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Lesbian, Gay, Bisexual, and Transgender (LGBT) Health Care

Guest Editor: Allen H. Maniker, MD

When I was a college student a legitimate question may have been, "Is there even such a thing as LGBT health care?" In the early 1970's, when the word "Gay" was just taking hold, there were a handful of physicians treating the large number of sexually transmitted diseases seen among otherwise healthy, young homosexual men. Some area doctors' offices were known as "clap clinics," where one could make a quick visit after discovery of an STD, pick up the requisite dose of antibiotics, and be on their way. Lesbian health, Gay teen health, and Transgender health were so far off the radar that those particular health care issues were not even considered, let alone studied. LGBT health was hardly the stuff of a separately defined health care discipline.

I can still remember reading the 1981 New York Times article that discussed 18 cases of a rare skin cancer that had been seen in young, otherwise healthy, homosexual men. Little did I realize the torrent of misery the article foretold for the Gay community. AIDS broke into our consciousness slowly at first and then crashed over us with such a tsunami of horror that we could think of nothing else. At that point, I was a medical student and wrote an article for the first issue of the then fledgling organization, Gay Mens Health Crisis' Treatment Issues. Over the course of that year, I tried to secure funding for a safer sex "slide-sound" sequence from a major pharmaceutical company. I was ultimately turned down as the pharmaceutical company felt that the "slide-sound" did not address a large enough constituency. They were horribly wrong. As the decade went on, I watched helplessly as many friends and colleagues succumbed to this terrible disease.

The 1980s and early 1990s ushered in a close look at LGBT health with a focus on AIDS. As the years passed, the cause of HIV and AIDS was isolated and treatments were developed. We could now legitimately claim that LGBT health care was indeed a unique and identifiable discipline. LGBT health care was so synonymous with our most pressing need, HIV/AIDS, that it seemed HIV/AIDS would be our only issue. This was not the case. The focus and attention that HIV/AIDS placed on our community brought other LGBT health issues to society's attention. Researchers began to look at breast cancer, cervical cancer, and HPV rates among lesbian women. Gay teens' psychosocial development and suicide rates began to make headlines and garner the public's attention. Investigations into many other LGBT related issues began.

In 2000, the Clinton administration supported updating and expanding Healthy People 2000: National Health Promotion and Disease Prevention Objectives, to outline health care goals, initiatives, and issues for Americans for the next decade. When I was a member of the Board of Directors of the Gay and Lesbian Medical Association (GLMA), we were part of a discussion of gay health care leaders throughout the country who noted that exactly zero points in this report were devoted to LGBT health and healthcare. Through the diligent work of GLMA members, LGBT health care advocates, and other political activists, this situation was reversed. Appropriately, several LGBT health care issues were eventually included in the document, and the Health Resources and Services Administration (HRSA) supported the development of The Healthy People 2010 Companion Document for Lesbian, Gay, Bisexual, and Transgender Health. At the time, many of us who were actively involved with the American Medical Association (AMA) worked and succeeded in obtaining recognition and membership of the GLMA as a constituent society within the AMA. At the start of the new century, LGBT health care was clearly established.

In the short time since the 1970s, LGBT health care has emerged as a legitimate area of concern, one that encompasses HIV/AIDS, as well as many other pressing issues. This issue of *New Jersey AIDSLine* is a direct result of the journey of the last 35 years. LGBT health care today is not just about AIDS.

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CONTINUING EDUCATION INFORMATION

BEYOND HIV: Addressing the Spectrum of Lesbian, Gay, Bisexual and Transgender (LGBT) Health Care Issues

Part I: Examining LGBT Health Disparities

Part II: Human Papillomavirus (HPV) Screening and Vaccination: Are We Missing Women Who Have Sex with Women?

Release Date: August 1, 2006 **Expiration Date: June 30, 2008** **Course Code: 08HC03 - DE01**

Target Audience

This activity is designed for physicians and nurses, and other health care professionals in New Jersey.

Statement of Need

The U.S. Secretary of Health & Human Services (HHS) published national health objectives and priorities for 2000-2010 in ***Healthy People 2010***.
www.health.gov/healthypeople.

The Health Resources and Services Administration provided funding to the Gay and Lesbian Medical Association (GLMA) to coordinate the process of creating a companion document to identify public health issues of highest priority for the health of lesbian, gay, bisexual and transgender (LGBT) people. ***The Healthy People 2010 Companion Document for Lesbian, Gay, Bisexual, and Transgender Health*** highlights 120 LGBT-specific objectives, including sections on health disparities, access to care, HIV/AIDS, STDs, tobacco, substance abuse, and many other medical issues, in a 488-page report. The Companion Document describes its purpose as: "to examine health care disparities and a lack of access to needed services related to sexual orientation or gender identity."
http://www.glma.org/_detain_0001/resources/live/HealthyCompanionDoc3.pdf

The goal of this continuing education activity is to provide an overview of the key recommendations of the ***Healthy People 2010 Companion Document for Lesbian, Gay, Bisexual, and Transgender Health*** and to note their relevance to clinical practice. Part I of this article is an overview of the document and LGBT health disparities, with a focus on New Jersey. Part II provides a specific example of potential care gaps related to provider knowledge about sexual behavior and identity, sexually transmitted diseases, and effective screening practices including unbiased patient sexual histories. The newly-released HPV vaccine provides a new opportunity to improve screening practices.

Learning Objectives

Upon the completion of this activity, participants should be able to:

1. Describe personal, community, institutional and provider-based barriers to health care faced by lesbian, gay, bisexual and transgender (LGBT) patients.
2. Identify various cancers and other health conditions for which the LGBT population may have a higher risk.
3. Understand the epidemiology, transmission, and clinical implications of human papillomavirus (HPV) infection in women who have sex with women (WSW).
4. Promote targeted use of HIV/STI prevention and screening protocols in health care settings for men who have sex with men (MSM).

Method of Instruction

Participants should read the learning objectives and review the activity in its entirety. After reviewing the material, complete the self-assessment test consisting of a series of multiple-choice and True/False questions.

Upon completing this activity as designed and achieving a passing score of 70% or more on the self-assessment test, participants will receive a CME credit letter awarding AMA/PRA category 1 credit™ and the test answer key four (4) weeks after receipt of the self-assessment test, registration, and evaluation materials. Estimated time to complete this activity as designed is 1 hour.

UMDNJ-Center for Continuing and Outreach Education is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

UMDNJ-Center for Continuing and Outreach Education designates this educational activity for a maximum of 1 category 1 credit™ toward the AMA Physician's Recognition Award. Each physician should claim only those credits that he/she actually spent in the activity.

The UMDNJ-Center for Continuing and Outreach Education certifies that this continuing education activity meets the criteria for 0.1 Continuing Education Units (CEUs), as defined by the National Task Force on the Continuing Education Unit. One CEU is awarded for 10 contact hours of instruction.

Faculty

Ross G. Hewitt, MD, is a Consulting Physician, ID Clinic at Heritage Health Center in Harlem, and an Infectious Disease Specialist with more than 20 years of experience in LGBT & HIV care, clinical research, and training.

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Mary Ellen O'Brien, MBA, MS IV, is a 4th-year medical student in the Department of Obstetrics and Gynecology, UMDNJ-Robert Wood Johnson Medical School.

Disclosure

In accordance with the disclosure policies of UMDNJ and to conform with ACCME and FDA guidelines, all program faculty are required to disclose to the activity participants: 1) the existence of any financial interest or other relationships with the manufacturers of any commercial products/devices, or providers of commercial services, that relate to the content of their presentation/material, or the commercial contributors of this activity, that could be perceived as a real or apparent conflict of interest; and 2) the identification of a commercial product/device that is unlabeled for use or an investigational use of a product/ device not yet approved.

Faculty Disclosure Declarations

Patricia Kloser, MD, MPH (Field Tester and Activity Director) has the following financial relationships to disclose: Speaker's Bureau: GlaxoSmithKline, Roche; Consultant: Gilead, Boehringer Ingleheim.

The following faculty have no financial relationships with any corporate organization whose product(s) will be discussed in this presentation: Ross G. Hewitt, MD, Samuel Jacobs, MD, and Mary Ellen O'Brien, MBA, MS IV.

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The drug selection and dosage information presented in this activity are believed to be accurate. However, participants are urged to consult the full prescribing information on any agent(s) presented in this activity for recommended dosage, indications, contraindications, warnings, precautions, and adverse effects before prescribing any medication. This is particularly important when a drug is new or infrequently prescribed.

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BEYOND HIV:
Addressing the Spectrum of Lesbian, Gay, Bisexual and Transgender (LGBT) Health Care Issues
Part I: Examining LGBT Health Disparities

Ross G. Hewitt, MD, FACP, FIDSA

LEARNING OBJECTIVES:

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Data from the 2000 Census gives us some insight into NJ's LGBT population. Census questionnaires ask for "unmarried partner," and then match partners as same-sex or not. 16,604 (9.4% of NJ total) of coupled households were same-sex, and over 5,000 households included an average of 2 children.[1] New Jersey ranked 10th in the nation with the number of same sex couples. These figures are likely to be underreported due to confidentiality concerns and the perceived non-applicability of census descriptive terms. 35% of lesbian couples were raising children, compared to 26% of gay male couples. The municipalities with the largest number of gay couples were Jersey City, Newark and Paterson.[2]

Unfortunately, the 2000 census does not measure how many LGBT individuals there are in the country.

National survey data on the number of LGBT people in the country is scarce. A 1994 report that compiled two surveys estimated that 2.8% of men and 1.4% of women self-reported as gay or lesbian, while 7.7% of men and 7.5% of women reported homosexual desire.[3]

New Jersey had a population estimate of 8.7 million people in 2005, 75.2% of which is 18 years old or older, and 51.3% is female.[4] Thus, a reasonable estimate of the number of gay male adults in New Jersey is 89,000 and lesbian adults in New Jersey is 47,000.

Surveillance data for HIV and AIDS in homosexual and bisexual men have been reported for many years. As of December 31, 2005, over 15,000 cases of AIDS were reported in men who have sex with men, and over 7,000 men who have sex with men (MSM) are living in New Jersey with HIV or AIDS.[5]

Health & Well-Being

There are four factors that influence health and well-being: genetics, environment, health services, and habits or lifestyle. Perceptions about sexual orientation and gender identity are clearly affected by attitudes regarding these factors. People (including health professionals) who believe that sexual orientation and gender identity are due primarily to genetic influences are more likely to be accepting of differences, than those who believe that differences are due to environment or the result of choice. Discrimination within the health care system, whether overt or subtle, also exists. Lifestyle practices such as drug and alcohol consumption have long been important health determinants in LGBT communities.

Key Health Concerns for LGBT Communities

The Gay & Lesbian Medical Association, along with Columbia University's Center for LGBT Health, identified the following key health concerns for LGBT communities: cancer, HIV/AIDS, mental health, suicide among youths, substance abuse, and access to quality care.[6] In recent years, outbreaks of syphilis among gay men have added sexually transmitted diseases (STDs) to the list as well.

(Continued on next page)

Ross G. Hewitt, MD, is a Consulting Physician, ID Clinic at Harlem Hospital, and a Board-Certified Infectious Disease Specialist with more than 20 years of experience in HIV care, clinical research, and training.

Cancer

LGBT people may be disproportionately affected by some types of cancers, including breast cancer, cancers related to acquired immunodeficiency syndrome (AIDS), lung cancer, and cancers caused by human papillomavirus (HPV).

Lesbians may be at increased risk for ovarian cancer. In addition to traditional risk factors such as family history of ovarian, breast or colon cancer, not bearing children, not using oral contraceptives and lack of gynecologic care may contribute to such an increased risk. Lesbians may also be at higher risk for breast cancer than heterosexual women due to higher rates of obesity, alcohol consumption, lack of bearing children, and lower rates of breast cancer screening.

A study of the New York and California cancer registries and the National Death Index found gay and bisexual men to be at excess risk for anal cancer, non-Hodgkin's lymphoma, and Hodgkin's disease. Although the authors determined that the increase in risk for both non-Hodgkin's lymphoma and Hodgkin's disease was related to increased incidence of HIV/AIDS among gay men, they found the increased risk for anal cancer to be unrelated to HIV/AIDS.[7]

The increased risk of anal cancer in gay men is clearly due to infection with HPV and HIV, although HIV-negative men have increased rates of anal cancer as well. A history of receptive anal intercourse and a high lifetime history of sexual partners, along with a history of smoking (which is increased already among gay men) are also risk factors.[8] The important issue here is that early detection and prevention is possible. Precancerous dysplastic lesions can be detected with cytopathologic tests ("anal PAP smears").

It is also likely that lesbians and gay men are at higher risk for lung cancer, as smoking rates and alcohol consumption, two important risk factors, are higher in LGBT populations than in the general community.

There are no data on incidence of cancer in transgender persons. Long-term exposure to hormones could increase risk of certain cancers. For example, breast cancer has been reported in male-to-female transsexuals, and ovarian cancer in female-to-male transsexuals.

Although data is needed on the national incidence of cancers in the LGBT population in the United States, no national cancer registries collect data on sexual orientation or gender identity.

Obesity

There is general concern about the rate of obesity in the United States. While there is no definitive data on LGBT populations, there is concern that some segments of the LGBT community experience high rates of obesity. In such people, long-term adverse health consequences are likely. Persons who are overweight or obese are at increased risk for high blood pressure, type 2 diabetes, coronary heart disease, stroke, gallbladder disease, osteoarthritis, sleep apnea, respiratory problems, and some types of cancer.

There are studies that suggest that lesbians are more likely to be obese than heterosexual women or their heterosexual sisters. In addition, lesbians tend to be less preoccupied with weight and body image than heterosexual women.[9]

One population of gay and bisexual men, known as "bears," may be at significant risk for adverse health outcomes associated with poor nutrition and being overweight. "Bears" typically celebrate large bodies as more masculine and generally identify a sexual attraction to other large men.[10]

HIV/AIDS

Men who have sex with men (MSM) have been among the higher risk groups for HIV infection since the beginning of the epidemic. Within this group, men of racial and ethnic minority backgrounds have even greater rates of HIV infection. Gay or bisexual men who live in rural areas may not be diagnosed or, when diagnosed, may be at a later stage of disease due to lack of health resources and provider knowledge in rural areas. Transgender individuals, particularly male to female, have HIV sero-prevalence rates ranging from 22 to 47 percent in urban populations. Urban populations of male gay youth, aged 15 to 22 found that rates of HIV infection were high, especially among African American (14%) and Latino (7%) youth when compared to white (3%) youth.[11]

Due to advances in antiretroviral therapy, there is now an indication that many gay or bisexual men may be less concerned about being infected than in the past. Recent public health efforts have been focused on people, particularly those at higher risk, knowing their HIV status. A movement is now afoot to get primary care providers to incorporate annual HIV antibody testing into the care of all adolescents and adults. Some health officials are even proposing relaxing the written informed consent procedure to oral consent, a proposal that has met with some opposition in the LGBT community.

Prevention activities are still needed for the LGBT community, and new approaches may

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have to replace ones currently in use. The condom use message is less effective now, and people are concerned about names reporting in HIV antibody testing programs. Anonymous HIV antibody testing options continue to be an important alternative for those with confidentiality concerns. All HIV testing programs must be culturally sensitive and accessible to LGBT populations.

Viral Hepatitis

Men who have sex with men and transgender male to female persons who have sex with men have long been known to be at elevated risk for hepatitis A and B. Epidemic outbreaks of hepatitis A in many urban areas have occurred in the late 1990s. In 1996, the CDC recommended adding hepatitis A vaccination to hepatitis B vaccination for sero-negative men who have sex with men.[12]

Opportunities for increased detection of hepatitis status and provision of vaccination are needed. The new combination hepatitis A and B vaccine can help to simplify the issue. Many adolescents have received hepatitis B vaccine, so gay and bisexual male youth are benefiting from being vaccinated as adolescents prior to sexual activity. These youth need to be monitored over the course of their lives to ensure that immunity does not wane.

Hepatitis C has been reported in MSM cohorts, although evidence for sexual transmission is contradictory. Many MSM with hepatitis C also have a history of potential exposure through injection drug use or blood transfusion, complicating the analyses.

Sexually Transmitted Diseases

The LGBT community is at disproportionate risk for STDs. MSM are generally believed to be at increased risk for urethritis, proctitis, pharyngitis, prostatitis (due to gonorrhea or chlamydia), hepatitis A virus, hepatitis B virus, syphilis, herpes, genital warts caused by HPV, molluscum contagiosum, and HIV. Increases of rectal gonorrhea and syphilis in gay men have been documented in recent years across the country.[13,14] These outbreaks are directly associated with a decrease in consistent condom use, and indicate a continued risk for HIV transmission as well.

Lesbians may not be thought of as being at risk for STDs, but in fact, many lesbians have a history of sex with men, and therefore still need to receive appropriate screening. In addition, trichomonas and HPV can be transmitted between female sex partners.[15]

Most STDs are linked to unprotected sex, and condom use was shown to reduce HPV transmission in women, adding HPV to the list of reducible STDs by condoms: HIV, chlamydia and gonnorrhea.[16] Consistent condom use by MSM remains an important public health priority. A recent obstacle is the use of stimulant recreational drugs such a methamphetamine (crystal) and libido-enhancing drugs such as Viagra used in a recreational, non-medically indicated manner.

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BEYOND HIV: PART I

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The long-term consequences of STDs can be severe: life-threatening cyto-megalovirus, herpes infection (especially in HIV+ persons), anal cancer from HPV, neurosyphilis, and cirrhosis from chronic hepatitis. LGBT individuals who are not "out" to their health care providers may not receive appropriate STD prevention counseling, accurate diagnoses, or culturally appropriate treatment.

Health Communication

Because many LGBT individuals may be reluctant to seek care from mainstream providers because of previous negative experiences with the health care system, health care providers need to make a concerted effort to create a health care delivery environment that is not only open to serving LGBT populations but also conducts active outreach to engage LGBT clients. At the same time, LGBT people often do not understand that they have specific health needs and, therefore, see no reason to inform their health care providers about their sexual orientation or gender identity.

Creating a welcoming environment is an easy step primary care providers can take. The recommendations as proposed by the Gay & Lesbian Medical Association can be found elsewhere in this issue.

Conclusion

The health needs of the LGBT community require much additional study. While data are awaited, there is much that health care providers can do now to improve the health of their LGBT patients. Simply being aware of the generally accepted health needs surrounding screening and detection of cancer, HIV, mental health issues, substance abuse, obesity, and STDs will have a major impact. Perhaps most important of all will be the enhancement of access to quality services through the provision of a welcoming environment free of value judgment and discrimination.

BEYOND HIV: Part II

Human Papillomavirus (HPV) Screening and Vaccination: Are We Missing Women Who Have Sex with Women?

Mary Ellen O'Brien, MBA, MS IV and Samuel L. Jacobs, MD

Cervical cancer is the second leading cause of deaths due to cancer among women in the world. Each year in the United States, 10,000 women are diagnosed and 4,000 die from cervical cancer, attributed to infection with human papillomavirus (HPV).[1] Recently, there has been a surge in news coverage surrounding cervical cancer with the announcement by the FDA and Merck on June 8, 2006, of FDA approval of GARDASIL®, the first human papillomavirus (HPV) vaccine. This is the first anti-cancer vaccine.[2,3] As with other sexually transmitted disease-related news reports, much of the discussion has centered around HPV as a sexually transmitted disease spread between men and women who engage in sexual intercourse. There is no mention of HPV transmission between same-sex partners or how the new vaccine will impact the population of women who have sex with women (WSW). This term, similar to the increasingly commonly "men who have sex with men," is used in this paper to describe individuals with sexual partners of the same gender, regardless of whether they are comfortable with identification as gay, lesbian, or bisexual, especially in encounters with medical providers. The media reports' sole focus on heterosexual women as the target group at risk for HPV contributes to continuing the widely held myth that WSW do not have to practice safe sex or undergo yearly gynecological examinations because they are not at risk. Therefore, the emergence of the HPV vaccine should serve as a learning opportunity for the public, as well as healthcare providers, to understand the implications of HPV, as well as the healthcare barriers faced by WSW, an often-ignored population.

OVERVIEW OF HPV

A double stranded circular DNA virus in the family Papovaviridae, HPV is among the most common sexually transmitted diseases in the United States. The HPV genome is comprised of six early proteins (E1-E6) that are associated with viral gene regulation and cell transformation and two late proteins (L1, L2) that form the outer shell of the virus. E6 and E7 are the two proteins that are most responsible for malignant transformation of cervical cells.[4] There are many pathways by which

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these proteins work. One such mechanism involves the p53 protein, which functions as a tumor suppressor protein that stops cell growth after chromosomal damage, allowing repair of DNA. The HPV virus protein E6 binds to the p53 protein, causing it to degrade. This allows the cell to continue its division unhindered, while chromosomal mutations accumulate without DNA repair.[5] The differences in the DNA base sequences of these two proteins (E6 and E7) accounts for the approximately 100 subtypes of HPV virus. These subtypes are divided based on how closely they are linked to cervical cancer, with HPV types 16, 18, 31, 33 labeled as high-risk and 6, 11 labeled as low-risk.

Prevalence

The true prevalence of HPV is unknown because routine screening for HPV does not occur. Furthermore, most infections are sub-clinical, and HPV is not a reportable disease. Studies estimate that 20 million men and women are infected with HPV. This accounts for about 75% of sexually active adults and about 25% of people ages 15 to 24.26 In addition, about 80% of females will have acquired HPV by age 50.[2] Studies have shown that anywhere from 13%-30% of WSW have HPV, including 13% of WSW who have never had sex with a man.[7,10]

Transmission

HPV has been detected in the epithelium of the penis, scrotum, anal canal, cervix, vulva, and perianal area.[8] Spread occurs through unprotected penetrative intercourse and close physical contact around the affected area. This includes digital/anal, oral/anal, digital/vaginal, oral/genital, and genital/genital contact as well as fomite contact such as penetrative sex toys. In addition, HPV as also been detected in the oropharynx, where there are mucous membranes that are similar to those of the genital region.[9] This is of particular significance for WSW because oral/genital contact is often the focus of sexual interactions between same-sex partners. Further, there are case reports as well as published studies that show evidence of female to female transmission of sexually transmitted diseases, including HIV, chlamydia, gonorrhea, HSV, and HPV. Female-to-female transmission of sexually transmitted diseases is more common among lesbians with prior heterosexual contact, which is about 80% of the lesbian population.[7,11]

Implications

HPV infects epithelial tissues and mucous membranes. Cutaneous manifestations include a variety of warts, including common, plantar and flat warts. The most common anogenital manifestation is condylomata acuminata or genital warts, caused mainly by HPV subtypes 6 and 11. These can appear on the penis, vulva, cervix, vagina, perineum, or anal region. In women, external HPV lesions are frequently associated with cervical lesions (including intraepithelial neoplasia) and squamous intraepithelial lesions of the cervix, anus, vulva, penis, and vagina. 15% of HPV infections will progress to cervical intraeipithelial neoplasia or carcinoma within two to three years if left alone.[12] Other manifestations include oropharyngeal cancer where HPV, mostly type 16, has been detected in 8-36% of head and neck squamous cell carcinomas.[9] Finally, HPV can be linked to about 90% of the cervical cancers, with types 16 and 18 accounting for 70% of cases. In addition, in at least 3 million out of the 4.7 million abnormal Pap tests each year, HPV has been implicated.[2,3]

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"Studies have shown that anywhere from 13% to 30% of women who have sex with women (WSW) have HPV, including 13% of WSW who have never had sex with a man . . . Despite these high numbers, WSW generally do not understand their risk for sexually transmitted diseases."

Diagnosis and Treatment

Clinicians have not routinely screened for HPV because a positive HPV DNA test reveals little about the course of the infection nor will it affect treatment and outcome. Most infections spontaneously resolve over a few years and do not cause any cervical changes. The Pap smear test, used for screening for cervical cancer shows the presence or absence of changes in cervical cells. When abnormalities are noted, an HPV DNA test is run. In most cases cervical changes regress spontaneously, and when HPV manifests in wart-like lesions there is treatment, but there is no treatment for the high-risk HPV types that can cause cervical malignancies. Abnormal PAPs are repeated and watched carefully until abnormal changes regress or surgical intervention is indicated.

Vaccination

In June 2006, the FDA approved the first HPV vaccine, and specifically recommended targeting its use to women age 9-26 and those who have not been already exposed to HPV subtypes 6, 11, 16 and 18. GARDASIL® was developed as a recombinant, quadrivalent HPV vaccine, prepared from highly purified virus-like particles of the major capsid L1 protein of HPV subtypes 6, 11, 16 and 18. The clinical trials have shown that in women who have not already been exposed to these HPV subtypes, about 70%-100% of HPV-related cervical changes can be prevented. Both target groups include a significant number of WSW. The studies cannot conclude that the HPV vaccine would alter the course of the infection in women previously exposed to HPV, but results do show that genital warts will be prevented. Because the research is ongoing, no one is certain how long the immunity will last.[2,3] Clearly, more research needs to be done to determine the length of immunity, as well as the implications for women previously exposed to the relevant HPV subtypes.

ADVICE TO HEALTHCARE PROVIDERS

The problem of HPV in the population of WSW can fall under two main causes: lack of education, from provider and patient, and lack of patient-doctor time. There are very specific things that healthcare providers can do to try to alleviate these barriers. Here are some recommendations to foster a trusting doctor-patient relationship.

1. Create an open environment

There are many things healthcare providers can do, from placement of pro-gay stickers such as the rainbow flag on their office door to wearing a pro gay pin on a white coat. Creating forms with questions that are inclusive of all sexual orientations or having displayed brochures relevant to the LGBT population are also helpful. These things will be noticed and will help relieve anxiety in the patient.

2. Screen for sexual history

Having the patient fill out a form that asks about sexual orientation is not sufficient because people may not feel comfortable revealing this on paper. The key question is "Are you sexually active with men, women or both?" Doctors should also inquire into the patient's sexual past because statistics show that the majority of WSW have had sex with men before.

3. Educate patient and self

Being able to correctly educate a patient is essential. Therefore, healthcare providers must keep their knowledge up to date about the health risks of all their patient populations. Doctors should speak to women of all sexual orientations about the importance of safe sex practices and annual gynecological examinations. Further, doctors should be aware of the general issues specific to WSW, particularly the psychosocial aspects of living a lifestyle different from much of the population. Most importantly, the best way for a doctor to learn is to listen to their patients and address their individual needs.[14]

For more detailed recommendations, please see the Gay and Lesbian Medical Association's recommendations for creating a welcoming environment for the LGBT population. (www.glma.org).

HEALTHCARE ISSUES RELEVANT TO WSW

In the United States, 2.3 million women, about 4% of the female population, identify as lesbians, with an additional 4% of women who engage in same sex behavior with women who do not label themselves as lesbians. In addition, about 80% of WSW have had sexual interactions with men and about 20% continue to do so. Despite these high numbers, WSW generally do not understand their risk for sexually transmitted diseases. On the whole, WSW do not engage in safe sex practices such as using a dental dam or a finger condom. The general belief is that there is no sexual risk if one's sexual partner is not a man. Therefore, the first issue is lack of knowledge of the importance of safe-sex practices.

With regards to HPV, less than 1/3 of the general US population has heard of HPV.[10,11,13] Those who have heard of HPV are generally not aware of its implications or transmission. Based on this, it is not surprising that most women, including WSW, cannot identify the purpose of the Pap smear in detecting changes indicative of HPV even though about 4% of WSW have cervical changes associated with HPV.

Further, research has shown that the average interval between Pap smears for WSW is 21-34 months compared to 8-12 months for other women. Women who have never had sex with men receive pap smears even less frequently and have their first pap smear at an older age than those who did have sex with men. Studies have shown that when WSW were told they didn't need a Pap test, 90% of the time it was their doctor who misinformed them.[6] Therefore, the second issue is that of failure to get screened regularly for HPV.

In addition to lack of knowledge of HPV, WSW have an additional disadvantage of having less "face time" with doctors. One reason, stated above, is the perception that annual Pap smear tests are not needed. Other reasons include lack of health insurance compared to their married hetero-sexual counterparts, and lack of a referral system of LGBT-friendly doctors. One other significant factor is the negative reactions faced by WSW when they disclose their sexual orientation. About 53%-72% of WSW do not disclose their sexual orientation. But when they do, up to 30% of WSW face negative reactions from their doctors.[6,7] Therefore, the third issue is that of barriers to regular healthcare.

RESOURCES

NEW JERSEY LGBT HEALTHCARE LISTSERV

You can receive periodic e-mail updates on resources, information and news that will be of interest to all who provide care to or are concerned about the health and healthcare of lesbian, gay, bisexual, and transgender individuals in New Jersey and the U.S. Listserv members can also send messages to the full list, including announcements about resources or events. Email to the list can only be sent from a subscribed email account.

TO JOIN THE LIST: Write to LISTSERV@LISTS.UMDNJ.EDU and, in the text of your message (not the subject line), write: SUBSCRIBE LGBT-HEALTHCARE

New Jersey does not have an LGBT health center. However, you can find information about sites that are designed to serve the LGBT population in nearby areas:

- **The National Coalition for LGBT Health (Washington, DC)**
  (202) 797-3516 • www.lgbthealth.net
- **Callen-Lorde Community Health Center**
  356 West 18th Street, New York, NY 10011 • 212- 271-7200 • www.callen-lorde.org
- **Mazzoni Center**
  1201 Chestnut St., Philadelphia, PA 19107 • (215) 563-0663 • www.mazzonicenter.org

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SELF-ASSESSMENT TEST

BEYOND HIV: Addressing the Spectrum of Lesbian, Gay, Bisexual and Transgender (LGBT) Health Care Issues

Part I: Examining LGBT Health Disparities

Part II: Human Papillomavirus (HPV) Screening and Vaccination: Are We Missing Women Who Have Sex with Women?

Self-Assessment Test

Questions refer to the content of the article and the notes that follow. To receive CME/CEU credit: complete exam, registration, and evaluation forms on-line at http://ccoe.umdnj.edu/online/AIDSLine/index.htm or fill in the forms on the next two (2) pages, and mail or fax to UMDNJ-CCOE (see next page).

1. **There have been recent outbreaks of which STD(s) in gay and bisexual men?**
   A. Rectal gonorrhea
   B. Syphilis
   C. Both rectal gonorrhea and syphilis
   D. Neither rectal gonorrhea nor syphilis

2. **STDs cannot be transmitted during female-to-female sex.**
   A. True
   B. False

3. **Gay and bisexual men who are HIV negative may still be at higher risk of developing which kinds of cancer?**
   A. Testicular, anal
   B. Anal, lung
   C. Hodgkins, lung
   D. Kaposi's sarcoma, Hodgkins

4. **Lesbians may be at higher risk of developing which kinds of cancer?**
   A. Ovarian, breast, lung
   B. Ovarian, colon, pancreas
   C. Breast, lung, colon
   D. Breast, colon, pancreas

5. **All of the following methods are helpful in promoting an open doctor-patient relationship with WSWs, EXCEPT:**
   A. Wearing a rainbow flag pin on one's white coat
   B. Asking a patient if she is a lesbian
   C. Asking a patient whether she has sex with men, women or both
   D. Having a copy of an LGBT magazine in the waiting room.

6. **How effective is the HPV vaccine in preventing cervical lesions due to HPV?**
   A. 20%-40%
   B. 30%-50%
   C. 50%-70%
   D. 70%-100%

7. **Which one of the following health topics was not identified as a priority for the LGBT population:**
   A. Substance abuse
   B. Mental health
   C. Cancer
   D. Ulcers

8. **HPV is transmitted only through oral/genital or genital/genital contact:**
   A. True
   B. False

9. **The CDC recommends that all sexually active gay and bisexual men who are not immune be vaccinated against:**
   A. Hepatitis A only
   B. Hepatitis B only
   C. Neither hepatitis A or B
   D. Both hepatitis A and B

10. **At least 30% of women who have sex with women have never been sexually active with men in the past.**
    A. True
    B. False

08HC03 - DE01

CONTINUING EDUCATION REGISTRATION

BEYOND HIV: Addressing the Spectrum of Lesbian, Gay, Bisexual and Transgender (LGBT) Health Care Issues

Part I: Examining LGBT Health Disparities

Part II: Human Papillomavirus (HPV) Screening and Vaccination: Are We Missing Women Who Have Sex with Women?

Registration Form

CCOE
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In order to obtain continuing education credit, participants are required to:

(1) Read the learning objectives, and review the activity, and complete the self-assessment.

(2) Complete this registration form and the activity evaluation form on the reverse side, and record your test answers below.

(3) Send the registration and evaluation forms to: UMDNJ-Center for Continuing and Outreach Education
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(4) Retain a copy of your test answers. Your answer sheet will be graded and if you achieve a passing score of 70% or more, a credit letter awarding 1 AMA/PRA category 1 credit™ or 0.1 continuing education units (CEUs), and the test answer key will be mailed to you within four (4) weeks.

Individuals who fail to attain a passing score will be notified and offered the opportunity to complete the activity again. This activity will be posted online at http://ccoe.umdnj.edu/catalog/aids

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SELF-ASSESSMENT TEST Circle the best answer for each question:	**1.** A B C D	**3.** A B C D	**5.** A B C D	**7.** A B C D	**9.** A B C D
	2. A B	**4.** A B C D	**6.** A B C D	**8.** A B	**10.** A B

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I attest that I have completed the activity as designed and I am claiming [up to 1 credit]:

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CONTINUING EDUCATION EVALUATION

BEYOND HIV: Addressing the Spectrum of Lesbian, Gay, Bisexual and Transgender (LGBT) Health Care Issues

Part I: Examining LGBT Health Disparities

Part II: Human Papillomavirus (HPV) Screening and Vaccination: Are We Missing Women Who Have Sex with Women?

Activity Evaluation Form

CCOE
Center for Continuing & Outreach Education

The planning and execution of useful and educationally sound continuing education activities are guided in large part by input from participants. To assist us in evaluating the effectiveness of this activity and to make recommendations for future educational offerings, please take a few moments to complete this evaluation form. Your response will help ensure hat future programs are informative and meet the educational needs of all participants.

Please note: CE credit letters and long-term credit retention information will only be issued upon receipt of completed evaluation form.

PROGRAM OBJECTIVES: Having completed this activity, are you better able to:	**Strongly Agree**				**Strongly Disagree**
Objective 1: To describe personal, community, institutional and provider-based barriers to health care faced by lesbian, gay, bisexual and transgender (LGBT) patients	5	4	3	2	1
Objective 2: Identify various cancers and other health conditions for which the LGBT population may have a higher risk.	5	4	3	2	1
Objective 3: Understand the epidemiology, transmission, and clinical implications of human papillomavirus (HPV) infection in women who have sex with women (WSW)	5	4	3	2	1
Objective 4: Promote targeted use of HIV/STI prevention and screening protocols in health care settings for men who have sex with men (MSM).	5	4	3	2	1

OVERALL EVALUATION:	**Strongly Agree**				**Strongly Disagree**
The information presented increased my awareness/understanding of the subject.	5	4	3	2	1
The information presented will influence how I practice.	5	4	3	2	1
The information presented will help me improve patient care.	5	4	3	2	1
The faculty demonstrated current knowledge of the subject.	5	4	3	2	1
The program was educationally sound and scientifically balanced.	5	4	3	2	1
The program avoided commercial bias or influence.	5	4	3	2	1
Overall, the program met my expectations.	5	4	3	2	1
I would recommend this program to my colleagues.	5	4	3	2	1

If you anticipate changing one or more aspects of your practice as a result of your participation in this activity, please provide us with a brief description of how you plan to do so.

Please provide any additional comments pertaining to this activity (positives and negatives) and suggestions for improvement. Please list any topics that you would like to be addressed in future educational activities:

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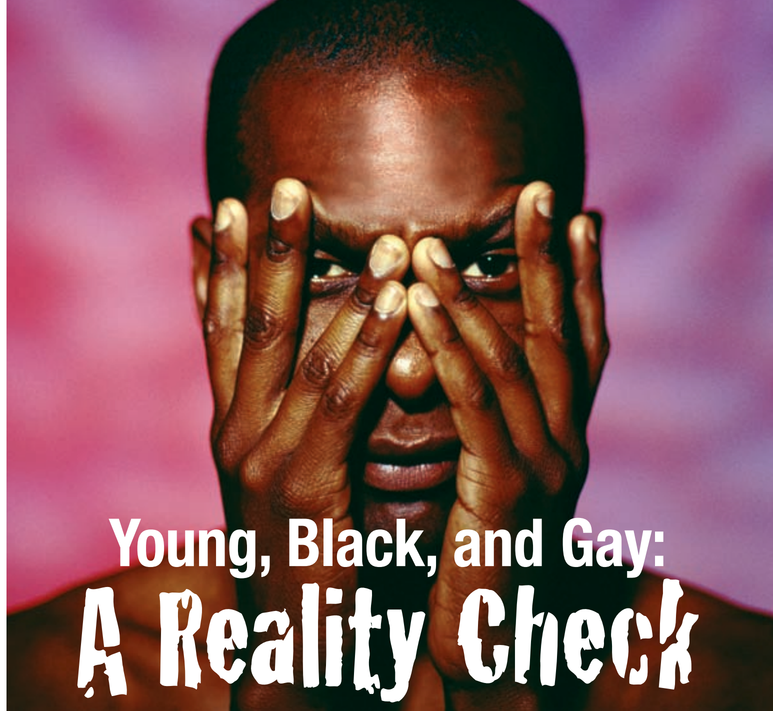

Young, Black, and Gay: A Reality Check

Gary Paul Wright

In the early 1990s, there was an outcry within the community of Black Gay males because, in certain scientific circles, we were being referred to as an endangered species. At the time I was working at Gay Men's Health Crisis (GMHC) as an assistant coordinator for the People of Color Prevention Program. I worked with Craig G. Harris, Colin Robinson, Ronald Johnson and George Bellinger, Jr.; all openly gay Black men who were writers, policy makers, and above all, AIDS activists. The argument of the day centered on the word "species." It was insulting, as if Gay Black Men (GBM) were being compared to animals in a laboratory. In retrospect, perhaps we should have focused on the other word – endangered.

Today, young Black men who are sexually active with other men (MSM), whether they identify as gay or not, are at great risk for HIV. The media is full of stories about Black men being on the "down low," but the attention is generally framed on the effect it has on the increasing numbers of HIV infections for African American women. The effect that it is having on young MSMs of color is rarely emphasized. According to writer and activist Keith Boykin, "The down low is not the cause of the Black AIDS epidemic. The real reason why we are obsessed with women who are infected by men who are on the down low is because we don't want to deal with the reality that Black Gay men are the greatest victims of this disease. Rather than talk about the tragedy among Black Gay men, we create an illusion about straight Black women. It is much easier to talk about sympathetic straight Black women who are being infected by stereotypical deceptive and predatory Black men than to address what is really going on."[1,2] As a subculture, these young men are continually lumped under one umbrella. In truth, there are many layers of Black Gay men, layers which are more clearly defined as these men begin to tell their stories.

The most recent figures from the Centers for Disease Control paint a dismal picture for gay and bisexual young men of color. At the 2005 CDC National HIV Prevention Conference held in Atlanta, it was reported that nearly 46% of young Black Gay men are already HIV-positive compared to 21% of white gay men.[3] Of those 46%, more than two-thirds of the HIV-infected Black men were unaware of their infection. Data for this five-city National HIV Behavioral Surveillance (NHBS) study was collected in Baltimore, Los Angeles, Miami, New York City and San Francisco. In a similar 1994 study, the CDC found that 21% of Black MSM were infected with HIV. Six years later, the number had risen to 30%.[4] Black Gay leaders are asking, "Where is the outrage? Where is the urgency?" The Black AIDS Institute posted an open letter on its website which states, "Forty-six percent isn't a catastrophe. It's genocide!"[5]

In New Jersey, the trend is just as disturbing. While injection drug users (IDU) still lead in cumulative HIV/AIDS cases, new HIV infections for MSMs have surpassed those of IDUs for two consecutive years. According to the New Jersey HIV/AIDS Report, MSM exposure accounted for 34% of HIV/AIDS cases reported January 2005 – December 2005, while only 13% can be attributed to IDUs.[6]

Outspoken gay African Americans are now calling for an all out war against HIV. Many cite that Black Gay men stand at the crossroads of the epidemic. Leo Rennie, a Washington, D.C. consultant and activist, writes that "Our nation needs a comprehensive response across all sectors – government, national AIDS policy organizations and local CBOs, physicians and state and local health departments – to reverse the devastating HIV infection trends among black, gay men. (It) should include strategies that step in to mitigate those factors that are precursors to risk behaviors and that facilitate ongoing access to care. These programs must take into account psychosocial issues such as depression, childhood sexual abuse, partner violence, alcohol and substance use and the effects of discrimination based on race and sexual orientation."[7] He also points to health care providers' bias, prejudice, and

(Continued on page 14)

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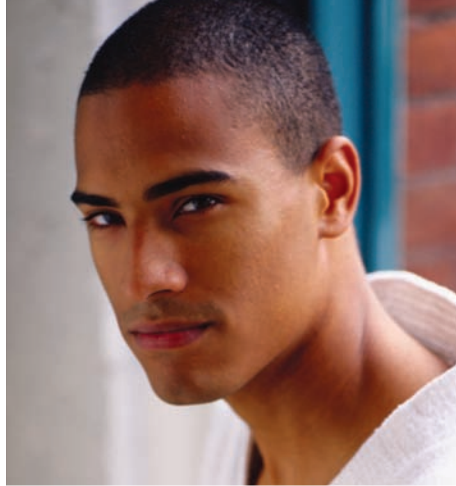
Young, Black, and Gay: A Reality Check

(Continued from previous page)

stereotyping as a potential contributor to the disparity in numbers for young MSM. "If such discrimination is an issue for heterosexual people of color, imagine the impact of racism and homophobia on the quality of HIV testing, care, and treatment Black Gay men are able to access."[7] Phill Wilson, executive director of the Black AIDS Institute, states that a total lack of interest in an entire segment of the population is inexcusable. "Many people are taking from this data that gay Blacks are engaging in riskier behavior, but that's not the case. HIV prevention in the Black community was delayed, which is why there's higher incidence."[5]

According to researchers Drs. Vickie M. Mays and Susan D. Cochran, effective prevention strategies must consider the interaction between MSM of color, their communities, society, and the hopes and dreams they either embrace or lack in their daily social connections. Racism in the gay White community, homophobia in the Black community, and invisibility vs. full citizenship with recognized relationships; along with a host of other inequities in education, the labor market, and housing all serve as "influential factors in the choices of risk or protective engagements."[8] As co-authors of the original Black Gay Men's study (c. 1990), they have charted the epidemic in this community for two decades. Sexual behaviors are often mired in the perception of power, privilege, and position. "Power, privilege, and position are not merely about the resources of money and education but about being a male – a Black male – in American society." Often, they ask themselves if their lives even matter. "While the world paid attention to the murder of Matthew Shepard, most African American men know that in America, if they are beaten or killed because of presumed homosexuality, they are just another dead Black man, not a cause nor a symbol."[8]



That very idea was also broached at last year's Black Gay Research Summit held in Brooklyn, NY. Dr. Ron Simmons, director of the Washington, D.C. organization Us Helping Us (UHU) challenged, "The question isn't whether or not Black Gay men can be saved. The question is whether or not we believe that we are worth saving."[1] The answer was a resounding "YES!"

In response to what is now referred to as "The 46% Report," numerous position papers, including the aforementioned Open Letter from the Black AIDS Institute, have been published. GMHC's Institute for Gay Men's Health has partnered with AIDS Project Los Angeles (APLA) to produce a statement appearing on both websites entitled, Black Gay Men's Lives Matter! The GMHC and the APLA state that the lack of media reaction is "not surprising when the lives of Black Gay men are routinely reduced to sex acts and when Black Gay men are continuously labeled as sexual pariahs or portrayed in the media as the vectors of disease."[2] Mays and Cochran contend "We have allowed America to define masculinity for men of color, heterosexual or gay. If we are serious about HIV prevention, we must begin this dialogue and not wait for permission to begin this discussion."[8]

Fortunately, the dialogue has begun. Groups like the National Black Gay Men's Advocacy Coalition (NBGMAC), made up of health care advocates from across the country, are being formed. The NBGMAC hopes to encourage the federal government to improve prevention efforts targeted at Black men and to channel more money into researching why prevalence rates are so high among African Americans. In April, members of the group kicked off their campaign with Congress, members of the Bush administration, and the Department of Health and Human Services.[9] The New Jersey Department of Health and Senior Services funds, through the Division of HIV/AIDS Services; programs which specifically target MSMs of color. These include the BROTHER Project, the Hyacinth AIDS Foundation, and NJCRI's Project WOW; all of which facilitate the CDC-approved intervention, Many Men, Many Voices.

More importantly, young Black Gay men are courageously taking the lead and speaking for themselves. Two such men include Shelton Jackson and Jonathan W. Jones, young authors whose short lives echo their experiences of living openly Gay, dealing with the African American community, and being surrounded by the AIDS epidemic. While they have produced very different publications, both have clearly become activist warriors and contribute to the voice of their generation.

Shelton Jackson is not only openly Gay, but also has AIDS. His first book of poetry, *The Second Chapter: Acceptance,* chronicles his journey from being a "victim of AIDS" and the loss of his partner to HIV to his ultimate victory over fear of loneliness, hopelessness, and abandonment; of being a person infected and facing life threatening situations. He writes, "Poetry has helped me face all of the things I fear about myself. This is my acceptance that life goes on."[11] Jackson grew up in Newark and lost his father to AIDS when he was in high school. His mother lived a drug clouded existence, leaving Shelton to raise himself at the age of sixteen. He recently released his second publication, *The Dawn Of A New Day,*[12] and is currently

"If such discrimination is an issue for heterosexual people of color, imagine the impact of racism and homophobia on the quality of HIV testing, care, and treatment Black Gay men are able to access."

ENDANGERED?

"Our nation needs a comprehensive response across all sectors – government, national AIDS policy organizations and local CBOs, physicians and state and local health departments – to reverse the devastating HIV infection trends among black, gay men. (It) should include strategies that step in to mitigate those factors that are precursors to risk behaviors and that facilitate ongoing access to care."

earning his bachelor's degree in journalism at Morgan State University. Additionally, he belongs to Hope's Voice, a student group that tours the nation's colleges to educate young people about AIDS. The group reaches out to their peers to show them the true faces of AIDS. "There aren't a lot people that look like me speaking out," says Jackson. "The Black community and its stigmas about homosexuality, it's not a very popular subject. I'm trying to be a voice that changes that perception. It's changing, but it's moving too slow for me."[13]

Nineteen year old Jonathan W. Jones has written his own version of what it means to be Black and Gay. In his book, *Get By: A Survival Guide for Black Gay Youth,*[14] Jones has captured the essence of what he sees as "the greatest taboo." He writes, "Growing up with such a stigma presents the young African American homosexual with a lifetime of dilemmas." His book gives Black Gay youth a comprehensive guide to embracing their identity and becoming proud, strong, and powerful members of their communities. Currently a student at Rutgers University in Newark, he wants to be a resource for others who search to find their own faces in the literature and media outlets that so often ignore Black Gay men. "Don't ride your bike without a helmet," he quotes his mother as saying. "I'll bet if I were to get into a bicycle accident, from that day afterward, I would never ride without a helmet again." He goes on to say, "Communication is the key to any good relationship. If you want your boy to know something, you have to let him know it. If you absolutely want him to use a condom, tell him. And if he refuses, tell him again."

These are just two examples that prove that the lives of young, Black Gay men do matter. Jackson and Jones continue to fuel a torch that was lit over two decades ago by activists intent on saving younger generations. Back in the 1980's, HIV and AIDS was a new tragedy to my generation, but it has always been a part of their world. As adults and as professionals; we can neither fail them, nor let them go it alone. It is time for a reality check. Theirs is a crisis within a crisis and our efforts have to be refocused and redoubled if we are to save the valuable lives of today's generation.

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If Gay Means Happy, Why Am I Always Getting High?

The Impact of Alcohol, Tobacco and Other Drugs on LGBT Communities

Philip McCabe, CSW, CAS

Historically the connection between HIV and drug use has been long established, with significant focus on intravenous drug use in the early days of the epidemic. Simultaneously, reports of excessive alcohol and drug use among members of the LGBT communities have been debated, criticized, suspected, and; more often, ignored. Those within the LGBT communities use Alcohol, Tobacco and Other Drugs (ATOD) for many of the same reasons as others; however, their probability of using is heightened by personal and cultural stresses which result from anti-gay bias. Reliance on bars for socialization, stress caused by discrimination, and targeted advertising by tobacco and alcohol businesses in gay and lesbian publications are all believed to contribute to increased pressures on LGBT individuals to engage in substance use and potential abuse.

Reliable information about the size of the LGBT population is not available for a number of reasons: a lack of research about this community, fear of LGBT to self-identify, and no clear, universally accepted identifiers of who is LGBT. This lack of information makes it difficult to determine the extent of LGBT substance abuse problems. Available studies indicate that LGBT people are more likely to use alcohol, tobacco, and other drugs than the general population. They are less likely to abstain from alcohol, tobacco, and other drugs, they report higher rates of substance abuse problems, and they are more likely to continue heavy drinking into later life.

While the exact percentage of addicted LGBT individuals continues to be debated, the reality of elevated exposure to alcohol, tobacco, and other drug use is obvious. Clear indicators of the LGBT community's connection to legal and illicit substances are in plain sight at many gay events, venues, clubs, or social environments. From mimosas at brunch to Meth used in sex clubs and parties – if one wishes to partake, it's easy to find others to use, deal, trade, or indulge in substances in combination with sexual activity. Alcohol, Tobacco, and Other Drugs have significant impact within the LGBT community and an even more serious influence on HIV prevention, infection, and treatment. Education, prevention, intervention, and treatment efforts for the LGBT community are further complicated by dependence upon alcohol and tobacco funding sources to support basic community services, cultural activities, and AIDS awareness.

Alcohol

In many segments of the LGBT community, alcohol use is common. Perhaps, due to the frequent use of alcohol that occurs in gay bars, clubs, cocktail parties, and fundraisers, the abuse of alcohol is sometimes overlooked. While social drinking is considered acceptable, the risk of over-indulgence increases in social situations. Problem drinking and alcohol dependency can often be ignored until there is a life threatening situation, i.e. lost of job, physical ailment, accident, injury, and harm to others.

A National Institute of Health study showed that alcohol can reduce CD4 function, prompting HIV to multiply faster, which taxes the brain and central nervous system. Alcohol and HAART together stress the liver (particularly in the hepatitis and HIV co-infected) and lessen medicine potency, while inviting kidney stones, pancreatitis, and insulin resistance, which can lead to diabetes. Intoxication can also encourage erratic HAART adherence and treatment-spoiling resistance. Though alcohol may seem to ease depression and anxiety; it can actually mask and intensify them, interfering with diagnosis and treatment.

Tobacco

In recent years, research has begun to look at tobacco use and HIV among LGBT. In the 2003 Lesbian, Gay, Bisexual, and Transgender Tobacco Survey, it is reported that "LGBT people smoke much more than the rest of the population. A recent full probability research study showed LGBT men smoked at rates 50% higher than the general population and LGBT women smoked at rates almost 200% higher than the general population." It is estimated that smoking kills more LGBT people than any other health issue.

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Second hand smoke is a health hazard for everyone, regardless of race, gender, ethnicity or sexual preference. Each year, approximately 3,000 Americans die from cancer caused by second-hand smoke. Studies suggest that second hand smoke may also be a key factor in as many as 62,000 deaths from coronary heart disease annually. While there is little research specific to second hand smoke and people living with HIV/AIDS, there is a significant body of research showing the impact smoking has on people living with HIV/AIDS when it comes to heart disease, cancer, and other common diseases and conditions that people living with HIV/AIDS face. HIV infection is associated with an increased risk of many types of cancer. HIV-associated malignancies, such as anal and cervical cancer are observed more frequently among HIV/AIDS patients who smoke.

Other Drugs

Current reports about the increase of Meth usage among gay, bisexual, and MSM indicate further complications of HIV sero-conversion or re-infection. Meth users report that the high from Meth coupled with increased stamina and sexual desire is a dangerous, but highly desirable combination. Recent investigations by the Center for Health, Identity, Behavior, & Prevention Studies (CHIBPS – formerly known as C.H.E.S.T.) in New York City have documented that among gay or bisexual male party or club drug users, approximately 62% reported frequent use of Crystal Meth. Furthermore, a substantial proportion of men reported poly-drug use, combining Meth with alcohol (45%), Ecstasy (39%), K or ketamine (32%), Viagra (29%), inhalant nitrates (28%), and cocaine (25%). However, in a more general sample of gay and bisexual men collected in 2005, Crystal Meth use is estimated at 20-30%. NYU-CHIBPS also found that Crystal Meth use crossed lines of race/ethnicity, age, income, and HIV status. In NYU-CHIBPS's study called "Project Tina", the ages of the participants ranged from 20 to 55. In terms of race/ethnicity, 45% of the sample were men of color. 50% of users reported being HIV positive. This was corroborated in Project BUMPS in which 42% of the Meth using sample was men of color, and approximately 40% were HIV-positive.

Recent reports show an increase in club drug use, particularly Crystal Meth, for gay, bisexual, and MSM. Meth is known to increase sexual desire and often diminishes previously maintained "safer-sex" practices. Even though Meth can have a negative effect on performance (impotency), many users combine Meth with PDE-5 Inhibitors (erectile dysfunction medications) to counter the affects of this drug. One needs only to read the personal ads in any gay publication or on an Internet site to see the influence of drugs within the community. "Drugs & Disease Free," "Party and Play," "420 Friendly" or the conflicting "No Drugs–Poppers and Smoke OK" appear as often as age, stats, and location in many ads. The reality is that many in the LGBT community deal with drug use on a continual basis, either in an attempt to abstain or avoid drug use or to seek out a co-user for relationships and intimate encounters. Crystal Meth can make users forget about the importance of practicing safe sex. In Project BUMPS, men who tested positive for HIV (even though they thought they were negative), had 11 times more unprotected receptive anal sex while high on Meth than those who were confirmed to be HIV-negative.

Preparing People to Change, and Treatment

Early prevention recommendations for positive HIV individuals often followed the protocol established by the government at that time. The "Just Say No" ad campaign was a single focused approach to all maladies of the eighties, including teen sexual activity, drug use, underage drinking, and HIV transmission. What was missing and ineffective in this approach was the consideration of the range of substance use that occurs. School curricula that educated or provided drug awareness messages to students were often counterproductive by introducing risk-taking individuals to a broader representation of abuse substances, while distorting the consequences of experimental or recreational use.

It's important to remember that not all individuals who use alcohol, tobacco and other drugs become dependent on these substances. Substances like Nicotine and Meth can become addictive even with minimal use and addictions to others develop over time. Some individuals move from the experimentation phase to abuse or misuse phase and then stop using when they experience problematic behavior. Others progress on to dependence and addiction. The distinction between phases is a significant factor when developing interventions to help an individual.

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If Gay Means Happy, Why Am I Always Getting High?

(Continued from previous page)

Interventions need to be tailored for each individual and can include psycho-social education, harm reduction, moderation, behavior modification, contingency management, abstinence-based treatment, or self help programs. Additionally, healthcare providers can benefit from education about trans-theoretical models utilized to meet the individual at his personal stage of dependence and to assist with moving them along the change process. Someone who is concerned about drinking alcohol while on HIV meds is different than someone who is an alcoholic and unable to maintain a consistent medicine regime because his liver is being destroyed by alcohol, making any medicines ineffective.

Nearly all addicted individuals believe in the beginning that they can stop using drugs on their own and most try to stop without treatment. Most of these attempts, however, result in failure to achieve long-term abstinence. Research has shown that long-term drug use results in significant changes in brain function that persist long after the individual stops using drugs. These drug-induced changes in brain function may have behavioral consequences, including the compulsion to use drugs despite adverse consequences of the defining characteristic of addiction.

No single drug addiction treatment is appropriate for all individuals. Matching treatment to an individual’s needs, core issues, current usage, and past success and failure is critical. The best treatment programs provide a combination of therapies and other services to

THE FIVE A'S: Ask, Advise, Assess, Assist, and Arrange

Ask	Ask every patient at every contact, “I would like you to tell me about your drug use, including alcohol, tobacco, prescribed, non prescribed and over the counter.”
Advise	Make it personal a relevant to the individual. “As your healthcare provider I am concerned about your use of …” Or, “Based on your current health status I need to advise you that …”
Assess	Assess what is the client’s current level of motivation to quit? Ask, "Do you want to quit?" Determine when, “Now? This week? This month? Within the next several months?” “Would you like assistance to stop? What has helped you in the past, when you needed to make a change in your life?”
Assist	Help the patient prepare for the quit date. “Can I help you find a local self help group such as AA/NA?” “Can I provide you with a referral to a specialist for treatment?” “I would like to refer you for an assessment or further evaluation. Are you willing to go?” “Would you like to consider medications that can help with withdrawal or co-occurring symptoms?”
Arrange	Schedule a follow-up session to review progress. Additional contacts should be scheduled as indicated. Restart the process if the patient relapses.

Adapted from: Quick Guide for Clinicians - Treating Tobacco Use and Dependence.
http://www.surgeongeneral.gov/tobacco/tobaqrg.htm#table

meet the needs of the individual patient. For LGBT individuals, treatment must include a focus on the effects of stigma, homophobia, and heterosexism in order to be beneficial to the patient. Not only does treatment need to be inclusive of the core issues affecting LGBT clients, it also needs to maintain a LGBT affirming understanding of the life skills necessary to develop and maintain a drug free existence.

Early approaches for dealing with addicted individuals often relied on direct confrontation followed by aggressive attacks on the individual's defense structure. Current trans-theoretical models, however, recognize that change itself is influenced by biological, psychological, sociological, and spiritual variables. A client's motivation to change can be influenced. These models recognize that although the client is ultimately responsible for change, the clinician shares responsibility through the development of a therapeutic partnership. (For a more detailed explanation see SAMHSA/CSAT Treatment Improvement Protocols. TIP 35: Enhancing Motivation for Change in Substance Abuse Treatment.) Along with Motivational Interviewing, Brief Interventions models developed for health care providers can be useful. The Five A's approach was originally developed for tobacco cessation, but can be adapted in most clinical settings to address other types of addictions. Another simple brief intervention model is the CAGE questionnaire. (See box below.)

For many LGBT individuals, alcohol, tobacco, and other drugs have become entwined in every sexual experience. For treatment to be successful, it needs to include a supportive and affirming experience for a client to discuss issues of identity, gender, sexuality, sexual behavior, and intimacy free from judgments and heterosexual biases. Providers need to be comfortable and knowledgeable about discussing all aspects of human sexual health. Asking patients directly about ATOD use and sex behavior must be done with respect and can facilitate an open dialog between client and provider.

Recovery is possible. Lesbian, Gay, Bisexual, Transexual, Intersex, Queer, and Questioning Individuals can lead productive lives free from Alcohol Tobacco and Other Drugs. For those unwilling to stop at this time, assistance to reduce the risk of harm can be a step along the process of change. Providing accurate information, appropriate support, and referrals along with empathy can be the catalyst that moves a patient from the edge of despair to a new way of life.

The CAGE Questionnaire

- Have you ever felt you should **C**ut down on your drinking?
- Have people **A**nnoyed you by criticizing your drinking?
- Have you ever felt bad or **G**uilty about your drinking?
- Have you had an **E**ye opener first thing in the morning to steady nerves or get rid of a hangover?

SCORING

Assign one point for each positive answer. Scores of 2 or greater should create a high index of suspicion of alcohol dependence, and warrants further evaluation.

Ewing JA. Detecting alcoholism, the CAGE questionnaire. Journal of the American Medical Association. 252(14): 1905-1907, 1984.

RESOURCES

The National Association of Lesbian and Gay Addiction Professionals
The National Association of Lesbian and Gay Addiction Professionals is a membership organization founded in 1979 and dedicated to the prevention and treatment of alcoholism, substance abuse, and other addictions in lesbian, gay, bisexual, transgender communities. www.nalgap.org

Alternatives is the nation's only gay owned and operated alcohol, drug and mental health program, whose leadership has provided over 30 years of pride and service to the Gay, Lesbian, Bisexual and Transgender Community. http://www.alternativesinc.com/

LGBT Companion Document (PDF File, 3MG) to the U.S. Secretary of Health & Human Services' national health objectives for the next ten years, ***Healthy People 2010,*** presents 120 LGBT-specific objectives, including sections on tobacco (PDF File, 255KB) and on substance abuse (PDF File, 232KB). This landmark project of the Gay and Lesbian Medical Association (GLMA) involved several NALGAP members and other lgbt health professionals and advocates. www.GLMA.org

A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals (2001), Center for Substance Abuse Treatment/Substance Abuse & Mental Health Services Administration, DHHS, 192 pages. Printed copies may be ordered as Inventory Number BKD392 from the National Clearinghouse for Alcohol & Drug Information (NCADI), toll-free, 1-800-729-6686, or from info@health.org.

NEW JERSEY Special LGBT Health Issue
AIDSLine

Working With GLBT Survivors of Domestic Violence

Kelcie Cooke, LCSW

Domestic violence is a systematic pattern of behavior used by one person in an intimate relationship to assert power and control over their partner/spouse/lover. While physical wounds may be the most overt signs of abuse, domestic violence is exerted within a continuum of behaviors such as, but not limited to, emotional, sexual, and economic abuse. Medical providers, who are often first responders to domestic violence, have become increasingly savvy in screening for signs of abuse in their patients. However, because domestic violence is still considered to be an issue faced only by heterosexual women, victims who are gay, lesbian, bisexual, and transgender (GLBT) frequently go undetected, continue to exist in isolation, and suffer long-term psychological, emotional and physical harm.

The battered women's movement has succeeded in bringing the seriousness of domestic violence within heterosexual relationships to the public consciousness; however it has tended to view this problem as an extension of men's oppression over women. While the subjugation of women is well documented, adhering to this conceptualization cannot explain the existence of GLBT domestic violence. Within this paradigm it is impossible to view women as abusers or men as victims. Furthermore, studies indicate that domestic violence in GLBT relationships is just as widespread as domestic violence in relationships between heterosexual couples, with a prevalence ranging from 20%-35%, depending on the definition of domestic violence used. (Lundy, 1993, 273). In 2003, a record 6,523 domestic violence incidents were reported to GLBT anti-violence programs across eleven cities and regions across the U.S. and Toronto, Ontario. (NCAVP, 2003, pg.3 para.1) However, due to the scarcity of information about GLBT domestic violence, the isolation experienced by those being abused, and the lack of resources for GLBT victims, it is likely these numbers reflect only a small portion of the actual cases nationwide. Additionally, New Jersey, like many other states, does not track domestic violence incidents by sexual orientation and/or gender identity. In 2004, there were 76,109 incidents of domestic violence reported by the police throughout the state (Crime in NJ, 2004, p.196). Although 77% of the victims were female and 23% male, there are no statistics to determine how many of these individuals were involved in GLBT relationships.

Thus, the first step in aiding GLBT survivors of domestic violence is to eradicate the assumption that all victims are heterosexual.

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DYNAMICS OF DOMESTIC VIOLENCE

For many it is easy to comprehend how physical violence or the threat of physical violence could control another person's actions. However, domestic violence often starts off in a more innocuous fashion -- which may or may not escalate into physical abuse. Emotional abuse leaves no visible scars but is often characterized by victims as the most damaging aspect of what they endure. Much like brainwashing, emotional abuse systematically wears away at a person's self-confidence, trust in their own perceptions, and self-concept. The more that abusers exploit, lie, insult, demean and ignore the needs of their partners, the easier it is for them to take control over their partners' finances, access to friends and family, sexual behaviors, medical care and ability to receive help.

Although there is a great deal of overlap in how abuse is perpetrated in hetero and homosexual couples, oppression at the societal level can shape the tactics employed

POWER & CONTROL TACTICS

in Lesbian, Gay, Transgender and Bisexual Relationships

Psychological and Emotional Abuse
Criticizing constantly. Using verbal abuse, insults and ridicule. Undermining self-esteem. Trying to humiliate in private or public. Manipulating with lies and false promises. Denying partner's reality.

Threats
Making physical, emotional, economic or sexual threats. Threatening to harm family or friends. Threatening to make a report to city, state or federal authorities that would jeopardize custody, economic situation, immigration or legal status. Threatening suicide.

Physical Abuse
Slapping, hitting, shoving, biting, choking, pushing, punching, beating, kicking, stabbing, shooting or killing. Using weapons.

Entitlement
Treating partner as inferior; race, education, wealth, politics, class privilege or lack of, physical ability, and anti-Semitism. Demanding that their needs always come first. Interfering with partner's job, personal needs and family obligations.

Using Children
Threats/actions to take children away or have them removed. Using children to relay messages. Threats to or actual harm to children. Threats to or revealing of sexual or gender orientation to children or others to jeopardize parent-child relationship, custody or relationships with family, friends, school or others.

Economic Abuse
Controlling economic resources and how they are used. Stealing money, credit cards or checks. Running up debt. Fostering total economic dependency. Using economic status to determine relationship roles/norms, including controlling purchase of clothes,

Sexual Abuse
Forcing sex. Forcing specific sex acts or sex with others. Physical assaults to "sexual" body areas. Refusing to practice safe sex. In S&M refusing to negotiate or not respecting contract/scene limits or safe words.

HIV-related Abuse
Threatening to reveal HIV status to others. Blaming partner for having HIV. Withholding medical or social services. Telling partner she or he is "dirty." Using illness to justify abuse.

Intimidation
Creating fear by using looks, actions, gestures and destroying personal items, mementos or photos. Breaking windows or furniture. Throwing or smashing objects. Trashing clothes, hurting or killing pets.

Isolation: Restricting Freedom
Controlling personal social contacts, access to information and participation in groups or organizations. Limiting the who, what, where and when of daily life. Restraining movement, locking partner in and out.

Heterosexism
Perpetuating and utilizing invisibility of LGB relationships to define relationship norms. Using heterosexual roles to normalize abuse and shame partner for same sex and bisexual desires. Using cultural invisibility to isolate partner and reinforce control. Limiting connection to community.

Homo/Biphobia
A part of heterosexism. Using awareness of fear and hatred of lesbians, gay men and bisexuals to convince partner of danger in reaching out to others. Controlling expression of sexual identity and connection to community. Outing sexual identity. Shaming. Questioning status as a "real" lesbian or gay man or bisexual.

Transphobia
Using fear and hatred of anyone who challenges traditional gender expression, and/or who is transsexual, to convince partner of danger in reaching out to others. Controlling expression of gender identity and connection with community. Outing gender identify. Shaming. Questioning validity of one's gender.

Many of these power and control tactics are common to all abusive relationships, but dynamics of GLBT relationships are complicated by bias and fear of disclosure.

Source: Building Safer Communities for Lesbian, Gay, Transgender, Bisexual and HIV-Affected New Yorkers © 2003 New York City Gay & Lesbian Anti-Violence Project

by batterers within GLBT relationships. Both straight and gay batterers use threats to control their partners; however, GLBT abusers can also use their partners' sexual and/or gender identity or HIV status to further jeopardize their partners' employment, custody of children and/or ties to family. GLBT abusers will also use negative stereotypes and myths to shape their partners' perceptions. For instance, a batterer might convince his partner that rape is just "rough gay sex" or justify aggression by claiming that she's "only being butch." Unlike straight batterers, the GLBT abuser can rely on societies' hatred of and discrimination toward the GLBT community to convince his/her partner that no one will come to their aid or believe them. These are but a few ways homo, bi, and trans phobia can shape the dynamics of GLBT domestic violence.

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2002 Domestic Violence Victim Age

Age	Percent
Under 18	5%
18-22	10%
23-29	19%
30-44	52%
45-64	13%
65 & Over	<1%

ROLE OF THE MEDICAL PROVIDER

Domestic violence is a significant underlying cause of poor health and a serious public health issue. The effects of abuse are far-reaching, influencing patients' ability to follow through on treatment, their access to care, and the course of their medical condition. Outcomes of domestic violence on a person's health can include complication of pregnancy, the transmission of HIV, depression and anxiety disorders, alcoholism, and exacerbation of chronic medical conditions.

Detection of domestic violence is challenging because victims can present with a variety of symptoms but may not discuss their history of abuse. Thus as a part of routine care providers should screen all patients, regardless of sexual orientation and/or gender for abuse, whether signs, symptoms, or behaviors suggesting abuse manifest during a medical visit. Simply asking, "Have you ever felt afraid or controlled by your partner/spouse?" is an intervention. Even if the patient does not disclose, he/she will know that the provider is concerned, able to intervene, and that the hospital or clinic is a safe place to receive assistance should he/she need it in the future. Unfortunately, even when patients are properly screened, many providers still respond inappropriately to same-sex violence. Homophobia, lack of knowledge, and services intended for heterosexual survivors continue to stigmatize and disenfranchise the GLBT community. This article aims to educate medical providers by 1) offering an understanding of the dynamics of domestic violence with a focus on the unique experiences of GLBT survivors 2) dispelling common myths and biases concerning GLBT domestic violence and 3) supplying useful strategies for working with GLBT patients.

Common Myths and Misperceptions

Negative attitudes and beliefs about the GLBT community, minimization of the seriousness of same-sex abuse, and antiquated perceptions about male and female gender roles can lead to inappropriate interventions with victims of same-sex domestic violence. In order to accurately assess and intervene in these cases, providers must first identify their own personal biases when treating this population. The myths listed below are but a few ways bias and ignorance serve as barriers to proper care.

***Myth 1:* There is not an inherent power inbalance in GLBT relationships like there is in heterosexual relationships, so therefore the violence must be "mutual."**

There is no such thing as "mutual battering." The definition of domestic violence assumes that there is a power imbalance between two individuals. While an abused partner may use physical violence in some way to defend themselves, s/he is not attempting to control, abuse, or manipulate the abuser. Dismissing domestic violence as a "lovers' spat" belittles and excuses violence that is real and dangerous.

***Myth 2:* It isn't really violence when gay men fight. It's just boys being boys.**

This idea stems from the attitude that it is normal and acceptable for men to be violent. It is not normal for any person to inflict injuries on another. This idea, coupled with the assumption that men should be able to defend themselves, makes it difficult for healthcare providers to recognize signs of abuse in their male patients.

***Myth 3:* The abuser is always bigger, stronger, or more "butch."**

Domestic violence takes many forms that defy the need for abusers to be large or strong. A person who is small is still capable of behaving in emotionally abusive, manipulative, and controlling ways. Treating someone as inferior, humiliating someone in public and denying someone's reality does not require muscle strength. Moreover, any person prone to violence and rage (regardless of size) can victimize someone who may be taller and stronger but non-violent in nature. Such myth-based misconceptions often lead providers into misidentifying just who is the actual victim versus who is the actual batterer.

***Myth 4:* It is easier for GLBT survivors of domestic violence to leave an abusive relationship.**

Same-sex couples are just as committed and involved in each other's lives as are heterosexual couples. Though there are now some forms of legal recognition for GLBT relationships, the crude patchwork of local, state and/or federal protections actually makes it more difficult for a GLBT victim to leave his/her abuser. For example, the lack of clear and consistent laws governing custody and/or visitation of children, equitable distribution of property and potential for alimony merely compound the emotional barriers to leaving that have been documented among heterosexual women. GLBT relationships are not privileged with the same social, religious, legal, and family support as the vast majority of heterosexual relationships. The invisibility and lack of resources available to GLBT victims often keep them isolated. Finally, many GLBT individuals who are closeted fear that disclosing the abuse will mean having to "out themselves" to society.

***Myth 5:* Domestic violence laws don't apply to GLBT victims.**

While this may be true in a number of other states, New Jersey's domestic violence laws apply equally regardless of sexual orientation or gender (Clark, 1993, 1) and victims can access civil restraining/protective orders against an abuser. Unfortunately, the law is not always practiced as it is intended. Institutional and personal bias among police officers, court personnel, and judges may hinder individuals from obtaining the legal assistance they need. Therefore, individuals must make personal decisions within their safety plan about if, how, and when they will make use of the legal system.

Strategies for working with GLBT patients

As mentioned previously, GLBT individuals who have experienced domestic violence are commonly re-victimized by both institutional and individual homo/bi/trans phobia. Thus providers must carefully examine their feelings towards the GLBT community and ability to serve them fairly and competently. Once this is accomplished, the following strategies can help guide proper clinical practice:

1. Do not assume heterosexuality in anyone who comes to seek medical help.
2. Validate GLBT victims for coming forward to seek help. This is a huge sign of strength.
3. As you would for any person, reinforce that they did not deserve the assault and provide the same range of assessment and practice protocols as you would for aiding heterosexual survivors of domestic violence.
4. Do not force disclosure of sexual orientation or gender identity. It may be very important for a patient to have control of this information. However, if the patient does disclose a GLBT identity to you, do not ignore it as irrelevant to the situation. There may be a need for further exploration – especially if the sexual/gender identity seems to be directly linked to the experiences of abuse.
5. Use gender-neutral language. When you talk about the perpetrator, avoid gender specific pronouns until the victim has identified the gender of this person.
6. Be realistic about the homophobia or gender bias in the service systems that the survivor may encounter. Respect a client's choices if s/he opts not to enter systems that s/he perceives to be biased.
7. Make yourself aware of GLBT affirmative and supportive domestic violence programs in your area. Provide referrals to and seek consultation with these professionals. Some websites which may be of use for seeking out GLBT affirmative and supportive programs include:

   - New Jersey Anti-Violence Project (NJ-AVP)973-285-1595
     http://www.gaamc.org/services.html
   - The New York City Gay and Lesbian Anti-Violence Project
     http://www.avp.org
   - The Philadelphia Center for Lesbian & Gay Civil Rights
     http://www.center4civilrights.org
   - New Jersey Coalition For Battered Women
     http://www.njcbw.org
   - New Jersey Coalition Against Sexual Assault
     http://www.njcasa.org
   - UMDNJ-Consumer Health Info Task Force: "HealthyNJ Project"
     http://www.healthynj.org/health-wellness/domesticv/links.htm
   - An Abuse, Rape and Domestic Violence Aid and Resource Collection
     http://www.aardvarc.org/dv/gay.shtml
   - National Coalition of Anti-Violence Programs
     http://www.ncavp.org/AVPs/AVPDetail.aspx?id=106

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Anti-Lesbian, Gay Bisexual and Transgender Violence in 2004: A Report of the National Coalition of Anti-Violence Programs. http://www.ncavp.org/publications/NationalPubs.aspx

NEW JERSEY AIDSLine Special LGBT Health Issue

Generation "Q"

Meeting the Needs of Lesbian, Gay, Bisexual, Transgender (LGBT) Youth

David Rosen, MSW, LCSW, C-ASWCM

The majority of evidence-based research suggests that sexual orientation is determined sometime during childhood. Prospective studies with adolescents show gay males and lesbians self-identifying by age 16. Anecdotal evidence suggests that many transgender youth feel, from an early age, uncomfortable with their biological gender and expected gender role. The coming out age may be dropping as increased access to information and services for LGBT youth, particularly in urban areas, provides greater opportunities for self-affirmation and socialization.[1]

According to Dr. Ritch Savin-Williams, PhD, Professor of Clinical and Developmental Psychology at Cornell University, LGBT adolescents have evolved into a new breed of teens who – despite having same-sex attractions, engaging in same-sex behaviors, and entering into same-sex relationships – do not *feel* particularly gay. In his 2005 book, *The New Gay Teenager,* Dr. Savin-Williams argues that today's gay teenagers represent a generational shift where sexuality is fluid. Instead of proclaiming their gay identity or embracing the gay subculture, as prior LGBT generations have done, Generation "Q" (Gen Q) youth age 13-24 greet their burgeoning sexuality with a nonchalance bordering on indifference. Dr. Savin-Williams suggests that the LGBT community's success in mainstreaming acceptance may be fueling this shift in attitude. The need for a gay identity has diminished; any social, political, and personal value is becoming obsolete. Dr. Savin-Williams believes that "we must move away from the pathos of gay teens to a recognition of their pride and resiliency and, eventually, of the *ordinariness* of same-sex attracted individuals."

Is "gay" really the new "ordinary" among Gen Q? According to the *National Coalition of Anti-Violence Programs,* harassment of gay identified youth was up 8% in 2004 compared to 2003. The Sticks and Stones Project of the ACLU in Georgia found that the average high school student hears anti-gay slurs 25 times a day. Research supports the notion that LGBT youth are far more likely than straight youth to suffer from a range of social and personal pressures connected to their sexuality. Under these types of conditions, teens could have many reasons other than being "too ordinary" for not identifying as gay.[2]

All teenagers face developmental challenges, but most LGBT youth must also cope with prejudiced, discriminatory, and violent behavior and messages from their families, schools, and communities. Such behavior and messages negatively affect the health, mental health, and education of LGBT adolescents.[3] A better understanding of school-based harassment, suicide, tobacco use, substance use, HIV risks, and racism will enable adolescent care providers to better understand the various psycho-social forces impacting Gen Q youth and help to shape policies and interventions that more effectively reduce harm among LGBT adolescents.

School-based Harassment

Despite the growing number of "out" Gen Q teens and active high school Gay-Straight Alliances (GSAs), a majority of LGBT students still do not feel safe at school. LGBT students are more than five times as likely as heterosexual students to miss school due to fear, threats by other students, or property damage at school. In one national survey of 3,400 high school-aged adolescents, conducted on behalf of Gay, Lesbian & Straight Education Network (GLSEN) by Harris Interactive during the

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2004-2005 academic year, 90% of LGBT students reported they were harassed or assaulted compared to only 62% of heterosexual students. The poll showed that being gay or being perceived as gay was second to appearance as the primary reason for harassment. Although 85% of teachers polled in this survey said they have a duty to keep school a safe place for LGBT students, 57% of all students admitted that they would not report incidents of harassment to teachers or other school personnel.[4]

The National School Climate Survey (NSCS), an on-line survey conducted by GLSEN from April-August of 2005, polled 1,732 LGBT adolescents ages 13-20 about their experiences in high schools across the nation. The survey results found that the average GPA for LGBT students who were frequently physically harassed was half a grade lower than that of LGBT students experiencing less harassment. Over a third of students said they experienced physical harassment at school on the basis of sexual orientation and more than a quarter on the basis of their gender expression. Nearly 20% of LGBT students reported having been physically assaulted because of their sexual orientation and 10% because of their gender expression.[5] With regard to verbal harassment, 75.4% of students heard fellow classmates call someone "dyke" or "faggot" in a school hallway. 90% of respondents reported hearing "that's so gay" or "you're so gay" used as an insult. The survey also reported that only 16.5% of respondents reported witnessing a school staff member intervene when hearing such insults. About 18% of respondents reported actually hearing adult staff making homophobic comments during class or in school hallways. Students who experienced more frequent physical harassment were more likely to report they did not plan to go to college and, overall, LGBT students were twice as likely as the general population of students to report they were not planning to pursue any post-secondary education.[6]

States with inclusive policies that specify categories including sexual orientation and gender identity have significantly lower rates of anti-LGBT verbal harassment (31.6% vs. 40.8%). The NSCS found that states with generic anti-bullying laws had rates of verbal harassment that were equal to states with no anti-bullying laws.[7] To date, only New Jersey, California, Maine, Minnesota, and D.C. prohibit school harassment and discrimination based on sexual orientation and gender identity. Maryland, Rhode Island, Vermont, Massachusetts, Washington, Connecticut, and Wisconsin prohibit only sexual orientation-based discrimination and harassment in schools.[8]

Suicide

Traditionalists among providers working with LGBT adolescents contend that there are high rates of attempted and completed suicide among LGBT youth. A number of studies link attempting suicide and gender nonconformity, early awareness of sexual orientation, stress, violence, lack of support, school dropouts, family problems, homelessness, and substance use.[9] In 1994, Dr. Savin-Williams published a seminal work on LGBT adolescents in which he described how verbal and physical abuse act as stressors in the lives of lesbian, gay male, and bisexual youths and are associated with school problems, running away, substance abuse, prostitution, and suicide. In his LGBT youth survey, 41% of female respondents and 35% of males had reported having attempted suicide.[10] One survey of Massachusetts high school students conducted in 1999 showed that 33% of LGBT high school students report having attempted suicide in the previous year, compared to 8% of their heterosexual peers.[11]

However, in an article published in the December 2001 issue of the Journal of Consulting and Clinical Psychology, Dr. Savin-Williams found that LGBT youth are only slightly more likely than heterosexual youth to attempt suicide, refuting previous research that suggested much higher rates. Dr. Savin-Williams points to discrepancies between what gay youth report about suicide attempts and what they are actually doing. The article details two studies that conclude that even though sexual-minority teens are more likely than heterosexual youth to report suicide attempts, half of those reports are false. While the adolescents had thought about suicide, they had not actually attempted suicide. In one study, 23% of 83 young sexual-minority women said they had attempted suicide at least once. After further questioning, 29% of the reported attempts turned out to be false. Dr. Savin-Williams found that as high as 80% of the true attempts reported were not life-threatening. In the second study, Savin-Williams compared reported suicide attempts in 126 LGBT young adults to 140 young heterosexual young adults. While LGBT subjects were more likely to report suicide attempts than heterosexual subjects, the two groups showed similar rates of actual suicide attempts.[12]

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Is "gay" the new "ordinary" for Gen Q?

"We must move away from the pathos of gay teens
to a recognition of their pride and resiliency and,
eventually, of the *ordinariness*
of same-sex attracted individuals."

Ritch Savin-Williams, PhD

Generation "Q"

(Continued from previous page)

The findings suggest that gay youth are vulnerable to well meaning, but negative depictions of gay youth as highly troubled people. Dr. Savin-Williams believes that "there's a script we have in our culture – a 'suffering suicidal' script--that these kids have picked up on." He further states that a better approach for researchers, teachers, and other youth workers would be to treat all LGBT adolescents as ordinary kids with great potential, unless they show research-based or visible indicators of suicide risk.[13]

Tobacco Use

LGBT youth may be at much higher risk of smoking than their heterosexual counterparts. According to a recent California Department of Health study, smoking prevalence in the LGBT community was double the state average. Lesbians were found to smoke three times as much as heterosexual women and gay men smoke one and a half times as much as heterosexual men. The highest smoking rates were found among LGBT 18 to 24 year olds at 43.7%, two and a half times the overall smoking rate for this age group.[13]

The New Jersey Department of Health and Senior Services' fall 2001 school smoking survey, conducted among 9,589 students ages 12-19, found that that 24.5% of high school respondents reported smoking cigarettes within 30 days of taking the survey.[14] New Jersey does not document LGBT youth smoking rates, but if New Jersey LGBT youth follow the same trends as California LGBT youth, smoking rates among LGBT youth in New Jersey are likely higher than 24.5%.

Increased smoking rates among LGBT youth could be attributed to copying the behavior of role models, seeing smoking as socially desirable, having easy access to cigarettes, being rebellious, feeling unsupported, having low self-esteem, suffering from depression and other mental health factors, and having to cope with physical and verbal assaults. Tobacco companies' increased marketing efforts towards the LGBT community could also be a significant factor in LGBT youth smoking rates.[15]

Substance Use

For some LGBT youth, alcohol and drugs become mechanisms to cope with their shame, to deny same-sex sexual feelings, and to serve as a defense against ridicule and violence. Studies of high school students found that those who suffered harassment because of their real or perceived sexual orientation were more likely than non-harassed youth to use crack cocaine, marijuana, alcohol, and inhalants. Those who were self-identifying as LGB reported far more use of these substances than did their harassed, but heterosexual peers.[16] A study of public high school students in the ninth to twelfth grades in the 1995 Massachusetts Youth Risk Behavior Surveillance found that an LGB sexual orientation was associated with an increased lifetime frequency of use of cocaine, crack, anabolic steroids, inhalants, and injectable drugs, and that LGB youth were more likely to report using tobacco, marijuana, and cocaine before 13 years of age.[17] Neither survey provided data regarding usage patterns among self-identified transgender youth, but if one accepts the premise that trans-youth constitute a particularly vulnerable sub-population of adolescents, their rates of negative coping behaviors such as drug and alcohol use would be at least similarly high to LGB youth, if not higher.

The Kaiser Family Foundation's 2003 *National Survey of Adolescents and Young Adults: Sexual Health Knowledge, Attitudes, and Experiences* looked at a nationally representative sample of more than 1,800 young people in three key age groups: young adolescents (ages 13 to 14), adolescents (ages 15 to 17), and young adults (ages 18 to 24). Participants were asked not only about their knowledge and attitudes toward sexuality and their sexual experience, but also how alcohol and drug use may have influenced their decisions. Among other things, the survey found that 35% of sexually active participants ages 15 to 24 said "alcohol or drugs [had] ever influenced their decision to do something sexual."[18] While this survey did not break down the statistics according to sexual orientation or gender identity, it begs the question: if LGBT youth are more likely to engage in substance use than their heterosexual peers, are they also more likely to be making poor sexual behavior choices while under the influence of alcohol or drugs?

HIV Infection

In the United States, half of all new HIV infections occur in people under age 25; one-fourth in people under the age of 21. Many HIV positive youth are unaware of their HIV status because they have not been tested. In a nationally representative survey of teens, ages 15 to 17, only 27% of sexually experienced youth said they had been tested for HIV and only 48% knew where they could be tested.[19] Assuring that HIV infected youth have access to health care is difficult and even when it is available, many HIV-infected youth do not receive adequate health care.[20]

In 2001, 62% of reported HIV infection cases among males ages 13-19 occurred among young men having sex with men (YMSM). Only 13% of infected young men ages 13-19 and 14% ages 20-24 acquired HIV through

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heterosexual contact, while 37% of infected young women acquired HIV through heterosexual contact.[21] In a new study, 93% of HIV infected black young men who have sex with men were unaware of their infection. 71% of those with unrecognized HIV infection said it was very unlikely that they were infected; 42% believed there was little chance they would ever be infected; and 37% had had unprotected anal intercourse in the previous six months.[22]

Structural racism in United States contributes to a greater incidence of poverty and drug use within urban minority communities. This creates high HIV transmission risks for many African Americans and Latinos living in such communities.[23] Young lesbians of color, particularly African Americans and Latinas, are at risk for HIV infection and pregnancy due, in part, to the strong value placed on motherhood and childbearing in their ethnic communities and the desire to conform to their community standards and pass for straight.[24]

Racism

Surviving racial or ethnic discrimination requires strong connections to family and ethnic community. LGBT youth of color seldom receive support regarding sexual orientation or transgender identity from their communities of origin. Indeed, ethnic communities often perceive gay, lesbian, and bisexual orientation or transgender identity as a rejection of ethnic heritage. Unlike racial stereotypes that family and ethnic community positively reframe, many ethnic minority communities strongly reinforce negative cultural perceptions of homosexual orientation and of being transgender.[25] When such community-directed stigma is continuously experienced by young LGBT of color, the likelihood they will adopt negative coping skills such as substance use, violence, and risky sexual behaviors increases. LGBT youth of color have a disproportionate risk for abuse, suicide, and HIV infection. Up to 46% of LGBT youth of color report experiencing physical violence related to their sexual orientation and nearly 45 percent of youth in one survey were verbally harassed in school regarding sexual orientation and race or ethnicity.[26] In one survey, 61% of LGBT youth of color reported being victims of violence from family members and 40% reported physical abuse from peers and strangers.[27] In a study of YMSM of color, HIV prevalence was higher among African Americans, men of mixed or other race/ethnicity, and Hispanics than among Asian American/Pacific Islanders or whites (14.1%, 12.6%, and 6.9% versus 3% and 3.3%, respectively).[28]

Bridging the Generations

As a member of an earlier generation of so-called LGBT youth, I have often found it difficult to relate to the experiences of today's Gen Q. Same-sex attracted teenagers live in a world of conflicting cultural messages. Today's LGBT teens are more often than not exposed to images and ideas that help to normalize the expression of non-heterosexual sexual and gender identities. MTV's *The Real World,* Alex Sanchez' *Rainbow High* young adult novels, and emerging hip-hop bands such as *Rainbow Flava* all highlight a different cultural reality than what I experienced as a teen. Conversely, pervasive and negative community attitudes about same-sex attraction and non-conforming gender identity continue to fuel incidents of school-based harassment, legislative backlashes, and religion-based intolerance. Today's members of Generation Q barely resemble the people I came out with fifteen years ago. Perhaps that's progress, but I suspect that the more things change, the more things stay the same. As an adolescent-serving and gay-identifying social service provider, I will be there to help this generation of LGBT youth however I can – despite their confusing lack of self-labeling and their ignorance of "things Madonna."

Today's Gen Q barely resembles earlier generations that came out before 1995.

Meeting the Needs of Generation "Q"

LGBT youth programs will most effectively meet the needs of Gen "Q" when they[28]:

- Use language that is inclusive and non-pejorative with regard to sexual orientation and gender identity
- Involve youth, including LGBT youth, in planning, running, and evaluating the programs
- Focus on the assets of each teen participant, irrespective of sexual orientation and gender identity
- Address the needs of the whole young person
- Ask young people how they self-identify and use the same terms
- Offer activities and opportunities that are inclusive as to gender and sexual orientation
- Build skills in communication, interpersonal relationships, and coping
- Acknowledge culturally specific values, attitudes, and beliefs
- Consider the social and cultural factors that influence behaviors
- Hold discussions that explore the added impact of racism on LGBT youth of color
- Provide peer support to change peer norms, especially those regarding sexual orientation, gender identity, and gender expression
- Acknowledge when culture and sexual orientation cause conflicts for LGBT youth, and recognize and confront cultural biases regarding sexual orientation and gender identity within the program

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Improving Transgender Healthcare

NEW JERSEY Special LGBT Health Issue AIDSLine

Randi Kaufman, PsyD

In the recent film Transamerica, transwoman Bree (Felicity Huffman), tells her psychotherapist that when her surgery is complete "not even a gynecologist will be able to tell the difference". Her therapist looks suspiciously at Bree over the top of his glasses; there is an awkward silence. The scene is reminiscent of a typical encounter between transgender patient and medical provider. The patient is educating the therapist;the therapist remains suspicious and doubtful. Similar to the early days of HIV/AIDS when patients, primarily gay men, knew more than their doctors, and needed to educate them in order to receive the appropriate and cutting-edge care, transgender patients are often in this position today. As health care providers, it behooves us to learn more about this group of people, and their specialized healthcare needs.

Increasingly, many people believe that gender identity issues are not pathological per se, but often give rise to other mental health issues (Israel & Tarver, 1997). Primary mental health issues that transpeople experience include depression, suicidal feelings, and anxiety. Low self-esteem, shame and humiliation are also frequently part of these diagnoses.

It is important to note that psychosocial, and other healthcare issues have implications for the transperson's mental health. These include violence and safety issues, HIV, substance abuse, health care access, homelessness, joblessness, and sex-work. All of these areas deserve an in-depth conversation, which is beyond the scope of this article.

Depression and Anxiety

Depression is likely the most prevalent symptom associated with gender dysphoria (Israel & Tarver, 1997). The depression has often been chronic, as many transpeople are aware of their gender dysphoria from as early as the age of three or four. However, certain situations can increase the severity of the depression. Most notably, puberty is a time that many transpeople have great difficulty with. As the body begins to show secondary sex characteristics of a gender that feels wrong, the gender dysphoric person experiences feelings of betrayal. The changes can also be shocking, despite an intellectual understanding of puberty. Monthly menstrual periods and PMS in biological females who feel male, and nocturnal emissions in biological males who feel female, can also increase depression acutely. For those who masturbate or are sexually active, being confronted with the reality of one's anatomy may increase depression and dysphoria.

Anxiety can also be long-standing, and is likely associated with the repression of one's gender dysphoria. It is extremely common for children to adopt behaviors that are expected of them based on their biological sex, and to repress their gender dysphoria. Anxiety is also associated with the fear that others will find out their secret.

When a transgender individual begins psychotherapy, there can be an increase in symptoms. Directly confronting one's long-standing issues, and the need to begin figuring out choices about gender transition can increase depression and/or anxiety. Frequently transpeople feel a sense of urgency once they begin to address their issues. Being unable to move into gender transition immediately is often frustrating and anxiety-producing.

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Although beginning treatment can also provide relief, many of the issues a transperson must face include the possibility of loss. Coming out to one's friends and family can result in loss of relationships; coming out at work can result in loss of job, financial stability, medical insurance, and sense of purpose. Discrimination, social intolerance, and facing the uncertainty of the future can increase anxiety and depression.

The depression may require psychopharmacological interventions. Some transpeople wish to avoid treating the depression, fearful that this will allow their gender dysphoria to go unaddressed. It is important to note that while medication may help alleviate the depression, the gender issues must be addressed, often through psychotherapy and related services, such as a support group.

Hormone administration (generally female hormones) can induce or increase depression. However, hormone administration often leads to a decrease in depression, and brightening of mood, as the person sees tangible progress in resolving their gender dysphoria. Sudden withdrawal of hormones will likely result in depression and mood swings.

Suicide

Studies of transgender populations in Philadelphia, Washington, Chicago, San Francisco, and Houston (Xavier, et al., 2004) report suicidal ideation rates ranging from 16% up to 64%, with most people attributing their suicidality to their gender identity issues. Recent studies look specifically at the relationship between gender role, homosexuality, and suicide risk. Fitzpatrick, et al., (2005) specifically assessed gender role and sexual orientation in relation to suicidal ideation, and found that cross-gender role is a unique predictor of suicidal symptoms. They concluded that cross-gendered people, regardless of sexual orientation, appear to have a higher risk for suicidal symptoms. This appears to be particularly true for boys (Van Wormer & McKinney (2003).

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Improving Transgender Healthcare

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HIV/AIDS

The New Jersey HIV/AIDS report published by the New Jersey Department of Health and Senior Services in December 2005 does not include statistics on the transgender population, despite being broken down into categories of gender, age, race, and method of transmission. Xavier et. al. (2004) found that recent studies of transwomen populations show HIV rates ranging from 19% in Philadelphia, 21% in Chicago, 22% in Los Angeles, 21% to 30% in New York, 27% in Houston, 32% in Washington, DC, and 26%, 35%, and 47% in San Francisco. Kammerer, Mason and Connors (1999) note that one of the main factors in contracting HIV is the quest for a feminine body and the need for identity affirmation.

Suggestions for Improving Care of Transgender Individuals in Healthcare Settings

What is most important for treating transgender patients is being humane. In a meta-analysis of 221 studies (Hall & Dornan, 1988) the number one factor of patient satisfaction with health care in the transgender population is being humane. [Note: technical competence was rated second]. Be non-judgmental. Speak frankly, and mirror the patient's language.

Ask if the patient has a name they prefer to be called, and whether they prefer male or female pronouns. It is much more important to ask, than to assume, and perhaps be wrong. Most trans people do not mind questions, which show concern about showing respect for the person. Making assumptions can easily provoke upset or anger, as trans people have had their gender be assumed their entire lives. Using the preferred pronouns promotes feelings of being understood, being respected, and feeling safe. It will also promote the patient's confidence in the staff. Don't worry if you make a mistake. Most trans people are quite reasonable in understanding that changing language, or using unfamiliar language, takes time. Simply apologize and move on.

Don't be afraid to ask questions. Be willing to ask your transgender patient about anything you don't understand, as it pertains to the care you are delivering. If you feel embarrassed, remember that your patient has had to deal with embarrassment, shame and humiliation on a frequent basis.

Don't be afraid to say you don't know some-thing. Be prepared to try to find out the information. Be willing to spend time consult-ing with other clinicians, and doing some research. See documentaries and movies, and attend conferences about gender identity.

Be aware of when it is not appropriate to ask questions related to gender identity. For example, if a transgender patient comes in with a strep throat, treating the throat is the focus of care. Asking questions about one's gender issues would not be appropriate, and can feel intrusive, and even voyeuristic, to the patient.

Provide a unisex restroom that is unisex, if your health center does not have one already. Sometimes single-use handicapped bathrooms can be used for this purpose. While it is something most people never think about, having to decide which restroom to use for a transgender person can easily produce anxiety, shame, and fears for one's safety.

When providing medical care, be aware that many transpeople are extremely sensitive to having their bodies looked at, touched, and prodded. It is common for transmen to refuse breast and pelvic exams, and for transwomen to refuse testicular and prostate exams. It is important to acknowledge the inherent sensitivity in participating in these exams, and equally important to respect the patient's refusal of care. It may take working on a good alliance with the patient and more than one visit for the patient to allow these exams.

Bree's statement that "not even a gynecologist will know" may be seen as a metaphor for the way in which transgender people and their health care needs tend to remain invisible in our culture today. However, just as HIV/AIDS care is increasingly becoming routine medical practice, approaches to transgender care must similarly move to the more visible and routine if providers are going to be successful in engaging and retaining transpeople in comprehensive health care.

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Creating A Welcoming Clinical Environment for Lesbian, Gay, Bisexual, and Transgender (LGBT) Patients

These Guidelines for Care have been provided by the Gay & Lesbian Medical Association (GLMA). The GLMA's mission is to ensure equality in health care for lesbian, gay, bisexual and transgender (LGBT) individuals and health care professionals. GLMA achieves its goals by using medical expertise in professional education, public policy work, patient education and referrals, and the promotion of research. For a PDF of the full text see Provider Guidelines–Creating a Welcoming Environment on the GLMA website.

Studies show that lesbian, gay, bisexual, transgender and (LGBT) populations, in addition to having the same basic health needs as the general population, experience health disparities and barriers related to sexual orientation* and/or gender identity or expression. Many avoid or delay care or receive inappropriate or inferior care because of perceived or real homophobia, biphobia, transphobia, and discrimination by health care providers and institutions.

Homophobia in medical practice is a reality. A 1998 survey of nursing students showed that 8-12% "despised" lesbian, gay, and bisexual (LGB) people, 5-12% found them "disgusting," and 40-43% thought LGB people should keep their sexuality private.[1]

Health care providers can take positive steps to promote the health of their LGBT patients by examining their practices, offices, policies, and staff training for ways to improve access to quality health care for LGBT people.

There are some simple ways to make your practice environment more welcoming and safe for your LGBT patients. Here are a few ideas to update your physical environment, add or change intake and health history form questions, improve provider-patient discussions, and increase staff's knowledge about and sensitivity to your LGBT patients. We hope you find this tool useful.

Create a Welcoming Environment

Lesbian, gay, bisexual, and transgender (LGBT) patients often "scan" an office for clues to help them determine what information they feel comfortable sharing with their health care provider.

Participating in provider referral programs through LGBT organizations or advertising your practice in LGBT media can create a welcoming environment even before a patient enters the door.

If your office develops brochures or other educational materials, or conducts trainings, make sure that these include relevant information for LGBT patients.

Open dialogue with a patient about their gender identity/expression, sexual orientation, and/or sexual practices means more relevant and effective care.

You may want to implement some of the following suggestions as appropriate for the type and location of your office:

- Post rainbow flag, pink triangle, unisex bathroom signs, or other LGBT-friendly symbols or stickers.
- Exhibit posters showing racially and ethnically diverse same-sex couples or transgender people. Or posters from non-profit LGBT or HIV/AIDS organizations.
- Display brochures (multilingual when possible and appropriate) about LGBT health concerns, such as breast cancer, safe sex, hormone therapy, mental health, substance use, and sexually transmitted diseases (STDs – also called sexually transmitted infections or STIs – such as HIV/AIDS, syphilis, and Hepatitis A and B).
- Disseminate or visibly post a non-discrimination statement stating that equal care will be provided to all patients, regardless of age, race, ethnicity, physical ability or attributes, religion, sexual orientation, or gender identity/expression.
- Acknowledge relevant days of observance in your practice such as World AIDS Day, LGBT Pride Day, and National Transgender Day of Remembrance.
- Display LGBT-specific media, including local or national magazines or newsletters about and for LGBT and HIV-positive individuals.

General Guidelines for Forms and Patient-Provider Discussions

Filling out the intake form gives patients one of their first and most important impressions of your office. The experience sets the tone for how comfortable a patient feels being open about their sexual orientation or gender identity/expression.

Include more inclusive choices for answers to questions, open-ended questions, and adding "partner" wherever the word "spouse" is used. The following are additional topics for possible inclusion in health history forms or to help a provider with in-person discussions with LGBT patients:

- Intake forms should use the term "relationship status" instead of "marital status," including options like "partnered." When asking – on the form or verbally – about a patient's significant other, use terms such as "partner," in addition to "spouse" and/or "husband/ wife."

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***The term "sexual orientation" is used in this document to mean sexual orientation identities, behaviors, and/or attractions, all of which are important in the health care context.**

Creating A Welcoming Clinical Environment for Lesbian, Gay, Bisexual, and Transgender (LGBT) Patients

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➤Adding a "transgender" option to the male/female check boxes on your intake form can help capture better information about transgender patients, and will be an immediate sign of acceptance to that person.

➤As with all patient contacts, approach the interview showing empathy, open-mindedness, and without rendering judgment.

➤Prepare now to treat a transgender patient someday. Health care providers' ignorance, surprise, or discomfort as they treat transgender people may alienate patients and result in lower quality or inappropriate care, as well as deter them from seeking future medical care.

➤Transgender individuals may have had traumatic past experiences with doctors causing fear or mistrust. Therefore, developing rapport and trust with transgender patients may take longer and require added sensitivity from the provider.

➤When talking with transgender people, ask questions necessary to assess the issue, but avoid unrelated probing. Explaining why you need information can help avoid the perception of intrusion, for example: "To help assess your health risks, can you tell me about any history you have had with hormone use?"

➤Be aware of additional barriers caused by differences in socioeconomic status, cultural norms, racial/ethnic discrimination, age, physical ability, and geography. Do not make assumptions about literacy, language capacity, and comfort with direct communication.

➤When talking about sexual or relationship partners, use gender-neutral language such as "partner(s)" or "significant other(s)." Ask open-ended questions, and avoid making assumptions about the gender of a patient's partner(s) or about sexual behavior(s). Use the same language that a patient does to describe self, sexual partners, relationships, and identity.

➤When discussing sexual history, it is very important to reflect patients' language and terminology about their partners and behaviors. Many people do not define themselves through a sexual orientation label, yet may have sex with persons of their same sex or gender, or with more than one sex. For example: some men who have sex with men (MSM), especially African American and Latino men, may identify as heterosexual and have both female and male partners.

➤When assessing the sexual history of transgender people, there are several special considerations:

1. Do not make assumptions about their behavior or bodies based on their presentation;
2. Ask if they have had any gender confirmation surgeries to understand what risk behaviors might be possible; and
3. Understand that discussion of genitals or sex acts may be complicated by a disassociation with their body, and this can make the conversation particularly sensitive or stressful to the patient.

➤Ask the patient to clarify any terms or behaviors with which you are unfamiliar, or repeat a patient's term with your own understanding of its meaning, to make sure you have no miscommunication.

➤It is important to discuss sexual health issues openly with your patients. Non-judgmental questions about sexual practices and behaviors are more important than asking about sexual orientation or gender identity/expression.

➤Be aware that sexual behavior of a bisexual person may not differ significantly from that of heterosexual or lesbian/gay people. They may be monogamous for long periods of time and still identify as bisexual; they may be in multiple relationships with the full knowledge and consent of their partners. However, they may have been treated as confused, promiscuous, or even dangerous. They may be on guard against health care providers who assume that they are "sick" simply because they have sexual relationships with more than one sex. Yet they may also, in fact, lack comprehensive safer-sex information that reflects their sexual practices and attitudes and may benefit from thorough discussions about sexual safety.

➤When discussing sexual practices and safer sex avoid language that may presume heterosexuality or discriminate.

There are so few trained experts in transgender health that you will often have to become that expert. Likewise, providers who treat transgender patients often have to build the base of specialty care referrals by prescreening other providers for sensitivity or guiding them to educational resources. Do not be afraid to tell your patient of your inexperience. Your willingness to become educated will often stand out from their previous healthcare experiences.

Confidentiality

Encourage openness by explaining that the patient-provider discussion is confidential and that you need complete and accurate information to have an understanding of the patient's life in order to provide appropriate care. Ensure that the conversation will remain confidential and specify what, if any, information will be retained in the individual's medical records.

Developing and distributing a written confidentiality statement will encourage LGBT and other patients to disclose information pertinent to their health knowing that it is protected. Key elements of such a policy include:

1. The information covered
2. Who has access to the medical record
3. How test results remain confidential
4. Policy on sharing information with insurance companies
5. Instances when maintaining confidentiality is not possible2

Display the confidentiality statement prominently and provide it in writing to every patient. Consider having staff members agree to the statement in writing.

Some Specific Issues to Discuss with LGBT Patients

Homophobia, biphobia, transphobia, discrimination, harassment, stigma and isolation related to sexual orientation and/or gender identity/expression can contribute to depression, stress, and anxiety in LGBT people. Conduct depression and mental health screening as appropriate, and do not discount these sources of stress for your LGBT patients.

➤Explore the degree to which LGBT patients are "out" to their employers, family, and friends, and/or the extent of social support or participation in community. One's level of identification with community in many cases strongly correlates with decreased risk for STDs (including HIV) and improved mental health.

➤Understand that LGBT people are particularly vulnerable to social stresses that lead to increased tobacco and substance use. A recent large study showed GBT men smoked 50% more than other men, and LBT women smoked almost 200% more than other women. Emphasis on other health issues may leave many people unaware of the disproportionate impact of tobacco in this population. Be prepared to intervene and provide treatment options. Likewise, explore whether LGBT patients are dealing with social stress through alcohol or drug use and be prepared to present treatment options. Social stress may also contribute to body image, exercise, and eating habits.

➤Discuss safer sex techniques and be prepared to answer questions about STDs and HIV transmission risk for various sexual activities relevant to LGBT people.

➤If a female patient identifies as lesbian, or indicates a female sexual partner, do not assume that she has never had a male sexual partner, has no children, has never been pregnant, or has little or no risk of STDs. If a male patient identifies as gay or bisexual, or identifies a male sexual partner, do not assume that the patient has never had a female sexual partner or has no children. Do not make assumptions about past, current, and future sexual behavior.

➤Rates of syphilis are rising among MSM in some areas. Other STDs among MSM continue to be of concern to public health officials. The CDC now recommends annual screening of MSM for syphilis, gonorrhea, Chlamydia, HIV, and immunization against hepatitis A and B for those MSM who are not already immune. If patients do not have coverage for vaccination, refer them to a community clinic or STD clinic offering free or low-cost vaccination.

➤Transgender people are sometimes subject to the most extreme levels of social exclusion. This can destabilize individuals and create a host of adverse health outcomes. Risks and response behaviors to watch out for include: cycling in and out of employment (and therefore health insurance); having a history of interrupted medical care; avoiding medical care; pursuing alternate gender confirmation therapies (like injecting silicone or taking black market hormones); engaging in survival sex; interrupted education; social isolation; trauma; and extreme poverty. Health interventions will need to consider the aggregate impact of health risks resulting from this stigma.

➤Conduct violence screening: LGBT people are often targets of harassment and violence, and LGBT people are not exempt from intimate partner/domestic violence. Individuals being battered may fear being "outed," i.e., that if they report the violence to providers or authorities, their batterer could retaliate by telling employers, family, or others that they are gay. Assure the patient of confidentiality to the extent possible depending on your state laws regarding mandatory reporting.

ASK ALL PATIENTS – men and women – violence screening questions in a gender neutral way:

- Have you ever been hurt (physically or sexually) by someone you are close to or involved with, or by a stranger?
- Are you currently being hurt by someone you are close to or involved with?
- Have you ever experienced violence or abuse?
- Have you ever been sexually assaulted or raped?

Transgender people who are visibly gender variant may be exposed to a very high routine level of violence. For this population, the assessment of risk should be much more in-depth. If a person reports frequent violence, be sure to explore health issues related to long-term and post-traumatic stress. Regardless of whether a transgender person is visibly gender variant, they may experience trauma, increased stress, and direct grief as a result of violence against other community members. Asking about possible associative trauma can help identify health risks.

Language

➤Listen to your patients and how they describe their own sexual orientation, partner(s) and relationship(s), and reflect their choice of language. Be aware that although many LGBT people may use words such as "queer," "dyke," and "fag" to describe themselves, these and other words have been derogatory terms used against LGBT individuals. Although individuals may have reclaimed the terms for themselves, they are not appropriate for use by health care providers who have not yet established a trusting and respectful rapport with LGBT patients. If you are in doubt as to how to refer to a patient, ask what word or phrase they prefer.

➤Avoid using the term "gay" with patients even if they have indicated a same-sex or same gender sexual partner. If patients themselves have not indicated a particular identity or have indicated a sexual orientation other than "gay," using this term may cause alienation and mistrust that will

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interfere with information gathering and appropriate care. The key is to follow the patient's lead about their self description (which builds respect and trust) while exploring how this relates to their current and potential medical needs.

➤Young people as well as adults may be unlikely to self-identify using traditional sexual orientation labels such as gay, lesbian, or bisexual. While some may identify as "queer," others may not choose any label at all.

➤Respect transgender patients by making sure all office staff is trained to use their preferred pronoun and name. Clearly indicate this information on their medical record in a manner that allows you to easily reference it for future visits.

Staff Sensitivity and Training

➤When possible, it is helpful to have openly lesbian, gay, bisexual, and transgender people and perspectives about serving LGBT patients, as well as help patients feel represented and comfortable.

➤It is especially important to train all front-line staff in office standards of respect towards transgender people, including: using their chosen name, and referring to them by their chosen pronoun.

➤Circulate these Guidelines to all administrative, nursing, and clinical staff. Training for all staff is critical to creating and maintaining practice environments deemed safe for LGBT patients. Training should be periodic to address staff changes and keep all staff up-to-date. Designate an on-site LGBT resource person to answer any questions that arise in the interim.

Topics to include in a staff training program should include:

1. Use of appropriate language when addressing or referring to patients and/or their significant others
2. Learning how to identify and challenge any internalized discriminatory beliefs about LGBT people
3. Basic familiarity with important LGBT health issues (e.g., impacts of homophobia, discrimination, harassment, and violence; mental health and depression; substance abuse; safe sex; partner violence; HIV/STDs)
4. Indications and mechanisms for referral to LGBT-identified or LGBT-friendly providers

Developing resource lists and guidelines for patient interactions can reduce possible staff anxiety in dealing with LGBT patients.

➤All employees need to understand that discrimination against LGBT patients, whether overt or subtle, is as unethical and unacceptable – and in many states as illegal – as any other kind of discrimination. Employers should make it clear to employees that discrimination against LGBT patients "will not be tolerated." It is also important to monitor compliance and provide a mechanism for patients to report any disrespectful behavior.

➤Some of your employees may have longstanding prejudices or negative feelings about LGBT patients due to ignorance or lack of familiarity with LGBT issues. Some may also feel that their religious beliefs require them to condemn LGBT people.

➤Some employees may need individual training and counseling.

Other Suggestions

➤A universal gender-inclusive "Restroom" is recommended. Many transgender and other people not conforming to physical gender stereotypes have been harassed for entering the "wrong" bathroom, so at least one restroom without Men or Women labels would help create a safer and more comfortable atmosphere.

➤Be aware of other resources for LGBT individuals in your local community, as well as, national/internet resources, and build collaborative relationships between your office and local lesbian, gay, bisexual, and transgender organizations and support groups.

Acknowledgment

This excerpt of the Gay and Lesbian Medical Association Provider Guidelines is reprinted with the generous permission of GLMA. For PDF of full text see Provider Guidelines – Creating a Welcoming Environment on the GLMA website: http://glma.org

Additional Resources

1. Kaiser Permanente National Diversity Council and Kaiser Permanente National Diversity Department. A Provider's Handbook on Culturally Competent Care: Lesbian, Gay, Bisexual, and Transgender Population, 2nd ed., 2004.
2. Gay Men's Health. Small Effort, Big Change. http://www.gmhp.demon.co.uk/health/gp/gay-men.html
3. Dean, L., et. al. Lesbian, Gay, Bisexual, and Transgender Health: Findings and Concerns. *Journal of the Gay and Lesbian Medical Association,* Vol. 4, No. 3, 2000. www.glma.org
4. Feldman J, Bockting W. Transgender Health. (review) *Minn Med* 2003;86(7):25–32. Available online at www.mmaonline.net/publications/MNMed2003/July/Feldman.html
5. Gay and Lesbian Medical Association and LGBT Health Experts. Healthy People 2010 Companion Document for LGBT Health (2001). www.glma.org
6. Harry Benjamin International Gender Dysphoria Association. The Standards of Care for Gender Identity Disorders, Sixth Version. Dusseldorf: Symposion Publishing, 2001. http://www.hbigda.org/soc.htm

Internet Resources

African American Office of Gay Concerns
http://www.aaogc.org
Provides HIV/AIDS services to Gay Community in the Newark, NJ area

Black AIDS Institute
http://blackaids.org
Black HIV/AIDS policy center devoted to encouraging Blacks to confront AIDS in their own communities

Callen-Lorde Community Health Center
http://www.callen-lorde.org
Health care for LGBT community and those living with HIV/AIDS (NYC)

Healthy People 2010 Companion Document
http://www.glma.org/_data/n_0001/resources/live/HealthyCompanionDoc3.pdf
First comprehensive document on state of LGBTI Health

Gay and Lesbian Medical Association
http://www.glma.org
Resources, news, events, and information for physicians and patients

Gay Health. Com
http://www.gayhealth.com
Health and Wellness website dedicated to Lesbian, Gay, Bisexual, and Transgender men and women

Gay Men's Health Crisis
http://www.gmhc.org
HIV/AIDS prevention, information, and support services

GLITZ (Girls Living in the Trans Zone)
Jersey City Connections, Inc.
Phone: 201-963-4779
Web: http://www.hudsonpride.org
E-mail: jcconnections@hudsonpride.org

National Coalition for LGBT Youth
www.lgbthealth.net

New Jersey Lesbian & Gay Coalition
http://www.njlgc.org
Committed to enhancing the lives of LGBTI and fighting discrimination

The Sexuality Information & Education Council of the United States (SIECUS)
http://www.siecus.org
National voice for sexual education, sexual health, and sexual rights

New Jersey LGBT Youth Resources

Bergen Rainbow Youth (B-RAY)
C/o Ethical Culture Society
687 Larch Avenue, Teaneck, NJ 07666
Phone: 888-345-1886
Web: http://www.b-ray.org
E-mail: info@b-ray.org
Meets Sundays 2-5 PM

Gay, Lesbian & Straight Education Network
http://www.glsen.org
National education organization promoting safe schools for all students
New Jersey Chapters: http://www.njglsen.org

HiTOPS, Health-Interested Teens' Own Program on Sexuality
Teen Health and Education Center
21 Wiggins Street, Princeton, NJ 08540
Phone: 609-683-5155
E-mail: hitops@hitops.org

Parents and Friends of Lesbians and Gays
http://www.pflag.org
NJ Chapters List and Information:
http://www.pflag.org/New_Jersey.226.0.html

Project WOW
North Jersey Community Research Initiative
Phone: 888-688-9078
Web: http://www.njcri.org/services/wow.php

The Pride Center of New Jersey
1048 Livingston Avenue, North Brunswick, NJ 08902
Phone: 732-846-2232
Web: http://www.pridecenter.org
E-mail: info@pridecenter.org
Under the Rainbow meets the 1st & 3rd Wednesday of each month at 7:30 PM.
Youth Drop In meets 2nd, 3rd, & 4th Saturdays of each month at 1:00 PM

YouthConnect Program
Jersey City Connections, Inc.
Phone: 201-963-4779
Fax: 201-963-7983
Web: http://www.hudsonpride.org/youthconnect.asp
E-mail: YouthConnect@hudsonpride.org
Meets Fridays & Saturdays 3-8 PM

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