

What's the Difference?

Health Issues of Major Concern to Gay, Lesbian, Bisexual,
Transgender and Intersex (GLBTI) Victorians

Research Paper

Ministerial Advisory Committee on
Gay and Lesbian Health



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Research Paper

'Coming out needs to be seen on a life continuum...as not just an adolescent issue of behaviour (from GLBTI statewide consultations).'

'You get so irritated that everyone assumes you are heterosexual...you feel so invisible. It's not that you want to scream about your sexuality at every street corner, it's just that it's part of who you are and you don't want that overlooked...you are a whole person, including the person you sleep with or are attracted to (from GLBTI statewide consultations).'

Edited by William Leonard

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Foreword

The Ministerial Advisory Committee on Gay and Lesbian Health (MACGLH) was established in April of 2000 to advise the Minister for Health and the Department of Human Services on matters relating to the health and wellbeing of members of Victoria's gay and lesbian communities. The Committee's terms of reference were extended to include the health concerns of bisexual, transgender and intersex people, insofar as they overlap with those of gay men and lesbians.

On behalf of the MACGLH, the Department commissioned five research papers that address areas of major health concern for gay, lesbian, bisexual, transgender and intersex (GLBTI) Victorians. These areas were identified following an initial round of community consultations in which the Department called for submissions from GLBTI organisations and individuals regarding the key health issues they faced. Each of the five papers covers one of the following:

- Physical health.
- Sexual health.
- Mental health.
- Life stage issues.
- Drug and alcohol issues.

This publication consists of edited versions of the five research papers and an accompanying introductory paper that develops a framework for understanding patterns of health and illness specific to GLBTI people. The resource is the first of its kind to be produced within Australia and offers a preliminary outline of the current health status of GLBTI Victorians. Because both the papers and the work of the MACGLH are covering new ground, it is important that this resource is made available to people with an interest in GLBTI health issues. The papers represent an invaluable research tool for anyone concerned with understanding the health effects of sexual orientation and gender identity discrimination and with improving the health and wellbeing of GLBTI people.

I would like to thank those who undertook the research.

To: Rhonda Brown, Amaryll Perlesz and Kerry Proctor of the Bouverie Centre, La Trobe University; Dr. Ruth McNair, Department of General Practice, the University of Melbourne; Dr. Nick Medland, The Centre Clinics, Victorian AIDS Council/Gay Men's Health Centre; Rebecaa Bentley, Associate Professor Gary Dowsett, Associate Professor Anthony Smith, Dr. Lynne Hillier, Philomena Horsley and Anne Mitchell, the Australian Research Centre in Sex, Health and Society, La Trobe University; Cathryn Harland, private research consultant; Jo Harrison, University of South Australia.

Thanks are also due to the Executive Officer of the MACGLH, William Leonard who, with the assistance of the members of the MACGLH working parties and the Transgender and Intersex Subcommittee, produced edited versions of the issues papers for distribution to the GLBTI community and beyond.

A handwritten signature in black ink, appearing to read 'Tony Keenan', with a long horizontal flourish extending to the right.

Tony Keenan
Chair, MACGLH

Introductory Paper: Developing a Framework for Understanding Patterns of Health and Illness Specific to Gay, Lesbian, Bisexual, Transgender and Intersex (GLBTI) People

William Leonard

1. Introduction

1.1 Background

The Department of Human Services, on behalf of the Ministerial Advisory Committee on Gay and Lesbian Health (MACGLH), has commissioned five discussion papers that address areas of major health concern for gay, lesbian, bisexual, transgender and intersex (GLBTI) Victorians.

These areas were identified following an initial round of community consultations in which the Department called for submissions from GLBTI organisations and individuals across the State. Each paper addresses one of the following areas:

- Physical health.
- Sexual health.
- Mental health.
- Life stage issues.
- Drug and alcohol issues.

1.2 Purpose of this Introductory Paper

This introductory paper accompanies each of the five discussion papers. It outlines the social model of health shared by all five papers. It uses this model to develop an understanding of the deeper social forces leading to patterns of health and illness *common* to GLBTI people. It also uses this model to identify health problems *specific* to each of these groups.

This paper includes a glossary of the key terms used in the five discussion papers and recent estimates of the proportion of the population who are gay, lesbian, bisexual, transgender and intersex.

2. The Social Model of Health

2.1 Key Social Determinants of Health

A social model of health identifies key social factors or *social determinants* that influence broader patterns of health and illness within any given population. Key social determinants include socioeconomic status (of which income is one indicator), race, ethnicity, gender and geographic location. So for example, socioeconomic status or income can be shown to have a direct impact on the health of any given population. Those with higher income generally enjoy better health than those with lower income.¹ Similarly, racial background has been shown to influence patterns of health and illness in the Australian context. Research demonstrates that indigenous Australians have poorer health outcomes for a range of preventable illnesses than non-indigenous Australians.²

The government has used this model to identify patterns of health inequalities across the State and to focus on the needs of marginalised and disadvantaged groups within the Victorian population as a whole.³

2.2 Sexual Orientation and Gender Identity as Key Social Determinants of Health

Absent from this list of the social determinants of health are sexual orientation (or sexuality) and gender identity. There has been very little Australian research on how sexual orientation

¹ Turell, G. and Matthews, C.D (2000) "Socio-economic status and health in Australia". *Medical Journal of Australia* 172: 434–38.

² *The National Indigenous Australians' Sexual Health Strategy 1996–97 to 1998–99: A report on the ANCARD Working Party on Indigenous Australians' Sexual Health* (March 1997). Commonwealth Department of Health and Family Services: Looking Glass Press.

³ See the results of the *Victorian Burden of Disease Study: Mortality* (July 1999) and the *Victorian Burden of Disease Study: Morbidity* (December 1999).

and gender identity influence patterns of health and illness. Although there is an emerging awareness of sexual orientation and gender identity as key social determinants in the international literature,⁴ this awareness has yet to be incorporated into mainstream health policy and the design and delivery of programs and services.

All five discussion papers argue that sexual orientation and gender identity determine patterns of health and illness specific to GLBTI people in at least two ways:

- Dominant understandings of sexual orientation and gender identity continue to marginalise and discriminate against GLBTI people. One of the major effects of this shared discrimination is a set of health problems *common* to GLBTI people.
- Sexual orientation and gender identity interact with other social and biological processes, to produce patterns of illness *specific* to each of these groups.

3. Health Concerns Common to GLBTI People

3.1 A Common Source of Discrimination

The five discussion papers adopt the term *heterosexism* to describe negative attitudes towards gay men, lesbians and bisexuals *and* towards transgender people. Heterosexism can be defined as the belief that all people are and should be heterosexual and that alternative sexualities pose a threat to society.⁵ Heterosexism also assumes that sex and gender—and the relationship between the two—are fixed at birth. Put simply, heterosexism assumes that men are masculine, women are feminine and sexuality is a sexual attraction between male and female. This is a rigid system that cannot accept the legitimacy of homosexual desire, nor the

possibility that sexuality may be fluid and open to change (such as bisexuality or someone whose sexual identity changes over their life from hetero to homosexual). It is also a system that cannot acknowledge gender fluidity (such as ‘butch’ women and ‘effeminate’ men who may be heterosexual), or the possibility that someone’s sense of their gender may not match their sex assigned at birth.

In this way heterosexism includes *homophobia* and *transphobia*, a fear of alternative sexualities and a fear of alternative gender identities. It may also include a fear of intersex people who do not fit neatly into the binary categories of male and female. The five discussion papers use the term *sexual orientation discrimination* when talking specifically of the negative effects of homophobia and the term *gender identity discrimination* when addressing the negative consequences of transphobia.

3.2 The Impact of Heterosexism on GLBTI People

In a recent report by the Victorian Gay and Lesbian Rights Lobby (VGLRL), 84 per cent of GLBT respondents reported discrimination as a result of their sexual orientation.⁶ Seventy per cent reported having experienced at least one form of public abuse, from physical violence (7 per cent) to verbal abuse (63 per cent). Transgender people reported consistently higher levels of public abuse and all rates were higher than those reported in the Australian Bureau of Statistics (ABS) report for Victoria in 1997.

The impact of heterosexism on GLBTI people includes:

- Violence and the ongoing threat of violence.
- Isolation.
- Social invisibility.
- Self-denial, guilt and internalised homophobia or transphobia.

⁴ Two excellent and comprehensive US examples are the June 2001 edition of the *American Journal of Public Health* dedicated solely to GLBTI health and the *Healthy Living 2010: Companion document for lesbian, gay, bisexual and transgender health*. (2001) San Francisco, CA: Gay and Lesbian Medical Association.

⁵ *Healthy Living 2010*, op cit.

⁶ Victorian Gay and Lesbian Rights Lobby (June 2000) *Enough is Enough: A report on the Discrimination and Abuse Experienced by Lesbians, Gay Men, Bisexuals and Transgender People in Victoria* Victorian Gay and Lesbian Rights Lobby: Melbourne (Further references to this report appear as *Enough is Enough*).

3.2.1 The Impact of Heterosexism on the Health of GLBTI People

GLBTI people's experiences of heterosexist discrimination lead to a *common* set of health problems. These problems can be divided into two types. The first type includes primary health issues and patterns of illness specific to and shared by GLBTI people; the second includes the effects of discrimination on GLBTI people's access to quality health care.

3.2.1a Primary Health Consequences: Patterns of Illness Common to GLBTI People

Each of the five research papers documents how GLBTI people's shared experiences of homophobic and transphobic abuse, social isolation and invisibility lead to common primary health problems and shared patterns of illness. They lead to GLBTI-specific patterns of mental, physical and sexual ill-health and to shared life stage and transition issues. They also result in common GLBTI patterns of drug and alcohol use.

The life stage paper, for example, demonstrates that heterosexist discrimination and its effects are experienced across a number of life stages. Both same-sex attracted and transgender youth and older GLBTI people are confronted by institutionalised homophobia and transphobia. They must decide how to be open about their sexual orientation, gender identity or intersex status, whether in the school environment or the aged care sector, or cope with being exposed.

The mental health paper documents how experiences of heterosexist abuse and internalised homophobia and transphobia may have similar negative effects on the mental health and wellbeing of GLBTI people. It also suggests that members of these groups share many of the negative *and* positive mental health effects of confronting heterosexism and "coming out".

3.2.1b Secondary Health Consequences: Reduced Access to Quality Health Care

Amongst GLBT Victorians, 23 per cent have experienced discrimination in relation to medical care.⁷ These figures compare with a review of several international GLB health consumer surveys, showing that between 31 per cent and 89 per cent of GLB people had experienced health care professionals displaying negative attitudes toward them.⁸ All five discussion papers suggest that these negative experiences explain research showing that GLBTI people under-utilise health services, compared with the population as a whole. However, the papers also suggest that under-utilisation may result from an *expectation* on the part of GLBTI people that they will be subject to heterosexist abuse or indifference within mainstream health services.

4. Health Concerns Specific to Different Groups and Subgroups within the GLBTI Community

4.1 Differences between Gay, Lesbian, Bisexual, Transgender and Intersex People

Each of the papers addresses the ways in which sexual orientation and gender identity interact with other social and biological processes to produce patterns of illness *specific* to each of the groups that make up the GLBTI community. Put differently, they deal with the health differences *between* gay men, lesbians, bisexuals, and transgender and intersex people.

4.1.1 Physical Health Needs

The differences between GLBTI people are most obvious when addressing their physical health needs. The physical health paper documents health problems specific to females or males, including research that suggests higher rates of cervical and breast cancer among lesbians and anal cancer among gay men, compared to their exclusively heterosexual female and male

⁷ *Enough is Enough*, op. cit. In a separate study of young lesbians in Sydney, 89.5 per cent of participants had experienced discrimination as a result of their being lesbian. Barbel, V. (1992) *The Young Lesbian Report: A study of attitudes and behaviours of adolescent lesbians today*. Twenty Ten Association, Young Lesbian Support Group: Sydney.

⁸ Harrison, A. E. (1998) "Primary Care of Lesbian and Gay Patients: Education Ourselves and Our Students". *Family Med* 28(1): 10–23

counterparts respectively. The paper also highlights the very particular physical health issues facing transgender and intersex people and the need for specialist services to address them. The life stage paper argues that issues of reproductive health have a much greater impact on the physical health of lesbians than gay men, while the sexual health paper demonstrates that gay men continue to be the group most at risk of and affected by HIV and AIDS in Victoria.

4.1.2 Cultural Variations

There are also differences between GLBTI people that may be characterised as cultural. The drug and alcohol paper demonstrates that patterns of recreational drug use among young gay men on the dance party scene and increased rates of smoking among lesbians (compared to either gay men or heterosexual women) are due, in large part, to cultural norms, practices and values specific to each of these groups. Similarly, changes to gay male sexual behaviour following the advent of HIV and AIDS can be directly linked to interventions directed at the communal or cultural level.⁹

4.2 Other Key Social Determinants of Health

The discussion papers also address, in a more limited fashion, the ways in which other social determinants such as socioeconomic status, geographic location, gender, ethnic and racial background and physical and intellectual disability interact with sexual orientation and gender identity to produce health concerns specific to subgroups within the GLBTI communities.

4.2.1 Socioeconomic Status

Socioeconomic disadvantage is recognised as a powerful predictor of poor health.¹⁰ There has been no analysis of the average income of GLBTI subgroups in Australia. Nonetheless, there is evidence suggesting that variations in socioeconomic status lead to different health needs and health outcomes for different subgroups.

International data, particularly from the US, suggest that lesbians and gay men have a lower annual income than the general population, despite a higher educational level.¹¹ For transgender people, loss of work during transition is commonplace. TransGender Victoria estimates that 95 per cent of its members have been forced to give up their job during gender reassignment. In a recent study of people living with HIV/AIDS (PLWHA), almost half the respondents were experiencing financial hardship, while approximately one third were living below the poverty line.¹² Women were significantly more likely to fall below the poverty line due, in part, to lower average income and increased likelihood of caring for dependent children.

4.2.2 Geographic Location

Recent Victorian health data show significant variations in morbidity and mortality rates for people living in rural and regional areas, compared to those living in metropolitan centres.¹³ There is little Australian research looking at variations in GLBTI health across different geographic locations. However, the five discussion papers identify a number of factors

⁹ Leonard, W. and Mitchell, A. (2000) *The Use of Sexually Explicit Materials in HIV/AIDS Initiatives Targeted at Gay Men: A guide for educators*. Prepared for the National Council on AIDS, Hepatitis C and Related Diseases, Canberra.

¹⁰ Turell, G. and Matthews, C.D (2000), op cit.

¹¹ O'Hanlan, K.A., Cabaj, R.B. et al (1997) "A review of the medical consequences of homophobia with suggestions for resolution". *Journal of the Gay and Lesbian Medical Association* 1(1): 25-39.

¹² Grierson, J., Bartos, M. et al (2000) *HIV Futures 11: The Health and Well-being of People Living with HIV/AIDS in Australia*. The Living with HIV Program, The Australian Research Centre in Sex, Health and Society. La Trobe University, Melbourne.

¹³ *Victorian Burden of Disease Study: Mortality (July 1999)*, op cit.

that may contribute to poorer health outcomes for rural and regional GLBTI people.

They include:

- Fewer health service providers with a knowledge of and expertise in GLBTI health issues.
- Increased levels of homophobia and transphobia.
- Reduced access to GLBTI community and support networks.

4.2.3 Gender Inequality

Women's health is inextricably linked to their position in society. Women are the primary caregivers, have lower rates of income than men and suffer more domestic violence.¹⁴ Although the discussion papers focus primarily on the health effects of sexual orientation and gender identity discrimination, research demonstrates that gender and gender inequality influence the health issues specific to lesbians, including patterns of illness and reduced access to and standards of care.¹⁵ Gender inequality is also likely to play a role in the health issues specific to male-to-female transgender people.

4.2.4 Ethnicity and Racial Background

Recent Australian evidence suggests that certain ethnic groups—and in particular asylum seekers and recent immigrants—have a lower health status than the general population. These differences may be linked to lower socioeconomic status, difficulties in accessing services due to differences in language and reduced quality of care due to cultural insensitivities on the part of health service

providers. There has been little work done on how ethnic differences interact with alternative sexual orientation and gender identities.

However, one study of Vietnamese gay men in Sydney highlighted the importance of ethnic and family identity that often resulted in pressure for these men to marry, even while they continued to have sex with other men.¹⁶

Indigenous Australians have significantly higher rates of mortality and morbidity than the general population.¹⁷ This may be due in part to cultural differences and to reduced standards of care resulting from racial discrimination and insensitivity within the health care system. However, research demonstrates that many of the health problems experienced by indigenous Australians are the result of material disadvantage and social marginalisation.¹⁸ Little work has been done on the health issues specific to GLBTI indigenous Australians and how they may vary according to geographic location.

4.2.5 Physical and Intellectual Disability

GLBTI people living with a disability may be subject to the combined effects of sexual orientation or gender identity discrimination and discrimination directed against people with a disability. For example a disabled lesbian may not feel supported or welcome within a disability support network, nor within the lesbian community.¹⁹ This lack of connection to GLBTI or disability support networks makes it difficult for GLBTI people with a disability to access education material. GLBTI people with a disability also face major barriers to the open

¹⁴ *Victorian Women's Health and Wellbeing Strategy: Discussion Paper* (2001) Victorian Government Department of Human Services: Melbourne, Victoria

¹⁵ Horsley, P., McNair, R. and Pitts, M. (2001) *A discussion paper on lesbian health issues developed for the Victorian Women's Health and Wellbeing Strategy*, DHS Victoria. The Australian Research Centre in Sex, Health and Society and the Department of General Practice, The University of Melbourne.

¹⁶ McMahon, T. (1996) "Passive men are more sissy you know: Experiences of sexuality for men of Vietnamese background lining in Sydney who have sex with men". *Proceedings of the 1st Health in Difference Conference*, Australian centre for Lesbian and Gay Research, Sydney. This may be only a matter of degree. There is pressure on gay men and lesbians across the Australian cultural spectrum to marry someone of the wrong sex.

¹⁷ *The National Indigenous Australians' Sexual Health Strategy* (1997), op. cit.

¹⁸ *The National Indigenous Australians' Sexual Health Strategy* (1997), op. cit.

¹⁹ Myers, H. and Lavender (1997) "An overview of lesbian health issues" Prepared for the Coalition of Activists Lesbians (COAL)

expression and acceptance of their sexuality.²⁰ They must contend not only with heterosexism but with widely shared prejudices that see people with a disability as lacking in sexual desire, irrespective of their sexual orientation or gender identity.

There are also support issues for GLBTI people caring for partners, friends or relatives with a disability. A study examining family care-giving responsibilities among gay men and lesbians showed that 32 per cent of gay men and lesbians were care-givers. Lesbians were more likely to be caring for children or elderly people, whereas gay men were more likely to be assisting working-age adults with a disability.²¹

²⁰ Johnson, Kelley, Hillier, Lynne et al (2001) *People with intellectual disabilities: Living Safer Sexual Lives*. Australian Research Centre in Sex, Health and Society: La Trobe University, Melbourne.

²¹ Fredriksen, K.I. (1999) "Family care giving responsibilities among lesbians and gay men". *Social Work* 44(2): 142–155.

Glossary of Key Terms²²

Affirming gender The process of adopting a lifestyle and/or body that matches a person's sense of their gender. The process may take some time, involve a number of different but related processes and often starts before an individual undertakes any changes to his or her public identity (see **Transsexual**).

Bisexual A person who is sexually and emotionally attracted to people of both sexes.

Coming out The process through which an individual comes to recognise and acknowledge his or her sexual orientation. Coming out often involves a decision to be open about one's sexual orientation. In the discussion papers, "coming out" is also used to describe the processes through which transgender and intersex people come to recognise and acknowledge their gender identity and intersex condition respectively.

Cross-dresser Someone who has an inescapable emotional need to identify as a member of the opposite gender, on a temporary or permanent basis.

Gay Refers to a person whose primary emotional and sexual attraction is toward people of the same sex. It is often used to describe individuals who are open about their sexuality and who self-identify *as* gay. However, the term is most commonly applied to men. The term lesbian is commonly used to describe women whose primary emotional and sexual attraction is for other women.

Gender identity A person's sense of identity defined in relation to the categories male and female. In the discussion papers, the term is primarily used to describe people whose gender identity does not match their biological sex. However, it is important to note that not everybody identifies exclusively with one sex or the other. Some people may identify as both male and female, while others may identify as male in

one setting and female in other. This suggests a *gender continuum*, rather than simply an opposition between one gender (male) and another (female).

Heterosexism The belief that everyone is or should be heterosexual and that other types of sexuality are unhealthy, unnatural and a threat to society. Heterosexism also assumes that sex and gender (and the relationship between the two) are fixed and not open to change. In the discussion papers, heterosexism includes both homophobia and transphobia.

Homophobia The fear and hatred of gay and lesbian people and of their sexual desires and practices.

Homosexual An individual whose primary sexual attraction is toward people of the same sex.

Internalised homophobia The internalisation of negative attitudes and feelings toward homosexuality, on the part of gay men and lesbians.

Internalised transphobia The internalisation of negative attitudes and feelings toward transgenderism, on the part of transgender people.

Intersex A biological condition where a person is born with reproductive organs and/or sex chromosomes that are not exclusively male or female. The previous term for intersex was hermaphrodite.

Lesbian A woman whose primary emotional and sexual attraction is toward other women. The term is often used to designate women who identify as same-sex attracted, as opposed to women who have sex with other women, but who do not self-identify as lesbian.

Men who have sex with men Men who engage in sexual activity with other men, but who do not necessarily self-identify as gay.

²² These are provisional or working definitions. A number are open to debate within and outside the GLBTI community reflecting the fluidity of sexual and gender identities and the importance members of marginalised groups attach to the processes of self-definition and redefinition.

Queer An umbrella term that includes a range of alternate sexual and gender identities, including gay, lesbian, bisexual and transgender.

Same-sex attraction Attraction toward people of one's own gender. The term has been used in the context of young people whose sense of sexual identity is not fixed, but who experience sexual feelings toward people of their own sex.

Transgender Refers to someone whose identity or behaviour falls outside stereotypical gender norms. In the discussion papers, it refers to individuals who do not identify with the gender assigned to them at birth. The terms male-to-female and female-to-male transgender persons are used to refer to individuals who are undergoing or have undergone a process of gender affirmation (see **Transsexual**)²³.

Transphobia Fear and hatred of people who are transgender.

Transsexual Refers to individuals who are born anatomically male or female but have a profound identification with the gender opposite to that assigned to them at birth. In the discussion papers, transsexual refers to people who are making, intend to make, or have made the transition to the gender with which they identify. It also includes people who wish to make the transition, but are prevented from doing so. Transition refers to a number of different though related processes, including changes to a person's outward appearance, hormone treatment and surgical gender reassignment (see **Affirming Gender**).

Women who have sex with women Women who engage in sexual activity with other women, but who do not necessarily self-identify as lesbian.

²³ The terms "transgender" and "transsexual" are currently subject to vigorous debate within the transgender, transsexual and intersex communities.

Estimated Proportion of the Population Who Are Gay, Lesbian, Bisexual, Transgender or Intersex

Gay and lesbian Sexual orientation can be defined according to sexual attraction, sexual activity and/or sexual identity. The estimate of the proportion of the population that is gay or lesbian varies according to which of these three definitions (or combination thereof) is being used. Popular estimates still rely on data from the Kinsey Institute that estimate that 10 percent of the male population and 5 to 6 percent of the female population are exclusively or predominantly gay and lesbian, respectively.²⁴ A recent US analysis (1996) of the limited data available estimated that in the US 9.8 per cent of men and 5 per cent of women report same-sex sexual behaviour since puberty; 7.7 per cent of men and 7.5 per cent of women report same-sex desire and 2.8 per cent of men and 1.4 per cent of women report homosexual or bisexual identity.²⁵ There are no comparable Australian studies. However, recent Australian research reveals that between 8 and 11 per cent of young people are not unequivocally heterosexual.²⁶

Difficulties in determining the percentage of the population that is exclusively gay and lesbian, or the percentage of the population that is bisexual, are compounded by the fluidity of sexuality and sexual identity.

Transgender and Transsexual The proportion of the population who are transgender is small: a 1981 report suggests rates of 1:24,000 males and 1:150,000 females.²⁷ According to 1993 population statistics, this would mean there are about 2,500 transgender people in Australia. More recent data from Europe suggest that 1 in 30,000 adult males and 1 in 100,000 adult females are seeking sex reassignment surgery.²⁸ If we use a broader definition of transgender, however, one not restricted to individuals who are undertaking medical treatments for gender affirmation, then estimates suggest about 1 in 11,900 males and 1 in 30,400 females are transgender.²⁹

Intersex The proportion of people who are intersex is estimated at 1 in 1,000, while it is estimated that approximately 1 child in 2,000 is born with genitalia that is exclusively neither male nor female.³⁰

²⁴ The statistics for the Kinsey Institute are quoted in *Healthy Living 2010*, p. 14 op cit.

²⁵ Michaels, S. (1996) "The prevalence of homosexuality in the United States" in Cabaj, R.P. and Stein, T.S. eds. *Textbook of Homosexuality and Mental Health*. Washington, DC: American Psychiatric Press.

²⁶ Hillier, L, Dempsey, D. et al (1998) *Writing Themselves In: A National Report on the Sexuality, Health and Well-Being of Same-Sex Attracted Young People*. Australian Research Centre in Sex, Health and Society, La Trobe University: Melbourne

²⁷ Ross cited in Perkins, R. (1995) *Transgender HIV/AIDS Needs Assessment Project, Australia* and Submission to the MACGLH, Victoria, March 2000. Transgender Community Working Party.

²⁸ Submission to the MACGLH, Transgender Community Working Party, op. cit.

²⁹ *Standards of Care for Gender Identity disorders, 6th Version* (2001) The Harry Benjamin International Gender Dysphoria Association, USA.

³⁰ Cole J. Legal issues for those with intersex conditions. AIS Support Group Australia, 2001. www.vicnet.net.au/~aissg

Physical Health Issues for GLBTI Victorians

Ruth McNair and Nick Medland

1. Introduction

This paper identifies a range of physical health issues affecting gay, lesbian, bisexual, transgender and intersex (GLBTI) Victorians.

The physical health of GLBTI populations differs from the general population, due to the impact of sexual orientation and gender identity discrimination.¹ GLBTI people's experiences of discrimination lead to *common* physical health problems and patterns of physical ill health. At the same time, differences of sex and gender within GLBTI communities lead to physical health issues *specific* to each of these groups. In particular, they lead to physical health problems specific to lesbians as women, to gay men as men and to transgender and intersex people as they renegotiate the relationships among biology, sex and gender.

2. Physical Health Issues Common to GLBTI People

Sexual orientation and gender identity discrimination impact *directly* on the physical health of GLBTI people, as acts of violence or the threat of victimisation.

They also impact *indirectly* on the physical health of GLBTI people by:

- Interacting with GLBTI cultural practices to produce health-related risk factors

more prevalent among members of GLBTI communities.

- Leading to reduced standards of care from service providers who are unaware of the needs of their GLBTI clients, or who hold prejudiced attitudes toward transgenderism and/or same-sex attraction.
- Leading to the under-utilisation of primary health care services or a delay in seeking treatment, on the part of GLBTI people.

2.1 The Direct Impact of Discrimination

2.1.1 Physical Abuse and Discrimination

A report from the Victorian Gay and Lesbian Rights Lobby documents acts of physical abuse directed at GLBTI people because of their sexual orientation or gender identity.² At their most extreme, these acts can result in a range of physical injuries. The threat of such abuse can also contribute to the continuation or worsening of existing physical conditions.

Violence and the threat of violence can discourage GLBTI people—in particular young people and those who do not have access to GLBTI support networks—from being open about their sexual orientation or gender identity. Non-disclosure can lead to a range of mental health problems, including social isolation and disconnectedness, the anxiety and distress that accompany the fear of being outed and the continuous undermining of a coherent and positive sense of identity.³ These mental health

¹ Meyer, I.H. (2001) "Why lesbian, gay, bisexual and transgender public health?" *American Journal of Public Health* 91(6): 856–859.

² Victorian Gay and Lesbian Rights Lobby (2000) *Enough is Enough: A Report on Discrimination and Abuse Experienced by Lesbians, Gay Men, Bisexuals and Transgender People in Victoria*. Victorian Gay and Lesbian Rights Lobby (VGLRL), Melbourne.

³ Herek, G. M., Cogan, J. C. et al (1997) "Correlates of internalized homophobia in a community sample of lesbians and gay men" *Journal of the Gay and Lesbian Medical Association* 1(1): 17–25. and Sandfort, T., de Graaf, R. et al (2001) "Same-sex behaviour and psychiatric disorders: Findings from the *Netherlands Mental Health Survey and Incidence Study (NEMESIS)*". *Archives of General Psychiatry*, Chicago.

problems have a negative impact on the physical health and wellbeing of those concerned.⁴

2.2 Health-Related Risk Factors

GLBTI communities have their own distinctive social and cultural practices. In part, they are the result of the interaction between GLBTI people’s alternative sexual and gender identities and their collective experiences of homophobia and transphobia. A number of these practices, along with the more immediate effects of discrimination, are risk factors for a range of physical health problems. They include a high rate of drug and alcohol use and misuse within the commercial scene, conformity among subgroups within GLBTI communities to

stereotypic images of an ideal body type, and a skepticism regarding the level and quality of care given to GLBTI clients within mainstream health services.⁵

The following table lists a number of health-related risk factors that are linked to GLBTI cultural practices and to systematic discrimination and their possible negative physical health effects. A number of these factors and their potential negative health effects are dealt with in more detail below. Issues relating to reduced screening are addressed in section 2.4.2. Issues related to drug and alcohol use and misuse, safe sex and smoking are addressed in the other papers.

Health-Related Risk Factor	Potential Negative Physical Health Effects
Drug and alcohol misuse	Damage to liver, brain and kidney; risk of accident, injury and overdose.
Smoking	Damage to lung, heart, blood supply and fertility.
Reduction in safe sex practices*	Risk of STIs, including HIV.
Stress	Hormonal changes leading to heart disease and cancers. Can also increase the likelihood of a range of other risk factors, including reduction in immune function.
Body image	Increased risk of eating disorders and secondary long term effects of poor diet, stress and depression; effects of steroid use.
Obesity	Increased risk of heart and lung disease, joint problems, diabetes and premature death.
Reduced screening	Decreased opportunity for early intervention for cancers, heart disease, STIs and diabetes.
Non-compliance with medication	People with intersex conditions often do not maintain hormone treatment, with possible negative effects on bone density.
Skepticism regarding service delivery	Reduced utilisation of health services, leading to delayed diagnosis health and treatment.

* Some GLBTI subgroups that do not receive safer sex educational materials (bisexuals, transgender people and lesbians) and individuals who are well informed but nonetheless at certain times practice unsafe sex (peer pressure, influence of drug and alcohol, stress).

⁴ Division44/Committee on Lesbian, Gay, and Bisexual Concerns (2000) “Guidelines for Psychotherapy with lesbian, gay and bisexual clients”. *American Psychologist* 55(12): 1440–1451.

⁵ Gardiner, J. M. (1987) *Medical Education and the Health Needs of Gay Men*. Gay Men’s Community Health Centre: Melbourne

2.2.1 Body Image

2.2.1a Eating Disorders

The importance of body image in gay male culture may improve health by encouraging exercise and an awareness of physique. However, it can also lead to an excessive valuation of an ideal bodily type, resulting in a range of eating disorders. Gay men have been identified in a number of studies to be more likely than heterosexual men to have a negative body image and to have experienced an eating disorder.⁶ One retrospective study found that over 40 per cent of males presenting with bulimia identified as gay or bisexual and that of these, a high percentage also reported substance misuse and depression.⁷ By contrast, research shows that lesbians have a more positive body image than heterosexual women.⁸

2.2.1b Gym Culture and Physical Activity

The gym culture can be understood as a subculture within GLBTI communities that focuses as much on physical appearance as on physical health. There is anecdotal evidence of increased steroid use among gym goers. The long term effects of drug use include increased risk of heart disease that can be compounded by fluctuations in weight associated with repeat dieting.

Lesbians have been shown to be more physically active than heterosexual women.⁹ This may lead to increased protection from diseases such as diabetes and heart disease and may offset the negative effects of risk factors such as obesity. Transgender and intersex people may be barred or discouraged from participating in organised sport and community-run physical activity programs, resulting in the loss of those physical,

psychological and social benefits associated with participating in sport.

2.2.1c Atypical Genitalia

Despite the striking variation of identities and politics represented in the sample, I found amazing consistency among individuals' experiences with medical attempts to "normalise" their bodies. Throughout the interviews, individuals conveyed that being encouraged to keep silent about their differences and surgical procedures only served to enforce feelings of isolation, stigma, and shame.

Comments from Sharon E. Preves, *For the Sake of the Children*.

The focus on genital difference, ambiguity and abnormality can create a very negative body image for many intersex people and can have a profound effect on their physical health and sense of wellbeing.¹⁰ These negative health effects are compounded by early and often recurrent surgical interventions aimed at genital "repair" and remodeling. Some intersex people also have issues related to sexual intimacy and body image, due to the anatomical particularities of their intersex condition.

2.2.2 Obesity

US studies show a higher prevalence of obesity among lesbians compared to women nationally.¹¹ Obesity is linked to increased risk for a range of physical health problems including diabetes, heart disease, joint problems and ovarian, bowel and uterine cancers. There is no Australian research on obesity rates among lesbians.

⁶ Siever, M.D. (1994) "Sexual orientation and gender as factors in socio-culturally acquired vulnerability to body dissatisfaction and eating disorders". *Journal of Consulting and Clinical Psychology* 62(2): 252–60 and Herzog, D.B., Newman, K.L. and Warshaw, M. (1991) "Body image dissatisfaction in homosexual and heterosexual males". *Journal of Nervous and Mental Disease* 179(6): 356–59.

⁷ Carlat, D.J., Camargo, C.A. and Herzog, D.B. (1997) "Eating disorders in males: A report on 135 patients". *American Journal of Psychiatry* 154(8): 1127–32.

⁸ Herzog, D. B., Newman, K., Yeh, C. and Warshaw, M. (1992) "Body image satisfaction in homosexual and heterosexual women". *International Journal of Eating Disorders* 11: 391.

⁹ Aaron, D. J., Markovic, D. M. E. et al (2001) "Behavioral risk factors for disease and preventive health practices among lesbians". *American Journal of Public Health* 91(6): 972–975

¹⁰ Dreger, A. (1999) *Intersex in the Age of Ethics*

¹¹ Aaron, D. J., op. cit.

2.3 Quality of Care

2.3.1 Prejudiced Attitudes of Health Care Providers

A review of international GLB health consumer surveys shows that between 31 per cent and 89 per cent of respondents had experienced health professionals displaying negative attitudes toward them because of their sexuality.¹² These reactions included looking embarrassed, responding in an inappropriate way, refusing to see the patient, showing hostility and displaying excessive curiosity, pity and condescension. In a 1994 survey of members of the then American Association of Physicians for Human Rights, 52 per cent of the physicians surveyed had observed colleagues providing reduced care or denying care to patients because of their sexual orientation; 88 per cent reported colleagues making disparaging remarks about lesbian, gay and bisexual patients.¹³ The findings of the VGLRL report *Enough is Enough* suggest that at least 23 per cent of GLBT Victorians have experienced discrimination in relation to health care.

The Australian Intersex Support Group (AIS Support Group) has reported to the Ministerial Advisory Committee on Gay and Lesbian Health (MACGLH) that intersex people are often given unnecessary medical examinations and that medical students may be present without the prior consent of the patient. Being treated as a medical curiosity may discourage intersex people from seeking medical care unless it is absolutely necessary. So too may intersex people's experiences of inappropriate surgery as children or infants. The AIS Support Group also notes a number of other quality of care issues for intersex people, including lack of consent for

childhood surgical procedures, lack of support services for intersex individuals and their families and lack of information on alternative care treatments.

2.3.2 Communication with Health Care Providers

Disclosure of sexual orientation, gender identity or intersex condition is crucial to the provision of appropriate and individualised care. It enables better rapport building, honesty and understanding of the whole-life context of any GLBTI person. In a US study, lesbians who had disclosed their sexual orientation to their health care providers were more likely to seek preventative health care such as Pap smears than lesbians who had not.¹⁴ However, non-disclosure is common, due to fear of negative responses and reduced standards of care. Over 50 per cent of respondents in a Canadian study of lesbians' and bisexuals' experiences of health care had never come out to their health care provider.¹⁵

Insofar as disclosure enhances the health outcomes for GLBTI clients, health care providers have a duty of care to provide an environment in which clients feel safe and are encouraged to be open about their sexual orientation, gender identity or intersex status. Lesbian consumers report that health service providers often assume their clients are heterosexual, while surveys of service providers' knowledge of lesbian health reveal that many perceive they have few if any lesbian clients.¹⁶ A survey of the level of awareness of lesbian health needs among staff at Melbourne's Royal Women's Hospital found that 52 of the 64 staff interviewed would never ask if a female client was lesbian, saying it was not relevant to patient care or was none of their business.¹⁷

¹² Harrison, A. E. (1998) "Primary Care of Lesbian and Gay Patients: Educating ourselves and our students". *Family Medicine* 28(1): 10–23.

¹³ Schatz, B.O. and O'Hanlan, K. (1994) *Anti-gay Discrimination in Medicine: Results of a National Survey of Lesbian, Gay and Bisexual Physicians*. San Francisco: American Association of Physicians for Human Rights (now known as the Gay and Lesbian Medical Association (GLMA)).

¹⁴ White, J. C. and Dull, V.T. (1998) "Room for Improvement: Communication between lesbians and primary care providers". *Journal of Lesbian Studies* 2(1): 95–110.

¹⁵ Mathieson, C.M. (1998) "Lesbian and Bisexual health care: Straight talk about experiences with physicians". *Canadian Family Physician* 44: 1634–1640.

¹⁶ Horsely, P. and Tremellen, S. (1996) "Legitimizing lesbian health—challenging the lack of a demonstrated need argument". *Healthsharing women newsletter* 6(4): 8–11 and McNair, R. M. (2000) "Do GPs contribute to lesbian invisibility and ill health?" *Australian Family Physician* 29(6): 524–516.

¹⁷ Brown, R. (2000) *More than lip service: The report of the lesbian health information project*. Royal Women's Hospital Victoria.

2.3.3 Limited Health Provider Knowledge

A review of a number of physician surveys relating to their level of knowledge of lesbian health concludes that the vast majority of physicians have not received adequate training in human sexuality and nothing to do with homosexuality.¹⁸ Fifty-seven per cent of respondents to the Royal Women's Hospital staff survey rated their knowledge of lesbian health as low, though a majority expressed an interest to learn more.

Submissions to the MACGLH from transgender and intersex groups suggest that health care providers lack of knowledge of transgender and intersex health is particularly acute. Like GLB people, both transgender and intersex consumers complain of having to educate health professionals concerning their specific health needs. There are limited specialist services available for transgender and intersex clients and often the costs for meeting their physical health needs are prohibitive. This is particularly the case for a number of surgical procedures linked to gender affirmation for transgender people.¹⁹ There is limited professional knowledge concerning hormone therapies and their long term physical health effects on transgender people. There are also issues related to accessing hormones and in particular, the prescription of testosterone to female-to-male transgender people.

Current models of care, such as the Harry Benjamin International Gender Dysphoria Association Standards of Care²⁰ and the DSM IV diagnostic model, tend to adopt a surgical and psychiatric focus and do not encompass a more holistic, social approach to the health and wellbeing of TG people. The Monash Gender Dysphoria Clinic has used the Harry Benjamin Standards in establishing guidelines for the

medical assessment and management of gender affirmation. However, there are no standard guidelines for individual medical practitioners. Individual health providers are in the uncomfortable position of having to invent treatment models, leaving them exposed legally and ethically and subjecting clients to variable standards of care.

There is evidence of unnecessary and at times damaging surgical intervention on intersex infants and children, including genital surgery, which may lead to ongoing physical health problems.

2.4 Utilisation of Health Services

2.4.1 Delayed Attendance

GLBTI populations are found to *utilise health services less* than the general population.²¹ International surveys have shown that GLBTI people are more likely to attend health care after specific problems arise and present later in an illness when it is potentially more severe and less amenable to treatment.²² For example, though there is no demonstrated link between sexual orientation and gonadal and prostate cancer, gay and bisexual men who under-utilise health services are likely to present when the disease is more advanced.

GLBTI people's under-utilisation of health services may be due to their perception that a percentage of health service providers hold prejudiced attitudes toward same-sex attraction and transgenderism. There is no national data in Australia on the health seeking patterns of GLBTI people. However, data from a New Zealand national survey of lesbian health confirmed that there was a delay in lesbians seeking health care from both mainstream and alternate systems.²³

¹⁸ Harrison, A. E. (1998) "Primary care of lesbian and gay patients: Educating ourselves and out students". *Family Medicine* 28(1): 10–23.

¹⁹ Men's Australia Network (MAN), a group representing female to male transsexuals, has argued in a submission to the MACGLH that there is a need for research into improved surgical outcomes including phalloplasty for f to m transsexuals.

²¹ Diamant A.L., Wold, C., Spritzer, K. and Gelberg, L. (2000) "Health behaviours, health status and access to and use of health care: a population-based study of lesbian, bisexual and heterosexual women". *Arch Fam Med* 9 (10): 1043–51.

²² Roberts, S.J. and Sorenson, L. (1995) "Lesbian health care: a review and recommendations for health promotion in primary health care settings". *Nurse Practitioner* 20(6): 42–47.

²³ Saphira, M. and Glover, M. (2000) "New Zealand National Lesbian Health Survey". *Journal of the Gay and Lesbian Medical Association* 4(2): 49–56.

2.4.2 Reduced Screening

GLBTI people's under-utilisation of health services may lead to reduced screening for a number of physical health conditions. This is compounded by a lack of health promotion material within the GLBTI community, highlighting the need for screening and a false belief that GLBTI people are at minimal risk for a range of conditions because of their sexual orientation, gender identity or sexual practices. Reduced screening can also result from too narrow a focus on sexual health when dealing with GLBTI people. The focus on sexual health services for gay men, for example, may have resulted in reduced screening for risk factors linked to other conditions, such as cardiovascular disease and certain cancers.

2.4.2a Cancer Detection and Early Screening

- **Smoking-related cancers**

Numerous studies have documented higher rates of smoking among GLBTI people and in particular among lesbians.²⁴ Smoking is the single largest preventable predictor of the development of chronic diseases. There is a need for health promotion material targeted at the GLBTI community highlighting the health risks associated with smoking and for screening and early detection for a range of chronic health conditions, including smoking-related cancers.

- **Pap smears and mammogram screening amongst lesbians, transgender and intersex people**

Reduced utilisation of national screening programs such as cervical (Pap tests) and breast screening (mammograms) has been identified as a health risk for lesbians and bisexual women.²⁵ Studies suggest that lesbians are at risk for human papilloma virus, one of the major known causes of cervical cancer, through contact with women alone (and with men).²⁶ The

misperception that lesbians do not require cervical screening has been perpetuated both within the lesbian community and among health care professionals. The Anti-Cancer Council of Victoria has responded to this issue by developing an educational resource targeted at lesbians and health care providers, outlining the need for lesbians to undergo regular cervical screening.²⁷

There is a general lack of understanding of the physical health needs of transgender people and in particular of the need for cancer screening. A female-to-male transgender person who has not undergone gender reassignment surgery still requires cervical cancer screening. In addition, hormone replacement therapy with testosterone may increase the risk of breast, uterine, ovarian and cervical cancer. Currently, male-to-female transgender people who have not undergone reassignment surgery but are taking hormones for breast development cannot access Medicare rebates for mammograms. Nor are male-to-female people who develop breast tissue included in the usual breast screening programs.

A large percentage of people with an intersex condition are on hormone therapy for an extended period of time. It is imperative that they are regularly screened for breast cancers and/or cervical cancers (depending on their intersex condition). Screening should start earlier than for the non-intersex population, necessitating different techniques such as ultrasound rather than mammograms.

- **Prostate screening amongst male-to-female transgender people and gay men**

It is common for male-to-female transgender people to express a desire to have the prostate removed with gender reassignment surgery. There is a lack of technical information on the effects of removing the prostate.

²⁴ For Australian data see Murnane, A. et al (2000) *Beyond Perceptions: A report on alcohol and other drug use among gay, lesbian, and queer communities in Victoria*. Australian Drug Foundation: Melbourne.

²⁵ Rankow, E.J. and Tessaro, I. (1998) "Cervical cancer risk and Pap screening in a sample of lesbian and bisexual women". *Journal of Family Practice* 46: 139-143 and Rankow, E.J. and Tessaro, I. (1998) "Mammography and risk factors for breast cancer in lesbian and bisexual women". *American Journal of Health Behavior* 22: 403-410.

²⁶ Ferris, D. G., Batish, S. et al (1996) "A neglected lesbian health concern: Cervical Neoplasia". *Journal of Family Practice* 43: 581-584.

²⁷ Anti-Cancer Council of Victoria (2000) *PapScreen Victoria Communications and Recruitment Strategy 1996-99*. Final Report. Melbourne.

- **Anal cancer screening**

Anal cancer is eighty times more common in gay and bisexual men than in the general population.²⁸ The progression from low-grade lesions to anal cancer is thought to be similar to the development of cervical cancer. Since the introduction of widespread cervical cancer screening, the incidence of cervical cancer among women has dropped by 75 per cent.²⁹ Given the similarities in disease progression between cervical and anal cancer, screening programs may have the potential to drastically reduce the incidence of anal cancer among gay and bisexual men. At present, no such screening programs exist in Victoria.

- **Gonadal (testicular and ovarian) cancer**

Lesbians may be at higher risk for ovarian cancer, due to a higher prevalence of obesity and lower protective factors, such as oral contraception and childbearing.

Exposure to hormone therapy over many years may place transsexual or intersex persons at increased risk of certain cancers, however data are not available.³⁰ Breast cancer in male-to-female transgender people and ovarian cancer in female-to-male people have been reported. Concerns about the sensitivity or invasiveness of vaginal, rectal or breast examination may discourage intersex and transsexual people from seeking appropriate medical care.

Post-pubertal gonadal cancer screening is vital for those intersex people with internal testes or with gonadal dysgenesis. Screening should occur at least once a year, although no statistics are currently available.

2.4.2b Cardiovascular Screening

Due to their reduced health seeking behaviours, GLBTI people may not receive preventative health advice concerning a reduction in behaviours associated with an increased risk of cardiovascular disease, including smoking, low levels of exercise and excessive alcohol intake. These risk factors may be offset by protective factors such as increased physical activity amongst members of the gym culture and lower intake of the contraceptive pill amongst lesbians.

HIV-positive people on anti-retrovirals and transgender people on certain long term hormonal therapies may be at increased risk of high lipid levels, which in turn carries an increased risk of cardiovascular disease. These potential long term side effects of medication are yet to be studied.

2.4.2c Bone Mineral Density Screening

Bone mineral density loss has been reported in a significant proportion of both male-to-female and female-to-male transgender people after gonadectomy and appears to be related to underdosing of sex hormones.³¹ It has also been reported in people with intersex conditions, but especially those who have either had their gonads removed or have been lax in complying with their hormone therapy.

2.4.2d Diabetes

Obesity is a known risk factor for diabetes. US studies show that the prevalence of obesity is higher in the lesbian community and therefore it is likely that the prevalence of diabetes will be higher. No comparable studies have been carried out in Australia.

²⁸ Biggar, R. J. and Rabkin, C.S. (1996) "The epidemiology of AIDS-related neoplasms". *Hematol Oncol Clin North Am* 10:997-1011.

²⁹ Qualters, J. R., Lee, N.C. et al (1992) "Breast and cervical cancer surveillance, United State 1973-1987". *MMWR Surveillance Summary* 41: 1-15.

³⁰ van Kesteren, P. J., Asscheman, H. et al (1997) "Mortality and morbidity in transsexual subjects treated with cross-sex hormones". *Clinical Endocrinology* 24(3): 337-324

³¹ Van Kesteren, P., Lips, P. et al (1998) "Long-term follow up of bone mineral density and bone metabolism in transsexuals treated with cross-sex hormones". *Clinical Endocrinology* 48(3): 347-54.

Sexual Health Issues for GLBTI Victorians

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1. Introduction

This paper identifies a number of sexual health issues affecting gay, lesbian, bisexual, transgender and intersex (GLBTI) Victorians. It focuses on rates and patterns of sexually transmitted infections (STIs) common to GLBTI people. Research suggests that GLBTI cultural values, norms and practices may lead to patterns and rates of STIs among GLBTI people that differ from those in the community at large. At the same time, differences within GLBTI communities—in particular differences of sex and gender—lead to patterns and rates of STIs specific to members of each of these groups.

The World Health Organisation (WHO) defines sexual health as the “Capacity to enjoy and control sexual and reproductive behaviour in accordance with a social and personal ethic”. It adopts an holistic approach which links sexual health to wider social and political freedoms, including “freedom from shame, guilt and false belief which inhibits sexual response and impairs socio-sexual relationships”.¹

Definitions of sexual health are notoriously slippery, relying on at least three different understandings of sexuality.² Sexuality can be defined according to sexual behaviour, sexual attraction or sexual identity. Although all three understandings overlap, there is no necessary or

fixed relation between them. Furthermore, any one (or any combination of all three) may change over the course of an individual’s life. Men who identify publicly as heterosexual for example, but who continue to have sex with men, assume a single identity, even as they demonstrate a fluidity of sexual attraction and a range of sexual practices. Such men are unlikely to access sexual health information and services that are targeted at openly gay men.³

Similarly, there is no necessary relation between gender identity and sexual orientation. Transgender people demonstrate a similar range of sexual identities, behaviours and attraction as the population at large. Acknowledging the diversity and fluidity of gender and sexual identity and of sexual attraction and sexual practices is an ongoing challenge for sexual health services generally.

2. Sexual Health Issues Common to GLBTI People

2.1 Discrimination and Disclosure

GLBTI people’s experience of sexual orientation and gender identity discrimination impacts negatively on their sexual health and wellbeing and on rates and patterns of STIs within GLBTI communities.⁴ There is evidence that young GLBTI people’s experiences of homophobia and

¹ WHO/TRS 572, (1975).

² Greenhouse, Peter (1995) “A definition of sexual health”. *British Medical Journal* 310: 1468-1469 for a brief overview of recent definitions.

³ Leonard, W. and Mitchell, A. (2000) *The Use of Sexually Explicit Materials in HIV/AIDS Initiatives Targeted at Gay Men: A guide for educators*. Prepared for the National Council on AIDS, Hepatitis C and Related Diseases, Canberra.

⁴ Sandfort, T., de Graaf, R. et al (2001) “Same-sex behaviour and psychiatric disorders: Findings from the Netherlands *Mental Health Survey and Incidence Study* (NEMESIS)”. *Archives of General Psychiatry*, Chicago and Hillier, L. et al (1998) *Writing Themselves In: A National Report on the Sexuality, Health and Well-Being of Same-Sex Attracted Young People*. Monograph Series No.7. National Centre in HIV Social Research and the Australian Research Centre in Sex, Health and Society.

transphobia lead to higher rates of drug and alcohol use, compared to exclusively heterosexual youth.⁵ Increased drug and alcohol use are linked to increased sexual risk-taking, suggesting that discrimination may impact directly on the sexual health and patterns and rates of STIs among young GLBTI people.⁶

Australian research suggests that those most at risk of HIV/AIDS are more likely to change their sexual behaviours when they can be open about their sexual orientation or gender identity and when the threat or likelihood of discrimination and abuse is minimal.⁷ This suggests a direct link between improvements in GLBTI people's sexual health and ongoing processes of legislative and social reform.

Research also demonstrates that GLBTI people under-utilise health services due, in part, to their experiences of homophobia or transphobia.⁸ This raises complex issues regarding GLBTI people's use of sexual health services, where disclosure of sexual practices and sexual identity may have a direct impact on quality of care and health outcomes. This is particularly the case when addressing the sexual health needs of the many GLBTI people in long term stable relationships.

2.1.1 GLBTI Youth

A national survey of same-sex attracted youth in Australia found that:

- Seventy-three per cent of participants had had sex.
- Nearly 70 per cent of women reported 'never' using protection in same-sex encounters.
- Fifty per cent of men reported always using condoms, regardless of sex of partner.

- Young women were more likely than males to be same-sex attracted, but only having heterosexual sex.
- More same-sex attracted young women become pregnant than heterosexual young women.
- Same-sex attracted youth were lacking information about gay and lesbian relationships and safe sex, particularly in rural areas.⁹

In addition, nearly one third of participants believed they had been unfairly treated or discriminated against because of their sexual orientation. The authors noted concerns over the potential spread of HIV and other STIs into the adolescent population. Another Australian schools-based survey found 24 per cent of same-sex attracted youth had had an STI, compared with an estimated 8 per cent of heterosexual youth.¹⁰

A recent US study showed that GLB students at schools with GLBTI sensitive education reported fewer sexual partners, less recent sex, and less substance use before engaging in sex than students at schools without such programs.¹¹

2.1.2 Rural/Non-Metro

The major sexual health issues for GLBTI people in rural areas include:

- Lack of appropriate services.
- Hostility to same-sex attraction and transgenderism.
- No peer support.
- Lack of GPs familiar with GLBTI patients.
- Issues to do with disclosure.
- A lack of safe sex messages and information in rural settings that may place men who use city sex-on-premises venues at increased risk for STIs.

⁵ Hillier, L. et al (1998), op. cit.

⁶ *Dangerous Liaisons: Substance Abuse and Sex* (1999) The National Centre on Addiction and Substance Abuse at Columbia University, USA.

⁷ Pereira, D. (1999) "HIV/AIDS and its 'willing executioners': The impact of discrimination". Murdoch University *Electronic Journal of Law* 6 (online only).

⁸ Diamant A.L., Wold, C., Spritzer, K. and Gelberg, L. (2000) "Health behaviours, health status and access to and use of health care: a population-based study of lesbian, bisexual and heterosexual women". *Arch Fam Med* 9 (10): 1043-51.

⁹ Hillier et al, op. cit.

¹⁰ Lindsay, J., Smith, A. et al (1997) *National Survey of Australian Secondary Students HIV/AIDS and Sexual Health, 1997: Final Report*. Melbourne: Centre of the Study for Sexually Transmissible Diseases.

¹¹ Blake, S. M., Ledsky, R. et al (2001) "Preventing sexual risk behaviours among gay, lesbian and bisexual adolescents: The benefits of gay-sensitive HIV instruction in schools". *American Journal of Public Health* 91(6): 940-946.

The research literature on the sexual health needs of rural populations tends to focus on men who have sex with men (MSM) and highlights the need for sexual health services that acknowledge and support alternative sexualities¹² and that do not bundle all MSM into a single group.¹³ A study of discrimination against GLBT found that participants from regional centres or rural areas were more likely than other groups to report 'Breach of Confidentiality' by medical providers.¹⁴

There is very little reference to lesbian, transgender, bisexual women and intersex groups in regard to sexual health and service provision in rural and non-metro areas.

2.1.3 Fertility and Parenting

Gay men and lesbians are increasingly involved in biological and social parenting. Infertility in gay men, which can be a complication of some STIs, is rarely considered to be a sexual health issue by researchers and service providers. Men with a chronic infection, including HIV positive and HBV positive gay men, may also want to be biological parents. New techniques of sperm washing are currently being developed, but are not yet sufficiently reliable to guarantee prevention of transmission to the possible biological mother.

About one in four lesbians care for children, either within the context of a same-sex relationship or from a previous heterosexual relationship.¹⁵ For lesbians planning children and particularly for those using self-insemination with donor sperm, access to safe semen and non-discriminatory health care is important. In Victoria, the current ruling on the *Infertility*

Treatment Act 1995 is that only clinically infertile women can access assisted reproductive technologies. The demonstration of clinical infertility makes it difficult for lesbians to access in vitro fertilisation (IVF). Under the terms of the Act, lesbians cannot access donor insemination programs.

For male-to-female transgender people, there is a need for counselling prior to gender reassignment surgery or hormone therapy regarding sperm donation, to enable later conception of a child if desired.

Intersex people are often infertile, or have been rendered infertile by childhood removal of testes.

2.1.4 Older GLBTI People and Sexuality

Older people are aware of misconceptions that they are no longer sexually active. This is equally the case for GLBTI people, and can lead to failure to target such groups for sexual health messages. An example is the use of Viagra amongst older gay men and the need to ensure awareness that Viagra should not be taken with nitrites such as amyl. Aged care facilities also do not recognise same-sex partners.¹⁶

3. Issues Specific to Each Group

3.1 Gay and Other Homosexually Active Men

The majority of studies on the sexual health of GLBTI populations have focused on gay men. A number of these studies use the term "men who have sex with men" which does not refer exclusively to self-identified gay men, but includes men who identify as bisexual and heterosexual.

¹² Thorpe, A. (1995) "Sexual health, sexuality and straightjackets (men's sexual health in rural communities)." in *National Men's Health Conference*, pp. 246-50 Canberra: Australian Government Publishing Service.

¹³ Thorpe, A. (1996) "Myths of manhood: Sexual health and gay education in rural communities". *National AIDS Bulletin* 10: 34-5.

¹⁴ Victorian Gay and Lesbian Rights Lobby (2000) *Enough is Enough: A Report on Discrimination and Abuse Experienced by Lesbians, Gay Men, Bisexuals and Transgender People in Victoria*. Victorian Gay and Lesbian Rights Lobby (VGLR), Melbourne.

¹⁵ Horsley, P., McNair, R. and Pitts, M. (2001) *A discussion paper on Lesbian health issues developed for the Women's Health and Wellbeing Strategy*, Department of Human Services Victoria. Melbourne: The Australian Research Centre in Sex, Health and Society and the Department of General Practice, The University of Melbourne.

¹⁶ Minichiello, V., Plummer, D. et al (1996) "Sexuality and Older People: Social issues". In Minichiello, V., Chappell, N. et al eds. *Sociology of Aging: International Perspectives*. Melbourne International Sociological Association and Waite, H. (1997) "Lesbian and Grey" in *Health InDifference Conference Proceedings*. Centre for Lesbian and Gay Research, University of Sydney, Australia. Such discrimination is now unlawful.

The major STIs associated with male-to-male sex include HIV/AIDS, Hepatitis A (HAV), Hepatitis B (HBV), gonorrhoea, Chlamydia trachomatis, human papilloma virus (HPV), herpes, syphilis and external STIs such as pubic lice.

3.1.1 HIV/AIDS

In Victoria, HIV is transmitted primarily by sexual contact between men, accounting for 72 per cent of new diagnoses in 2000. The number of cases of new HIV infection peaked in 1984–85, when around 530 cases were reported in Victoria. By 1999, rates of HIV infection had fallen to 140 cases. However, in 2000 198 new cases were recorded, representing a 41 per cent increase over the number of cases recorded in 1999.¹⁷

It has been suggested that this increase is due to an increase in rates of unprotected anal sex among MSM. There are different levels of risk of HIV transmission associated with different sexual practices. For example, receptive and insertive anal sex carry a higher risk of HIV transmission, compared to low risk practices such as oral sex. There is a perception among those working in HIV/AIDS education that there has been a gradual reduction in HIV/AIDS education prevention programs. This reduction, combined with more effective long term therapies for HIV positive people, may have resulted in a level of complacency within and outside the gay community regarding safer sex practices. This is particularly so for young and newly homosexually active men who have not been exposed to earlier HIV/AIDS educational campaigns. It may also include older gay men experiencing what has been termed “AIDS fatigue”, a relaxation in safer sex practices after years of living in the shadow of HIV/AIDS.

The Victorian Government has recently commissioned research into the possible causes of this increase in HIV infection and funded new HIV prevention initiatives targeted at those places where gay and other homosexually active men socialise and “sexualise”.

Post-exposure prophylaxis (PEP) is another prevention strategy now recommended by the National Health and Medical Research Council (NHMRC) for high risk sexual exposure. However, there is limited knowledge of its availability.

3.1.2 Gonorrhoea

There is a continuing outbreak of gonorrhoea in Victoria, concentrated in MSM.¹⁸ The incidence of infection in 1999 was the highest in over 10 years. The greatest increase was in men aged between 20 and 40 years and living in inner suburban Melbourne. Such cases were typically associated with sex with a local casual male partner at a sex-on-premises venue, or at a beat. There are concerns regarding the significant number of infected men having no symptoms and the levels of antibiotic resistant strains of gonorrhoea.

3.1.3 Chlamydia

There was an increase in the number of cases of Chlamydia trachomatis notified in 1999 (a total of 2952 cases, compared with 2494 in 1998) continuing an upward trend.¹⁹ While 60 per cent of reported infections occurred in females, 16 per cent of men notifying with Chlamydia identified as homosexual, indicating a significant effect to this group.

¹⁷ These figures come from a draft of the *Victorian HIV/AIDS Strategy 2002–2004* and from the (2001) *Victorian Infectious Disease Bulletin* 4(1).

¹⁸ Public Health Division, DHS, 2000.

¹⁹ Public Health Division, Department of Human Services 2000.

3.1.4 Hepatitis B (HBV)

Between 1993 and 1998, the highest rates of HBV notification and hospitalisation occurred among young men between 20 and 24 years of age.²⁰ The most likely modes of transmission among this group include sexual practices (particularly unprotected anal sex) and intravenous drug use. The National Health and Medical Research Council of Australia (NHMRC) recommends Hepatitis B virus (HBV) immunisation for gay men.

3.1.5 Hepatitis A (HAV)

Between 1995 and 1998, the highest rate of notifications and hospitalisations for HAV was for men aged 15–59 years.²¹ McIntyre argues that this is likely to represent outbreaks amongst MSM. An association has been found in a Sydney study between use of drugs and increased HAV infection.²²

A 1993 Melbourne-based study found that the majority of men, in particular those with fewer years of sexual activity, were not immune to HAV.²³ The study recommended inactivated HAV vaccines should be available to non-immune gay and bisexual men. While vaccination against HAV is available in Australia, there have been no initiatives targeting the gay and bisexual community.

3.1.6 Genital Warts (HPV)

Human papilloma virus is responsible for genital warts. Certain strains of HPV have also been linked to the development of precancers and cancers of the anus, penis, cervix, vagina and vulva.²⁴ US evidence shows that rates of anal precancer and cancer among MSM are on the rise. It has been suggested that anal Pap tests might prove a cost effective measure for screening for HPV and assist in the early detection and treatment of anal precancers and cancers in MSM.²⁵ However, the effectiveness of such screening procedures has yet to be demonstrated.

3.2 Lesbians and Other Women Who Have Sex with Women (WSW)

Lesbians have received little attention in the sexual health literature.²⁶ Rates of transmission and the prevalence of STIs among women who have sex with women (WSW) are unknown.²⁷ Unlike studies of gay and other homosexually active men, there has been little research into the behavioural and cultural determinants of patterns and rates of STIs among lesbians and little accessible information regarding safer sex practices for WSW.

²⁰ McIntyre, Peter, Janaki, Amin et al (2000) Vaccine preventable diseases and vaccination coverage in Australia, 1993–1998. Sydney: National Centre for Immunisation Research and Surveillance of Vaccine Preventable Diseases.

²¹ McIntyre et al, op. cit.

²² Delpech, V. et al (2000) "Hepatitis A in South-Eastern Sydney 1997–1999: Continuing concerns for gay men and an outbreak among illicit drug users". *Communicable Diseases Intelligence* 24(7): 203–206.

²³ Carmody, C. (1992) "Hepatitis A: A sero-prevalence study of homosexual and bisexual men in Melbourne during 1991". *Venereology* 5: 161.

²⁴ *Healthy Living 2010: Companion document for lesbian, gay, bisexual and transgender health* (2001) San Francisco, CA: Gay and Lesbian Medical Association.

²⁵ *Healthy Living*, op. cit.

²⁶ VGLRL, *Enough is enough*, op. cit.

²⁷ *Healthy Living*, op. cit.

3.2.1 Sexually Transmitted Infections (STIs)

STIs are common in the lesbian community. In one US study of lesbian health, about one third of the women had had an STI²⁸ while in a similar survey, 17 per cent of respondents had had one or more STIs.²⁹ A discussion paper developed for the *Women's Health and Wellbeing Strategy*³⁰ identifies the following as key lesbian sexual health issues:

- Infections transmissible during woman-to-woman sexual activity including HPV (linked with cervical cancer), bacterial vaginosis (BV), Candida, Trichomonas, Chlamydia and herpes (HSV).³¹
- Bacterial vaginosis, a common infection with up to 35 per cent of lesbians having had symptomatic BV.³²
- Lesbians who have and have had sex with men and therefore are at risk of additional infections including HSV, Trichomonas, HBV, Chlamydia, gonorrhoea and other bacteria that can lead to pelvic inflammatory diseases (PID) and HIV.

3.2.2 Safe Sex Practices for WSW

There is little knowledge among health care providers regarding safe sex practices for WSW. Practices include the use of latex dams, gloves and condoms on sex toys. Dams, however, are expensive and difficult to access. There are few patient resources and those that do exist are difficult to access. The lack of information and accessibility, combined with a perceived immunity to STIs, results in limited safer sex behaviours amongst lesbians.

3.2.3 Access to Health Services

The myth that lesbians are at less risk of STIs has led to lesbians being under-screened, under-informed and under-diagnosed. Recent US studies indicate that WSW do not receive adequate Pap test screening. Additionally, concerns around possible loss of fertility from PID are rarely addressed.

A number of surveys have documented lesbians' dissatisfaction with sexual health services generally. They highlight the need for better gynaecological, sexual and reproductive health care for lesbians, access to reproductive health services, and more information on health, STIs and sexual practices for WSW. Similar dissatisfaction with service provision in the UK has led to the successful implementation of a number of lesbian family planning services.³³

3.3 Bisexually Active People

Very little work has been done on the sexual health needs of bisexually active people. Insofar as their sexual health needs are raised at all, they tend to appear in research on gay men and lesbians, respectively.

3.3.1 Bisexual Men

Research indicates bisexual men need to feel safe about disclosing their sexuality when receiving medical treatment.³⁴ They are less likely to identify with the gay community for a number of reasons, including a potential threat to their anonymity, most notably in rural areas. Bisexually active men are unlikely to disclose their bisexuality to female partners, making it difficult to estimate heterosexual female exposures to STIs from sex with undisclosed bisexual males.³⁵ There is also evidence to suggest

²⁸ Carroll, (1997)

²⁹ Diamant, op. cit.

³⁰ Horsley, P., , op. cit.

³¹ Skinner, C.J., Stokes, Y. et al (1996) "A case-controlled study of the sexual health needs of lesbians". *Genitourinary Medicine* 72: 277–80 and Fethers, K., Marks, C. et al (2000) "Sexually transmitted infections and risk behaviours in women who have sex with women". *Sexually Transmitted Infections* 76: 345–49.

³² Skinner, op. cit.

³³ Carr, S.V., Scoular, A. et al (1999) "A community based lesbian sexual health service—clinically justified or politically correct". *British Journal of Family Planning* 25:93–5.

³⁴ Submission from the Gay and Married Men's Association (GAMMA) to the Ministerial Advisory Committee on Gay and Lesbian Health, 2000.

³⁵ Dean, L., Meyer, H. H. et al (2000) "Lesbian, Gay, Bisexual and Transgender Health: Findings and concerns". *Journal of the Gay and Lesbian Medical Association* 4:101–51.

bisexual men should be targeted for HIV prevention strategies. A study of 26 men who had been married and had sex with men found 38.5 per cent reported having unsafe sex with men prior to marriage, 23.1 per cent while married and 60 per cent after their marriage had ended.³⁶

3.3.2 Bisexual Women

A retrospective survey of 585 women recruited at a number of gay and lesbian community events found that 15 per cent of respondents identified as bisexual.³⁷ Of these, 29 per cent reported sex with gay or bisexual men, compared with 1 per cent of lesbians and 6 per cent of heterosexuals. Because bisexually identified women are more likely than women identified as lesbian or heterosexual to have sex with gay men, they are at greater risk of HIV/AIDS as well as other STIs prevalent in the gay community.³⁸ Bisexual women are also at risk of STIs more common in WSW such as HPV, bacterial vaginosis, Candida and herpes.

3.4 Transgender People

It has been estimated that 60 per cent of transgender people have been infected with some kind of STI.³⁹ However, no prospective studies have been done on the risk of STIs for transgender persons. Most health care providers lack knowledge about transgender issues. Ongoing professional support through gender reassignment is often inadequate and little is known about the long term effects of hormone therapy, or the ongoing need for gynaecological services for female-to-male transgender people,

or urological services for male-to-female transgender people.⁴⁰

A disproportionate number of transgender persons take up sex work because of discrimination in the workplace and financial hardship, due to the common experience of job loss during or following transition.⁴¹ A study of 146 transgender people in Sydney indicated 45 per cent had spent some time in the sex industry, reporting high levels of violence and sexual assault.⁴² Because of stigmatisation within the sex industry, transgender people are more likely to engage in unprotected sex on client demand.⁴³

A number of American studies document rates of STI and HIV among transgender people. A study in Chicago found that 46 per cent of respondents had been forced to have sex, 14 per cent were HIV Positive, 22 per cent had had an STI and 48 per cent of male-to-female and 85 per cent of female-to-male transgender people had had sex without a latex barrier.⁴⁴ A retrospective study of the health status of transgender persons in the US reported a 35 per cent prevalence of HIV for male-to-female transgender persons.⁴⁵

Research suggests a firm correlation between the sexual health of transgender people and their psychological wellbeing. Adult transsexuals often recall that their gender dysphoria started early in life, well before puberty.⁴⁶ The emotional crisis of being transgender can lead to low self-esteem, often leading to risk-taking activities such as drug taking and unsafe sex, factors contributing to high rates of HIV infection.

³⁶ Higgins, D.J. (2000) "Gay men from heterosexual marriages: Attitudes, behaviours, childhood experiences, and reasons for marriage". *Journal of Homosexuality* 41.

³⁷ Richters, J., Lubowitz, S. et al (1998) "HIV risks among women in contact with Sydney's gay and lesbian community". *Venereology* 11: 35-8

³⁸ Richters, op. cit.

³⁹ *Report from the Transgender Working Party*, 2000.

⁴⁰ VGLRL, *Enough is enough*, op. cit.

⁴¹ *Transgender Working Party*, op. Cit. and the *Companion to Healthy Living 2010*, op. cit.

⁴² Harcourt, Christine, van Beek, Ingrid et al (2001) "The health and welfare needs of female and transgender sex workers in New South Wales". *Australian and New Zealand Journal of Public Health* 25: 84-89.

⁴³ Dean et al, op. cit.

⁴⁴ Kenagy, Gretchen P., Bostwick, Wendy B. and Addams, Jane (2001) *Health and Social Service Needs of Transgendered People in Chicago*. Chicago: College of Social Work University of Illinois, Chicago.

⁴⁵ Clements-Nolle, K. R., Marx, R. et al (2001) "HIC Prevalence, Risk Behaviour, Health Care Use, and Mental Health Status of Transgender Person for Public Health Intervention". *American Journal of Public Health* 91(6): 915-921.

⁴⁶ Gooran, "Hormonal Sex Reassignment" cited in the *Transgender Working Party*, op. cit.

3.5 Intersex People

What little research has been done on intersex conditions has tended to focus on whether or not to surgically assign intersex infants and children to one sex or the other. Follow-up research is rare, although very small international studies show that people often do not “grow” into the sex/gender assigned for them.⁴⁷ Hormone therapy in intersex people has not been researched or understood, with the bulk of research grants on intersexuality going to genetic research.⁴⁸ Consequently, the sexual health of this population in Victoria is virtually unknown. However, the Royal Children’s Hospital Melbourne is currently conducting a follow-up study of children with intersex conditions treated at the hospital over the last 30 years.

Anecdotal evidence suggests intersex people experience difficulties accessing sexual health services because of embarrassment about unconventional anatomy. Consequently, it is likely that intersex people under-utilise services, leading to lack of screening, untreated problems and psychological distress.

⁴⁷ Dean et al, op. cit.

⁴⁸ Submission from the Transgender and Intersex Subcommittee of the MACGLH, 2001.

Mental Health Issues for GLBTI Victorians

Rhonda Brown, Amaryll Perlesz and Kerry Proctor

1. Introduction

The impact of mental illness on the overall health and productivity of the Australian population is immense. In 1996, mental disorders accounted for 30 per cent of the non-fatal disease burden in Australia.¹ VicHealth estimates that in 1989–1990, the direct economic costs to the country of mental disorders were around \$2 billion.²

This paper focuses on mental health issues common to gay, lesbian, bisexual, transgender and intersex (GLBTI) Victorians. It draws on research that suggests a link between rates and patterns of mental illness among GLBTI people and their shared experiences of sexual orientation and gender identity discrimination. It also looks at variations in the types and severity of mental disorders within GLBTI communities according to differences in age, socio-economic status and cultural and ethnic background.

Mental health refers to the level of mental function required to:

- Engage in productive activities.
- Form and maintain fulfilling relationships with other people.
- Adapt to change and cope with adversity.³

Mental illness arises when the mental functioning associated with any one or all these cognitive, emotional and social abilities is impaired or compromised. A distinction can be made between mental *disorders* that are severe, of long duration (or recurrent) and often involve professional diagnosis and treatment, and mental *problems* that are less severe and shorter in duration. This distinction is not absolute, however, as mental problems may develop into mental disorders.

The determinants of mental health include a range of biological, psychosocial and environmental factors such as income level, employment, poverty, education and social connectedness. Stressful life events are strongly associated with the onset of mental health problems and mental disorders; such events include experiences of discrimination and abuse.⁴ Repeated rejection, hostility and feelings of shame can undermine an individual's sense of self-worth and lead to psychological distress.⁵

¹ Commonwealth Department of Health and Aged Care (2000) *Promotion, Prevention and Early Intervention for Mental Health—A Monograph*. Mental Health and Special Programs Branch, Commonwealth Government, Canberra.

² VicHealth (1999) *Mental Health Promotion Plan, 1999–2002*. Victorian Health Promotion Foundation, Melbourne.

³ *Healthy Living 2010: Companion document for lesbian, gay, bisexual and transgender health* (2001) San Francisco, CA: Gay and Lesbian Medical Association, p. 206.

⁴ Commonwealth Department of Health and Aged Care (2000), op. cit. and VicHealth (1999), op. cit.

⁵ Kirby, L. D. and Fraser, M. (1997) "Risk and resilience in childhood" in *Risk and Resilience in Childhood: An Ecological Perspective*. Fraser, M. ed. NASW Press: Washington DC.

2. Mental Health Issues Common to GLBTI People

It is only over the last 25 years that homosexuality has been declassified as a mental disorder in major diagnostic manuals, while the latest edition of the *International Classification of Diseases (ICD-10)* continues to list “transsexualism” and “gender identity disorder” as sexual deviations and disorders of psychosexual identity.⁶

Research comparisons between GLBTI populations and heterosexual groups have reported no significant differences in happiness, overall adjustment or psychiatric status.⁷ However, there is clear evidence that exposure to discriminatory behavior—including sexual orientation and gender identity discrimination—is associated with psychological distress and mental disorders.⁸ This suggests that mental problems and patterns of mental illness specific to GLBTI people are the result of homophobia and transphobia and that same-sex attraction and transgenderism are not in themselves risk factors for mental illness.

2.1 A Common Source of Discrimination

Research suggests that GLBTI people’s experiences of sexual orientation and gender identity discrimination lead to increased rates of mental problems and disorders, compared to the heterosexual population.⁹ Two of the major ways in which sexual orientation and gender identity discrimination is expressed and impacts on the mental health and wellbeing of GLBTI people is through processes of social labelling or

stigmatisation and through acts of psychological and physical abuse. These two processes can lead to reduced self-esteem, social withdrawal and isolation, all of which are risk factors for mental illness.

2.1.1 Stigma

Dominant homophobic and transphobic attitudes continue to stigmatise GLBTI people. The stigma attached to transgenderism and same-sex attraction can:

- Lead to internalised homophobia or transphobia.
- Compromise GLBTI people’s ability to develop and maintain relationships.
- Act as a barrier to GLBTI people seeking mental health care.

Internalised homophobia and internalised transphobia have a profound impact on the mental health and wellbeing of gay and lesbian, and transgender people, respectively. They can lead to high rates of depressive symptoms, lowered self-esteem, greater psychological distress, less likelihood of self-disclosure and lack of connection to GLBTI communities.¹⁰ Intersex people may also experience a range of long term mental health issues related to stigmatisation and psychological and physical abuse linked to the clinical management of their intersex condition as children.

A range of other social prejudices may interact with negative attitudes toward same-sex attraction and transgenderism to further marginalise and isolate certain sections of GLBTI communities.

⁶ In 1973 the American Psychiatric Association declassified homosexuality, but it was not until 1999 that the International Classification of Diseases decided to no longer assign homosexuality a disease code. In 1973 the Australian and New Zealand College of Psychiatrists also declassified homosexuality. See ANZ College of Psychiatrists (1973) “Homosexuality” *Clinical Memorandum No.6*.

⁷ Patterson, C. J. (2000) “Family Relationships of Lesbian and Gay Parents”. *Journal of Marriage and the Family* 62: 1052–1062 and Safen, S.A. and Heimberg, R.G. (1999) “Depression, hopelessness, suicidality, and related factors in sexual minority and heterosexual adolescents”. *Journal of Consult Clin Psychol* 67: 859–866.

⁸ Gilman, S.E, Cochran, S. et al (2001) “Risk of Psychiatric Disorders Among Individuals Reporting Same—Sex Sexual Partners in the National Co-morbidity Survey”. *American Journal of Public Health* 91(6): 933, Sandfort, T, de Graaf, R. et al (2001) “Same-sex behaviour and psychiatric disorders: Findings from the Netherlands *Mental Health survey and Incidence Study (NEMESIS)*”. *Archives of General Psychiatry* 58: 85–91 and Hillier, L., Dempsey, D. et al (1998) *Writing Themselves in: A national report on the sexuality, health and well being of same-sex attracted young people*. Australian Research Centre in Sex, Health and Society. La Trobe University: Melbourne.

⁹ Division 44/Committee on Lesbian, Gay, and Bisexual Concerns (2000) “Guidelines for Psychotherapy with lesbian, gay and bisexual clients”. *American Psychologist* 55(12): 1440–1451 and Sandfort, T, de Graaf, R. et al (2001) op. cit.

¹⁰ Herek, G.M., Cogan, J. C. et al (1997) “Correlates of internalised homophobia in a community sample of lesbians and gay men”. *Journal of the Gay and Lesbian Medical Association* 1(1): 17–25.

These include prejudice against:

- HIV positive people.
- People with an intellectual and/or physical disability.
- GLBTI people in outer urban, rural and remote areas.
- GLBTI people who are members of certain ethnic minorities.
- Indigenous GLBTI people.

These prejudices also operate *within* GLBTI communities. This dual process of discrimination—from within and outside GLBTI communities—is likely to have a major negative impact on the mental health and wellbeing of those concerned.

2.1.2 Violence

Over 70 per cent of the participants in a Victorian study of violence against GLBTI people reported at least one experience of public abuse in the last 5 years.¹¹ The abuse ranged from verbal abuse to physical violence. While not all GLBTI people will be subject to violence, it is clear from the Victorian data that all are subject to the threat of violence. Both the actuality and threat of abuse have profound effects on the mental health and wellbeing of GLBTI people. These include:

- A reluctance or inability to “come out” or be open about sexual orientation and gender identity.
- The stress that accompanies the fear of disclosure or outing.
- Increased rates of substance abuse.
- An undermining of their sense of personal identity.

2.2 Formation and Maintenance of Relationships

I think, generally, we are all affected to some extent. Just not being able to do the same things in public that straight people do, like hold hands, kiss etc.

Quoted from the Victorian Gay and Lesbian Rights Lobby’s report, *Enough is Enough*.

Supportive relationships are important determinants of mental health and wellbeing. GLBTI people’s experiences of sexual orientation and gender identity discrimination may have a major negative impact on their ability to form and sustain relationships.¹² This may lead to further marginalisation and isolation from key social structures including school, family and work and to feelings of inadequacy, guilt and depression.

2.2.1 Friends and Community Relationships

Friendship and connectedness to community are vital in the promotion of mental health and wellbeing.¹³ An Australian study of the mental health of lesbians showed that friendship networks enhance their emotional and spiritual health and wellbeing. Young GLBTI people may have difficulty in forming relationships due to intense pressure not to be open about their sexual orientation, gender identity or intersex condition.¹⁴ Young GLBTI people who are open about their sexual orientation or gender identity are often subject to bullying and harassment, particularly within the school environment, and are further isolated by a lack of positive role models such as out GLBTI teachers or public figures. The need for positive role models and in particular, out GLBTI people within the local community, was highlighted in submissions to the MACGLH.

¹¹ Victorian Gay and Lesbian Rights Lobby (2000) *Enough is Enough: A Report on Discrimination and Abuse Experienced by Lesbians, Gay Men, Bisexuals and Transgender People in Victoria*. Victorian Gay and Lesbian Rights Lobby (VGLR), Melbourne (further references, *Enough is enough*).

¹² Sandfort, T, de Graaf, R. et al (2001), op. cit.

¹³ Lienert, T. (1999) “Lesbians and Mental Health: Importance of Friendship”. Paper presented at the *Health In Difference 3* Conference, Adelaide.

¹⁴ Hillier, L. and Dempsey, D. et al (1998) op. cit.

Older GLBTI people, particularly those who come out later in life and those living in rural communities, may experience difficulty in maintaining friendships and social networks and making contact with GLBTI communities for support.

2.2.2 Formation of Intimate Relationships
GLBTI intimate relationships suffer from a lack of public recognition and social support. Recent legislative changes including the *Statute Law Amendment (Relationships) Act 2001* extend the rights and responsibilities of same-sex couples, but are yet to provide GLBTI couples with the same level of social recognition and support given to heterosexual relationships.

There are few mainstream social venues in which GLBTI people can meet potential partners and limited social spaces in which expressions of same-sex physical intimacy are tolerated, let alone encouraged. There is also a lack of mental health information and service providers aware of and sensitive to the relationship problems specific to GLBTI people.¹⁵

These problems include:

- Internalised homophobia or transphobia of one or both partners in a relationship, which may inhibit the integration of sexual orientation or gender identity and emotional intimacy.¹⁶
- Violence within GLBTI relationships. There is evidence that the level of violence within GLBTI relationships is similar to that among heterosexual couples.¹⁷ GLBTI people may underreport violence in their relationships due to a fear that reporting will lead to increased levels of discrimination.¹⁸

2.2.3 Family Relationships

2.2.3a GLBTI Parents

GLBTI parents must consider whether or not to be open about their sexual orientation or gender identity and how that decision is likely to affect not only their own mental health and wellbeing, but that of their children. They must decide whether to be open in all social contexts, or only in a restricted number of settings. For example, GLBTI parents must decide whether to be open in the school environment, at work, in their local community or when dealing with health service providers.¹⁹ This complex and ongoing set of negotiations is specific to GLBTI families and places parents and children under intense social pressure. This added social pressure can bring with it an increased risk of a range of mental health problems including depression, anxiety and mood disorders.

A study of the children of lesbian parents shows that they are concerned about being stigmatised because of their parents' sexuality.²⁰ The pressures faced by the children of GLBTI parents are often most extreme within the school environment, where disclosure brings with it a lack of understanding on the part of most students and staff and the threat of ridicule, social isolation and violence.²¹

2.2.3b GLBTI Children

Evidence suggests that rejection by family is a major health risk for same-sex attracted youth. A US study showed that those adolescents who came out to family and friends reported higher rates of suicide ideation than those who did not.²² A high percentage of those who came out were subject to verbal and physical abuse by family

¹⁵ Meyer, I, Rothblum, E. and Bradford, J. (2000) "Lesbian, gay and bisexual health concerns: Mental health and mental disorders". *Journal of the Gay and Lesbian Medical Association* 4(3): 116-120 and Eliason, M.J. (1996) "Lesbian and gay family issues". *Journal of Family Nursing* 2(1): 10.

¹⁶ Polansky, J. S., Karasic, D. H. et al (1997) "Homophobia: Therapeutic and Training Considerations for Psychiatry". *Journal of the Gay and Lesbian Medical Association* 1(1): 41-47.

¹⁷ Eliason, M. J. (1996) op. cit., Meyer, I. et al (2000) op. cit. and Pitt, E. L. (2000) "Domestic Violence in Gay and Lesbian Relationships". *Journal of the Gay and Lesbian Medical Association* 4(4): 195-196.

¹⁸ Meyer, I. et al (2000) op. cit.

¹⁹ Ahmann, E. (1996) "Working with families having parents who are gay or lesbian". *Paediatric Nursing* 25(5): 531-535.

²⁰ Patterson, C.J. (2000), op. cit.

²¹ Ray, V. and Gregory, R. (2001) "Rainbow children: Children raised by lesbian and gay parents discuss school, family and friends". *Lesbiana* 102: 21-23 and Hillier, L. et al (1998) op. cit.

²² Armesto, J.C. and Weisman, A.G. (2001) "Attributions and emotional responses to the identity disclosure ("coming out") of a homosexual child". *Family Process* 40(2): 145-161.

members. In another study, 25 per cent of respondents reported that members of their family had attempted to change their sexual orientation including using psychotherapy, religious instruction or forcing them to have heterosexual experiences.²³ Rather than improving the mental health and wellbeing of GLBTI youth, forced religious instruction and the use of psychotherapeutic techniques may have a detrimental effect on their health and operate as risk factors for a range of mental disorders.

2.3 Mental Health Problems and Disorders

Mental health issues were the third most common subject raised in 56 submissions from GLBTI individuals and organisations to the Victorian Ministerial Advisory Committee on Gay and Lesbian Health (MACGLH). They included concerns over depression, anxiety, suicide, isolation, marginalisation, and homelessness and the lack of appropriate, accessible and affordable counselling services for GLBTI people.²⁴ Several US surveys have found elevated rates of some anxiety disorders, mood disorders, substance misuse and suicidal thoughts and attempted suicide among GLB people.²⁵ Little research has been done on the mental health and wellbeing of transgender and intersex people. However, surveys showing they are subject to increased levels of sexual orientation and gender identity discrimination suggest that they may experience patterns of

mental illness that overlap significantly with those of GLB people.²⁶

2.3.1 Depression and Suicide

2.3.1a Gay Men and Lesbians

An Australian study of 403 gay men reported that 27 per cent of respondents were suffering major depression.²⁷ In a study of 200 lesbians, 60 per cent of respondents reported feelings of depression related to their sexual orientation, while 63 per cent had contemplated suicide and 30 per cent had attempted suicide.²⁸ These findings are consistent with the results of a New Zealand study of lesbians' mental health: 21 per cent of respondents had been diagnosed with depression while 53 per cent had contemplated and 20 per cent had attempted suicide.²⁹ Studies suggest that the suicide rate among homosexuals is 2–7 times higher than among heterosexuals.³⁰ Estimates of the percentage of same-sex attracted people who have contemplated or attempted suicide range from 31 per cent to 63 per cent,³¹ while same-sex attracted people living in rural areas are at particular risk.³²

2.3.1b Transgender and Intersex People

Rates of depression among transgender people are reported to be even higher than among gay men and lesbians. One US study reports that 62 per cent of male-to-female and 55 per cent of female-to-male transgender people were depressed, while 32 per cent of both groups had attempted suicide.³³ The GLMA companion document notes that for a small percentage of

²³ D'Augelli, A.R., Hershberger, S.L. and Pilkington, N.W. (1998) "Lesbian, gay and bi-sexual youth and their families: Disclosure of sexual orientation and its consequences". *American Journal of Orthopsychiatry* 68(3): 361–371.

²⁴ McNair, R., Anderson, S. and Mitchell, A. (2001) "Addressing health inequalities in Victorian lesbian, gay, bisexual and transgender communities". *Health Promotion Journal of Australia* 11(1): 32–38.

²⁵ Gilman, S., Cochran, S. et al (2001) "Risk of Psychiatric disorders among individuals reporting same-sex sexual partners in the National Comorbidity Survey". *American Journal of Public Health* 91(6): 933–939.

²⁶ *Enough is enough.*

²⁷ Rogers, G. (October 2000) "Gay men, depression and dysthymia". Paper presented at the Australian Society for HIV Medicine Conference, Melbourne.

²⁸ Barbeler, V. (1992) *The young lesbian report: A study of attitudes and behaviours of adolescent lesbians today.* Twenty Ten Association, Sydney.

²⁹ Welch, S., Collings, S. and Howden-Chapman, P. (2000) "Lesbians in New Zealand: Their mental health and satisfaction with mental health services". *Australian and New Zealand Journal of Psychiatry* 34: 256–263.

³⁰ Cochran, S.D. and Mays, V.M. (2000) "Lifetime prevalence of suicidal symptoms and affective disorders among men reporting same-sex sexual partners: results from NHANES III". *American Journal of Public Health* 90: 573–578 and Barbeler (1992), op. cit.

³¹ D'Augelli, A.R. and Hershberger, S.L. (1993) "Lesbian, gay, and bisexual youth in community settings: Personal challenges and mental health problems". *American Journal of Community Psychology* 4: 421–447 and Garofalo, R., Wolf, R.C. et al (1999) "Sexual orientation and risk of suicide attempts among a representative sample of youth". *Archives of Paediatric and Adolescent Medicine* 153(5): 487–493.

³² Victorian Department of Human Services (1998) *Victorian Youth Suicide Task force Report.* Victorian Government, Melbourne.

³³ Clements-Nolle, K., Marx, R. et al (2001) "HIV prevalence, risk behaviours, health care use, and mental health status of transgender persons: Implications for public health intervention". *American Journal of Public Health* 91(6): 915–921.

pretransition transgender people, their experiences of gender dysphoria can lead to genital and other forms of bodily mutilation.³⁴ Results from the Amsterdam Gender Clinic suggest that for some transgender adolescents, early intervention with puberty-delaying hormones allows them time to explore gender issues under expert medical care.³⁵

There is little research on the mental health effects of “reconstructive” genital surgery on intersex infants and children. Surgery is often performed to deal with the concerns and confusion of the parents and not necessarily to address the long term health needs of the intersex person.³⁶ Anecdotal evidence and the results of a limited number of studies suggest that surgery performed on intersex people when there is no clear medical benefit, carries an increased risk of long term negative physical and mental health effects.³⁷ There is also little research on how intersex people deal with their intersex status in a world that assumes two unambiguous and totally distinct sexes.

2.3.1c Bisexuals

Findings of a 1993 report from the Bisexual Men’s Association (GAMMA) identifies depression as a major mental health issue for bisexual men.³⁸ Many bisexual men who remain in long term committed heterosexual relationships and continue to have sex with men may experience feelings of dishonesty, disloyalty and alienation, resulting in significant stress and depression. Bisexual men and women in heterosexual relationships may also have reduced access to support and health information.

2.3.1d People Living with HIV and AIDS (PLWHA)

There is growing evidence that depression, anxiety, dementia and other general psychological issues are critical factors in the wellbeing of positive people. An Adelaide study reported high rates of depression among gay men living with HIV.³⁹ A national survey of PLWHA reported that over a six-month period, 25 per cent of respondents had been taking medication prescribed for depression, while 26.5 per cent had taken medication for anxiety.⁴⁰

The national survey noted that issues to do with body image were of importance to the wellbeing of positive people, particularly in light of the discussion of some of the possible effects of antiviral medications on body shape—51.7 per cent of respondents agreed with the statement: “Changes in my body due to HIV/AIDS have made me feel unattractive”.

2.3.1e GLBTI Young People

Youth suicide rates in Victoria have increased four-fold for males and doubled for females since 1964.⁴¹ There is strong evidence of a link between same-sex sexual attraction and youth suicide. Same-sex attracted young people (SSAY) are reported to be six times more likely to attempt suicide than the population as a whole. In one US survey 20 per cent of SSAY reported having attempted suicide, while in another study the percentage was considerably higher at 62 per cent.⁴² SSAY living in rural areas are known to be at particular risk.⁴³

³⁴ *Healthy Living 2010* op. cit.

³⁵ *Healthy Living 2010* op. cit.

³⁶ *Healthy Living 2010* op. cit.

³⁷ Submission from the Transgender and Intersex Subcommittee to the MACGLH and *Healthy Living 2010* op. cit.

³⁸ GAMMA (1993) *Men who have sex with men and women: Resource kit for health professionals*. Australian Bisexual Men’s Association, Mont Albert.

³⁹ Evans, P. (1999) “Blues Busters’: A new approach to depression and HIV”. Workshop presented at *Health In Difference 3 Conference*, Adelaide.

⁴⁰ Grierson, J., Bartos, M., De Visser, R. and McDonald, K. (2000) *HIV Futures 11: The health and well-being of people living with HIV/AIDS in Australia*. The Living with HIV Program at The Australian Research Centre in Sex, Health and Society: Latrobe University.

⁴¹ Victorian Department of Human Services (1998) *Victorian Task Force Report: Suicide Prevention*. Impact Printing: Melbourne.

⁴² Remafedi, G. (1999) “Sexual orientation and youth suicide”. *Journal of the Gay and Lesbian Medical Association* 4(3): 116–120 and Bagley, C. and Tremblay, P. (1997) “Suicide behaviours in homosexual and bisexual males”. *Crisis* 18(1): 24–34.

⁴³ Hillier, L., Dempsey, D. et al (1998) op. cit. and Commonwealth Government (2000) *National Mental Health Strategy*. Commonwealth Government, Canberra.

The mean age for suicide attempts for SSAY is 15–17 years.⁴⁴ Most suicide attempts occur after self-identifying as gay or lesbian, but prior to having a same-sex relationship or publicly coming out. There is little research on the mental health status and needs of same-sex attracted young people and even less on the status and needs of transgender and intersex youth.

2.3.2 Substance Misuse and Mental Health

In a recent report by the Alcohol and Drug Foundation of Victoria (ADF), the use of alcohol and other drugs in the GLB and queer communities was found to be higher across all age groups than in the general population. The report identified a number of reasons for patterns of substance misuse specific to GLBTI Victorians. They included:

- Confusion surrounding sexual orientation or gender identity.
- The stress associated with coming out to friends, family and work colleagues.
- Low self-esteem, depression and insecurity.
- Family conflict.
- Homophobic or transphobic abuse, including physical, sexual and verbal abuse.

This list overlaps significantly with indicators of increased risk of mental illness among GLBTI people. This overlap is consistent with US studies that demonstrate the co-occurrence of addictive disorders and mental disorders. The GLBT companion document to *Healthy Living 2010* references studies showing that among adults aged 18 and older with a lifetime history of mental disorders, 29 per cent have a history of an addictive disease.⁴⁵ Of those with a diagnosis of alcohol disorder, 37 per cent have had a mental disorder, while among those with other drug disorders, 53 per cent have had a mental disorder.

2.4 Under-utilisation of Mainstream Mental Health Services by GLBTI People

US research shows that negative attitudes on the part of mental health professionals toward homosexuality and transgenderism may lead to a deterioration in the mental health of their GLBTI clients.⁴⁶ Submissions to the Ministerial Advisory Committee on Gay and Lesbian Health (MACGLH) from Victorian GLBTI organisations and individuals noted a high rate of dissatisfaction among GLBTI people with the quality of mental health services. Many GLBTI people fear discrimination, abuse and reduced standards of care due to prejudiced beliefs on the part of mental health professionals toward transgenderism and same-sex attraction. This expectation results in reduced access to and use of mental health services on the part of GLBTI people.⁴⁷

⁴⁴ Fontaine, J. H. (1997) "The sound of silence: Public school response to the needs of gay and lesbian youth". *Journal of Gay and Lesbian Social Services* 7(4): 101–109.

⁴⁵ *Healthy Living 2010: Companion document for lesbian, gay, bisexual and transgender health* (2001) San Francisco, CA: Gay and Lesbian Medical Association.

⁴⁶ Division 44/Committee on Lesbian, Gay, and Bisexual Concerns (2000) op. cit.

⁴⁷ Gardiner, J. M. (1987) *Medical Education and the Health Needs of Gay Men*. Gay Men's Community Health Centre: Melbourne.

Life Stage Issues within GLBTI Communities

Ruth McNair and Jo Harrison

1. Introduction

This paper identifies health and wellbeing issues for gay, lesbian, bisexual, transgender and intersex (GLBTI) Victorians at key transitional stages in their lives. Transitional stages refer to major experiences or periods of personal change. They involve one or more of the following:

- A redefinition of personal identity.
- The reformulation of social relationships.
- Significant alterations to living arrangements.

Periods of transition may occur at any time throughout an individual's life. This paper uses a model of ageing which identifies a number of key transitional periods. These are:

- Childhood and adolescence.
- The formation of intimate relationships.
- Family formation.
- Mid-life.
- Ageing.

It is important to note, however, that although this model of key transitional stages is the dominant model in the research literature on life stages and ageing, there are a number of alternative approaches. Furthermore, each of these key transitional stages may have a different importance and significance in the lives of GLBTI people, compared to exclusively heterosexual, gender normative or non-intersex individuals and couples.

There is a growing body of research suggesting that sexual orientation and gender identity play a major role in how individuals experience each of these transitional periods. For GLBTI people,

their shared experiences of sexual orientation and gender identity discrimination lead to a *common* set of health problems associated with each of these stages. At the same time, gender identity and sexual orientation interact with other differences within GLBTI communities—including biological and cultural differences—leading to health concerns *specific* to each of these groups during these transitional periods.

2. Issues Common to GLBTI People across Key Transitional Life Stages

2.1 A Common Source of Discrimination

The maintenance of health and wellbeing during each of these transitional life stages is linked to the degree to which people feel supported by family, friends and the wider society and to people's ability to access quality health care and welfare services. International research demonstrates that social support and access to quality health care are often lacking for GLBTI people.¹ In societies that assume everyone is and should be heterosexual, GLBTI identities, relationships and living arrangements are rarely given positive acknowledgement. In addition to the stresses and strains that accompany each of these periods of transition, GLBTI people must contend with:

- Social invisibility and lack of recognition of their relationships and living arrangements.
- The threat (and actuality) of discrimination and abuse that accompanies those GLBTI people who are open about their identity and

¹ O'Hanlan, K.A., Cabaj, R.B., Schatz, B., Lock, J. and Nemrow, P. (1997) "A review of the medical consequences of homophobia with suggestions for resolution". *Journal of the Gay and Lesbian Medical Association* 1(1): 25-39 and *Healthy Living 2010: Companion document for lesbian, gay, bisexual and transgender health* (2001) San Francisco, C.A: Gay and Lesbian Medical Association.

relationships (including the possibility of reduced standards of health care).

- The pressures associated with deciding when, where and with whom to be open about their sexual orientation, gender identity or intersex status.

Disclosure or “coming out” is a major issue across all life stages for GLBTI people. Both older GLBTI people and adolescents must confront institutionalised homophobia and transphobia in deciding if and when to be open about their sexual orientation, gender identity or intersex status; the former when seeking quality health care within the aged care sector, the latter within the school environment as they begin to develop a sense of their own identity and to negotiate intimate personal relationships. Furthermore, coming out is not a one-off event. Each time a GLBTI person enters a new social context, including changing jobs or joining a local community group, they must decide whether or not to be open about their sexual orientation, gender identity or intersex status.

2.1.1 Childhood and Adolescence

I would have liked to have been more open about it [being lesbian] and had a more open school life. Cause I felt a lot of the time I couldn't connect with anyone in my year because of the way that I felt and I couldn't openly talk to them about it

(Mary, 19, Eastern suburbs private school. Quoted from *To Turn a Blind Eye*).

2.1.1a Childhood

Some GLBTI people are aware that they are different at a very early age.² In submissions to the MACGLH many GLBTI people report being “unable to fit in” at primary school because they were different, although they were not able to name that difference until later in life. Similarly, the parents of such children may be ignorant of or unable to deal with issues of same-sex attraction, transgenderism or intersex status. In the absence of school-based educational materials that address these issues, such children

are likely to be systematically misunderstood and socially marginalised.

Children of GLBT or I parents are also likely to experience discrimination in a school or social environment that is hostile toward or ignorant of GLBTI issues.

2.2.1b Identity Formation and Coming Out

In the research literature, adolescence is the life stage during which individuals develop a sense of their own identity. This involves a renegotiation of social relationships and decreasing dependence on their family of origin.

Adolescence can be a particularly stressful period for GLBTI people. Neither their emerging identities nor intimate personal relationships conform to the dominant heterosexual norm. Unlike their exclusively heterosexual peers, they have few positive role models, a lack of GLBTI teachers or peers whom they can rely on for support and advice, and a lack of school-based educational resources that address their specific needs. Many GLBTI adolescents are also unsure of where they can get help if required.

These problems are particularly acute for transgender and intersex adolescents. Those who are seeking to support transgender young people often do not have a clear understanding of the distinction between gender identity and sexual orientation. At the same time, the classification of gender identity dysphoria as a psychiatric or mental disorder has the potential to undermine young transgendered people's emerging sense of identity. While some young intersex people may have an awareness of their intersex condition before adolescence, others may not. Intersex youth need support, not only when they decide to come out as intersex but also when they are first informed of their intersex condition.

Bisexual adolescents may identify neither as heterosexual nor homosexual. They may be subject to a widely held prejudice that understands bisexuality as either a passing phase or as an inability to accept a gay or lesbian sexual

² *Healthy Living 2010, “Introduction”, op. cit.*

orientation. As such, bisexual adolescents may feel excluded from both mainstream and gay and lesbian support networks.

Adolescents who are perceived to be gay, lesbian, bisexual, transgender or intersex (whether or not they identify as such) are subject to high levels of discrimination and abuse within and outside the school environment.³ A comparative study of school aged young women showed that lesbian/bisexual women were more likely to report physical abuse (19 per cent) and sexual abuse (22 per cent) than heterosexual women (11 and 14 per cent respectively).⁴ In an Australian same-sex attracted young people's study, 46 per cent of respondents had been verbally abused (52 per cent and 39 per cent of same-sex attracted young men and women respectively) and 13 per cent reported being physically abused.⁵ Seventy percent of the abuse occurred within the school environment, while 10 per cent was carried out by family members. This places GLBTI adolescents under intense pressure not to disclose their sexual orientation or gender identity. In the same-sex attracted young people's study, 20 per cent of participants had not told anyone about their sexual orientation.

The consequences of sexual orientation and gender identity discrimination on the health and wellbeing of GLBTI adolescents include:

- Increased rates of homelessness, due to rejection by family and friends.⁶

- Increased and multiple risk-taking behaviors, including substance abuse and unsafe sex.
- Earlier initiation into risk-taking behaviours.
- Feelings of guilt and self-denial and in some instances internalised homophobia or transphobia.
- Increased rates of depression.
- Increased incidence of suicidal and self-harming behaviours.

Evidence from the La Trobe study showed that same-sex attracted young women were more likely to have sex exclusively with men, compared to their heterosexual counterparts. A study comparing pregnancy rates among adolescent women showed that 12 per cent of those who identified as lesbian had been pregnant, versus 5 per cent of the heterosexual respondents.⁷ These results suggest that these young women overplay overtly heterosexual behaviours, in an effort to deny or hide their same-sex attraction. It is also difficult for same-sex attracted young women to obtain information on safe sex practices for sex between women.

There is US evidence suggesting that for many young gay, lesbian, bisexual, transgender and intersex adolescents, adopting risky behaviors is one way of coping with the pressures of being GLBT or I. While such coping strategies may build up an individual's resilience, they can also have a major negative impact on his or her health and wellbeing.⁸

³ Garofalo, R., Wolf, R.C., Kessel, S., Palfrey, J. and DuRant, R.H. (1998) "The association between health risk behaviours and sexual orientation among a school-based sample of adolescents". *Pediatrics* 101(5): 895–902.

⁴ Saewyc, E. M., Bearinger, L. H. et al (1999) "Sexual intercourse, abuse and pregnancy among adolescent women: Does sexual orientation make a difference?" *Family Planning Perspectives* 31(3): 127–131.

⁵ Hillier, L., Harrison, L. and Dempsey, D. (1999) "Whatever happened to duty of care? Same-sex attracted young people's stories of schooling and violence". *Melbourne Studies in Education* 40(2): 59–74. See also Baker-Johnson, Matt (2000) *To Turn a Blind Eye: A Report into Discrimination Based Upon Sexuality and Transgender Identity in Victorian Secondary Schools – Causes, Effects, Responses*.

⁶ According to Hillier et al same-sex attracted youth are over represented amongst Australia's homeless, with proportions as high as 35 per cent. See Hillier, L., Matthews, L. and Dempsey, D. (1997) *A low priority in a hierarchy of need: A profile of the sexual health of young homeless people in Australia*. Monograph series No.1, Centre for the Study of Sexually Transmissible Diseases, National Centre in HIV Social Research, La Trobe University.

⁷ Saewyc, E. M., op. cit.

⁸ Lock, J. and Steiner, H. (1999) "Relationships between sexual orientation and coping styles of gay, lesbian and bisexual adolescents from a community high school". *Journal of the Gay and Lesbian Medical Association* 3(3): 77–82

2.1.2 Formation of Intimate Relationships

For many GLBTI people, the formation of an intimate relationship is an impetus to coming out and can signal a growing confidence in their sexual or gender identity. Sydney research indicates that the single most important source of emotional support for gay men is their partner.⁹ GLBTI relationships may gain greater acceptance insofar as they conform to a notion of the “normal couple”. Nonetheless, GLBTI relationships—particularly same-sex relationships—are subject to a lack of public recognition and a wider social context in which they are valued and actively supported.

2.1.2a Relationship Breakdown

US studies demonstrate that many gay men and lesbians maintain secure long term relationships.¹⁰ However, a lack of public support for and recognition of these relationships may lead to pressures and strains specific to these couples. For example, people who use their relationship as a way of coming out are likely to bring to the relationship the tensions and increased social pressures that accompany the coming out process.

2.1.2b Violence within GLBTI Relationships

There is evidence to suggest that violence within intimate relationships involving GLBT people is under-reported. This is particularly true for same-sex relationships and may be due to a fear within GLBTI communities that their relationships will be further stigmatised if the issue is publicly acknowledged.¹¹ Factors that may contribute to an increased risk of violence in GLBT relationships include:

- Isolation from supportive social networks.
- The level of homophobia and transphobia directed towards the couple and the individuals in the relationship.

- The degree of openness on the part of the individuals regarding their relationship and their own sexual orientation or gender identity.
- Individuals’ degree of comfort and acceptance of their sexual orientation or gender identity.

2.1.2.c Transition from Heterosexual to Same-Sex Relationships

A large number of GLBTI people have been involved in previous heterosexual de facto or marriage relationships. While living in a heterosexual relationship, they may experience a sense of conflicting sexual identities that may have a negative impact on their health and wellbeing.

Transition to a gay, lesbian or transgender way of living has been described in the research literature as a “new adolescence”. As such, it brings with it many of the identity issues faced by GLBTI adolescents. The major health-related issues associated with the transition from a heterosexual to a same-sex and/or transgender relationship include:

- Rejection by family (including children), friends and work colleagues.
- Custody battles for children.
- A major change in living arrangements.
- Feelings of guilt.
- Coming to terms with a radical shift in one’s sense of personal identity.

Stress and depression are common during and following transition from a heterosexual to a same-sex relationship and without adequate support from within and outside GLBTI communities, this can be ongoing.

There is evidence that men who move from a heterosexual to a gay way of life may have little exposure to safe-sex health education materials.

⁹ Prestage, G. (1997). “Gay men and health: Findings from the Sydney Men and Sexual Health (SMASH) Study”. *Proceedings from Health in Difference 1*. Australian Centre for Gay and Lesbian Research, Sydney.

¹⁰ Johnson, S.E. (1990) *Staying power: Long term lesbian couples*. The Naiad Press Inc. and Eliason, M. J. (1996) “Lesbian and Gay Family Issues”. *Journal of Family Nursing* 2(1): 10–29.

¹¹ Scherzer, T. (1998) “Domestic violence in lesbian relationships: Findings of the lesbian relationships research project”. In Ponticelli, C.M. ed. *Gateways to improving lesbian health and health care*. Haworth Press Inc.: New York.

Their range of sexual behaviours may change following an end to their heterosexual relationship, and may include behaviours that carry an increased risk of HIV. While these men remain heterosexually active and closeted, they may pose a health risk to their female partner(s).

2.1.3 Family Formation, Pregnancy and Parenting

The Australian Bureau of Statistics census of 1996 showed that lesbian and gay parents headed a number of Australian families. A survey of 670 GLBTI people in Victoria in 2000 (81 per cent of whom were partnered) showed that 21 per cent of participants were living with children and 41 per cent wanted to have children within their relationship. Among GLBTI respondents under 30 years, 63 per cent expressed a desire to have children.¹²

There are family formation issues specific to each of the groups that make up GLBTI communities. However, many of the options currently being pursued by GLBTI communities rely on the development of and access to a range of medical procedures in conjunction with ongoing processes of legislative reform.

2.1.3a Surrogacy, Adoption and Fostering

Heterosexist prejudice is often most pronounced around issues to do with family formation. In Australia, current legislation prohibits surrogacy and prevents lesbians and gay men accessing adoption in most States and Territories including Victoria (Adoption Act 1984). Although fostering is an option for GLBTI people, a recent study showed that only one in eight foster care agencies were directly promoting their services to GLBTI communities.¹³

2.1.3b Assisted Reproductive Technologies (ART)

In Victoria the current ruling on the *Infertility Treatment Act 1995* is that only clinically infertile women can access assisted reproductive technologies. Clearly the demonstration of

clinical infertility makes it difficult for lesbians to access in vitro fertilization (IVF). Under the terms of the Act lesbians cannot access donor insemination.

For lesbians in Victoria who wish to have their own biological children, their first option is self-insemination, their second is interstate donor insemination. Interstate donor insemination guarantees lesbians access to screened donor sperm. However, the financial and emotional costs and the time and effort involved in interstate travel are immense. They can lead to a number of stress-related physical and mental health problems for individual women and couples. Furthermore, many lesbians are reluctant to access reproductive services or disclose their sexual orientation, because of prejudiced attitudes on the part of many service providers towards lesbian parents.¹⁴ Under current regulations, gay men are restricted from donating sperm unless they have not been sexually active for more than five years.

Self-insemination can carry a number of health risks if the donor is not screened for potential transmissible infections such as chlamydia, gonorrhoea, syphilis, Hepatitis B and HIV. The recipient may be reluctant to access pre-pregnancy health advice. She may also not have access to information regarding recognition of ovulation, so that she can time insemination.

Hormonal and surgical reassignment for both male-to-female and female-to-male transgender people can often result in infertility. Male-to-female transgender people could donate sperm prior to treatment, if they were made aware of this option. Some female-to-male transgender people may elect to conceive a child prior to hormone treatment and surgery. Most people with intersex conditions are infertile. Those who are able to reproduce usually need medical assistance from specialist endocrinologists. People with intersex conditions are able to adopt children if they are in a heterosexual relationship. Involvement in foster care is another option.

¹² Victorian Gay and Lesbian Rights Lobby (2001) *Everyday Experiments: Report of same-sex domestic partnerships in Victoria*.

¹³ Clark, T. (2000) *Gay People Becoming Foster Parents* (unpublished report). Northern Publicity and Recruitment Unit for Foster Care.

¹⁴ Myers, H. and Lavender (1997) *An Overview of Lesbian Health Issues*. Prepared for the Coalition of Activist Lesbians (COAL).

2.1.3c Parenting

Parenting is a time of increased interaction with service providers including the health, welfare, childcare, preschool and school systems. Parents constantly face decisions regarding whether or not to disclose their sexual orientation. They must balance the need for openness with the risk to themselves and their children of negative and sometimes violent responses. Disadvantages associated with non-disclosure include lack of recognition of the non-biological parent's role, lack of support and the constant fear of discovery.

2.1.4 Midlife and Ageing

Well, these two men in the hostel held hands and the manager said they were brothers. The hostel management didn't want me to think that the men were gay...

(Bureaucrat, retired. Quoted from "A Lavender Pink Grey Power").

There has been very little research on the health-related needs of gay men, lesbians and bisexuals as they age; even less on the needs of transgender and intersex people. At the same time the development of midlife and aged care policy and the design and delivery of health services assume a heterosexual norm. As a consequence, a key issue for midlife and older GLBTI people is their invisibility within the aged care sector.

What research has been done, both in Australia and overseas, shows that as GLBTI people age their major concerns do not relate directly to specific physical or mental conditions. Rather, their major concerns relate to institutionalised sexual orientation and gender identity discrimination, which affects their dealings with the aged care sector and the level and quality of care they receive.

2.1.4a Mid-life

• Ageism within GLBTI Communities

The widely held perception of ageing as a process of increasing loneliness and isolation can have an added impact on communities whose members are already subject to processes of social marginalisation. Ageism combined with sexual orientation and gender identity discrimination can lead to a heightened fear of ageing *within* the GLBTI community. It may explain research that suggests some gay men experience themselves as older earlier in life than heterosexual men.¹⁵

• Exclusion from GLBTI Social Networks

Australian research indicates that for gay men, attachment to the gay community and enhanced self-esteem contribute to positive mid-life experiences.¹⁶ Similar results have been found in studies on the effects of community attachment for lesbians as they age. However, for GLBTI people and in particular those who have relied heavily on the commercial scene for their social networks and sense of identity, mid-life can be a time of social dislocation and confusion. There is a perception that the commercial scene is youth-driven and GLBTI people as they enter middle age may feel themselves increasingly excluded.

Images of mid-life often centre on changes to family structure, including children leaving home and the care of ageing parents and relatives. However, for GLBTI who have not formed families of their own and in particular, those who have relied on the commercial scene, there is no ready social script to navigate their movement into mid-life. This period of uncertainty can bring with it added social pressures and feelings of insecurity and anxiety, which can have a major impact on the mental health and physical wellbeing of GLBTI people.

¹⁵ Bennett, K.C. and Thompson, N.L. (1991) "Accelerated Aging and Male Homosexuality". *Journal of Homosexuality* 20(3-4): 65-75

¹⁶ Arblaster, W. (2001) *A Qualitative Study of Older Gay Males and Midlife Adjustment*. Masters Thesis, Counseling Psychology, Swinburne University of Technology: Hawthorn, Victoria.

Not all same-sex attracted, transgender and intersex people identify with the labels gay or lesbian, transgender and intersex respectively. Nor do they necessarily connect with or want to connect with GLBTI community groups. Overseas evidence indicates that many older lesbians do not consider themselves lesbian or apply the terms used by out lesbians to describe their own same-sex relationships or life arrangements.¹⁷ Preliminary research findings indicate similar experiences for many older gay men.¹⁸

• **GLBTI People Caring for Older Partners, Relatives and Friends**

Mid-life GLBTI people are providing significant support, care and advocacy for older parents, as well as for each other.¹⁹ There is little research on the specific health needs of these carers. There is no research on the level of sexual orientation and gender identity discrimination they face from within the aged care sector.

2.14b Ageing

• **Informal Support Networks**

A US study of lesbians' attitudes to ageing showed that a large percentage of respondents did not see mainstream institutionalised aged care as an option. Instead, they expected to be supported by informal lesbian community networks.²⁰ These networks represent a continuity of community attachment and belonging and have been shown to enhance the likelihood of "successful" adjustment to ageing on the part of GLBTI people.²¹

• **Institutionalised Aged Care**

A number of studies have shown that the major concern for GLBTI people in relation to institutionalised aged care is whether or not to disclose their sexual, gender or intersex identity. Overseas evidence documents abuses against GLBTI aged care residents because of their sexual orientation or gender identity. Anecdotal Australian evidence confirms these findings, but issues of confidentiality and residents' fear of further abuse if they are found to have raised such concerns make it difficult to assess the magnitude of the problem. The major issues GLBTI raise in relation to institutionalised aged care include:

- A fear of physical and emotional abuse if they disclose their sexual orientation or gender identity.
- A reduced standard of care as a consequence of prejudicial attitudes on the part of some carers.
- Being "forced back into the closet" as a consequence of the perceived threat of homophobic or transphobic abuse.
- Being treated inappropriately because of obvious anatomical variations due to an intersex condition.
- A lack of physical intimacy because of taboos against displays of same-sex affection.
- The attitude of religious service providers as they become increasingly involved in the delivery of aged care services.²²

Institutionalised prejudice against expressions of physical and emotional intimacy on the part of GLBTI people are reinforced by deeply held prejudices that older people should not be sexually active, regardless of their gender identity or sexual orientation.

¹⁷ Hockley, D. (2001 forthcoming) *Aged, Grey and Gay: Who will look after me when I am old?* Honours Thesis, Social Work and Social Policy: University of South Australia.

¹⁸ Hockley, D. (2001) op. cit.

¹⁹ Waite, H. (1995) "Lesbians leaping out of the intergenerational contract: Issues of Ageing in Australia". In Sullivan, G. and Wai-Teng Leong, L. eds. *Gays and lesbians in Asia and the Pacific: Social and Human Services*. New York: Haworth Press, pp. 109-127

²⁰ Waite, H. (1995), op. cit.

²¹ Fortunato, V. (1993) *Homosexuality, Ageing and Social Support*. Behavioural Health Sciences, La Trobe Thesis, Masters of Gerontology.

²² Harrison, J. (1999) "A Lavender Pink Grey Power: Gay and Lesbian Gerontology in Australia". *Australasian Journal on Ageing* 18(1): 32-37.

Drug and Alcohol Use within GLBTI Communities

Cathryn Harland

1. Introduction

Drug and alcohol misuse are of serious concern to all Victorians. Evidence suggests that the personal, social and economic costs are enormous. Recent initiatives at State and federal levels have sought to identify the underlying social causes leading to increased drug and alcohol use and misuse among different sections of the community. They have resulted in programs aimed at:

- Reducing drug and alcohol use.
- Minimising the negative health consequences for those who continue to misuse drugs and alcohol.
- Dealing with the immediate and long term health effects of drug and alcohol misuse.

This paper focuses on patterns of drug and alcohol use among gay, lesbian, bisexual, transgender and intersex (GLBTI) Victorians. Although members of these groups use drugs and alcohol for many of the same reasons as the population at large, there is evidence to suggest that sexual orientation and gender identity lead to patterns of drug and alcohol misuse specific to GLBTI people. The paper explores patterns of drug and alcohol use among GLBTI Victorians in terms of two distinct though overlapping social processes. Section 2.1 looks at patterns of drug and alcohol use *common* to GLBTI Victorians and argues they are the result of shared experiences of discrimination and abuse. Section 2.2 looks at patterns of use *specific* to each of these groups—

particularly variations in drug and alcohol use between gay men and lesbians—and argues they result from the interaction of gender and cultural differences within GLBTI communities.

2. Drug and Alcohol Issues Common to GLBTI People

The Australian Drug Foundation's 1998 study of alcohol and other drug use among gay, lesbian, and queer communities in Victoria found that alcohol and drug use within these communities is two to four-fold higher than in the Victorian population as a whole.¹ Gay men and lesbians are less likely to abstain from drug and alcohol use; are less likely to stop using both illicit drugs and alcohol as they grow older and there appears to be less distinction in patterns of use between lesbians and gay men than between heterosexual men and women.

Research suggests that the value placed on different drugs varies between different sectors of GLBTI communities and different age groups. Drugs such as LSD, ecstasy and speed are favoured by the commercial scene; tobacco use is common amongst lesbians; alcohol use is favoured by older gay men and lesbians and steroid use is more common among gym goers.²

¹ Murnane, A. et al (2000) *Beyond Perceptions: A report on alcohol and other drug use among gay, lesbian, and queer communities in Victoria*. Australian Drug Foundation: Melbourne (referred to in the remainder of this paper as the ADF report).

² Crompton, L. (1998) *Drug use within the gay and lesbian and associated community: Implications for Drug Education*. Proceedings of the 1996 Autumn School of Studies on Alcohol and Drugs, 15-17 May. St Vincent's Hospital, Melbourne, pp. 63-70.

2.1 A Common Source of Discrimination

The ADF report and the GLBT companion document to *Healthy Living 2010*³ suggest that patterns of drug and alcohol misuse common to GLBTI people may result from their shared experiences of sexual orientation and gender identity discrimination. A number of studies have demonstrated a link between an individual's drug and alcohol misuse and their experiences of discrimination and abuse.⁴

Drug and alcohol misuse among GLBTI people have been associated with:

- Confusion around sexual orientation or gender identity.
- The stress associated with coming out to family, friends and work colleagues.
- The ongoing threat of violence and abuse faced by those who are open about their sexual orientation or gender identity.
- Low self-esteem, depression, anxiety, and feelings of guilt and paranoia.

At the same time, patterns of drug and alcohol use and misuse vary among GLBTI communities according to a number of key social indicators, including age and geographic location.

2.1.1 GLBTI Youth

All this time I was smoking heaps of cigarettes and marijuana, taking lots and lots of acid and speed, alcohol. Just so I wouldn't think about things.

Rowena, aged 20, quoted from *Writing Themselves In*.

A national report on same-sex attracted youth argued that sexuality-based discrimination and abuse within and outside the school environment

had a profound effect on the health and wellbeing of these young people.⁵ It resulted in higher rates of absenteeism, depression and suicidal behavior, and was linked to increased use of illegal drugs compared to young people in the general population. In particular, same-sex attracted young people were more likely to have used marijuana and party drugs such as speed, ecstasy and LSD (acid). These results are consistent with recent US findings that also highlight the problem of multiple substance or polydrug use among GLBT youth.⁶

Findings from the National Center on Addiction and Substance Abuse at Columbia University indicate that drug and alcohol use among young people is linked to increased sexual activity, including risky sexual practices and multiple sexual partners.⁷

2.1.2 GLBTI People in Rural and Regional Areas

Submissions to the MACGLH suggest that GLBTI people living in rural and regional areas are subject to increased levels of discrimination and abuse as a consequence of more conservative attitudes toward sexual orientation and gender identity. At the same time they have reduced access to GLBTI support and community networks and to GLBTI aware and friendly health service providers.

These added social pressures may result in increased drug and alcohol use. They may also lead to different patterns of use and misuse. The same-sex attracted youth survey, for example, found that young people from rural areas were more likely to have injected than young people from metropolitan areas. They often use drugs alone or belong to "heterosexual" injecting drug networks, particularly those associated with

³ *Healthy Living 2010: Companion document for lesbian, gay, bisexual and transgender health* (2001) San Francisco, CA: Gay and Lesbian Medical Association.

⁴ Lock, J. and Steiner, H. (1999) "Gay, lesbian, and bisexual youth risks for emotional, physical, and social problems: Results from a community-based survey". *Journal of the American Academy of Child Adolescent Psychiatry* 38: 297–304.

⁵ Hillier, L. et al (1998) *Writing Themselves In: A National Report on the Sexuality, Health and Well-Being of Same-Sex Attracted Young People*. Monograph Series No.7. National Centre in HIV Social Research and the Australian Research Centre in Sex, Health and Society. The report notes that 70 per cent of the sexuality based abuse experienced by same-sex attracted young people occurred at school, with other students being the perpetrators in 60 per cent of cases. Ten percent of participants had been abused by family members.

⁶ Garofalo, R., Wolf, R.C., Kessel, S. et al (1998) "The association between health risk behaviors and sexual orientation among a school-based sample of adolescents". *Pediatrics* 101(5): 895–902.

⁷ *Dangerous Liaisons: Substance Abuse and Sex* (1999) The National Center on Addiction and Substance Abuse at Columbia University, USA.

street contexts that include speed and heroin.⁸ These young people are vulnerable due to their lack of information about the drugs they are using, harm minimisation strategies or awareness of how to access help services.

US studies confirm that drug and alcohol use among rural and regional GLBTI people is more likely to occur in private. This may increase feelings of isolation and lead to further drug and alcohol misuse.

2.1.3 HIV Positive People

A number of US surveys show that many gay and bisexual men either discontinue or reduce their substance use following a positive HIV diagnosis.⁹ However, the findings of the 1999 *Sydney Men and Sexual Health* (SMASH) report show that a percentage of HIV positive men continue to use recreational drugs.¹⁰ Continued or increased drug and alcohol use among HIV-positive men may reflect their greater involvement in a drug-tolerant culture. However, it may also reflect attempts to manage increased levels of stress and worry associated with HIV infection and with increased discrimination from within and outside GLBTI communities.¹¹ There is little research on the physiological effects of interactions between a range of recreational drugs and combination therapies for HIV positive people.

2.2 Drug and Alcohol Issues Specific to GLBTI People

The ADF report notes how gender and cultural differences interact within GLBTI communities to produce variations in drug and alcohol use and misuse between gay men and lesbians and between those GLBTI people who are part of the commercial and dance scenes and those who are not.

2.2.1 Cultures of Drug Use

2.2.1a *The Dancing Queen*

People around me, they need drugs to love. That disturbs me. What if the drugs really didn't work? What then? No dance parties, no clubs, no scene, no Mardi gras? No queer, no gay?

Christos Tsiolkas quoted from *Beyond Perceptions*

A 1995 qualitative investigation by Lewid and Ross of the gay dance party phenomenon in Sydney identified two major patterns of drug use; the first associated with attending dance parties, the second associated with having sex. Southgate argues that in both cases gay men often use drugs in combination. Southgate suggests that within the commercial gay scene, illegal drug use had been normalised to such a degree that for many its illegality is barely recognised.

Drug and alcohol use within the commercial scene is primarily a social and not a private activity. For many GLBTI people—especially young people and those moving from or between rural and metro areas—the commercial scene is one of the ways in which they take on or assume a public identity as gay, lesbian or transgender. Within the commercial scene, recreational drug and alcohol use may be part of what it *means* to be gay, lesbian or transgender.

Alcohol, marijuana, volatile nitrites, tobacco, amphetamines and ecstasy are the drugs most commonly used by gay men, with the 20–29 year age group demonstrating the highest rates of alcohol and other drug use (ADF). Australian and US research has documented the popularity of ecstasy at dance parties and one US study suggests a strong association between the use of ecstasy and high risk sexual behaviors among gay men.¹²

⁸ Southgate, E. and Hopwood, M. (1999) *The drug use and gay men project*. National Centre in HIV Social Research, University of New South Wales, Sydney.

⁹ Ferrando, S., Goggin, K., Sewell, M. et al (1998) "Substance use disorders in gay-bisexual men with HIV and AIDS". *American Journal on Addictions* 7(1):51–60.

¹⁰ *Changes in behavior over time* (1999) Sydney Men and Sexual Health (SMASH). Joint Research Project, National Centre in HIV Epidemiology and Clinical Research and the AIDS Council of NSW, Sydney.

¹¹ Greenwood, G. (2001) "Correlates of heavy substance use among young gay and bisexual men: The San Francisco Young Men's Health Study". *Drug and Alcohol Dependence* 61(2): 105–112.

¹² Klitzman, R.L., Pope, H.G. Jr., and Hudson, J. I. (2000) "(ecstasy) abuse and high-risk sexual behaviors among 169 gay and bisexual men". *American Journal of Psychiatry* 157(7): 1162–1164.

Gay men on the commercial scene may be at increased risk of hepatitis C and hepatitis A. Approximately 90 percent of all new hepatitis C infections in Australia arise from injecting drug use.¹³ The comparatively high rate of drug use on the commercial scene and anecdotal evidence suggesting an increase in steroid use—which often involves injection—among gay men in the gym culture, indicate that particular subpopulations of gay and other homosexually active men may be at increased risk of hepatitis C.

Various injected drugs have been associated with outbreaks of hepatitis A, including heroin, amphetamines and cocaine. Hepatitis A transmission has also been associated with non-injecting drug use, including infection or injection of contaminated drugs and direct or indirect person-to-person contact such as behaviours related to sharing needles, sexual contact or poor personal hygiene. In 1998 an outbreak of hepatitis A was identified in southeastern Sydney, with gay men at particularly high risk for contracting the virus.¹⁴ Australian and US sources have called for vaccination against hepatitis A among high risk groups, including gay men.¹⁵

Sharing injecting equipment can also lead to transmission of HIV.¹⁶ A comparison of 47 Australian studies of injecting drug users (IDUs) suggested that the practice of sharing injection equipment is becoming less frequent, but is still common.¹⁷

Smoking is widespread within the commercial GLBT scene. Both the ADF and the GLMA reports document higher rates of smoking among gay men and lesbians compared to their heterosexual counterparts. As the GLMA notes,

cigarette smoking is the single most important risk factor associated with the leading chronic diseases.¹⁸ The GLMA also suggests that GLBT people who participate in the commercial scene, including dance parties, bars and some sex-on-premises venues, may be at higher risk of exposure to secondhand or passive smoking. In addition to the immediate health consequences of smoking, there is evidence linking early use of tobacco (as well as alcohol) to later substance abuse and behavioural problems.¹⁹

The prominence of drug use within the commercial and dance scenes has led to the development of knowledgeable approaches to drug and alcohol use. The ADF report identified a range of harm reduction practices or “folk pharmacologies” widely adopted by GLBT people. For alcohol they included: counting drinks; eating while drinking; quenching thirst with non-alcoholic drinks; refusing alcohol; planning drinking and how to get home safely and minimising the effects of alcohol on other commitments, such as work. For other drugs they included: planned drug use; using drugs with reliable friends; knowing the dealer; knowing what they are taking and how much to take; not mixing drugs with alcohol; knowing the effect of different drug combinations; using in a safe environment; managing the effects of drug use; staying in control and minimising the impact of drug use on other commitments.

There appears to be a serious lack of alcohol-free and drug-free alternative activities for young GLBT people or people questioning their sexual or gender identity. In the absence of such alternatives the association between increased rates of drug and alcohol use and alternative sexual and gender identities is likely to continue.

¹³ Commonwealth Department of Health and Aged Care (2000) *National Hepatitis C Strategy: 1999–2000 to 2003–2004*. Commonwealth of Australia.

¹⁴ Delpech, V. et al (2000) “Hepatitis A in southeastern Sydney 1997–1999: Continuing concerns for gay men and an outbreak among illicit users”. *Communicable Diseases Intelligence* 24 (7): 203–206.

¹⁵ Delpech, op cit.

¹⁶ Wodak, Alex and Van Beek, Ingrid (1997) “HIV and injecting drug use” in *Managing HIV* Graeme Stewart ed. Australasian Medical Publishing Company Limited: North Sydney.

¹⁷ According to figures quoted by Wodak and van Beek, 90 per cent of IDUs shared injecting equipment in 1984, falling to less than 20 per cent in 1994. Wodak and van Beek, op cit.

¹⁸ GLMA, op. cit.

¹⁹ GLMA, op. cit.

2.2.1b *The Smoking Lesbian*

Young lesbians aged 20–29 years report the highest level of drug and alcohol use. Among the ADF respondents, alcohol was the most commonly used drug (80 per cent), followed by tobacco (40 per cent), marijuana (28 per cent), amphetamines and tranquillizers (8 per cent).

The ADF report expressed particular concern over the level of tobacco use among lesbians, with lesbians demonstrating higher rates of smoking and smoking over longer periods of time. Lesbians aged 30–39 years report the highest rate of tobacco use (44.9 per cent). The use of steroids (1.4 per cent) and cocaine (1.4 per cent) was also highest in this group.

Data reported by the Institute of Medicine (IOM) in the US suggests that higher rates of smoking among lesbians may be linked to higher levels of stress associated with lower socioeconomic status. The IOM quotes research that demonstrates smoking is more prevalent among poor women than women of higher socioeconomic status and among women who experience high levels of stress. It is also possible that smoking among lesbians may be a shared cultural practice, one that varies within the lesbian community according to socioeconomic status.

The GLMA argues that women may face different pressures and barriers to giving up smoking, such as greater likelihood of depression, weight-control concerns and child care issues. Cultural barriers to quitting may also exist for lesbians for whom smoking is a shared cultural practice, linked to their sense of personal and collective identity.

McNair, Anderson and Mitchell argue that sections of the lesbian community may be at higher risk of a number of conditions—including some cancers—for which smoking is a major risk factor.²⁰

2.2.1c *Body Image*

Anecdotal evidence suggests that the use of anabolic-androgenic steroids (AAS) by gay men is increasing. It may be linked to the rise of a gym subculture within GLBT communities and an increased emphasis on a particular type of body image. The general population of steroid users in Australia is older and almost all inject their AAS. While rates of needle-sharing are lower than observed in other populations of injectors, practices such as sharing steroid containers and the overlap between steroid injecting and injecting of other social drugs represents a significant population at risk of hepatitis C and HIV. The black market for hormone injection raises additional issues for safe injecting practices.²¹

Steroid use is also an issue for female-to-male transgender people who obtain black market steroids, often due to difficulties accessing testosterone or DHT through legal medical channels. Such individuals are placed at risk because their ongoing hormone levels are not being monitored. There is also a problem of testosterone rage resulting from excessive testosterone used in the hope of speeding up the process of masculinisation.²²

Related to body image issues is the use of Viagra by a sizable and growing subgroup of gay and bisexual men. Mansergh argues that there is a need for research on the effects of mixing Viagra with a number of other drugs.²³

²⁰ McNair, R., Anderson, S. and Mitchell, A. (2001) "Addressing health inequalities in Victorian lesbian, gay, bisexual and transgender communities". *Health Promotion Journal of Australia* 11(4): 305-311.

²¹ Peters, R. et al (1999) "Anabolic-androgenic steroids: User characteristics, motivations and deterrents". *Psychology of Addictive Behaviours* 13(3): 232-242.

²² Submission to the Transgender and Intersex Subcommittee of the MACGLH from Men's Australia Network (MAN).

²³ Mansergh, G. et al (2001) "The circuit party men's health survey: Findings and implications for gay and bisexual men". *American Journal of Public Health* 91(6): 953-958.

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