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Sexual History Taking: An Opportunity to Reduce Health Disparities

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Abstract

Sexual history taking is an important part of caring for any clinical population. However, the topic is often wrapped in discomfort that makes it more challenging than it needs to be for both the provider and the individual providing the history. The act of taking an effective sexual history is more than simply asking all the right questions in the right ways; it requires an awareness of the impact of the clinical environment, the provider's own comfort with the content, and an awareness of any personal biases. In this study, we provide a framework for evaluating and addressing many of these factors as well as providing key points for consideration as a health care provider of any level. We offer several concrete strategies for including these strategies and processes in multiple clinical environments.

Key words: clinical examination, clinical practice, LGBTGQI+ health, sex work, sexual function, sexuality, trauma

The topic of sexual history taking is critical for the effective care of individuals but a source of discomfort for many providers. Understanding the full breadth of the sexual history and past or current sexual practice along with the specificity of those practices requires internal personal reflection, careful listening, and constant revisiting by the provider to deliver care that is of high quality and responsive to those who come to us. As clinicians focused on the care of sex and gender minorities (SGM), including those living with HIV, we have found significant success at eliciting sexual history in a maximally inclusive and nonjudgmental way. We cover three essential components of effective histories: Preparation, Effective Interview Structure, and Special Considerations.

Taken together, we believe that these frameworks offer clinicians in a variety of settings the opportunity to communicate with individuals in effective and meaningful conversation regarding whole-person sexual health. Allowing individuals to fully describe their sexual histories and practices can help inform providers with the understanding of the individual's potential health risks, screen and test individuals appropriately for sexually transmitted infections (STIs), and work with individuals on practical risk reduction strategies. These recommendations are only the beginning of what one might learn about history taking and collaborative management of the individual in one's practice.

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http://dx.doi.org/10.1097/JNC.0000000000000290

Background

Individuals with a wide variety of experiences note reluctance to disclose complete histories of personal sex practices. Multiple studies have affirmed that provider judgment, or fear of judgment, makes individuals reluctant to tell clinicians the truth (Cucciare et al., 2016; Gutmanis et al., 2007; Levy et al., 2018; Murthy et al., 2004; Samuels et al., 2018). The sexual history is a sensitive topic for many individuals, particularly those individuals whose sexual histories are stigmatized—notably survivors of sexual violence and abuse, SGM, persons with disabilities, those involved in the sex work and street economies, and those who have several of these experiences and identities. Sexual stigma can affect any individual and is typically unknown before an initial interview. These topics must be considered before initiating the interview because they may emerge at any time, particularly if the provider is a skilled interviewer regarding sexuality and sexual history.

Preparation

Creating a Welcoming Environment

Health care providers must be able to ask questions about the details of sexual histories and practices to understand risks. Appropriately, individuals are sensitive to these questions and, as such, the health care provider's ability to ask these questions in a way that allows the person to feel comfortable is paramount, which will increase the person's honesty in providing information about their histories and actual practices. Many interview tools exist to structure these questions (Eckstrand et al., 2012; Frasca et al., 2019). However, the questions themselves do not necessarily create comfort for either the individual seeking care or the provider

in discussing sexual health and practices openly (Goodin et al., 2018; Hatzenbuehler & Pachankis, 2016; Holmes et al., n.d.; Kuzma et al., 2019; Milner & McNally, 2020; Rossman et al., 2017). To achieve a maximally inclusive interview and address the aforementioned challenges, we suggest a multilayered approach that addresses all components of a clinical microsystem: provider reflection and practice, all staff training (Table 1), intake paperwork and medical records, and physical environment appraisal.

These strategies are applicable to multiple clinical systems of practice, including practices and communities that are more or less accepting and/or welcoming to SGM persons. In their entirety, we believe that including maximal numbers of these components will increase the ability of people to feel comfortable in disclosing actual sexual practices and about multiple other lived experiences as part of the downstream effect of an inclusive interview.

Provider Inventory: Self-Curiosity as an Essential Interview Component

To understand an individual's sexual history and practices, first, we must understand our own values, attitudes, and beliefs. This self-reflective, deep inventory of understanding allows us to set aside our own experience while interviewing individuals. It also helps clinicians to develop their own awareness about the effect of their personal experiences and judgements on professional practice and to build the skills to interview patients without unacknowledged biases. The process of self-reflection and evaluation of these experiences may be ideally accomplished within a team of providers, with a supervisor or educator, with a professional coach, and/or a mental health professional. We recommend making this reflection a critical part of one's own work and find it beneficial in our work with individuals and personally for ourselves. We recommend providers engage in self-reflection in the following topical areas:

1. Personal values, attitudes, and beliefs regarding sex and sexuality.
2. Personal sexual histories, including stigmatized histories.
3. Personal perceptions regarding the sexual practice of groups dissimilar to oneself considering race, class, disability, gender, sexuality, nationality, and religion.
4. Personal experiences as interviewer and as interviewee.
5. Personal readiness to discuss sensitive topics, such as intimate partner or sexual abuse and violence, transactional sex, kinks and fetishes, polyamory, consensual nonmonogamous arrangements, and asexualities.

Failure to do this sort of inventory has the inevitable result of framing an interview in a "neutral" way, in which neutrality is nonaffirming and reinforces normative beliefs and practices, unconsciously discloses our own biases and beliefs to individuals seeking care, and closes us off to discussion of practices outside of our own comfort zones. This has the potential to result in the provider formulating a diagnosis and/or making clinical recommendations based on incomplete histories. For example, a person who has receptive oral sex only being screened for gonorrhea and chlamydia in urine due to the provider's failure to explore sexual experiences potentially results in a missed diagnosis of pharyngeal gonorrhea and delayed treatment of critical infection (Table 2).

Failing to reflect can also reproduce our own feelings of shame regarding sexuality, wherein an interview about sexual practice starts with: "I'm sorry to have to ask you this." We urge clinicians to have confidence in the purpose of their interviews and the questions they ask. Apologizing for doing the work frames this work as shameful. Furthermore, it creates a dynamic where the individual may understand your apology as an indication that you are not comfortable with the breadth of sexual practice that persons have, impairing your ability to effectively test, treat, and counsel individuals regarding sexual health.

Table 1. Components of all Staff Inclusiveness Training for Sexual Health and History Taking

Sex and gender definitions
Gender and sexuality distinction
EHR-specific inclusive sex and gender description (how to enter a preferred name, pronouns, etc.)
Exploration of staff values, attitudes, and beliefs regarding sex, sexuality, and gender
Welcoming clinic experiential practice (role play, problem solving)
Intervening when colleagues do not align with inclusive values
Pronoun pins for all staff

Note: EHR = electronic health record.

Intake Paperwork as Interview Component

For the individual, the tone of the clinical interview is set long before they talk with the provider. Individuals' perceptions of the encounter may be anchored in their front desk and preclinical experiences (e.g., scheduling delays, extensive preclinical screenings). These preinterview experiences should be designed to glean important contextual information that can

Table 2. Ten Topics for Inclusive Sexual Histories

1. Name used by individual
2. Pronouns used by individual
3. Current individual sexual practice
4. Transactional sex questions (if relevant)
5. Current STI prevention used (if relevant)
6. Current pregnancy prevention (if relevant)
7. Oral and/or urine and/or rectal screenings for GC
8. Syphilis screen (and HIV if negative)
9. PrEP for partners (or self if HIV negative)
10. Sexual function

Note: STI = sexually transmitted infection; GC = *Neisseria gonorrheae*/chlamydia trachomatis; PrEP = preexposure prophylaxis.

be leveraged to maximize a provider's ability to interview an individual successfully. As such, attending to the design of clinical paperwork to provide maximal inclusivity regarding history and sexual practice is a simple and effective way to demonstrate to individuals that they are safe disclosing the truth. Key components of clinical paperwork helping to create an inclusive environment include the following:

1. Ability to enter a preferred name.
2. Inviting individuals to select which pronouns (she/hers, they/them, he/his, xe/xem, other options) they use in day-to-day conversation, including the ability to select a combination of multiple pronouns.
3. Multiple options for gender, including at minimum: female, male, nonbinary, transgender, and genderqueer, including the ability to check multiple boxes.
4. A blank space for individuals to write out both their pronouns and gender identities, to encompass those not already included on paperwork.
5. Ensuring that all staff use the preferred names, pronouns, and words when interacting with and documenting care with the individual.

In our clinical practice, individuals repeatedly share that this inclusive intake form communicates openness and understanding about SGM communities and wide-ranging sexual practices.

Clinic Culture and Silent Strategies That Demonstrate Inclusive Practice

Similar to intake paperwork, the physical environment of a clinic provides multiple clues about inclusive and nonjudgmental practice. Giving all staff buttons that display the staff members' own pronouns, inclusive flag pins, HIV awareness pins, posters with a wide range of genders/bodies/family structures demonstrates to individuals that the staff and system is comfortable with individuals from a wide variety of backgrounds. Training front desk staff to reflexively ask the preferred name of the individual during the registration process allows individuals to signal the entire health care team who they are and how others can demonstrate respect for their realities. To find appropriate environmental strategies tailored to your community population, utilization of patient and family advisory committees can provide feedback around appropriateness and individual experiences as perspectives. We highly encourage staff-wide reflection about the physical environment of clinics to ensure multiple perspectives that include providers, administrative staff, and environmental service staff, along with marketing and publicity staff, as available in the clinical system and can provide multifaceted input into the work of creating a welcoming and friendly space.

Effective Interview Structure

Structuring the Interview

What constitutes a "full sexual history" and the related sexual risk assessment can vary significantly, and asking questions regarding sexual practice must be clearly framed by the interviewer as a part of understanding risk for health and disease, rather than personal interest or idle curiosity. We use the strategy of framing these conversations as offerings to individuals, so opening conversations may be stated as, "Our screening for sexually transmitted infections includes testing for oral, urine, and rectal options (as anatomically correct for the individual). Many individuals collect their own samples. Which of these might you be interested in?"

- If offering individuals this method, you should also assess and consider their health literacy and sexual risk literacy at the individual level to facilitate collaborative decision making. We explain that if people use different parts of their bodies for sex, they may wish to collect specific swabs for specific parts of their bodies because each "swab" only tests the specific area where the sample is collected.
- With this method, you must have a clear protocol for test collection of relevant specimens that is anatomically inclusive and correct for diverse populations.

As the provider partners with the individual seeking care, the following questions may also be included in the sexual history.

"What do you do to protect yourself from sexually transmitted infections when you have sex?"

- This question assumes that individuals do something to protect themselves and offers providers an opportunity for alliance building and creative risk reduction.
- Individuals may interpret this question as being about physical safety, which is an equally good opportunity to discuss interpersonal violence, involvement in sex work and street economies, and skills related to safety and risk reduction with the aforementioned experiences. What do you do to protect sexual partners from HIV infection or reinfection?"
- This question allows the opportunity to discuss PrEP for sex partners, U=U, and serosorting.

Asking individuals about a number of sexual partners (in total or within a time period) is often recommended as a way of stratifying risk. Although this may offer a window into individual risk, it is often a question that individuals perceive as judgmental, stigmatizing, or shameful. Anchoring your interview with this question also can obscure the reality of individual risk—someone with 15 partners in the last month, adherent to HIV medications or PrEP, who uses condoms for every encounter could reasonably be at less risk for an STI than someone with three nonmonogamous partners with regular unprotected sex. We recommend only pursuing numerical information in the context of a conversation regarding the particularities of that risk. An alternate framework is to think about a risk profile as either "screening indicated" (more than one partner with inconsistent STI prevention practice, uncertain monogamy status of monogamous partner) or "screening less indicated" (long-term partnership with confidence in mutual monogamy).

For those individuals who report practices with fewer indications for screening tests, we continue to offer regular, guideline-informed screenings for individual confidence. This also easily allows those who may not feel comfortable describing the full breadth of their sexual practice to opt-in to testing and can improve early detection and treatment of STIs and any related complications (e.g., head, neck, cervical, and anorectal cancers). It is also important to understand potential individual cost for screening tests. In states with varying insurance coverage via public insurance and private insurance, providers should know the cost of screening and testing to direct individuals to financial supports as necessary for comprehensive medical care.

When asking an individual about sexual practice and partners, it is important to consider the diverse ways that people refer to their genitals and those of their partners. Not only may individuals be unfamiliar with anatomically correct terms (penis, vulva/vagina, rectum) but also trans and gender diverse individuals and their partners may refer to their anatomy and the anatomy of their partners in different ways. For those individuals, it is appropriate to ask what terms they use, or to use the general terms "mouth," "front side," and "back side." Community-specific terms such as "top, bottom, versatile, or switch" can be useful to identify specific risks to inform screening. It is particularly crucial for the clinician to convey the motivation for asking about particular sex practices so that the question is not construed as inappropriate. A clinician may say, "I would like to talk about which screenings for sexually transmitted infections you might need during this visit. We can offer screenings for infections in a variety of locations including the throat and genitals." Again, these references may be better suited for using relative terms such as front/back side when an individual's preferred terminology is not yet known by the clinician. Some clinicians prefer to preface their interview with a simple explanation that the purpose of asking these questions is to make sure that the person has access to the screening and testing that are recommended for them. All clinicians need to reflect about their own comfort with terminology before the interview starts so as not to project discomfort on to the individual. If clinicians or trainees are uncomfortable, we recommend practicing with clinicians who are more comfortable asking these questions outside of clinical care. We have also suggested that trainees practice asking these questions to friends and loved ones outside of clinical practice, to increase comfort with the questions themselves.

Special Considerations: Trauma-Informed Sexual Histories

Given the prevalence of sexual assault, sexual abuse, and unwanted sexual experiences, incorporating trauma history into the sexual health interview is both critical and sensitive. Many individuals have never discussed sexual trauma with anyone, much less a health care provider. As such, provider openness and ability to sensitively navigate these disclosures is essential. We offer a general approach differentiated on unprompted versus prompted disclosure of sexual trauma.

Regardless of when persons disclose sexual trauma, the interviewer must ensure that they do not minimize the effect of the trauma by making statements such as "*this doesn't sound that bad",* or "*don't worry, other people have gone through worse."* It is critical for providers to remain present—using active listening, appropriate eye contact and body language—with the person who discloses this trauma and to let them share their story through their lens of understanding. Additionally, providers should note that when examining patients, a history of sexual trauma may make examination

maneuvers uncomfortable, and so providers should fully explain what they are doing before they do any exam maneuvers and are advised to ask for consent from the individual before proceeding.

Unprompted disclosure. When individuals bring up sexual trauma in the context of a standard interview without elicitation, it is important for the provider to pause and assess the recentness or remoteness of the trauma being discussed (e.g., "Tell me when this happened?"). Then, based on the individual's responses, the clinician should consider questions that are appropriate for the timing and nature of the trauma being disclosed. (See Table 3 for several suggested items to include following unprompted disclosures of sexual trauma during a clinical interview).

Prompted disclosure. We recommend discussing sexual trauma after several visits, when the provider–individual relationship is more thoroughly established. In earlier visits, a provider might ask the individual about their physical and sexual safety, or they may screen for related problems, including urinary dysfunction and sexual satisfaction during the annual visit. Given the profound effect of sexual trauma on psychological and physical function, it is useful and important to ask about any histories of unwanted sexual activity as a part of management and treatment for individuals. We tend to discuss trauma when it emerges in the individual interview. It can emerge in many ways:

- Discomfort in responding to direct questions related to sex.
- Discomfort when the specificity of sexual practice is discussed.
- Disclosure after conversation regarding the sex trade and street economies.

If individuals display this sort of discomfort, a neutral question allows individuals to disclose potential sexual trauma without feeling judgment from the health care provider, such as, "Have you ever experienced unwanted sex in any way?" affirming that the individual has a right to their own body and making decisions about it affirms the truth—that unwanted sexual activity is common and not the individual's fault. It is important to affirm an individual's right to choose when to disclose traumatic experiences.

Satisfaction as health indicator. As part of a comprehensive sexual history, it is also important to determine the individual's satisfaction with sexual activities—nature, frequency, and pleasure. Discussions of pleasure should also be contextualized within the individual's own perspective of pleasurable sexual activities. Additionally, such questioning may also facilitate the individual's disclosure of other information. Individuals are understandably reluctant to bring up these topics in interviews, but they offer an important opportunity to help individuals make incredibly effective changes to enhance their well-being and general health. When individuals bring up sexual dysfunction or difficulty as part of a general sexual history, this offers providers the opportunity to discuss illness narratives related to the dysfunction and assistance for any physical or psychological issues contributing to these concerns. Additionally, these discussions may also require seeking out potential contributing factors beyond those already discussed (Table 4).

Being able to discuss sexual pleasure is important. Providers typically do not address this because of personal discomfort, but neutral (although often closed ended) questions can be useful to ensure that individuals feel comfortable opening up about sexual function challenges, for example:

Table 3. Topics to Address for Recent or Remote Sexual Traumas

Recent sexual trauma	If timely (within 72 hr of assault), providers should offer postexposure HIV prophylaxis Empiric treatment for gonorrhea and chlamydia along with syphilis can be offered in the weeks and months after the assault if that exposure is known Individuals may be interested in PrEP and/or contraception Safety planning/crisis support if the experience is ongoing
Remote sexual trauma	Clinicians should acknowledge that disclosing traumatic experiences is difficult for individuals Affirmation that traumatic experiences can cause present pain and discomfort, and affirmation that the individual deserves competent care Diagnosis and treatment for sexual pain, chronic pelvic pain, and chronic generalized pain. Typical evaluation includes a detailed interview about the duration, quality, exacerbating and alleviating factors, and the treatments that a person has already tried to alleviate the pain. Persons with pelvic pain and sexual pain often benefit from behavioral health support, physical therapy focused on the pelvic floor, and the ongoing management from a gynecologic or other provider with expertise on pelvic and sexual pain Psychological support from clinicians skilled in the management of posttraumatic stress and other trauma sequelae

Note: PrEP = preexposure prophylaxis

- Do you have any concerns about your sexual health?
- Are you satisfied with your sex life?
- Have you had any experiences of pain or discomfort before or during sex, or after climax?
- Is your erectile function satisfactory for you?
- Have you had any experiences of urinary pain or dysfunction?

These questions assist in uncovering chronic conditions of all kinds, as well as focus medical care on issues that are exceptionally disruptive to individual well-being.

Sex trade, transactional sex, and sex work. For many individuals, sex for money can be both a source of income and potentially a risk for exposure to STIs along with potential for violence and coercion. We do not believe that this is always the case, and as such, we interview individuals with knowledge that individual involvement in sex for money is complex. Suggesting that individuals refrain from trading sex for money is judgmental and can be destructive to the individual–provider relationship given the frequent lack of alternate income streams. Instead, we recommend the following approach:

1. Learn the terms people use for involvement in trading sex for money (e.g., escorting, hustling, getting over).
2. Ask individuals if they have sex for money, gifts, or survival needs. It is critical to clarify that this is a question you ask all individuals, you may ask a question like: "A lot of my patients have traded sex for money to meet their own financial needs, is this something that you've done?"

Table 4. Concerns That May be Contributing to Sexual Dysfunction or Decreased Sexual Pleasure

For penile dysfunction	Smoking, hypertension, HIV, medications (e.g., antiandrogens, antihypertensives, SSRI, opiates), hormonal and nutritional deficiencies, anemia, thyroid dysfunction, depression, and anxiety
For vaginal dysfunction	Vaginal atrophy, depression/anxiety, peri- or postmenopausal, side effect of masculinizing gender affirming therapy, vulvodynia and other forms of chronic pelvic pain, endometriosis, interstitial cystitis, and douching
For rectal concerns	Diagnosis and treatment of anal fissure, hemorrhoids, infection, and other potential contributions to chronic rectal pain and injury (douching, insufficient fiber intake, IBS, and IBD)

Note: SSRI = selective serotonin reuptake inhibitors; IBS = irritable bowel syndrome; IBD = inflammatory bowel disease.

Providers (with the assistance and support of social workers, case managers, and other members of the interprofessional team) can help individuals develop a concrete plan for risk reduction across multiple dimensions of safety (physical, sexual, and emotional) in the context of transactional sex. Safety planning must be driven by what the individual finds realistic and may include STI-related safety (e.g., increasing condom use, regular sexual health screenings, increasing nonpenetrative sexual activity and/or oral sex rather than vaginal or anal sex). Another key component of safety planning is using safer methods for meeting clients (e.g., known clients instead of unknown people, screening potential clients ahead of time, internet-based sex trade practices). Providers may also encourage safer sex trade practices through suggesting working in tandem with a trusted ally or calling a trusted person before and after interactions with clients. Furthermore, personal security is of utmost importance, and individuals can improve their personal safety when involved in the sex trade by working in an area with easy access to transportation, maintaining password security for their cellphone, ensuring that cell phones are charged before leaving the house, and by not accepting drinks or drugs from clients. Finally, if individuals are interested in leaving the sex trade they may find it useful to connect with community-based organizations that provide culturally appropriate support and assistance with alternate work training and employment opportunities.

Future Directions

The topic of sexual history taking continues to evolve and warrants ongoing assessment and adaptation. We consider the provider inventory, paperwork audit, and clinical practice enrichment processes discussed in this work to be a solid foundation of education and training to significantly improve clinical effectiveness. This commentary provides a framework for improving person-centered sexual history taking in practice. As there are no consensus guidelines for trauma-informed clinical sexual history taking, it is imperative that professional organizations and advocacy groups continue to make concerted efforts to identify and share inclusive guidelines for sexual history taking that attend to not only the breadth of sexual practices and experiences but also encompass appropriate guidelines to address sexual trauma and other forms of abuse affecting sexual function.

Disclosures

The authors report no real or perceived vested interests related to this article that could be construed as a conflict of interest.

Author Contributions

Both authors meet the four criteria for authorship as described by the International Council of Medical Journal Editors. Specifically, Laura Mintz was involved in the conceptualizing the manuscript, and writing and revising the manuscript in its final form. Scott Moore was involved in conceptualizing the manuscript, as well as writing and revising the manuscript in its final form.

Acknowledgments

This article was created without direct financial support from governmental or private funding. The authors acknowledge the work of the Young Women's Empowerment Project, Shira Hassan, MSW, and Deborah Beete, MPH, for their assistance in conceptualizing this framework.

Key Considerations

- These practices constitute a multistep opportunity for enhancing your clinical skills and the clinical care provided by your team.
- The suggestions discussed in this article may not be immediately achievable based on the interest of management, prevailing community attitudes, or available resources; however, every single provider is able to do their own inventory and practice maximally inclusive interview techniques. Achieving any of this work is a step in creating the space for individuals to be transparent and comfortable in your environment, promoting improved health outcomes, including early detection of disease, prompt treatment of infection, and improvement in the health of the entire community.

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