of a Trans man being pregnant or a Trans woman producing sperm appears to be beyond the scope of comprehension and acceptance by most in today's society. True sexual and reproductive freedom requires the dismantling of gender binary structures that are so ingrained in current society. Challenging the existing notion that pregnancy is only possible to cisgender women and moving towards inclusivity and acceptance that parenthood is actually gender neutral is essential in order to progressively evolve.[48]

One of the first steps in obliterating the fostering of eugenics is removing the obstacles and regulations that prevent individuals from asserting themselves as the experts of their lives. Reproductive justice cannot be fully achieved until we examine and challenge the coercive systems that keep marginalized communities oppressed, perpetuate violations to a person's body, and strip away the right to make personal reproductive decisions. In order to accomplish reproductive freedom, the recognition and prioritization of reproductive self-determination must be uncompromisable. It is a grave injustice to continue legitimizing gatekeeping agendas when self-declaration, reproductive autonomy, and clear informed consent should always be the highest standard.

Please reach out to DESexualityGenderCollective@gmail.com with any questions.

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Building Comprehensive Gender Affirming Care Programs: Recommendations Based on Planned Parenthood of Delaware's Model of Care

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ABSTRACT

To truly embrace gender-affirming care, society must also address the broader social determinants of health that impact transgender and nonbinary individuals. This entails tackling issues such as housing instability, unemployment, and mental health challenges through tailored programs and inclusive policies. Holistic support mechanisms can help create a foundation where individuals not only access care but also feel empowered to lead fulfilling lives. Moreover, research and data collection must evolve to include and accurately represent gender-diverse populations. This can shape targeted interventions and foster a deeper understanding of the unique challenges faced within these communities. By prioritizing inclusive research practices, public health systems can ensure that policies and programs are grounded in evidence that reflects lived experiences. As the journey toward equitable care continues, it is essential to celebrate the resilience and strength of transgender and nonbinary individuals. Their voices and lived experiences should remain central in shaping policies, practices, and narratives surrounding gender-affirming care. Together, communities, policymakers, and healthcare providers can drive systemic change that affirms and uplifts every individual, embodying the true essence of equity and justice.

AN OVERVIEW OF GENDER AFFIRMING CARE

Gender Affirming Care (GAC) is currently one of the most politicized and debated forms of medical care in the United States and is often the most misunderstood and misrepresented. GAC Programs offer a wide range of services that are designed to affirm an individual's identity and offer treatment for symptoms of Gender Dysphoria or Gender Incongruence.[1] These interventions are interdisciplinary and expansive, ranging from psychotherapy to Hormone Replacement Therapy or Gender Affirming Surgery, with many services in between.

While treatment modalities such as Hormone Replacement Therapy (HRT) or surgery are the most widely known aspects of GAC, many programs offer other vital services such as hair removal, voice therapy, and assistance with the legal transition process (i.e. name changes and gender marker changes,) as well as fertility preservation. Comprehensive GAC programs hold the ability to collaborate with other disciplines, such as urology, pelvic floor therapy, reproductive medicine, gynecology, and provide non-judgmental medical care using an affirming approach.

While every patient will not require the full spectrum of care available, it is essential that GAC programs are holistic, incorporating an interdisciplinary approach to care-and avoiding an "one size fits all" approach to treatment. A comprehensive GAC program, such as what is offered by Planned Parenthood of Delaware, provides the ability to offer individualized services which present the patient with a range of options allowing for the most collaborative care possible, facilitating improved positive health outcomes.[2] This article will review the existing evidence supporting Gender Affirming Care, explore the importance of comprehensive and multifaceted GAC programs, as well as identify the potential risk to patient outcomes related to current legislative changes.

EVIDENCE-BASED CARE

The World Health Organization (WHO) defines **transgender** as an umbrella term for people whose gender identity differs from the sex they were assigned at birth (as opposed to **cisgender,** which refers to people whose gender identity aligns with the sex they were assigned at birth). **Gender incongruence** is characterized by a marked and persistent incongruence between an individual´s experienced gender and the assigned sex at birth. Gender Incongruence often leads to a desire to "transition" to live and be accepted as a person of the experienced gender, through HRT, gender affirming surgeries, or other healthcare services to align one's body with their experienced gender. The distress some individuals experience due to this incongruence is referred to as **gender dysphoria**. The World Professional Association for Transgender Health (WPATH) Standards of Care Version 8 states a diagnosis of Gender Incongruence or Gender Dysphoria may be necessary in some regions for patients to access transition-related care. The ability to access care heavily relies upon the health care provider's experience using the above definition for a formal diagnosis. Providers' understanding of the proper usage of criteria shapes the overall treatment and patient experience.

Transgender patients report a significantly worse overall health compared to the general population, including primary healthcare needs, sexual and reproductive health, and mental health. Barriers to improved overall health outcomes include access to competent healthcare providers, cost (including lack of insurance coverage for medications and procedures under a diagnosis of gender incongruence), in addition to the avoidance of seeking healthcare due to fear of discrimination or threats to safety. About half of trans patients report that they have experienced at least one negative interaction with a healthcare provider, including using the wrong name or pronouns, and

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patients having to teach their providers about trans appropriate care.[3] However, better health was reported in respondents who had the means and access to be able to socially and medically transition.[3] In a study observing changes in mental health over the first year of receiving either puberty blockers (PB) or gender affirming hormone therapy (GAHT), it was concluded that there was a 60% lower odds of depression, and 73% lower odds of suicidality compared with trans youths who had not received PBs or GAHT.[4] Like many studies involving transgender participants, there were limitations, for example this study only studied 104 youths (13-20 years old), however the overwhelmingly positive outcomes of GAC in this prospective observational cohort study are still impressive and significant.

Mental health services continue to be an integral component for transgender individuals. In a 2022 U.S. Transgender Survey (USTS) of over 84,000 binary and nonbinary trans people, 78% of transgender adults considered suicide, and 40% attempted suicide in their lifetime (compared to 13.2% and 2.4% respectively in the general population).[3] Unfortunately, the incidents of suicide attempts are increasing among transgender and nonbinary young people, as state-level anti-transgender laws are on the rise.[5] Not only are counseling services essential, having access to affirming mental health counselors cannot be overstated. Among respondents in the 2022 USTS survey who discussed their gender identity with a counselor, 12% reported that their mental health provider tried to persuade them to identify only as their sex assigned at birth, with 50% reporting similar experiences having consulted with religious counselors or therapists.[3]

As more comprehensive research is conducted, we are seeing an increase in **detransitioning** (discontinuing GAC and returning to living as one's sex assigned at birth) from 1% to 2-10%, although this data requires an understanding of the social, legal, and financial contributing factors that typically lead to a person's decision to detransition. This decision is distinct from the concept of 'regret', and the decision may be based on a number of reasons, including expansion of one's gender identity, changes to financial status or insurance coverage, competing health concerns, lack of social and family support, discrimination, and anti-trans legislation or worsening political climate.[6] This phenomenon is understood to be both highly nuanced in terms of complexity and rarely occurring. While a small percentage of respondents report detransitioning due to a deeper understanding of their gender and the reclamation of a cisgender identity, almost all respondents cite lack of family and community support, lack of access to gender affirming healthcare and legislative protection, lack of financial and insurance stability, and risks to their employment, housing, or general safety as their primary motivation.[7] What can be gleaned from this data, which is the largest and most comprehensive study focusing on detransitioning to date, is that most individuals who detransition due to these stressors eventually retransition later in life once they are in a more stable and supportive environment.[7] While continued research is needed, more enthusiastic, visible, and meaningful support for the trans community is vital to both life satisfaction and positive health outcomes, underscoring the need for GAC.[8] With 98% of respondents reporting that GAC increases their overall satisfactions with their lives, the research is overwhelming: Gender Affirming Care is evidence-based and, for many, lifesaving.[3]

EVOLUTION OF PLANNED PARENTHOOD OF DELAWARE'S SERVICES

Planned Parenthood of Delaware's Gender Affirming Care Program began in 2019 and has evolved into one of the largest programs in the state, serving over 900 patients. Like other GAC programs, Planned Parenthood of Delaware (PPDE) initially focused only on prescribing HRT and using a trans-affirming approach to other routine services like family planning, STI testing and treatment, abortion care, and annual preventative exams. In 2021, PPDE expanded its existing GAC program by offering behavioral health care, case management, crisis intervention and wrap around services to meet both social determinant needs as well as assistance with the legal transition process and letter writing services for Gender Affirming Surgery. The evolution of PPDE's GAC program was strategic, offering a seamless continuity of care for its patient population, while also carving out space for the specific needs of transgender patients. Over the years, this program continues to grow, offering a wider spectrum of options for Hormone Therapy, strengthening relationships with other trans-affirming specialists, and building strong referral relationships.

In the spirit of PPDE's values of patient autonomy and increasing access to healthcare, the organization has worked to decrease barriers to GAC by creating an informed consent structure within the program. Informed Consent in the context of GAC facilitates a robust collaborative relationship between the clinician and the patient. The patient is comprehensively educated on the risks, benefits, and alternatives to their potential treatment using educational materials, timelines of expected changes to their sexual and reproductive functioning (ex. vocal tone, fat redistribution, body hair, etc.). Patients are given extensive time to ask their provider questions about changes, what changes are permanent or reversible, and other GAC opportunities for affirming their gender. Providers work with patients to establish a collaborative relationship that allows for patient autonomy in choosing a treatment that meets their needs and anticipated goals. Barring complications related to medical or mental health concerns, patients can access GAC without the additional burdens of antiquated requirements such as a minimum amount of time spent in mental health treatment or a minimum amount of time spent publicly presenting as their chosen gender.

Early pioneers in GAC programming relied heavily on the co-facilitation of care with mental health professionals, often creating barriers to patients accessing the care in the hopes of avoiding transition regret. Research now shows that this method of gatekeeping does not decrease regret, but instead negatively impacts mental health outcomes by delaying access to care that affirms patients, helps more appropriately integrate them into their community, and increases their sense of confidence, safety, and wellbeing.[7]

With the integration of behavioral health services directly into the clinic, clinicians are able to quickly assess and screen potential mental health related risks at the time of service. Standardized suicide and depression screenings and a thorough review of mental health history are all standard parts of patients' intakes. Patients are screened for Social Determinants of Health (SDOH) needs, allowing for immediate linkage to case management and resources. Intimate Partner Violence (IPV) screenings are conducted at every visit, assessing not only for potential family or partner-based physical and emotional abuse, but also abuse related to tampering with or restricting access to birth control or other medications, a type of abuse that is most

commonly reported among transgender individuals, who often experience restricted access to HRT, threats of being outed, and intentional misgendering.[9]

Behavioral health services being available at the time of each patient's visit is vital for continued positive health outcomes and acts as the conduit to ensuring a fully comprehensive GAC program. After being screened for risk factors and opting in for care related to therapy, case management, legal transition assistance, or letter writing services, patients are able to directly access this care during the same visit. This eliminates barriers around going back on a waitlist, taking additional time off of work or school, paying an additional copay or out-of-pocket expense, or having to miss appointments due to lack of childcare or transportation. If there are mental health related concerns that are giving pause to starting HRT, patients can be assessed for readiness in-house with providers that can collaborate efficiently to help them reach stability and start treatment. If we can get patients in the door and fully meet their needs while they are here, we can ensure that they do not fall through the gaps while waiting for treatment.

CASE STUDY

Many patients struggle to access consistent, comprehensive, and affirming care. Below are two case examples, one that is typical of many patient-reported experiences and one that is a positive example of affirming care.

A 27-year-old, Mexican, transgender male using he/him pronouns presents for routine follow up for ongoing Hormone Replacement Therapy. The patient, Santiago, has been on HRT for five years and is experiencing typical, satisfactory changes to facial hair, fat redistribution, voice deepening, and decreased dysphoria and normal bloodwork. During the rooming process, the Medical Assistant (MA) reviews his chart and clarifies demographic information, asking him to confirm his name and date of birth. When Santiago confirms his full name, the MA clarifies, "no, like your real name - the one on your insurance." Santiago confirms that this is his legal name, and the visit continues.

When the Clinician enters and reviews Santiago's chart, the two agree that changes are progressing appropriately and Santiago is happy with the results from HRT. Santiago mentions that he has been experiencing intermittent spotting despite not having menstruated for several years and is experiencing vaginal dryness and discomfort during intercourse. The Clinician, who has not completed an organ inventory or comprehensive and open ended sexual history, struggles to understand the way in which Santiago uses his body during sexual intercourse and dismisses the symptom, stating "well, I can't imagine you would want to have penetrative sex anyway if you're trans, so I'm sure it's not too much of an issue."

The Clinician then moves to the issue of intermittent spotting, assuring Santiago that this is "just something that happens" after a few years on testosterone, and that there is nothing to worry about, but he is free to discontinue HRT if these symptoms bother him. After a few more minutes of discussing Santiago's bloodwork, the Clinician advises Santiago to schedule a follow up in three months if he continues to experience symptoms. Santiago leaves the visit without being offered STI testing, without any solutions for his vaginal atrophy or intermittent bleeding beyond stopping HRT, and without having a medical team that understands his sexual history or medical needs. Santiago does not return to the clinic.

CONSIDER, INSTEAD, AN EXAMPLE BASED ON CARE RECEIVED AT PPDE:

A 27-year-old, Mexican, transgender male using he/him pronouns presents for an initial Gender Affirming Hormone Therapy visit and is transferring care from a local Primary Care office. The patient, Santiago, has been on HRT for five years and is experiencing typical, satisfactory changes to facial hair, fat redistribution, voice deepening, decreased dysphoria and normal bloodwork. When scheduling his appointment, the Patient Access Center asks Santiago for his name and date of birth and other demographic information, as well as the legal name on his insurance and ID, if it is different from his chosen name.

Santiago arrives at the clinic and sees art hanging in the waiting room of patients that look like him and is able to read literature tailored to patients seeking similar types of care. The MA that rooms him greets him with a smile and confirms his name, pronouns, and date of birth, and shares their own name and pronouns. The MA, Tori, sits with Santiago and conducts a comprehensive intake, including a full sexual history; Santiago and Tori review an organ inventory to better understand how Santiago's body functions, and they review the organs that Santiago's sexual partners have in order to best assess for sexual health risks and interventions.

When the Clinician enters and reviews Santiago's chart, the two agree that changes are progressing appropriately and Santiago is happy with the results from HRT. Santiago mentions that he has been experiencing intermittent spotting despite not having menstruated for several years and is experiencing vaginal dryness and discomfort during intercourse. The Clinician asks Santiago open-ended and non-judgmental questions about his symptoms and potential contributing factors and works to establish a baseline for Santiago's body. The provider explains the limitation of research around intermittent spotting in transgender men, but works through several potential causes and interventions, including a hysterectomy, which Santiago had been interested in but did not know was an option.

Well-versed in gynecological health, the Clinician educates Santiago on the relationship between increased testosterone and vaginal atrophy and proposes the use of topical estrogen to alleviate symptoms. Given Santiago's reported sexual history and lack of appropriate sexual health screenings from his last provider, she offers STI testing, which he accepts. Finally, the Clinician proactively offers to connect Santiago with PPDE's co-located behavioral health services. PPDE's LCSW is an expert in transgender mental health and can work with Santiago to write a letter of medical necessity for his hysterectomy or connect him to local support groups and community resources. Santiago leaves the clinic with several solutions, feeling heard and valued by his provider, and is looking forward to his follow-up visit.

In this example, there are common themes throughout the visit that contribute to its success: respect, non-judgement, and the ability to view the big picture. Santiago is valued and respected throughout every interaction, from the Patient Access Center to the MA, to the Clinician. All of Santiago's options are explored, and his health needs are comprehensively assessed. Care provided at PPDE is grounded in mutuality, cultural

humility, and a high degree of expertise with transgender patients, allowing health to be approached as a full picture, not just individual pieces of a puzzle. Santiago's continuation of care increases his opportunities for basic cancer screenings, mental health maintenance, vaccinations, and blood pressure monitoring, all opportunities that are missed when a patient is lost to follow up or deterred from seeking care. By working to meet his needs in a way that is efficient, comprehensive, and meaningful, Santiago is able to have a positive clinic experience and remain an active participant in his healthcare.

POLICY IMPLICATIONS AND ADVOCACY

Nationally, the Planned Parenthood Federation of America (PPFA) lobbies for federal protections, while PPDE engages in state-level advocacy to ensure that Delaware remains a haven for transgender individuals seeking care. A new development at the federal level could impact this work. The U.S. House of Representatives narrowly passed the "One Big, Beautiful Bill Act" on May 22 with a 215-214 vote. This budget reconciliation measure includes a provision that prohibits the use of federal funds for Gender Affirming Care. As the bill moves to the Senate for consideration, the outlook for federal support of these healthcare services remains unclear. Should this legislation become law, it could significantly restrict access for LGBTQ+ patients relying on Medicaid. Services such as STI testing, HIV treatment, and mental health support might become unavailable under federally funded programs. Additionally, the complete elimination of federal funding for Gender Affirming Care would increase out-of-pocket expenses, potentially making these services unaffordable for many and creating serious barriers for receiving their care. PPDE's ability to engage in advocacy work, collaborate with legislators and other stakeholders, and commitment to evolving with best practices ensures that patient needs remain on the forefront.

Delaware stands as a progressive beacon for LGBTQ+ rights, particularly in the realm of Gender Affirming Care. In 2025, then-Governor Bethany Hall-Long established the state's inaugural LGBTQ+ Commission through Executive Order No. 1, aiming to enhance services and remove barriers for LGBTQ+ individuals. In June of 2025, Governor Matt Meyer signed Executive Order No. 11, creating extensive legal and practice protections for transgender Delawareans and GAC providers.

However, as the evolving political landscape and external pressures loom, consistent vigilance and advocacy allows for continued safeguarding against advancements that will adversely impact care. Delaware currently provides Gender Affirming Care for minors and adults. The First State has gone a step further by working to protect access to GAC through the introduction of bills like House Bill 205, spearheaded by Rep. Cyndie Romer, to fortify protections for gender-affirming care. This bill seeks to shield providers from out-of-state legal actions, ensure insurance coverage, and uphold patient confidentiality. This bill is currently in the Delaware Legislature.

Planned Parenthood of Delaware (PPDE) plays a crucial role as a vanguard in delivering GAC treatment and supportive resources for adults. While Delaware's commitment to supporting GAC access is laudable, it will take all of us to be vigilant. Residents are urged to engage in advocacy, stay informed, and support affected individuals in the Delaware community and beyond. By actively participating in advocacy efforts, Delawareans can help ensure the state continues to be a safe haven for Gender Affirming Care.

GAC PRACTICE CONSIDERATIONS AND RECOMMENDATIONS

Transgender patients are in the disadvantaged position of having to work harder to receive the same quality and standard of care that their cisgender peers receive. PPDE acknowledges many of these barriers or anxieties around providing care are born, not out of discriminatory attitudes, but out of misinformation or ignorance. Multiple studies show new healthcare providers feel unprepared to work with LGBTQIA+ patients and cite inadequate education and lack of clinical rotations focused on GAC as the basis for their limitations.[10] Moreover, a significant number of healthcare providers report having never worked with a transgender patient or talked to a transgender person about their experiences in healthcare.[11] If GAC is not a standard part of routine medical education, new and (more seasoned) clinicians are left to their devices which presents a disservice to transgender patient populations that often find themselves disenfranchised from the mainstream healthcare system.

This lack of foundational education results in a frustrating provider-patient relationship, where patients are often educating their providers on their bodies, experiences, risk factors, and medical needs instead of the other way around. This dynamic creates a lack of trust and is a deterrent to seeking care. Twenty-nine percent of transgender patients' report being refused care by a provider, solely based on the fact they are transgender and 21-29% of transgender patients report being physically, sexually, or emotionally abused by a provider.[12] These negative experiences significantly decrease motivation to seek care and serve to perpetuate cycles of illness and exacerbation of chronic disease, limiting the opportunity for early prevention and education by health care providers. This results in deleterious consequences such as unemployment, homelessness, and poverty. Nearly twenty-five percent of transgender patient's report postponing or avoiding seeking care entirely due to experiences of discrimination.[13] These circumstances must change and will only happen when GAC is a requisite component of medical education.

A more open culture of learning will help facilitate needed education on new research, practice standards, and intervention with the goal of decreasing avoidable missteps and improving patient satisfaction with their care. As clinicians continue to strengthen their knowledge, PPDE recommends a targeted focus on understanding current and upcoming legislation, especially as it relates to changes to the legal transition process and insurance coverage for GAC. Staying abreast of these important changes will allow practices to stay current and meet the needs of patients. Clinicians will be better equipped to engage in patient-centered care and meet the often-times complex needs of their patients.

PPDE urges clinicians to understand that many aspects of Gender Affirming Care include interventions that are already part of their routine wheelhouse practice. For example, many primary care providers are comfortable prescribing hormone therapy for cisgender patients with low hormone levels, topical estrogen to cisgender women experiencing vaginal atrophy, or supporting cisgender patients through postoperative care for procedures such as breast augmentations or mastectomies. These treatments require the same skills and scope of practice as they would in providing care for transgender patients. Similarly, mental health clinicians are well versed in performing biopsychosocial assessments and exploring motivation and readiness for change but often feel unprepared to perform similar interventions such as writing a surgical letter for a transgender client.

Many therapists have the knowledge and skillset to provide these services but may feel disinclined to work with transgender patients due to the personal and professional risks that are posed by providing GAC in this current political climate. This leaves a gap that clinicians working in GAC endeavor to fill but are met with intense threats. An example of this concerns The Gender Affirmative Letter Access Project (GALAP). GALAP is a database which was created for patients that provides information on therapists who pledge to provide low-cost or free surgical letters, which is a requisite step to accessing Gender Affirming Surgery. This database has recently been doxed and is no longer operational, leaving pledging providers vulnerable to threats and violence. These providers are now subject to false reports to their licensing board, sharing their private information on messaging boards, anti-GAC forums, and right-wing websites. Collectively, these actions serve to further disenfranchise transgender patients from accessing needed care. Instead of backing away from treating transgender patients out of fear, PPDE encourages clinicians to provide transgender patients with needed and lifesaving GAC services. In increasing the number of clinicians who feel comfortable incorporating GAC into their practice (and advertising that they do so), GAC will become more normalized and less stigmatized, ideally decreasing targeting of GAC providers who are seen as outliers in the medical field.

PPDE encourages providers to acknowledge the real and perceived barriers disproportionately impacting transgender patients. During the process of building, expanding, or revamping a GAC program, it is vital to seek the input of actual transgender people through hiring transgender consultants, transgender providers, and seeking feedback from transgender patients. Allowing transgender individuals to see themselves as decision makers in the creation and maintenance of a GAC program will afford them the autonomy that they deserve in seeking care. This inclusion does not start when the provider walks into the exam room, but instead begins with the way that services are advertised, the art in the waiting room, the scripting from staff in asking about pronouns, chosen and legal names, organ inventories, and the care that the provider takes when documenting in their chart, or speaking about them to other medical staff. Simple interventions, such as using a patient's correct name and pronouns, can reduce depression by 71% and reduce suicidal thoughts by 34%, offering a free, low effort opportunity that is literally lifesaving for many patients.[14]

Most importantly, PPDE urges you to view Gender Affirming Care as lifesaving, evidence-based, and medically necessary care. Treating transgender patients with dignity and respect and allowing them autonomy and partnership in their medical care is always within our scope. Doing our own learning, understanding our limitations, and acknowledging the reality of legislation, lack of supportive community, and barriers to seeking care are all part of the oaths that we take. Providers already understand these interventions and have the ability to navigate complex patient histories and risk factors. Working with transgender patients is no different than working with any other patients. Collectively, providers have the ability to make access to GAC a routine, standard aspect of their practice. Everyone has a role to play in ensuring care for the transgender community is holistic, compassionate and grounded in evidence which is supportive of meeting all of their individual needs.

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Cultivating Capacity: Supporting Professional Capacity, Burnout Support, and Burnout Recovery to Achieve LGBTQIA+ Health Equity

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The healthcare landscape and its service delivery are rapidly evolving, and lesbian, gay, bisexual, transgender, queer, intersex, and asexual (LGBTQIA+) communities continue to encounter disproportionate barriers to care, increased scrutiny, and frequent microaggressions in care, policies, and practices. This article aims to examine healthcare providers' emotional and mental capacity for delivering sexuality- and gender-affirming care, as well as supporting recovery from healthcare provider burnout and access to wellness resources. It explores the intersectional lived experiences of LGBTQAI+ youth, adults, and families within healthcare, along with the often-overlooked need for professional well-being. Specifically, I will analyze how intersectionality and healthcare equity in LGBTQIA+ services are influenced by providers' emotional and mental resilience and support systems for burnout prevention and recovery. Recognizing the underlying exploitation rooted in the rise of American capitalism, one of my most urgent questions is:

IN A SYSTEM THAT REQUIRES OUR PERPETUAL EXHAUSTION, HOW CAN WE PREVENT BURNOUT?

The lens through which I view the experience of intersectionality in healthcare is decolonial, integrative, and focused on desirability politics (i.e., eroticism). This means I deliver services from a healing-centered approach, considering the trauma impact of the survivor's experience rather than focusing solely on systems of harm and their agents. The delivery of care through this lens emphasizes a humanistic perspective that the personal is professional. Professional use of the self occurs when a practitioner therapeutically shares personal insights, lived experiences, and lessons learned as a way to provide psychoeducation and build trust in the therapeutic relationship. With over 23 years of seasoned experience as a crisis therapist, clinical social worker, integrative somatic sex therapist, clinical supervisor, community leader, and professional development facilitator in healthcare service delivery, I have worked across nearly every level of care within the State of Delaware—including juvenile justice, community-based programs, out-of-school youth employment, inpatient and outpatient services, community mental health, collegiate settings, and various community volunteer roles, including the United Way Pride Council.

Research on provider burnout and recovery indicates that professionals must develop and sustain the mental and emotional capacity for racial, gender, sexuality, disability, and environmental healthcare equity. This is a core belief of mine, both personally and professionally. Therefore, this is not just a personal choice, but also a professional duty and ethical obligation that extends across all levels—administration, management, support, and direct care. Due to issues like medical mistrust, which have historical roots among Black/African Americans—including Black Americans who are also LGBTQAI+—client participation in healthcare can be hindered, leading to poor outcomes. Our emotional and mental capacity directly impacts our ability to learn, understand, and compassionately apply the complexities of intersectionality in service delivery and providing affirming, trauma-informed, and integrative care that marginalized communities critically need and deserve. Without these—knowledge, attitude, and skill—we risk perpetuating the very systems of harm we aim to dismantle, thereby undermining the protection, quality, and sustainability of compassionate, affirming care for all LGBTQAI+ youth, adults, and families.

UNDERSTANDING INTERSECTIONALITY IN LGBTQIA+ HEALTHCARE & SERVICE DELIVERY

To effectively serve LGBTQIA+ communities, especially those facing multiple layers of marginalization in Delaware's rural areas, there is an increasing need to understand and incorporate the concept of intersectionality into our professional practice. Coined by legal scholar Kimberlé Crenshaw in 1989, intersectionality describes how various social and political identities—such as race, class, gender, sexual orientation, disability, and immigration status—interact with systems of power and those who control resources through discrimination and desirability.[1] Intersectionality goes beyond the 'oppression Olympics' approach by recognizing that people hold multiple identities at once—adopting a community-based perspective. According to Black feminist scholar and pioneer in intersectionality research Patricia Hill Collins' Matrix of Oppression, these identities are socially ranked from most to least desirable based on the colonial Western European patriarchy's ideology of desirability. The farther you are from the desires of a cisgender, non-disabled, affluent, land-owning white man, the less influence and access you have to shape your experiences of agency, autonomy, and opportunity. This racial, gender, economic, and ability caste society leaves little room for "others." For LGBTQAI+ youth and adults, especially those from the Global Majority, intersectionality is not just an abstract idea but a lived experience that impacts their access, participation, and outcomes—not only in healthcare but in overall quality of life.

For example, in Delaware, as in most areas within the United States, a Black transgender woman faces discrimination not just as a Black person, or as transgender, or as a woman, but specifically as a Black transgender woman—an experience different from that of a white gay man or a Black cisgender woman. Additionally, this woman may not identify as Black but as Haitian, Jamaican, Panamanian, Puerto Rican, Ghanaian, or Nigerian. Frequently used in patient demographics, Black is a United States identity that describes the formerly enslaved Africans and their descendants, known as African Americans. When you incorporate intersectionality into your worldview, you'll see that skin color does not necessarily indicate ethnicity, nationality, or

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culture. This layered human experience often leads to marginalization, which worsens health disparities. A Black trans woman of African American descent and a Black trans woman of Caribbean descent might respond differently to healthcare, and intersectionality helps to explain this and provides therapeutic approaches affirming to the care recipient and provider.

According to the World Health Organization, health is a fundamental right for every human being. This is not just health for the sake of having health, but *"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."*[2] In my 23 years of experience as clinical social worker and integrative somatic psychotherapist and 10 years as sex therapist, I have observed that one of our most essential human needs directly impacts a person's quality of health is not limited to the quality of care and interaction in care, is the quality of *therapeutic relationships* between the service-delivery provider and client, as well as among a team of service-delivery providers. This is also where, organizationally and fiscally, insurance providers, administrators, and management should consider, in cooperation, the impact of the quality of these therapeutic relationships.

The research, as explored in Ross et al., concurs that both provider-client and provider-provider relationships have an impact on healthcare engagement and healthcare outcomes.[3] In a 2017 discussion paper on burnout among healthcare professionals, burnout was attributed to emotional exhaustion and depression, stemming from both personal and professional factors.[4] In a 2024 article, anxiety and depression were reported to be higher in LGBTQAI+ physicians than in non-LGBTQAI+ providers, in addition to feeling less fulfilled professionally.[5] With stress factors sexuality, gender, and racial microaggressions, in addition to working with non-affirming professionals, and the lack of sexuality and gender work cultures, "stresses of being closeted, and concerns about being out to patient" cultivating emotional and mental capacity of healthcare providers is now a requirement to not only create inroads to healthcare equity but also create the healthcare system that consistently adds to our quality of lives.[6] Therefore, considering the exploratory question about professional burnout involves examining capacity building, with an understanding that burnout has most likely affected healthcare professionals. This is often underreported due to the stigma surrounding mental illness and distress, especially among those with multiple marginalized identities from the Matrix of Oppression. Relationships, both personal and professional, are another vital area where intersectionality plays a significant role in cultivating emotional and mental capacity for burnout support and recovery.

Personally, as a healthcare client in Delaware, I have experienced the minimization of a pregnancy loss because of my perceived age (i.e., agism). My daughter and I have faced racial microaggressions while observing care given to her oldest child, my grandchild. Professionally, I have witnessed and experienced the increasing racialized tokenization of Black queer and trans professionals, along with resistance from healthcare providers, including administrative staff, in being sexuality- and gender-affirming. This contributes to a growing apathy among White, Black, and People of Color LGBTQAI+ professional communities. This issue stems not only from caste perception but also from the emotional and mental capacity of providers and professionals to engage cooperatively. The quality of one's relationships reflects the strength of one's emotional and mental capacity.

Cultivating the capacity to be present in our service delivery is more critical than ever. Both extremely vulnerability individuals and communities like undocumented youth and adult queer immigrants face the constant threat of deportation, service gaps and barriers, social isolation, and discrimination based on both their sexual orientation, gender identity, and/or their immigration status. We must not let exhaustion from legal and political movements sustain the erosion of provider compassion fatigue. As I write this, a July 24, 2025 executive order to criminalize homelessness and those struggling with addiction and the Department of Health and Human Services granted the ability to " *seek, in appropriate cases, the reversal of Federal or State judicial precedents and the termination of consent decrees that impede the United States' policy of encouraging civil commitment of individuals with mental illness who pose risks to themselves or the public or are living on the streets and cannot care for themselves…"*[7]

As we experience the reversion of laws and funding of life-saving resources like the Trevor Project, insurance policy adjustments, and now criminalizing the homeless and those struggling with addiction in which queer and trans individuals experience some of the highest rates of homelessness and substance use while attempting to criminalize gender affirming care providers nationally, being intentional to fight for LGBTQAI+ healthcare equity will require healthcare providers (with the support of their healthcare organizations) to commit to caring and supporting healthcare professionals' emotional and mental capacity. One less seemingly stressful issue is the State of Delaware's efforts to protect healthcare providers' emotional and mental capacity. With the advocacy work of Delaware's ACLU, the 2024-25 State of Delaware General Assembly under Delaware's current governor, Matt Meyers, passed legislation and laws to make Delaware a safer state for its queer and trans immigrant citizens, medical refugees, and their healthcare providers in Delaware.[8]

I would be remiss if I did not explicitly name the lived experience of disability, like a mental health disability, which is often invisible, and intersects with LGBTQIA+ identities in complex ways. LGBTQIA+ individuals with disabilities usually face layered discrimination in healthcare by navigating ableism within LGBTQIA+ spaces and homophobia/transphobia within disability communities and healthcare systems. They may encounter physical and/or cognitive and intellectual barriers to care, a lack of accessible information, and/or providers who are not equipped to address both their disability-related needs and their LGBTQIA+ identities while being aware of their stigmatizing perceptions. In a 2023 paper on mental distress and burnout among LGBTQAI+ healthcare providers, the study author reported professional burnout can lead to delayed diagnoses, inadequate treatment, and a profound sense of isolation for LGBTQAI+ providers.[9] The author called for "health professions researchers need to attend to identity-based stress models to address discriminatory experiences with burnout and mental distress."

A REMINDER: THE IMPERATIVE OF TRAUMA-INFORMED AND AFFIRMING CONSENT-INFORMED CARE WITHIN LGBTQAI+ SERVICE DELIVERY

Given the pervasive discrimination and systemic oppression faced by Delaware's multi-hyphenated LGBTQIA+ communities, providing healthcare and its service delivery that is both trauma-informed and affirming is not merely best practice—it is a moral and ethical imperative that disrupts the siphoning of empathetic,

compassionate, and communal purpose of healthcare service delivery. Trauma-informed care is an organizational and clinical framework that acknowledges the historical and contemporary impact of trauma and recognizes potential pathways for recovery and healing. It integrates knowledge about the *effects* of trauma into institutional policies, operational procedures, and best practices in healthcare and service delivery, actively "resisting re-traumatization."[10] The core principles of trauma-informed care, as outlined by the Substance Abuse and Mental Health Services Administration (SAMHSA), include:

1. **Safety:** Ensuring physical and psychological safety for both clients and providers.
2. **Trustworthiness and Transparency:** Building trust through clear communication and consistent boundaries.
3. **Peer Support:** Incorporating individuals with lived experience into the healing process.
4. **Collaboration and Mutuality:** Sharing power and decision-making between clients and providers.
5. **Empowerment, Voice, and Choice:** Supporting clients in regaining control over their lives and making informed decisions.
6. **Cultural, Historical, and Gender Issues:** Actively moving past cultural stereotypes and biases, recognizing and addressing historical trauma, and acknowledging gender identity and expression.

Sexuality and gender affirming, consent-based care approaches like integrative, somatic, transpersonal, with a sustainable, compassionate lens, are closely tied to trauma-informed practice. This wholeness care and service delivery approach actively validates and supports the LGBTQIA+ and heterosexual identities and their lived experiences, and honors consent-based choices, clinical consideration, and the importance of ancestral healing arts of cultural health care systems such as Ayurvedic and Chinese medicine, transpersonal/spirituality, mind-body practices, energy medicine, hypnosis, bodywork, and somatic movement. As the initial 2002 White House Final Report on Complementary and Alternative Medicine or CAM suggests, these indigenous healing arts emphasize the embodiment of" mind, body, spirit, and environment" or a "wholeness orientation in health care delivery."[11] From Black, Caribbean, African, Indigenous Turtle Islanders, Latine, East Asian, South Asian, and Pacific cultures, these systems of care, now considered evidence-based, have been integral parts of healing, connection, and community building for centuries.

As with indigenous healing arts of the Global Majority, sexuality and gender have been historically, before Western colonization, seen as expansive and fluid. The impact of comprehensive sexuality education for healthcare providers has been shown to increase not only student and providers' knowledge base, but also improve their confidence in discussing sexuality and sexual health topics.[12] This involves providing care that includes and extends beyond the dignity of having one's correct pronouns and names used consistently, also encompassing awareness of power dynamics and an understanding of identity-related stress. It acknowledges sexual and gender diversity as natural variations of the human experience, while promoting more equitable healthcare experiences. For healthcare administrators and healthcare providers, this means moving beyond mere tolerance to genuine acceptance of the human experience. Given the non-support of healthcare equity at the current federal administration level, as suggested in a 2023 systematic review of LGBTQIA+ cultural competency training, "Organizations and health systems must prioritize organizational-level changes that support LGBTQ+inclusive practices to provide access to safe and affirming healthcare services for LGBTQ+individuals."[13] When healthcare and its service delivery are informed by comprehensive sexuality education, which is provided as developmentally appropriate, then healthcare and health equity would offer services that understand the difference between sexuality, sex, and sexual orientation. That difference will be evident in healthcare relationships.

As I often define in one of my earliest integrative professional development trainings, The WHOLE-Self: Gender and Sexuality Bootcamp, sexuality is our entire sense of being. It is our emotions, thoughts, beliefs, and behaviors, as influenced by our socialization, that shape the person we perceive ourselves to be. Sexuality is not the only sex. Sex is the medical descriptor for a person's genitalia, in which gender is assigned. To understand sex is to realize that sex is not just a short descriptor of sexual or sexuality. The term "sexual" is an adjective used to describe the intention of attraction, behavior, and/or activity. Furthermore, comprehensive sexuality education shapes a sexuality and gender-affirming healthcare provider to understand that gender is a performance based on cultural, individual, and collective attitudes, beliefs, and behaviors. There will be more caution in "judging a book by its cover." Comprehensive sex education for healthcare providers would inform our understanding of embodied relationships to safety, power, and our emotional and mental capacity. This is how intersectionality is reflected in healthcare and will continue to inform, support, and expand provider capacity for their participation in LGBTQIA+ healthcare equity.

With the continual plight of medical distrust, increased need for identity-informed trauma responses among healthcare providers, and re-emergence and reclamation of somatic and transpersonal care practices within the LGBTQAI+ communities of the Global Majority, the need to expand our somatic understanding of consent will be how trauma-informed healthcare operations and practices reinforce their commitment to LGBTQIA+ healthcare equity. This somatic understanding of consent enables clients to navigate their decision-making process within a framework of Authentic Consent safely and somatically. Developed by somatic sexologist and intimacy educator Amina Peterson, Authentic Consent follows not only the initial healing principles of the indigenous healing arts outlined in the CAM report, but it also provides a container to support the intentional capacity-building efforts of healthcare providers who are experiencing burnout or recovering from it. Informed by Betty Martin's Wheel of Consent, somatic sexology, sacred sexuality, and the healing justice lineage of disability justice and Womanism, Authentic Consent explores the relationship between survivors' ability to make decisions and their capacity to provide enthusiastic consent, as well as how to transition from trauma responses to empowered responses. Authentic Consent provides both healthcare providers and clients a safer container for healthcare participation that resists the capitalistic pace of "fast medicine."

THE ROLE OF EMBODIED INTELLIGENCE IN PROVIDER CAPACITY BUILDING AND WELL-BEING

Given what I have shared, I am sure some may be experiencing body tension or tension release. This is not uncommon when exploring sexuality and gender, regardless of profession or intention. This is part of how we have been socialized to experience discomfort without the tools to safely and confidently regulate discomfort. I have observed and experienced this as both a student and an embodiment facilitator. To support healthcare providers' emotional and mental well-being and develop sustainable, affirming service delivery frameworks for equitable LGBTQIA+ healthcare, we must expand our understanding beyond purely cognitive or behavioral approaches to include the wisdom of the body. This embodied intelligence is the alchemy of emotional intelligence, somatic intelligence, and erotic intelligence.

Emotional intelligence is the ability to manage the intensity of your emotions. Skills of emotional intelligence include psychological flexibility, self-regulation, empathy/ emotional safety, building rapport, and maintaining healthy relationships with self and others. The 2019 self-care report from U.S. Department of Health and Human Services Office of the Assistant Secretary for Preparedness and Response (ASPR) Technical Resources, Assistance Center, and Information Exchange (TRACIE) found "one continuous knowledge gap identified during this time has been the need for information for front-line healthcare and social services workers to use prior to a disaster to recognize and reduce their stress levels and maintain resilience during recovery."[14] This led to the development of the Professional Quality of Life Resource Tool Kit, which includes integrative healing practices of the Global Majority along with a quality of life self-assessment and 3-module digital health series. The impact of having healthcare providers participate in self-care that is supported at both the departmental and organizational levels is encouraging. A 2025 study on French nurses and doctors who participated in a mindfulness-based compassionate resilience program experienced a reduction of burnout-related symptoms, including emotional exhaustion.[15]

Somatic intelligence refers to the body's innate capacity for self-regulation, healing, and knowing. It acknowledges that trauma, stress, and societal oppression are not just mental experiences but are deeply held in the body, manifesting as mistrust of self and others, chronic tension, pain, dissociation, or dysregulation of the nervous system. Just as emotional intelligence requires somatic intelligence, somatic intelligence requires emotional intelligence. In the context of healing justice, the body is not only a site of trauma but also a site of resistance, transformation, and self-liberation. By integrating somatic care practices as evident in the 2025 French study, professionals can create emotional, mental, and energetic space to take care of their symptoms of burnout.

Professionals learn to understand their bodily sensations, recognize their physiological responses to burnout, and develop care practices and strategies for managing burnout, ultimately reclaiming emotional and mental capacity after experiencing burnout. Safer spaces must be an extension of space holders. Organizationally supported somatic practices offer healthcare providers and systems a pathway to supporting the embodied safety and self-trust healthcare professionals need to create emotional and mental capacity to provide sustainable delivery of LGBTQIA+ healthcare equity.

As Audre Lorde states in Uses of the Erotic, the erotic is not the suppression of feelings, but an internal sense of satisfaction.[16] In the article, *The Other EQ: Courageous Leadership Requires Erotic Intelligence*, I explore erotic intelligence as the catalyst for courageous leadership that can transform LGBTQAI+ healthcare equity. Erotic intelligence, as defined by The Center for Erotic Intelligence, is "the ability to navigate the interplay of desire, motivation, and relationship challenges in daily life.[17] It applies both personally and professionally. Erotic intelligence includes five key elements:

1. **Body Attunement**: The ability to connect with and understand your body's responses to core needs to thrive, core motivations to achieve, and core perceptions to succeed.
2. **Social Intelligence**: The ability to empathetically hold space for others while navigating conversations about vulnerability, relationships, and power with others.
3. **Emotional Intelligence**: Managing emotions in the context of self-awareness, self-regulation, emotional regulation, and interpersonal relationships.
4. **Self-Awareness on Steroids**: What I call a "*Presence Practice*", this is a deep, intuitive understanding of your senses, your expectations, your agreements, and your effort, and how they influence your life.
5. **Creative Imagination**: Using imagination to explore authentic consent and express your motivations and consent-informed boundaries in fulfilling ways.

As posited earlier in this article, healthcare providers and helping professionals should have both the emotional and mental capacity to do what they love and to love those they love well. By expanding the capacity for resiliency with the embodied wisdom of emotional, somatic, and erotic intelligence, healthcare professionals deepen their understanding and embodiment of this integrative relationship.

SHIFT: POLICY, ADVOCACY, AND PROFESSIONAL DEVELOPMENT FOR PROVIDER CAPACITY BUILDING

Somatics is the intuitive relationship between one's mind, body, energy, and spirit. Being somatic means being connected to wholeness or one's whole self. Additionally, somatics is a wellness approach that incorporates mind, body, energy, and spirit into daily self-care practices. Sexology is the scientific study of human sexuality, including human sexual interests, behaviors, and functions informed by one's WHOLE-Self. Burnout is a state of emotional, physical, and mental exhaustion caused by prolonged or excessive stress. It's characterized by feelings of cynicism, detachment, and a sense of ineffectiveness. Compassion fatigue is a state of emotional and physical exhaustion that can occur when caring for others who are suffering, resulting in a diminished ability to empathize and feel compassion. These phenomena are not weaknesses of the individual but rather occupational hazards for those in helping professions, especially when working with populations that face significant systemic injustices. When healthcare organizations do not integrate a humanistic wholeness approach in employee

and contractor wellness, healthcare professionals will continue to experience burnout and perpetual exhaustion, thus lose their ability to be present, empathetic, and nuanced in their healthcare and service delivery. They may struggle to hold space for complex, intersectional narratives, inadvertently rush clients, or even become emotionally detached, which can lead to re-traumatization for the client. This inattentive approach severely compromises efforts to create sustainable frameworks of LGBTQIA+ healthcare equity. This is antithetical to trauma-informed, consent-based, equitable, and affirming care. Notably, burnout and compassion fatigue robs our ability to be empathetic and equitable.

Professional capacity building is not a luxury or an optional add-on; it is an ethical imperative for competent practice. It is the foundation upon which a professional's capacity to engage with the nuances of intersectionality is built. Just as we advise clients to regulate their nervous systems and build internal resources, we as professionals must actively engage in these practices ourselves. This allows us to remain grounded, attuned, and resilient in the face of these challenging times.

An example of an integrative somatic wellness program is SHIFT Somatic Healing Practice. This consent-based, trauma-responsive framework offers a powerful model for professional capacity building. The core components of this healing practice includes Ground (Embodied Safety with Breathwork), Center (Embodied Awareness with Trauma-Informed Gentle Movement), Nurture (Embodied Self-Trust with Healing-Conscious Restorative Movement), Affirm (Empowered Presence with Guided Meditation and Intuitive Journaling), and Integration (Closing Circle)—can be adapted by professionals for their well-being.

- Grounding practices, such as the gentle breathwork (inhale for 4, hold for 4, exhale for 6) and guided body scans, help regulate the nervous system and bring the professional back into their body, preventing dissociation or overwhelm. This is about reconnection, not necessarily immediate distress reduction, recognizing that it's you are taking care of yourself because you are burnt out, not because you are ready to recover from burnout.
- Centering involves compassionately asking oneself clarifying questions, such as "Who is this moment for?", "What is in my best interest?", and "What is the purpose of the interaction?" This helps disrupt the pull to do emotional labor for others and supports boundary setting without guilt.
- Nurture emphasizes engaging with the five senses through at least two self-soothing or relaxation techniques for 10 minutes, chosen by the individual to combat resistance to self-care. It also clarifies the distinctions between dissociation (sensory disengagement), detachment (willful removal to return), and isolation (withdrawal with no intention of returning). Consistent, mindful routines (daily, weekly, monthly) are encouraged for longevity.
- Affirmation challenges negative self-talk and self-sabotage. It requires "being present in the moment, plus active imagination, i.e., visualizing". Affirmation practice replaces self-limiting beliefs and mirrors a practice of accountability and ownership in capacity building.

This integrative somatic approach is rooted in grace because healing is a journey, not an overnight destination. Healthcare professionals' passion is informed by supporting that client journey. Intersectionality in healthcare is not the academic "other considerations." Intersectionality is a call to action for professional accountability. The intention of this article is to explore the "both/and" of healing justice in which equity is its result. Rather than the performance-based, revenue-driven "either/ or" of our current system of care.

The imperative for professional self-care extends beyond individual practice; it has significant implications for policy, advocacy, and the broader landscape of professional development. Well-resourced and resilient professionals are not only better equipped to provide direct client care, but they are also more effective in managing their well-being. Still, they are also more capable of engaging in the sustained advocacy necessary to dismantle systemic barriers and advance health equity for intersectional LGBTQIA+ communities.

My "Sexuality and Somatics Professional Learning Intensive" is designed to fill this gap, offering a framework that not only educates on these critical topics but also provides practical tools for integrating somatic understanding into clinical practice and fostering authentic consent. The emphasis on "decolonizing sexology" and "healing-centered" approaches ensures that professionals are equipped to challenge their own biases and provide culturally humble care.

Beyond individual training, institutions and healthcare organizations have a responsibility to create environments that actively support professional well-being. This includes addressing the "defaults of socialization" that permeate healthcare, such as heteronormativity, the concept of "normalcy," monogamy, cis-gender assumptions, parental supremacy, adult supremacy, and pervasive white supremacy. These unquestioned assumptions create oppressive environments and contribute significantly to professional burnout. For example, the standard "nude" color in pantyhose serves as a simple yet powerful illustration of how white supremacy informs even mundane products and societal baselines.

When these defaults go unexamined, they lead to a "disconnect between policy and practice" and make "holding space" for clients, especially youth, significantly harder. Therefore, organizational support must include:

- Providing access to supervision and consultation: Especially for complex cases involving intersectional trauma.
- Implementing policies that promote work-life balance: Recognizing the demanding nature of the work.
- Offering opportunities for peer support and debriefing: Creating spaces for professionals to process challenging experiences.
- Investing in ongoing, specialized training: Focusing on intersectionality, cultural humility, trauma-informed care, and somatic approaches. My Integrative Somatic Approach, for example, is designed to integrate mind, body, and energy, activate compassion, and allow clients to self-determine their truth, moving beyond traditional cognitive-behavioral models that may overlook historical impact and systemic trauma.
- Fostering a culture of self-care: Normalizing and encouraging self-care practices among staff. This includes acknowledging the emotional labor involved in working with complex issues and moving from symptom reduction to a relationship with symptoms.

When organizations prioritize the well-being of their professionals by incorporating structural changes that integrate capacity building into employee wellness programs and resources, they are not just investing in individual health; they are investing in the quality, sustainability, and ethical integrity of the care they offer to the most vulnerable communities. This systemic support empowers professionals to take on roles as thought leaders and advocates, contributing to a broader movement for health equity. My role as an Sexuality and Somatics professional development facilitator rooted in intersectionality is based on this belief: that by empowering healing and helping professionals with trauma-responsive practices to trauma-informed care and expanding their knowledge base with consent-based comprehensive sexuality education with structural frameworks to integrate burnout support and recovery as professional development, we can collectively drive systemic change and create a more just and equitable public health landscape.

CONCLUSION

The current moment calls for an unwavering commitment to health equity for LGBTQIA+ communities, particularly those navigating the profound complexities of intersectional identities. As we strive to address the disproportionate barriers to care, heightened scrutiny, and increasing policy challenges, it is clear that a holistic approach is required—one that extends beyond clinical protocols to encompass the well-being of the very professionals tasked with providing care.

This article argues that robust professional self-care is not a secondary concern, but a foundational prerequisite for effectively addressing the nuances of intersectionality and delivering affirming, trauma-informed, and integrative care. Without cultivating our capacity through practices that promote embodied safety, self-trust, and emotional regulation, we risk burnout, professional shortages within healthcare, and inadvertently compromising the quality of healthcare and its service delivery.

Ultimately, advancing health equity for LGBTQAI+ care for Delaware's residents demands a multi-pronged strategy of trauma-response strategies for trauma-informed care, consent-based comprehensive sexuality education, and the expansion of organizational and structural support for professional development burnout support, recovery, and capacity building. Let us recognize that by nurturing ourselves, we cultivate the resilience, empathy, and nuanced understanding necessary to stand in solidarity with and effectively serve those at the intersections of marginalization, paving the way for a more just and equitable public health landscape for all.

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We Didn't Come Out to Blend In: The Demands of This Moment

Christopher Moore, *B.A.*.
Interim Executive Director, AIDS Delaware

I came out when I was 15 years-old; and not in some soft, quiet way. I came out in a blaze of adolescent chaos which left no room to turn back. It was the mid-90s, in rural Delaware, where being gay was something whispered about, laughed at, or outright denied. This act could have been dangerous and isolating — and I did it anyway.

By stepping into my own power, I laid claim to my identity — immediately stripping others of the authority to define it for me. I began the slow transformation into the person I was meant to become; and, decades later, I am grateful for this experience. The fire which was lit inside me still burns — and now not just for myself, but for every kid who's ever believed they had to choose between safety and truth.

Now, at 44, I know that truth of living as an out queer person teeters between revelatory and complex. The same is true for coming out. It isn't a one-time deal, or snapshot in time. It's richer than that — it's a reckoning which demands the burning of old bridges, not out of spite, but so the flames can light the way forward.

Like any reckoning, though, it has not been without its challenges. Many folks who are out know the real wounds don't always come from the bigots. They come from the people who love you the most — family, friends, teachers — people who think they're protecting you by asking you to shrink; and people who think they're showing care by asking you to be quiet.

Fortunately, as a teenager, I knew better — instinctively. I never wanted to be quiet about who I was. I wanted to live out loud, to be open, to be honest. Queerness, I would learn, was more than just personal truth. It would become a lens for viewing the world around me. It would be the drum beat which kept me in rhythm. It would be the call for personal rebellion against a system which, historically, was better at suppressing than supporting.

Now, as some version of an established adult, showing up authentically is part of my personal mission statement. I do this because we still live in a world where that's a risk — and with risk often comes a cost.

I would pay the price early in my career. I worked in a place which loved to tout equity in mission statements but often fell short in follow-through. At first, I turned a blind eye. Then, I played along. I wore the right clothes. I sat in the right rooms. I nodded when I should have questioned. I took the path of least resistance, believing I could bend myself just enough to fit. But slowly, I stopped recognizing the person I saw in the mirror. My voice got smaller. My joy dulled. My dignity — the part of me I'd fought so hard to build — started to fray at the edges.

Walking away wasn't easy, but it was necessary. I reclaimed my voice, my values, and the self I had almost abandoned. I remembered what too many queer people are taught to forget: surviving isn't the same as living. And no job title, paycheck, or LinkedIn endorsement is worth trading away your truth.

I understand why people are hesitant to show up as themselves — especially when they're queer. They don't want to make it political. They just want to live, to work, to exist in peace. But here's the truth: everything is political when your existence challenges the status quo.

That's why serving as guest co-editor of this special issue of the Delaware Journal of Public Health, focused on LGBTQ+ health and equity, is such an honor — and a responsibility — because the stakes right now are terrifyingly real.

Every day, we are watching hard-won rights be eroded. We are witnessing queer and trans people, especially youth, targeted by legislation designed to erase their autonomy, their access to care, and even their existence.

Hate has been rebranded as policy. And it's not just happening "out there." It's happening here — in our communities, in our schools, in our clinics — and yes, even in our boardrooms.

This moment demands something from us.

It demands that we show up — especially those of us who are out. Especially those of us who carry any kind of privilege — because of our race, our income, our education, our position at the table. We have a sacred duty to speak up and to advocate for those still being pushed to the margins.

This includes Black and brown LGBTQ+ folks, trans youth, queer elders, unhoused community members, people with HIV — anyone navigating systems which remain stuck in a time when equity was just a three-syllable word.

Our duty is not to blend in. It's to disrupt, to build, to tell the truth, and to make room.

It means showing up in policy meetings and hiring panels where equity is imperative, not performative. It means interrupting injustice even when it's subtle, and uncomfortable — even when it costs you something. It means mentoring queer people, fighting for them, and handing them the mic, and never expecting credit.

None of this is easy, and like many of you, I am growing weary. The headlines, the trauma, the gaslighting — it all adds up. Then I remember the 15-year-old version of myself. The one who passed a note to his mother which read "I'm gay," and waited for the world to shift. It wasn't the proudest moment of my life, but it was the most honest. That kid didn't have a blueprint, but he had resolve, and some chosen family who helped him find his way (including drag queens with bigger egos than most CEOs).

Now, I carry that resolve into every part of my life. Not because it's easy, but because I know what it feels like to think you're alone. And I won't stand by while others feel that way.

So, this is a call — to every out professional, every LGBTQ+ leader, educator, artist, lawyer, clinician, nonprofit director, barista, bartender, and bureaucrat: your presence matters. Your visibility matters. Your fight matters.

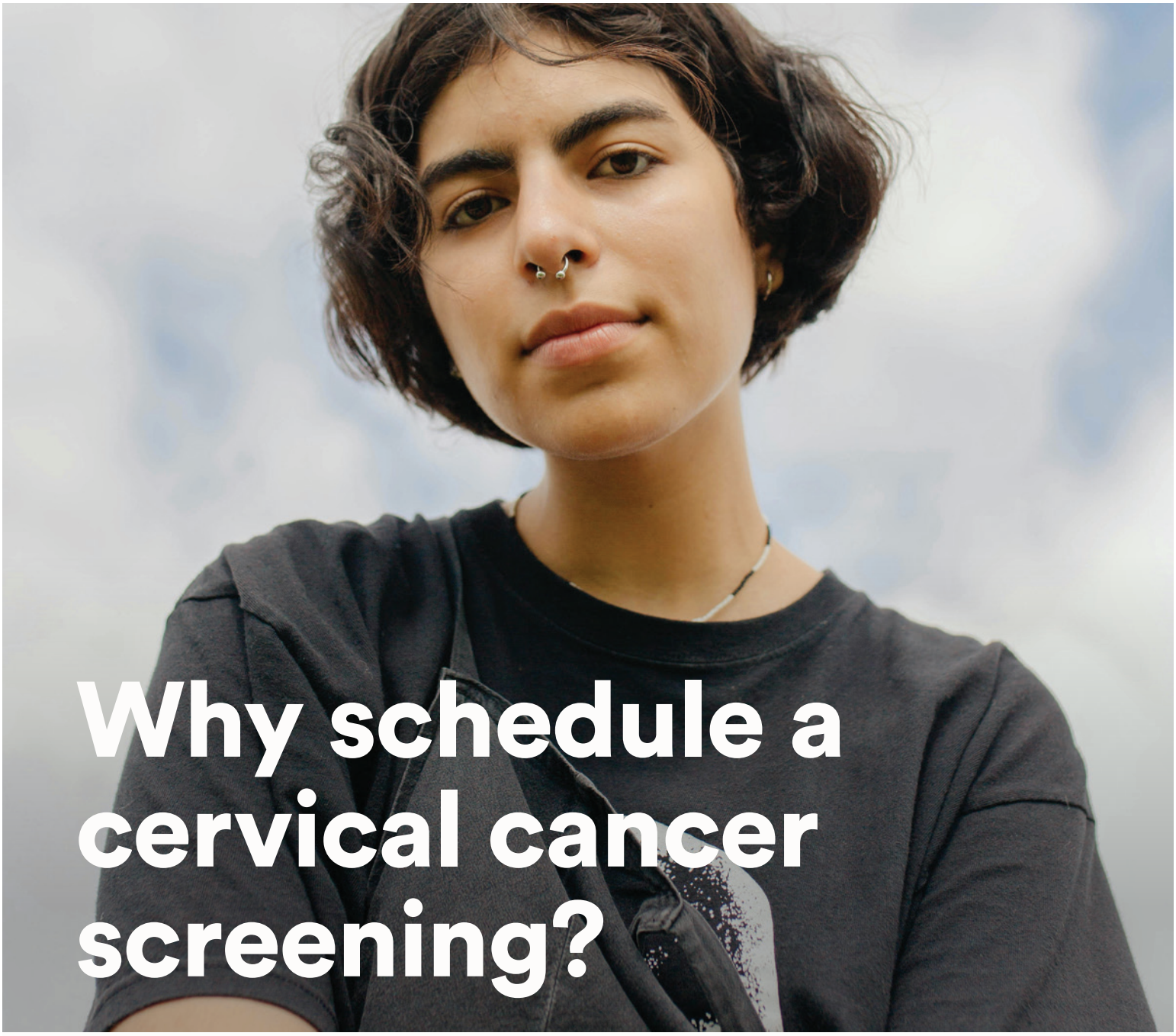
If you are out, and you are powerful, and you are not using that power to make life better for someone more vulnerable than you — it's time to ask why.

James Baldwin wrote, "Not everything that is faced can be changed, but nothing can be changed until it is faced." This is our moment to face it. Loudly. Publicly. Without apology.

We didn't come out to blend in. We came out to build something better. So, let's do it — together.

Mr. Moore may be contacted at cmoore@aidsdelaware.org.

Doi: 10.32481/djph.2025.07.19



For self-love.

The HPV test and Pap test can help prevent cervical cancer or find it early.* And an HPV vaccine can prevent it entirely. If you are uninsured or underinsured, you might qualify for a free Pap test cervical cancer screening through Screening for Life.

Learn more at HealthyDelaware.org/Cervical.

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health
Bureau of Cancer Prevention and Control

HEALTHY DELAWARE

DELAWARE CANCER CONSORTIUM

* Source: Centers for Disease Control and Prevention

The DPH Bulletin

From the Delaware Division of Public Health *May 2025*

Lieutenant Governor Kyle Evans Gay, left, and U.S. Senator Lisa Blunt Rochester, second from right, were guest speakers at the 19th Annual Delaware Healthy Mother & Infant Consortium (DHMIC) Summit, held on April 14 in Wilmington, Del. Greeting them are Tiffany Chalk, CMP, DHMIC Vice Chair, second from left; and Priscilla Mpasi, MD, FAAP, DHMIC Chair, at far right. Read the article on page 2. Photo by Moonloop.

On April 8, the Division of Public Health Office of Animal Welfare (OAW) visited Legislative Hall for the reading of Senate Concurrent Resolution 44 that designated April 11, 2025 as National Pet Day in Delaware. Pictured in the front row, from left, are: Senator John "Jack" Walsh (SD-9), Representative Kimberly Williams (RD-19), and Hailey Marcus, Jennifer Chace, and Bonnie Wu, Chief of Staff, all of Brandywine Valley SPCA (BVSPCA). Second row from left: Patrick Carroll, Executive Director, Humane Animal Partners (HAP), and Kate Callihan, HAP; Melody Purdy, OAW Program Coordinator; and Patty Seramone, BVSPCA volunteer. Back row from left: Mark Tobin, Chief, Delaware Animal Services, OAW; and Christina Motoyoshi, OAW Director. Photo by Jenna Greenlee, Senate Democratic Caucus.

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

May 22 Stop the Bleed® Training at Legislative Hall open to the public

Delaware Trauma System of Care members invite members of the Delaware General Assembly, members of the Executive branch, and the public to view their Stop the Bleed® display and brief demonstration of tourniquet use that you can visit on May 22 (Stop the Bleed® Day) any time between 9:30 a.m. and 3:30 p.m. The event is on the second floor of Legislative Hall, located at 411 Legislative Avenue in Dover, Del.

Uncontrolled bleeding is the number one cause of preventable death after an injury. A person with a severe bleeding injury can bleed to death in less than five minutes unless someone controls the bleeding until first responders arrive. Bystanders with this knowledge can save a life when an injured person is bleeding severely.

The DPH Office of Emergency Medical Services (OEMS) within the Emergency Medical Services and Preparedness Section offers Stop the Bleed® training. The one-hour course includes an interactive on-line course that can be completed at your convenience, followed by in-person hands-on practice of applying pressure, wound packing, and tourniquet use. Click here for the online course.

To receive this training, call OEMS at 302-223-2700 and ask for the Stop the Bleed® program.

At the 2024 Stop the Bleed® event, Niki Morris of Beebe Healthcare, at left, instructed Jazmine Gibbs of the Division of Public Health how to save a life during a bleeding emergency. Photo by Sean Dooley.

The Delaware Trauma System of Care includes the pre-hospital care of injured patients, the immediate care and transport to an appropriate trauma center, and post-acute care such as patient rehabilitation. In 2024, EMS personnel in Delaware responded to over 273,580 calls, equating to approximately 749 calls daily or 31 calls per hour, or approximately 15 calls every 30 minutes across the state, according to statistics from the Division of Public Health (DPH) Delaware Emergency Medical Reporting System.

DHMIC holds 19th annual summit and gives Health Equity Champion Awards

More than 400 people attended the 19th annual Delaware Healthy Mother & Infant Consortium (DHMIC) Summit on April 14, 2025. The Division of Public Health sponsors this event to bring together expert speakers, community leaders, and advocates to share updated evidence-based research on ways to address and reduce the maternal and infant mortality and morbidity rates in Delaware. U.S. Senator Lisa Blunt Rochester and Lieutenant Governor Kyle Evans Gay spoke.

The DHMIC presented the 2025 Kitty Esterly, MD, Health Equity Champion Awards. The awards recognize an individual and an organization for addressing and changing the root causes of infant mortality in Delaware by improving the overall health and well-being of mothers and the community.

Shawnisha Thomas, LPCMH, Thomas Clinical Consultation Services, received the outstanding individual award. Thomas founded her own practice, works for girls and women to have access to trauma-informed mental health care, and offers free counseling to underserved youth with the assistance of grant-funded efforts and partnerships. The Delaware Adolescent Program, Inc. (DAPI) received the outstanding organization award. DAPI serves pregnant teen mothers and their partners in high-risk ZIP Code zones by promoting equity and providing life skills training, family-centered care, and mentoring services for social and emotional well-being.

The Delaware Healthy Mother & Infant Consortium (DHMIC) presented the 2025 Kitty Esterly, MD Health Equity Champion Awards during their April 14 Summit. At left, Dr. Doris Griffin accepted the award to an outstanding organization on behalf of the Delaware Adolescent Program, Inc. (DAPI). At right, Shawnisha Thomas, LPCMH of Thomas Clinical Consultation Services, received the outstanding individual award. Photo by Moonloop.

In April, the second cohort of high schoolers graduated from the Health in Delaware (HEIDE) Institute. This is the first time that the program was offered during the school year. Pictured fourth from right is Dr. Sarah Hutton, HEIDE Training and Education Manager, along with seven of the eight graduates. This summer, HEIDE will be offering the program to 64 high schoolers. Division of Public Health photo.

2025 Rural Health Conference approaches on June 12 in Georgetown

The 2025 Rural Health Conference will be held on June 12 at Delaware Technical Community College, Jack F. Owens Campus, located at 21179 College Drive in Georgetown, Del. It will be held from 8:00 a.m. to 3:00 p.m. in the Carter Building, Rooms 540A through 540H. The theme is "The Frontier of Rural Healthcare."

The conference will showcase prominent national and local rural experts. They will share practical strategies and resources to enhance access to care and use innovative workforce approaches and digital technologies in rural areas.

There are two keynote speakers: Brock Slabach, MPH, FACHES, Chief Operating Officer of the National Office of Rural Health (NORH); and Eric Shell, MBA, CPA, Chairman of Stroudwater Associates. Their remarks will focus on the impact of federal policy on care providers and their communities with emphasis on value-based care and population health.

The Sussex County Health Coalition is organizing this event. Click here to register on Eventbrite. There is no cost to register. For more information, contact the Division of Public Health, State Office of Rural Health, at 302-744-4806.

CDC

Know the risk of stroke and act F.A.S.T.

May marks Stroke Awareness Month, World Hypertension Day (May 17), and High Blood Pressure Education Month, offering an important opportunity to highlight the connection between hypertension and stroke.

High blood pressure is a major risk factor for stroke, making its management essential for stroke prevention. You can lower your stroke risk by adopting a heart-healthy lifestyle: eating a balanced diet, staying physically active, quitting smoking, and regularly monitoring and tracking your blood pressure.

Recognizing the signs of a stroke can save lives. Remember the F.A.S.T. acronym:

- **F**ace: Does one side of the face droop?
- **A**rms: Can the person raise both arms, and/or is one weak?
- **S**peech: Is speech slurred or strange?
- **T**ime: If you observe any of these signs, call 911 immediately. Time is critical.

The Division of Public Health (DPH) Diabetes and Heart Disease Prevention and Control Program provides free blood pressure monitors and training through the Healthy Heart Ambassador Blood Pressure Self-Monitoring Program. Participants receive virtual one-on-one support from trained facilitators and attend virtual learning sessions over a four-month period. The program also includes cooking demonstrations and nutritional education to help participants confidently prepare affordable, heart-healthy meals. Additionally, Delaware Libraries offer loaner blood pressure monitors for those in need.

For more information about preventing stroke and managing high blood pressure, visit HealthyDelaware.org. For local resources and support, contact the Diabetes and Heart Disease Prevention and Control Program at 302-208-9097 or DHSS_DPH_HHA@delaware.gov.

DPH thanks 1,655 RespondDE Medical Reserve Corps volunteers

On April 23 during National Volunteer Week, the Division of Public Health (DPH), Emergency Medical Services and Preparedness Section hosted its annual recognition event to thank 1,655 RespondDE Medical Reserve Corps (MRC) volunteers for their hard work and generous time they gave to Delawareans in 2024. The event was held at the Clayton Fire Company's banquet hall.

Five individuals were honored for their outstanding dedication. Mary Boone received the Volunteer of the Year Award for embodying the spirit of service. Joyce Junious, Gloria Fong, Kathleen Hodges, and Cecilia Hodges received Top Volunteer Awards for their flexibility, creativity, teamwork, and joy they bring to every volunteer opportunity.

Learning stations from DPH partners provided training opportunities to attendees.

MRC volunteers provide critical support when communities need them most. During hurricanes, flooding, and other natural disasters, they assist with evacuation shelters, distribute supplies, and provide medical support. In public health emergencies, they support vaccination clinics, help with pandemic response, and educate communities on disease prevention. They offer crisis counseling and emotional support to first responders and disaster survivors.

Learn more at https://respondde.org/.

Volunteer Services Coordinator Chanise Roberson of RespondDE MRC presents Top Volunteer Awards to Joyce Junious, left, and Gloria Fong for their dedication to RespondDE Medical Reserve Corps. Not pictured are outstanding volunteers Mary Boone, Kathleen Hodges, and Cecilia Chandlee. Photos by Sean Dooley, DPH.

Stay tick-free in Delaware to prevent Lyme disease

Lyme disease, caused by the *Borrelia burgdorferi* bacteria and spread by blacklegged/deer ticks in the Mid-Atlantic region, is the most common tick-borne disease in Delaware. Lyme disease symptoms can range from fever and fatigue to severe joint pain and neurological issues if left untreated. About 70% of people develop the erythema migrans (bull's-eye) rash. View examples of this rash in the Centers for Disease Control and Prevention's *Tickborne Diseases of the United States, 2022*, a manual for health care providers.

Health care professionals with questions about tick-borne diseases can click here to register for the tick-borne Disease EpiChat on May 15, 2025.

Thankfully, you can enjoy the beautiful outdoors while reducing the risk of tick bites and tick-borne diseases. Follow these steps:

- **Dress smart:** When entering wooded or grassy areas, wear long pants, long sleeves, and tuck your pants into socks to minimize exposed skin. Light-colored clothing makes ticks easier to spot.
- **Avoid tick habitats:** Avoid walking in tall grass, leaf litter, or in wooded or brushy areas. Walk in the center of trails.
- **Tick repellent:** Use insect repellents containing at least 20% DEET, picaridin, or oil of lemon eucalyptus on your skin and clothing. This simple step creates an extra layer of protection.
- **Tick checks:** After enjoying the outdoors, check yourself, your kids, and pets for ticks and immediately take a bath or shower. Ticks like to hide in warm, hidden areas, so inspect armpits, groins, and behind the knees. If you find a tick, remove it promptly using fine-tipped tweezers. Grasp the tick as close to your skin as possible and pull it out gently.
- **Yard care:** Keep your yard tick-free by mowing the lawn regularly, removing leaf piles, and creating a buffer zone with gravel or wood chips between your lawn and wooded areas.

Click here for Division of Public Health tick-borne disease resources, including the Delaware Vector-borne Disease Surveillance Annual Report, 2023.

The CDC provides a video and an Insect Repellent chatbot to answer questions about repellents.

Ask the Experts

DPHMedia@delaware.gov

Insect Repellents

Q. Which insect repellents are safe for skin and which ones should be sprayed only on clothes?

A. When applying insect repellents, **ALWAYS** follow the instructions on the product's label. The product's label contains information on directions of use, duration of protection, health risks, and safety information for children. The following EPA-registered insect repellents are safe to use on skin: DEET (N,N-Diethyl-m-toluamide), Picaridin (KBR 3023), Oil of Lemon Eucalyptus (OLE) or PMD (para-menthane-3,8-diol), and IR3535 (Ethyl butylacetylaminopropionate). Permethrin and other pyrethroids are usually only approved for treating clothing, bed nets, tents, etc. They should never be applied directly to skin.

Q. What type of insect repellents should I use on my children's skin?

A. Follow the instructions on product labels to determine if repellents are safe to use on children's skin. The label will also provide instructions on how to apply the repellent. It is generally recommended to avoid applying repellents on a child's face, hands, and areas that may come into contact with eyes or mouth.

Q. What should I do if I find a tick on my skin?

A. When a tick is attached to your skin, use fine-tipped tweezers to remove it. Grasp the tick as close to the skin's surface as possible, and pull straight up with steady, even pressure. Do not twist, burn, jerk, or smother the tick. After removal, clean the bite area with rubbing alcohol, an antiseptic, or soap and water. You can save the tick in a small container so a health care provider can identify the species to determine the risk of disease transmission. It is not recommended to test the tick for pathogens.

Q. How fast can an attached tick spread disease?

A. Lone star ticks need to be attached for at least 12 to 24 hours to transmit the bacteria that cause the disease Ehrlichiosis. Blacklegged/deer ticks need to be attached for about 24 to 48 hours to transmit the bacteria that causes Lyme disease. Powassan virus transmission can occur very rapidly, potentially within 15 minutes of an infected tick being attached to a person. Prompt tick removal is important to avoid the risk of disease.

LGBTQ+ RESOURCES IN DELAWARE

Community and Support Organizations

AIDS Delaware
100 W. 10th Street, Suite 315, Wilmington, DE 19801
(302) 652-6776
https://aidsdelaware.org/
HIV prevention, testing, education, mental health support, case management, and advocacy.

CAMP Rehoboth
37 Baltimore Avenue, Rehoboth Beach, DE 19971
(302) 227-5620
https://camprehoboth.com
Advocacy, health programs, community events, support groups, youth services, HIV testing, counseling, and cultural programming.

Delaware Gender & Sexuality Collective
https://www.facebook.com/groups/dsgcprofessionals/
A group for LGBTQ+ community leaders and community organizations

Delaware Pride
https://delawarepride.org
Annual Pride festival, community building, advocacy, and educational events.

I Am Me, Inc.
https://www.iammecorp.org/
Peirrce@iammecorp.org
LGBTQ Pride organization the puts on Me Fest, provides community support and events, and is inclusive for allies and community members

Lavendar Programming Board
https://studentcentral.udel.edu/organization/lavendarprogrammingboard
University of DE's student-run LGBTQ organization

New Castle County Youth LGBTQ Youth Pride
https://www.facebook.com/NCCLGBTQYouthPride/
A nonprofit organization that puts on the annual NCC LGBTQ Youth Pride Festival and provides sexuality support and education for LGBTQ youth and families

Orgullo Delaware
https://www.facebook.com/OrgulloDelaware/
orgullodelaware@gmail.com
Providing bilingual (Spanish/English) gender- and sexuality-specific therapy, empowerment groups and intersectionality trainings

Parents of Trans Kids DE
www.ptkdelaware.org
Contact: ptkdelaware@gmail.com

PFLAG Wilmington/Northern Delaware
(302) 654-2995
https://pflagwilmde.org
Support meetings, advocacy, education, resources for LGBTQ+ individuals, families, and allies.

Point of Pride (National)
https://www.pointofpride.org/
Providing free chest binders and femme shapewear, offering trans financial support (for gender-affirming surgery and other services), HRT access fund and electrolysis support fund

LGBTQ+ RESOURCES IN DELAWARE

Health Services

ChristianaCare LGBTQ+ Health Initiatives
Multiple locations, based primarily in Wilmington and Newark, DE
(302) 733-1000
christianacare.org/services/lgbtq-health
Primary care, specialized LGBTQ+ healthcare, HIV prevention and care, gender-affirming hormone treatment, inclusive healthcare training.

Nemours Children's Health - Gender Wellness Program
1600 Rockland Road, Wilmington, DE 19803
(800) 416-4441
https://nemours.org
Pediatric and adolescent gender-affirming healthcare, psychological support, hormone therapy.

Planned Parenthood of Delaware
625 Shipley Street, Wilmington, DE 19801 (multiple statewide locations)
(302) 655-7293
https://plannedparenthood.org/delaware
LGBTQ-inclusive sexual and reproductive healthcare, gender-affirming hormone therapy, HIV testing, education, and resources.

Transitions Delaware, LLC
https://transitionsde.com
(302) 440-6737
Counseling for the LGBTQ+ community, support groups, consultation services, and LGBTQ+ trainings

Youth and Education

Big Brothers Big Sisters Big Siblings Delaware
https://bbbsde.org/programs
302.998.3577
Baynard Building, #240, 3411 Silverside Rd., Wilmington, DE 19810
Justice, Equity, Diversity & Inclusion (JEDI) program links LGBTQ mentors with LGBTQ youth in search of mentorship

GLSEN (National)
An organization to support LGBTQ+ youth in schools
https://www.glsen.org/

The Emerald Lighthouse
https://www.theemeraldlighthouse.org/
260 Chapman Rd suite 104a, Newark, DE 19702
302-722-6775
Info@theemeraldlighthouse.org
Parent support, community outreach & training, LGBTQ youth support groups, mental health support

The Village Delaware
https://aidsdelaware.org/the-village/youth-leadership-team-application/
Community support, resources, and social programming for LGBTQ+ youth and adults, including transgender and non-binary individuals.

LGBTQ+ RESOURCES IN DELAWARE

Legal and Advocacy Services

ACLU of Delaware
100 West 10th Street, Suite 706, Wilmington, DE 19801
(302) 654-5326
https://aclu-de.org
Legal advocacy, education, and protection of LGBTQ+ rights and civil liberties.

Equality Delaware
https://equalitydelaware.org
Advocacy, policy reform, legal resources, marriage equality information, and transgender rights advocacy.

Human Rights Campaign (National)
https://www.hrc.org/
LGBTQ legislation tracking, public & community education about LGBTQ+ issues, LGBTQ+ litigation

Transgender Law Center (National)
https://transgenderlawcenter.org/
Largest trans-specific, trans-led organization working towards trans liberation through legal work in the areas of employment, prison conditions, education, immigration, and healthcare

Crisis Support and Hotlines
Delaware Suicide Prevention Hotline
(800) 262-9800 (24/7)
Immediate support, counseling, crisis intervention, and referrals for mental health support.

Trans Lifeline (National)
(877) 565-8860
https://translifeline.org
Grassroots hotline and microgrant organization by and for trans folks

Trevor Project (National)
(866) 488-7386
https://thetrevorproject.org
Services: 24-hour crisis support, counseling, suicide prevention, and resources for LGBTQ+ youth.

Additional Community Spaces and Events

Rainbow Chorale of Delaware
https://therainbowchorale.org
LGBTQ+ inclusive community chorus, performances, cultural events.

Rehoboth Beach Bear Weekend
https://rehobothbeachbears.com
Annual community event promoting inclusivity, social activities, and advocacy.

Index of Advertisers

Delaware Journal of Public Health

Submission Guidelines

updated March, 2024

About the Journal

Established in 2015, The Delaware Journal of Public Health is a peer-reviewed electronic publication created by the Delaware Academy of Medicine/Delaware Public Health Association. The publication acts as a repository of news for the medical, dental, and public health communities, and is comprised of upcoming event announcements, past conference synopses, local resources, peer-reviewed content ranging from manuscripts and research papers to opinion editorials and personal interest pieces, relating to the public health sector. Each issue is largely devoted to an overarching theme or current issue in public health.

The content in the DJPH is informed by the interest of our readers and contributors. If you have an event coming up, would like to contribute an Op-Ed, would like to share a job posting, or have a topic in public health you would like to see covered in an upcoming issue, please let us know.

If you are interested in submitting an article to the Delaware Journal of Public Health, or have any additional inquiries regarding the publication, please contact the managing editor at managingeditor@djph.org, or the publisher at ksmith@delamed.org.

Information for Authors

Submission Requirements

The DJPH accepts a wide variety of submission formats, including brief essays, opinion editorials pieces, research articles and findings, analytic essays, news pieces, historical pieces, images, advertisements pertaining to relevant, upcoming public health events, and presentation reviews. Additional types of submission not previously mentioned may be eligible, please contact a staff member for more information.

The initial submission should be clean and complete, without edits or markups, and contain both the title and author(s) full name(s). Submissions should be 1.5 or double spaced with a font size of 12. Once completed, articles should be submitted via the submission page at https://djph.org/submissions/submit-an-article/ Graphics, images, info-graphics, tables, and charts are welcome and encouraged to be included in articles. Please ensure that all pieces are in their final format, and all edits and track changes have been implemented prior to submission. To view additional information for online submission requirements, please refer to the DJPH website: https://djph.org/submissions/submit-an-article/

Trial registration information is required for all clinical trials and must be included in the final article and/or abstract.

Abstracts

Authors must submit a structured or unstructured abstract along with their article. Abstracts will have a maximum of 200 words, including headings. Structured abstracts should employ 4-5 headings, and may include Objectives, Methods, Results, and Conclusions. A fifth heading, Policy Implications, may be used if relevant to the article. All abstracts should provide the date(s) and location(s) of the study if applicable, as well as any trial registration information.

Submission Length

While there is no prescribed word length, full articles will generally be in the 2,500-4,000-word range, and editorials or brief reports will be in the 1,500-2,500-word range. If there are any questions regarding the length of a submission or APA guidelines, please contact a staff member.

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Opinions expressed by authors of articles summarized, quoted, or published in full within the DJPH represent only the opinions of those authors and do not necessarily reflect the official policy of the Academy/DPHA, the DJPH, or the institution with which the authors are affiliated.

Conflicts of Interest

Any conflicts of interest, including political, financial, personal, or academic conflicts, must be declared prior to the submission of the article, or in conjunction with a submission. Conflicts of interest are any competing interests that may leave readers feeling misled or deceived, and/or alter their perception of subject matter. Declared conflicts of interest will be published alongside articles in the final publication.

Nondiscriminatory Language

Use of nondiscriminatory language is required in all DJPH submissions. The DJPH reserves the right to reject any submission found to be using sexist, racist, or heterosexist language, as well as unethical or defamatory statements.

Delaware Academy of Medicine / DPHA

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Historic New Castle, DE 19720

www.delamed.org | www.djph.org

Follow Us:

The Delaware Academy of Medicine is a private, nonprofit organization founded in 1930. Our mission is to enhance the well being of our community through medical education and the promotion ofpublic health. Our educational initiatives span the spectrum from consumer health education tocontinuing medical education conferences and symposia.

The Delaware Public Health Association was officially reborn at the 141st Annual Meeting of the American Public Health Association (AHPA) held in Boston, MA in November, 2013. At this meeting, affiliation of the DPHA was transferred to the Delaware Academy of Medicine officially on November 5, 2013 by action of the APHA Governing Council. The Delaware Academy of Medicine, who's mission statement is "to promote the well-being of our community through education and the promotion of public health," is honored to take on this responsibility in the First State.

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