Multnomah County Health Department
Office of Health & Social Justice

Speak Out Survey 2009:

Measuring Health and Wellness among Portland's Lesbian, Gay, Bisexual, Transgender, Queer, Genderqueer, and Intersex Communities

Final Report
March 2010

Office of Health & Social Justice
426 SW Stark, 9th Floor
Portland, OR 97204

Acknowledgements

Data Analysis & Reporting

Program Design & Evaluation Services – Multnomah County Health Department and Oregon Public Health Division: Linda Drach, Haiou He, Tyler Smith, Kari Greene, Susan Van't Hof

Survey Design & Recruitment

STD, HIV, Hepatitis C Program – Multnomah County Health Department: Molly Franks, Graham Harriman

Acknowledgements

The Speak Out survey project originated with staff in Multnomah County Health Department's STD, HIV, Hepatitis C Program. This report was produced by Program Design & Evaluation Services, a public health research and evaluation group housed within Multnomah County Health Department, Health & Social Justice Section, and the Oregon Public Health Division. Julie Maher, Alison Goldstein, and Julia DIlley reviewed this report and provided feedback; Doris Cordova and Alicia Knapp provided assistance with formatting.

Thanks to the Q Center in Portland, which generously hosted two community forums to disseminate survey results and gather community input about next steps.

Many thanks to the 843 Speak Out survey respondents who shared their experiences and opinions.

For More Information

Linda Drach, MPH

Multnomah County Health Department, Office of Health & Social Justice

Program Design & Evaluation Services

linda.drach@state.or.us

971-673-0591

Health Department
Director's Office
MULTNOMAH COUNTY OREGON
426 SW Stark, 8th Floor
Portland, Oregon 97204
(503) 988-3674 phone
(503) 988-4117 fax

March 2010

Dear Portland Area Residents,

I am pleased to present the Speak Out 2009 Survey Report, which identifies factors related to the health and well-being of sexual and gender minority people in the Portland metropolitan area. This report adds to the limited but growing set of national and local research information describing important health disparities between Lesbian, Gay, Bisexual, Transgender, Queer, Genderqueer, and Intersex (LGBTQI) people and their heterosexual and non-transgender peers. The survey's findings will aid efforts to use data to promote health equity for LGBTQI people.

In addition to questions about health care access, health behaviors, and health outcomes, the Speak Out survey explored life experiences, relationships and community connections, and interpersonal factors, in order to gain greater insight into the social determinants that affect health. The rich information shared by over 800 community respondents informs development of a comprehensive plan to diminish the structural barriers to health and well-being, and also support the strengths within the LGBTQI communities that protect and foster health.

Many community members, through collaborative effort, have made great strides toward improving the health and well-being of our LGBTQI residents and communities. The Speak Out survey results will add to the momentum of these efforts and help shape their direction.

Thank you for your interest and commitment to improving the health of all of our residents.

Sincerely,

Lillian Shirley

Lillian Shirley, BSN, MPH, MPA
Director, Multnomah County Health Department

Public Health
Prevent. Promote. Protect.

Executive Summary

The limited nature of research about lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI) populations makes it difficult to document and prioritize their health needs. Existing data point to significant health disparities between LGBTQI populations and their heterosexual and non-transgender peers, but more comprehensive data about LGBTQI health and wellness are needed to understand what promotes good health within the LGBTQI community.

The purpose of the Speak Out 2009 survey was to learn more about factors related to health and well-being across sexual orientation and gender identity, use those data to promote health equity for LGBTQI people, and develop a comprehensive agenda for LGBTQI wellness. The root causes of health disparities in any population include the unequal distribution of social and structural power. To promote wellness in the LGBTQI community, one must understand how underlying factors influence health-related decision making and health outcomes. To that end, the Speak Out 2009 survey included questions addressing larger cultural and systemic factors, which shape individual risk and protective factors; these include things like disclosure of sexual orientation or gender identity, experiences of harassment and violence, presence or absence of social and family support, and legal recognition of partnership status.

Extensive outreach efforts were made in order to ensure that data were gathered from as many people as possible within the self-identified LGBTQI communities in the Portland metropolitan area. Data were collected using a web-based survey tool, and participation was voluntary and confidential. A total of 843 adults who identified as LGBTQI participated in the survey.

Key Findings from Speak Out 2009:

- Speak Out respondents reported many risk factors for poor health; some of these are similar to the general population, while some appear to be elevated among LGBTQI people.

- Like most Americans, Speak Out respondents overall reported consumption of fewer fruits and vegetables and more alcohol and tobacco than recommended.

- Mental health issues (e.g., depression, anxiety, and post-traumatic stress) and experiences of violence (e.g., intimate partner violence, childhood sexual abuse) were prevalent, and rates appeared higher than the general population.

- People who experienced full support from their family related to sexual orientation and who had stronger community connections as adults reported better overall physical health.

- People who had fewer experiences of social isolation and teasing growing up also reported better overall physical health. Similarly, people who received more social support growing up reported less depression.

- There are different health risks within the community related to sexual orientation and gender identity. For example:
    - Transgender-identified individuals face significant disadvantages in accessing health care, reported higher rates of mental health issues, and reported more days of physical and mental disability.
    - Male-identified individuals reported much higher rates of STD and HIV infection.

The prevalence and magnitude of these different risk factors and negative health outcomes suggests that multiple intervention approaches (structural or systems-level, community-level, and individual-level interventions) are needed in order to improve the health and well-being of LGBTQI community members in the Portland metropolitan area. Furthermore, these interventions should be designed to specifically reach children, adolescents and adults. Some examples might include:

- Policies addressing homophobic and transphobic harassment and discrimination among children and adolescents, as well as equal opportunity and rights for LGBTQI adults.
- Health promotion campaigns designed to change social norms around alcohol and tobacco use within the LGBTQI community.
- Health promotion messages that encourage positive health behaviors among LGBTQI people, like getting more exercise and eating more fruits and vegetables.

Some limitations apply to these survey findings. Despite targeted recruitment, few people responded in some subgroups of interest. Readers should review information about respondents to think about who may have been missing and what effect that would have on results.

The survey results will be used to continue building momentum to document and address local LGBTQ health disparities. A coalition of committed organizations that includes The Quest Center for Integrative Health, Outside In, the Q Center, Basic Rights Oregon, Cascade AIDS Project and the Multnomah County Health Department are seeking funding to conduct a Community Based Participatory Research process focusing on LGBTQ Health. The Coalition's main goals will be to gather additional information, particularly from people who were not included in large numbers in this initial survey (e.g., older LGBTQ, people of color), and to develop and prioritize a social service and policy agenda to address LGBTQ health inequity.

Table of Contents

Introduction

Background

The limited nature of research about lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI) populations makes it difficult to document and prioritize their health needs. Many studies have been conducted with certain health conditions, like HIV in gay men and breast cancer in lesbians, but, as noted by the Gay & Lesbian Medical Association (GLMA) "in most other areas, data are seriously lacking and, for transgender individuals, very few studies have been attempted."[1] Data on the well-being of LGBTQI people living in the Portland metropolitan area have been similarly limited.

However, existing data suggest that there are important health disparities between LGBTQI people and their heterosexual and non-transgender peers. For example, a 2009 population-based study from Washington State found that lesbian and bisexual women were more likely than heterosexual women to have poor physical and mental health, asthma, and diabetes (bisexuals only), as well as to be overweight, smoke, and drink excessive alcohol. They also reported poorer access to health care and less frequent use of preventive services. Gay and bisexual men were more likely than heterosexual men to have poor mental health and to smoke, and were more likely to report having to limit their activities because of poor health. Bisexuals of both genders reported the greatest number and magnitude of health disparities compared to heterosexuals.[2]

Research describing the health care needs of transgender and intersex populations is in its infancy, and much remains to be done to design effective medical and mental health programs and interventions serving members of these populations.[3] Much of the available research has been HIV-focused rather than comprehensive in nature, but community needs assessments have been conducted in several cities, providing additional data and context on transgender health disparities. [4,5,6,7,8] Results from the body of existing transgender health research are difficult to interpret and compare because population definitions often change from study to study. In addition, the participant characteristics of most of these studies differ significantly from the Speak Out sample in that those participants are more likely to be male-to-female (MTF), people of color, living in poverty, heterosexual, and engaging in sex work or survival sex.[4,7,9] Despite these limitations in the scientific literature, transgender people do appear to experience significant health disparities in mental health, substance abuse, and HIV, and are disproportionately targets of violence.[6,9]

Research on the health of genderqueer-identified individuals is virtually non-existent.[10,11] Genderqueer is an emerging gender identity that has resonated with many of those who feel discomfort within the binary gender system. This group is not well-defined and it is unknown whether and/or how this population experiences health disparities.

Purpose

The purpose of the Speak Out 2009 survey was to gather descriptive data about the health and well-being of LGBTQI individuals in the Portland metropolitan area, in order to inform comprehensive efforts to promote health equity across sexual orientation and gender identity.

The root causes of health disparities in any population include the unequal distribution of social and structural power. To promote wellness in the LGBTQI community, one must understand how underlying factors influence health-related decision making and health outcomes. To that end, the Speak Out 2009 survey included a broad range of questions that measured larger cultural and systemic factors, such as experiences of harassment and violence, presence or absence of social and family support, and legal recognition of partnership status, as well as individual-level behaviors, like alcohol use and exercise.

Survey Design

Staff at Multnomah County Health Department (MCHD) took the lead in conceptualizing and designing the survey, drawing, where possible, from the scientific literature and national and international surveys with LGBTQI populations. The questionnaire was refined based on feedback from key informants with research and evaluation experience and/or who were transgender, elders, and/or people of color. A semi-final version was pilot tested with 10 members of the LGBTQI communities via Survey Monkey and final modifications were made before distribution to the community at large.

The final questionnaire consisted of 117 close-ended questions and one open-ended question addressing a comprehensive spectrum of topics related to health and well-being across the lifespan. The survey assessed individual-level factors, such as exercise, nutrition, and sexual behavior, as well as social and structural factors, such as experiences with harassment and discrimination, access to health care, and housing status. Respondents identifying as transgender or genderqueer filled out an additional module of 23 close-ended items about experiences related to gender identity. Respondents who identified as intersex filled out an additional module of 18 close-ended items about experiences related to being intersex.

Survey Measures

The survey included the following domains:

- Demographic and other respondent characteristics;
- Disclosure of and levels of support for sexual orientation (and transgender, genderqueer or intersex identity, as appropriate);
- Sense of identity and pride related to sexual orientation (and transgender, genderqueer or intersex identity, as appropriate);
- Experiences of discrimination and harassment;
- Self-esteem and self-efficacy;
- Overall physical and mental health status;
- Access to medical care;

- Chronic mental and physical health conditions;
- Physical activity and nutrition;
- Substance use, including tobacco, alcohol, and other drugs;
- Experiences of intimate partner violence;
- Childhood sexual abuse;
- Experiences growing up, including fitting in at school, experiencing unconditional love from family and having adult support and queer role models;
- Relationships and community connections;
- Sexual attraction and behavior; and
- Opinions on what would "make life better for LGBTQI people."

Survey measures for the key domains are described briefly below. All items were developed by MCHD staff except where noted.

Demographics and other respondent characteristics. We collected the following information about respondents: gender, sexual orientation, race/ethnicity, age, income, education, employment status, county of residence, and housing status.

Most surveys gather data on gender using a binary category—either male or female. The gender category for the Speak Out 2009 survey included seven options: male, female, transgender (female to male), transgender (male to female), transgender (not male or female), genderqueer, intersex (identify as male), and intersex (identify as female). These categories represent the respondent's current, self-identified gender. We did not collect information on sex assigned at birth.

Respondents identifying as transgender or genderqueer responded to an additional series of questions about transgender or genderqueer experiences; those identifying as intersex responded to an additional series of questions about intersex experiences. Because the survey was administered on-line, these question modules were only visible to individuals identifying as transgender, genderqueer, or intersex; all others skipped directly to the main body of the questionnaire, which was designed for all respondents to answer.

Coming out, being supported, feeling pride. Respondents were asked ("Yes" or "No") if they were out about their sexual orientation and, as appropriate, gender identity/intersex status to eight categories of people (e.g., friends, family, health care providers) and the extent to which those people supported them. Response options were "Not at all," "Somewhat," and "Completely." Another series of questions asked about positive experiences (e.g., "The experience of being trans/genderqueer has offered me valuable insight in my life." "I feel good about being LGBQ.") Responses were given on a four-point scale from "Strongly disagree" to "Strongly agree."

Experiencing discrimination. Respondents were asked if they had experienced different types of discrimination based on sexual orientation/gender identity/intersex status (e.g., refused employment, verbal abuse, physical violence).

Self-Esteem and self-efficacy. Five of ten questions from a widely-used, general self-efficacy scale were included.[12] A single question asked respondents to rate their self-esteem on a four point scale ranging from "Poor" to "Very good."

Physical and mental health status. A series of questions drawn from the Behavioral Risk Factor Surveillance System (BRFSS) asked about the number of days in the past 30 days that physical and mental health were not good (two items), and health behaviors such as physical activity, fruit and vegetable consumption, and substance use. We also asked about clinical diagnosis of a list of 12 conditions (e.g., depression, diabetes, gonorrhea); those items gleaned "Yes" or "No" answers.

Growing up. Eight questions explored respondents' experiences with family, peers, and LGBT community connections during their first 18 years of life. Respondents were asked to agree or disagree using a four-point scale to questions such as "When I was growing up, my family showed me unconditional love," "When I was growing up I had at least one close friend I could confide in about anything," and "When I was growing up, I knew other people who were openly LGBTQI."

Gender conformity. Three questions asked about gender conformity during childhood and three about current gender conformity: "[When you were growing up/Currently], in terms of your physical appearance, how masculine or feminine were you?" "[Did/Do you] try to change your behavior/appearance to conform to social expectations for [boys or girls/men or women]?" "[Were/How often are] you harassed for acting masculine or feminine?"

Relationships and community. A series of questions asked about respondents' relationship status and whether they had taken any steps to formally recognize their relationship, such as filing for domestic partnership or having a commitment ceremony. Another question set asked about community connections, including having a sense of belonging to an LGBTQI community and the broader non-LGBTQI community, a sense of helping others and making a difference, a sense of having someone to confide in, and a sense of being accepted for one's self. Another question asked about respondents' formation of a "chosen family," loving bonds with individuals to whom they are not biologically related.

Sex and sexuality. Two questions taken from the Australian "Private Lives" LGBTQ survey[13] asked whether respondents have been sexually attracted primarily to men, women, both, or neither, and with which genders respondents have had lifetime sexual experiences. The Speak Out survey added a response option to both questions of "People across the gender spectrum." Two questions asked about number and gender of sexual partners in the previous year. With regard to the respondent's most recent sexual encounter, two questions asked how emotionally and physically satisfying it was, one asked the partner's HIV status, and one asked how long the respondent had known the partner (response options ranged from "less than 24 hours" to "A year or more"). A series of ten questions asked about a series of sexual risk and protective behaviors within the past month, such as trading sex for money, having sex while drunk or high, and talking with partners about their sexual health histories.

Conclusion. A final, open-ended question asked respondents to name two things that would make life better for LGBTQI people living in their community.

Survey Administration

Speak Out 2009 was administered online via Survey Monkey, and, anecdotally, took most respondents between 15 and 30 minutes to complete. No financial incentives were given for completing the survey.

Recruitment, Sampling, and Eligibility

Sampling of LGBTQ populations for survey research is difficult.[14,15,16,17] To the extent possible, we attempted to recruit as many people as possible within the self-identified LGBTQ community in the Portland metropolitan area. The survey was launched at the Portland Gay Pride celebration (June 13-14, 2009); three laptops were set up at the Multnomah County Health Department booth and available for use by festival-goers to complete the survey. Ads were placed in the local LGBTQ newspaper, *Just Out*, emails with a link to the survey were distributed through online list-serves, and postings were placed on Facebook, Twitter, Craigslist, and LGBTQ community websites. Additional outreach efforts were made to reach people of color, low income people, elders, and transgender people.

Respondents read a written introduction to the survey and a consent statement. After indicating their agreement, they were asked a series of questions to determine eligibility. Eligibility criteria included:

- Filling out the survey for the first time;
- Identifying as lesbian, gay, bisexual, transgender, queer, genderqueer, intersex or another sexual or gender minority;
- Being at least 18 years old; and
- Living in Multnomah, Clackamas, Washington, Clark, or Benton Counties. (Benton County data were given to that county's health department and are not included in these analyses).

The final survey included 843 respondents.

Analyses

Our analyses were both descriptive and comparative. We described how respondents answered the survey by inspecting frequencies and made subgroup comparisons for key outcomes by gender and sexual orientation.

For subgroup analysis, we looked at gender in several different ways. Because of small numbers in some categories, and for the purposes of this report, we chose to pool the seven gender options into four categories: male-identified (hereafter listed as male), female-identified (hereafter listed as female), transgender-identified (includes TG MTF, TG FTM, and TG not M or F, hereafter listed as transgender), and genderqueer-identified (hereafter listed as genderqueer). Only two respondents identified as intersex; because of low numbers, they were excluded for subgroup analyses by gender. Sexual orientation options were pooled into three categories: Homosexual (Gay/Lesbian),

Bisexual, and Queer. Individuals who identified as heterosexual (n=1), undecided (n=12), or asexual (n=6) were excluded for subgroup analyses by sexual orientation. When examining responses by both sexual orientation and gender, there were very small numbers in some groups (e.g. transgender bisexuals), so results are generally reported for main effects (e.g. significant differences by gender or orientation).

We compared means across subgroups using t-tests and one-way analysis of variance, and proportions across subgroups using either Pearson Chi-square tests or Fisher's Exact tests if there were few respondents. In order to control for multiple factors that may be related to one another and, therefore, mask or inflate true differences between groups, we used logistic or linear regression for some analyses, where noted. All quantitative analyses were conducted with SPSS 17.0. In this report, differences between groups are reported if they are statistically significant; that is, where statistical significance—the "p value"—reached 0.05 or below (e.g., $p < .05$).

Analyses were conducted on non-missing and/or valid responses. In other words, if a respondent checked "not applicable" for a particular survey item or left it blank, their response was not included in the analyses for that item.

The open-ended question was analyzed using an open coding methodology in which themes were not identified beforehand but, instead, were allowed to emerge from the responses themselves. Initially, the lead analyst examined all responses, identified discrete categories and coded each response. Coding categories were refined through discussions with a second analyst and themes were identified. Each response was allowed as many codes as needed to identify all the discrete dimensions present; therefore, the number of responses among categories does not necessarily represent the number of respondents.

Limitations

Some limitations apply to these survey findings. First, because we do not have accurate estimates of the LGBTQI population in the Portland metropolitan area, we do not know how representative our survey sample is of the entire population. Although our final sample of 843 respondents was notably large, there were few economically disadvantaged people, people of color, and people over age 65 in the final sample, meaning the experiences of people in those subgroups were not well-represented in the Speak Out data. In addition, although there were relatively robust samples of transgender-identified respondents, all but one reported sexual minority status, meaning the experiences of heterosexually-identified transgender people may be different from what is reported in the Speak Out results. We also lacked information about sex assigned at birth, which limited our ability to have a more nuanced understanding of engendered experiences in childhood and adulthood. Finally, our sample of intersex respondents was very small, which prevented us from conducting any subgroup analysis with intersex respondents.

How the Report is Organized

This report first covers findings related to response rate and respondent characteristics, and then is organized topically, within six broad categories: Experiences of Discrimination and Harassment; Relationships and Community Connections; Personal and Interpersonal Factors; Access to Medical Care; Health Behaviors; and Health Outcomes. The report concludes with information about predictors of better and worse health outcomes, information about what respondents said would make life better for LGBTQI people, and next steps.

I. Response Rate and Respondent Characteristics

II. Experiences of Discrimination and Harassment Related to Sexual Orientation and Gender Identity

III. Relationships and Community Connections

IV. Personal and Interpersonal Factors

- Experiences Growing Up
- Disclosure, Support, Sense of Identity and Pride Related to Sexual Orientation and Gender Identity
- Self-Efficacy and Self-Esteem
- Gender Conformity

V. Access to Medical Care

VI. Health Behaviors

- Physical Activity and Nutrition
- Substance Use, including Tobacco, Alcohol, and Other Drugs
- Sexual Behavior

VII. Health Outcomes

- Overall Physical and Mental Health, including Chronic Conditions
- Sexual Health
- Intimate Partner Violence (IPV)

VIII. Predictors of Better and Worse Health Outcomes

IX. Epilogue: Opinions on What Would Make Life Better for LGBTQI People

X. Next Steps

Each section contains the following information: a brief introduction to the topic, a bulleted list of key findings, and data tables that provide exact numbers and percentages for the survey items. Survey results are presented, where possible, in the context of national and/or local data related to the topic, and references are provided. To date, few large, population-based studies have included sexual orientation and gender identity, and most funded studies of LGBTQ health focus on specific issues,

such as HIV or alcohol use. Therefore, available studies vary in terms of population, methodology, and generalizability; cited studies are briefly described, when appropriate.

We use the Oregon Behavioral Risk Factor Surveillance System survey (BRFSS) for comparison of Speak Out 2009 data that were collected using BRFSS survey questions. The Oregon BRFSS is a random digit dialed telephone survey that collects data from adults age 18 and older and, therefore, allows us to roughly compare our results from the LGBTQ population with "Oregon adults overall." However, some important differences should be noted that make results from the two surveys not directly comparable: 1) BRFSS data are statewide; Speak Out data are from the Portland metropolitan area, 2) the Speak Out survey was self-administered and on-line; the BRFSS is a telephone survey administered by a trained interviewer, 3) BRFSS data are from a random sample of telephone lines and are weighted to be representative of the Oregon population; the Speak Out survey was a convenience sample gathered through outreach efforts, 4) results are not age-adjusted, which could be important for some items (e.g. intimate partner violence, chronic health conditions).

I. Response Rate and Respondent Characteristics

The exact number of lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI) people in the United States, Oregon, or Portland metropolitan area is unknown. As stated in the Healthy People 2010 LGBT Companion Document: "Because of a lack of research focusing on the size of the population and the fear that many LGBT people, especially youth, have concerning revealing their sexual identity, reliable data are difficult to obtain. Moreover, in the few surveys that do provide data, respondents are usually asked about sexual behavior, not orientation or identity."[1]

The lack of population estimates and identifying data make it difficult to sample and reach LGBTQI populations.[14-17] We attempted to recruit a large and diverse sample of LGBTQI people in the Portland metropolitan area through multiple methods. The most commonly reported means of hearing about the Speak Out survey were through friends (25%) or Gay PRIDE activities (13%), but a notable proportion learned about it through internet-based recruitment like Facebook (9%) or a Listserve (9%). However, about 1 in 3 respondents didn't answer this question (Table 1a).

Table 1a: How Respondents Heard about the Survey (N=843)

Referral Source	% (n)
Friend	25% (n=213)
Gay PRIDE	13% (n=112)
Facebook	9% (n=79)
Listserve	9% (n=74)
Community Group	7% (n=59)
Just Out newspaper	4% (n=36)
Did not answer	32% (n=270)

Since 2003, the Oregon and Washington BRFSS surveys have asked respondents about sexual orientation, using three categories (straight, gay or lesbian, and bisexual). An examination of 2003-2005 BRFSS data from Oregon and Washington shows that 3.3% of Portland metropolitan respondents (Multnomah, Clackamas, Washington, and Clark Counties) identified as LGB, including 1.4% of males who identified as gay (.9%) or bisexual (.5%) and 1.9% of women who identified as lesbian (.8%) or bisexual (1.1%). Queer is not a valid response option on BRFSS and there are no BRFSS data on gender identity or intersex status. Although BRFSS data likely underestimate the number of LGBTQI individuals because they do not include transgender or intersex individuals or LGB individuals who experience same sex attraction and/or engage in same sex behavior, but are not out about their orientation, they provide a reasonable comparison to Speak Out 2009 data, since self-identification as LGBTQI was an eligibility criteria for participation.

LGBTQI individuals in the Portland metropolitan area participated enthusiastically in the Speak Out survey, given it was lengthy and there were no incentives: 843 individuals completed surveys. Despite targeted recruitment, however, low numbers of people of

color, low income people, and people over age 65 participated. It is important to remember who completed the survey and who did not, when interpreting results. Respondent characteristics are listed in Table 1b.

Key Findings from Speak Out 2009 Related to Response Rate and Respondent Characteristics:

- These results represent the experiences of a relatively privileged sector of the LGTBQI community: many respondents were white, well-educated, working, and of higher income.
- 3 in 4 respondents (76%) live in Multnomah County.
- People from across the adult age spectrum participated; the lowest proportion of respondents were in the 65 and older group (26 people, 3% of total).
- Half of respondents (51%) identified as female; another 35% identified as male. About 7% each reported being genderqueer or transgender. Fewer than 1% reported their gender as intersex.[a]
- Almost 1 in 4 respondents identified their sexual orientation as queer and 11% identified as bisexual.
    - At 60% and 69%, respectively, transgender and genderqueer respondents were much more likely to report a queer sexual orientation than males (10%) or females (21%).

[a] Four genders were used for comparison of items across self-identified gender: female, male, transgender (FTM, MTF, and transgender neither male nor female combined), and genderqueer; intersex was dropped in subgroup comparison because there were only two people in that group.

We don't know how many individuals are included in the male and female categories who were assigned a different gender at birth.

Table 1b: Characteristics of Survey Respondents (N=843)

Variable	% (n)
Sexual Orientation	
Lesbian	33% (n=281)
Bisexual	11% (n=95)
Gay man	31% (n=259)
Queer	22% (n=184)
Heterosexual/Straight	< 1% (n=1)
Not sure/Undecided	1% (n=12)
Asexual	< 1% (n=6)
Missing	< 1% (n=5)
Gender	
Male	35% (n=297)
Female	51% (n=433)
Trans FTM	4% (n=32)
Trans MTF	2% (n=15)
Trans, not male or female	< 1% (n=3)
Genderqueer	7% (n=61)
Intersex	<1% (n=2)
Age Group	
18-24	17% (n=146)
25-34	31% (n=264)
35-44	23% (n=192)
45-54	16% (n=134)
55-64	10% (n=81)
65+	3% (n=26)
Race/Ethnicity	
Latino/a	5% (n=41)
African-American	2% (n=15)
Asian/Pacific Islander	2% (n=17)
Native American	2% (n=13)
White	83% (n=696)
Multi-racial	6% (n=53)
Missing	1% (n=8)
Household Income	
Less than $11,000	6% (n=48)
$11,001-$20,000	8% (n=69)
$20,001-$60,000	33% (n=278)
$60,001-$100,000	15% (n=128)
>$100,000	10% (n=82)
Missing*	28% (n=238)

Table 1b continued: Characteristics of Survey Respondents (N=843)

Variable	% (n)
Education	
Less than high school	1% (n=7)
High school/GED	18% (n=151)
Associate's degree	13% (n=109)
College degree	35% (n=295)
Graduate degree	28% (n=234)
Missing	6% (n=47)
Employment Status	
Work full-time	57% (n=483)
Work part-time	12% (n=98)
Unemployed	9% (n=76)
Student	7% (n=61)
Retired	3% (n=29)
Disabled	3% (n=25)
Other	3% (n=26)
Missing	5% (n=45)
County of Residence	
Clackamas	7% (n=55)
Multnomah	76% (n=642)
Washington	12% (n=101)
Clark Co, Washington	5% (n=45)
Housing	
Living in house you own	39% (n=329)
Rent house or apartment	47% (n=396)
Temporarily staying with family/friends	7% (n=60)
Living in institution/special facility	1% (n=9)
Homeless	<1% (n=4)
Missing	5% (n=45)

*Readers should view items with large amounts of missing data with healthy skepticism.

II. Experiences of Discrimination and Harassment Related to Sexual Orientation and/or Gender Identity

Protection of civil rights based on sexual orientation and/or gender identity is not universally available. Sexual orientation and gender identity-based discrimination in housing, employment, and other important life areas is prevalent, as is verbal harassment.[18,19,20] In fact, a preliminary report from the National Transgender Discrimination Survey revealed that almost all of the nearly 6,500 respondents (97%) had experienced some form of employment discrimination or mistreatment.[21] Transgender people also appear to be especially vulnerable to hate crimes.[22] A 2003 report from the Southern Poverty Law Center documented that there were more hate crime murders in the U.S. targeting transgender people in that year than all other hate crime murders combined.[23]

Sexual and gender minorities report more experiences of prejudice and discrimination than heterosexual comparison groups,[24,25] with detrimental mental and physical health consequences, including depression and anxiety,[24] attempted suicide,[26] and sexual risk behavior.[27] However, a 2009 study of policies that reduce discrimination against sexual minorities found that state-level policies extending protections against hate crimes and employment discrimination based on sexual orientation modified the effect of lesbian, gay, or bisexual status on psychiatric disorders,[28] indicating that structural changes like anti-discrimination policies can positively affect health and well-being.

Key Findings from Speak Out 2009 Related to Experiences of Discrimination and Harassment:

- Fear of prejudice or discrimination affects a majority of Speak Out respondents. More than half of respondents (57%) said they sometimes modify daily activities because of fear and 16% said they <u>often or always</u> make fear-based modifications. However, just over 1 in 4 said that fear of prejudice or discrimination <u>never</u> affects their daily activities.
- Most respondents (82%) said they had experienced insults or verbal abuse at some point in their lives because of sexual orientation and more than half (55%) had experienced threats of violence or intimidation.
- Just under 1 in 4 (23%) had experienced physical violence because of sexual orientation and 10% had experienced sexual violence.
- Nearly 1 in 4 (22%) reported employment-based discrimination based on sexual orientation.
- Some people were significantly more likely to report experiences of harassment and discrimination based on sexual orientation than others. For example:
    - Genderqueer respondents were most likely and females least likely to report employment-based discrimination (35% vs. 19%, p=.03), verbal abuse (93% vs. 77%, p< .001), and threats of violence (71% vs. 46%, p < .001).
    - Males were most likely to have experienced physical violence because of sexual orientation and females least likely (36% vs. 12%, p <.001).

Table 2a: Fear of Prejudice and Discrimination Based on Sexual Orientation and/or Gender Identity

Question/Variable	% (n)	% (n)	% (n)
How often does fear of prejudice or discrimination about sexual orientation/gender identity cause you to modify your daily activities?	**Sexual Orientation (N=827)**	**Gender Identity (N=107)**	**Either Sexual Orientation or Gender Identity (N=824)**
Always	2% (n=16)	10% (n=11)	3% (n=24)
Often	14% (n=118)	18% (n=19)	15% (n=126)
Sometimes	57% (n=472)	56% (n=60)	57% (n=466)
Never	27% (n=221)	16% (n=17)	25% (n=208)

Table 2b: Harassment and Discrimination Based on Sexual Orientation and/or Gender Identity

Have you ever experienced any of the following because of your sexual orientation/gender identity?	**Sexual Orientation**	**Gender Identity**	**Either Sexual Orientation or Gender Identity**
Experienced insults or verbal abuse	82% (672/824)	88% (94/107)	82% (680/827)
Experienced threats of violence or intimidation	55% (447/818)	59% (63/106)	55% (452/818)
Experienced physical violence	23% (186/816)	24% (25/106)	23% (191/815)
Refused employment, denied a promotion or disciplined in an existing job	22% (178/817)	31% (33/106)	23% (188/816)
Experienced sexual violence	10% (77/813)	12% (13/106)	10% (79/811)
Refused housing	8% (67/817)	11% (12/105)	9% (72/815)
As a minor, been denied contact with your family	5% (37/807)	7% (7/105)	5% (37/804)
Denied a bank loan or financing	3% (27/813)	5% (5/106)	4% (28/810)
Lost child custody/child custody review	3% (22/808)	3% (3/106)	3% (22/805)

III. Relationships and Community Connections

How social relationships and community connections affect health behavior and health outcomes for LGBTQI individuals are complex and have not been not well studied. Nevertheless, a 2009 study found that bisexual adolescents reported significantly less family and school connectedness than did heterosexual and 'mostly heterosexual' adolescents, and concluded that these lower levels of protective factors may help explain their higher prevalence of risky behavior.[29]

The influence of social connections as a protective factor for health is gaining recognition. As such, we looked at partnership status, steps taken to formally recognize a partnership, and a range of items related to feelings of connection or belonging to a larger community.

Key Findings from Speak Out 2009 Related to Relationships and Community Connections:

- 2 in 3 respondents (66%) reported a current, ongoing romantic or sexual relationship.
  - Genderqueer (73%) and female (72%) respondents were most likely to report current partnership, and males least likely (56%) ($p < .001$).
- Of those in current relationships, few had taken steps to formally recognize them. Formal recognition most commonly took the form of filing for domestic partnership (23%) or having a commitment ceremony (16%).
- A majority of respondents reported feeling a sense of connection both within the LGBTQ community (74%) and outside of it (70%).
- 77% said they had formed close ties with individuals they consider a "chosen family," people with whom they are not biologically related, but who offer familial support and encouragement.

Table 3a. Relationship Status and Partner Recognition

Question/Variable	% (n)
Are you currently in an ongoing romantic or sexual relationship? (N=807)	
Yes	66% (n=530)
No	34% (n=277)
Have you taken any of the following steps to formally recognize your relationship with your partner? (N=530)	
Filed for domestic partnership	23% (n=123)
Commitment ceremony	16% (n=85)
Legally married	14% (n=74)
Legally changed names	5% (n=29)

Table 3b: Social and Community Connections

Question/Variable	% (n)
I feel a sense of belonging or connection to an LGBTQI community (N=807)	
Strongly agree	29% (n=232)
Somewhat agree	45% (n=362)
Somewhat disagree	19% (n=155)
Strongly disagree	7% (n=58)
I feel a sense of belonging or connection to a broader, non-LGBTQI community (N=800)	
Strongly agree	20% (n=158)
Somewhat agree	50% (n=398)
Somewhat disagree	23% (n=182)
Strongly disagree	8% (n=62)
I regularly help others and feel I make a difference in the world (N=803)	
Strongly agree	48% (n=387)
Somewhat agree	43% (n=343)
Somewhat disagree	8% (n=60)
Strongly disagree	2% (n=13)
I have at least one person in my life I can confide in (N=805)	
Strongly agree	78% (n=631)
Somewhat agree	17% (n=134)
Somewhat disagree	3% (n=21)
Strongly disagree	2% (n=19)
If people knew who I really am, they would accept me (N=789)	
Strongly agree	50% (n=393)
Somewhat agree	39% (n=304)
Somewhat disagree	8% (n=63)
Strongly disagree	4% (n=29)
I have formed a "chosen family," individuals whom I am not related biologically that offer support and encouragement (N=799)	
Yes	77% (n=617)

IV. Personal and Interpersonal Factors

Experiences Growing Up

Many early experiences have profound effects that can be felt throughout the lifespan. We examined both positive and negative childhood experiences among Speak Out respondents, including experiences of early support from family and peer groups; exposure to LGBTQ people, including adult role models; experiences of social isolation and bullying; and childhood sexual abuse.

Early Experiences of Support

A recent study found that family rejection related to sexual orientation and gender expression was significantly associated with poor health outcomes among LGB individuals. Specifically, LGB young adults who reported high levels of family rejection during adolescence were eight times more likely to report having attempted suicide, six times more likely to report high levels of depression, three time more likely to use illegal drugs, and three times more likely to have engaged in unprotected sexual intercourse compared to LGB peers who experienced little or no rejection from their families.[30]

Key Findings from Speak Out 2009 Related to Early Experiences of Support:

- Early experiences of support from family and peers varied significantly by gender.
- More than 2 in 3 Speak Out respondents (69%) said their family showed them unconditional love when growing up.
  - Men were most likely to report unconditional love growing up (73%), compared to 68% of women, 64% of genderqueer, and 56% of transgender respondents ($p = .042$).
- About 2 in 3 Speak Out respondents (61%) had at least one close friend to confide in when growing up.
  - Women (71%) and genderqueer respondents (70%) were more likely to report having a close friend growing up compared to transgender (50%) and male respondents (49%) ($p < .001$).
- About 1 in 3 respondents (36%) said they had an adult they could confide in when growing up.
  - 44% of women, 33% of genderqueer, 31% of males, and 26% of transgender respondents reported having an adult confidante when growing up ($p = .004$).

Table 4a: Early Support from Family and Peer Group

Question/Variable	% (n)
When I was growing up, my family showed me unconditional love (N=810)	
Strongly agree	36% (n=290)
Somewhat agree	33% (n=268)
Somewhat disagree	19% (n=152)
Strongly disagree	12% (n=100)
When I was growing up, I had at least one close friend I could confide in about anything (N=810)	
Strongly agree	31% (n=252)
Somewhat agree	31% (n=247)
Somewhat disagree	20% (n=159)
Strongly disagree	19% (n=152)
When I was growing up, I had at least one adult I could confide in about anything (N=808)	
Strongly agree	15% (n=121)
Somewhat agree	22% (n=181)
Somewhat disagree	31% (n=247)
Strongly disagree	32% (n=259)

Exposure to LGBTQI People

We asked two questions related to respondents' exposure to other LGBTQI individuals while growing up, including whether respondents had an openly-LGBTQI adult that they considered to be a role model.

Key Findings from Speak Out 2009 Related to Exposure to Other LGBTQI People while Growing Up:

- Few Speak Out respondents (33%) knew people who were openly LGBTQI while growing up, and even fewer (20%) had an adult role model who was LGBTQI.
- Younger people were far more likely to either say they knew openly LGBTQI individuals and/or that they had a role model. For example, 27% of respondents under 35 said they had a LGBTQI adult role model in their life growing up compared to 11% of respondents 55 and older ($p < .001$).

Table 4b: Early Exposure to LGBTQI Adults and Role Models

Question/Variable	% (n)
When I was growing up, I knew other people who were openly LGBTQI (N=806)	
Strongly agree	14% (n=112)
Somewhat agree	19% (n=156)
Somewhat disagree	19% (n=149)
Strongly disagree	48% (n=389)
When I was growing up, I had at least one adult I considered to be an LGBTQI role model (N=808)	
Strongly agree	9% (n=71)
Somewhat agree	11% (n=90)
Somewhat disagree	15% (n=117)
Strongly disagree	66% (n=530)

Social Isolation and Bullying

Studies—particularly those focused on youth— have found that negative at-school experiences, such as teasing, bullying, and other types of victimization, can have long-term negative health consequences. A 2009 study found that lesbian, gay, and bisexual (LGB) and sexually questioning youth were more likely to report high levels of bullying, homophobic victimization, and various negative outcomes than heterosexual youth. Students questioning their sexual orientation reported the most bullying, homophobic victimization, drug use, feelings of depression and suicidal thoughts, and more truancy than either heterosexual or LGB students.[31]

Another population-based study with youth found that the combined effect of LGB status and high levels of at-school victimization was associated with the highest levels of health risk behaviors. LGB youths reporting high levels of at-school victimization reported higher levels of substance use, suicidal thoughts, and sexual risk behaviors than heterosexual peers. Also, LGB youth reporting low levels of at-school victimization reported levels of substance use, suicidal thoughts, and sexual risk behaviors that were similar to heterosexual peers who reported low levels of at-school victimization.[32]

Key Findings from Speak Out 2009 Related to Social Isolation and Bullying:

- About 3 in 4 respondents (76%) felt they had to hide their sexual orientation growing up and 80% said they often felt they didn't fit in at school.
- Just under half of respondents (45%) said they were teased about their sexual orientation when growing up.
- Male respondents were significantly more likely to strongly agree with statements related to hiding their sexual orientation and being teased about it.
    - 2 in 3 male respondents (66%) strongly agreed they felt they needed to hide their sexual orientation compared to 42% each of transgender and genderqueer respondents and 33% of female respondents ($p < .001$).

- 80% of respondents either somewhat or strongly agreed that they felt they did not fit in at school.
  - Transgender and genderqueer respondents were significantly more likely to strongly agree that they felt they didn't fit in at school: 76% of transgender respondents strongly agreed that they felt they didn't fit in at school compared to 64% of genderqueer respondents, 49% of males, and 40% of females (*p* <.001).

Table 4c: Early Experiences with Social Isolation and Teasing

Question/Variable	% (n)
When I was growing up, I felt I had to hide my sexual orientation (N=805)	
Strongly disagree	13% (n=103)
Somewhat disagree	11% (n=92)
Somewhat agree	30% (n=239)
Strongly agree	46% (n=371)
When I was growing up, I was often teased about my sexual orientation (N=802)	
Strongly disagree	34% (n=276)
Somewhat disagree	21% (n=166)
Somewhat agree	27% (n=215)
Strongly agree	18% (n=145)
When I was growing up, I often felt I didn't "fit in" at school (N=809)	
Strongly disagree	9% (n=70)
Somewhat disagree	12% (n=94)
Somewhat agree	32% (n=260)
Strongly agree	48% (n=385)

Childhood Sexual Abuse

Several large cohort studies among a general health maintenance organization (HMO) population found that adverse childhood experiences, including childhood sexual abuse, were prevalent among all members, regardless of sexual orientation or gender identity; the abuse was associated with social problems (substance use and abuse, mental illness, and current problems with marriage and family), and negative health outcomes.[33,34] However, some studies have found disproportionate rates of childhood sexual abuse among sexual minority individuals compared to heterosexuals.[35,36,37,38] Studies specifically conducted with gay and bisexual men found a high prevalence of childhood sexual abuse and associations between the abuse and eating disorders,[39] psychological distress, substance use and HIV risk and infection.[40,41]

Key Findings from Speak Out 2009 Related to Childhood Sexual Abuse:

- 30% of Speak Out respondents (241/811) reported an experience of childhood sexual abuse, defined here as saying yes to the single question: "Before you were 18, did an adult or someone more than five years older than you ever force you to do something sexual with them or touch you in a sexual way?"

- Males were least likely to report childhood sexual abuse (24%). Genderqueer respondents reported the most childhood sexual abuse (42%), followed by transgender respondents (35%) and females (32%) (p =.017).

Disclosure, Support, Identity and Pride Related to Sexual Orientation and Gender Identity

Having social support has been related to positive health outcomes in many populations, including people who are elderly,[42] homeless,[43] and living with HIV disease.[44,45] Conversely, rejection after disclosure of sexual orientation has been independently associated with current and subsequent alcohol, cigarette, and marijuana use among gay, lesbian and bisexual youth.[46] Questions about disclosure, support, identity, and pride related to sexual orientation were asked of everyone; transgender and genderqueer respondents answered the same or similar questions related to gender identity.

Key Findings from Speak Out 2009 Related to Disclosure, Support, Identity and Pride:

- The vast majority of respondents were out to friends about their sexual orientation (98%) and/or gender identity (99%). Disclosure to family was similarly high related to sexual orientation (90%), but lower when it came to gender identity (75%).
  - Almost half of respondents (48%) said they were out and fully supported by their families related to sexual orientation; about 1 in 3 (34%) transgender and genderqueer respondents were out and fully supported by family related to gender identity.
  - Bisexuals were least likely to be out and fully supported by family (27%) compared to gay and lesbian (54%) or queer (42%) respondents ($p < .001$).
- Fairly high proportions were out to health care providers. More than 8 in 10 (85%) were out to health care providers about sexual orientation and 71% about gender identity.
- On average, there was a gap between the time respondents came out to themselves about sexual orientation (age 16) and gender identity (age 17) and when they came out to others; the average lapse was four years related to sexual orientation and six years related to gender identity.
- Most respondents answered affirmatively to gay or gender variant-positive identity items (e.g., “I feel good about being gay”) and negatively to gay or gender variant-negative identity items (e.g. “I would like to get help to change my gender from trans or genderqueer to non-gender variant”).

Table 5a: Disclosure to and Support from Others Related to Sexual Orientation and/or Gender Identity

Question/Variable	% (n)	% (n)
Are you out or open about your sexual orientation/gender identity to any of the following people right now?	**Sexual Orientation**	**Gender Identity**
Friends	98% (816/833)	99% (110/111)
Family	90% (746/825)	75% (81/108)
Health Care Providers	90% (702/783)	71% (71/100)
Classmates	89% (476/536)	62% (37/60)
Work colleagues	88% (641/732)	69% (63/92)
Employer	83% (593/720)	57% (54/94)
Faith Community	79% (257/324)	70% (26/37)
Neighbors	78% (582/750)	39% (40/103)
Out to everyone (e.g., all groups of people relevant to respondent)	66% (n=559/835)	31% (n=34/108)
Out and fully supported by family	48% (390/813)	34% (32/94)

Table 5b: Age of Disclosure to Self and Others

Question/Variable	% (n)	% (n)
	Sexual Orientation (N=822)	**Gender Identity (N=110)**
Age first self-identified as LGBQ/gender variant	Range 5-58 years Mean: 16 Median: 15	Range 2-63 years Mean: 17 Median: 17
Age first came out about orientation/gender identity to another person	Range 5-73 years Mean: 20 Median: 19	Range: 5-64 years Mean: 23 Median: 22

Table 5c. Sense of Identity and Pride Related to Sexual Orientation and/or Gender Identity

Question/Variable	% (n)	% (n)
I feel good about being… **…lesbian/gay/bisexual/queer (N=827)** **…trans/gender queer (N=106)**	**Sexual Orientation**	**Gender Identity**
Strongly agree	80% (n=658)	58% (n=61)
Somewhat agree	15% (n=125)	34% (n=36)
Somewhat disagree	3% (n=26)	6% (n=6)
Strongly disagree	2% (n=18)	3% (n=3)
The experience of being LGBTQ has offered me valuable insight in my life (N=824, sexual orientation; N=105 gender identity)		
Strongly agree	73% (n=597)	76% (n=80)
Somewhat agree	23% (n=189)	23% (n=24)
Somewhat disagree	3% (n=21)	1% (n=1)
Strongly disagree	2% (n=17)	0
I would like to get help to change my… **…sexual orientation from gay/lesbian/bisexual/queer to straight (N=826)** **…gender from trans or genderqueer to non-gender variant (N=103)**		
Strongly disagree	94% (n=780)	64% (n=66)
Somewhat disagree	2% (n=16)	26% (n=27)
Somewhat agree	1% (n=10)	5% (n=5)
Strongly agree	2% (n=20)	5% (n=5)
In general, I have tried to… **…stop being attracted to people of my same gender (N=825)** **…be the gender assigned to me at birth (N=103)**		
Strongly disagree	84% (n=694)	26% (n=27)
Somewhat disagree	9% (n=77)	28% (n=29)
Somewhat agree	4% (n=33)	37% (n=38)
Strongly agree	3% (n=21)	9% (n=9)

Self-Efficacy and Self-Esteem

Self-efficacy is the belief that one is capable of doing what is needed to attain certain goals. High levels of self-efficacy are often related to positive health outcomes. Self-esteem is a psychological construct that includes both self-confidence and self-acceptance. Although self-esteem is likely the concept that is more familiar to most Americans, self-efficacy may be more predictive of positive mental health and behavior change because it includes a sense of competence and control over one's life that is not included in the concept of self-esteem.

Key Findings from Speak Out 2009 Related to Self-Efficacy and Self-Esteem:

- Speak Out 2009 respondents indicated high levels of self-efficacy, with 80 - 95% agreeing that they could solve problems, get what they want in life, and deal efficiently with unexpected events.
- A majority of respondents also rated their sense of self-esteem as "very good" (37%) or "good" (42%).
- There were no differences in reported levels of self-efficacy or self-esteem by gender or sexual orientation.

Table 6: Self-Efficacy and Self-Esteem

Question/Variable	% (n)
I can always manage to solve difficult problems if I try hard enough (N=825)	
Strongly agree	56% (n=461)
Somewhat agree	38% (n=317)
Somewhat disagree	4% (n=31)
Strongly disagree	2% (n=16)
If someone opposes me, I can find the means and ways to get what I want (N=824)	
Strongly agree	24% (n=195)
Somewhat agree	56% (n=465)
Somewhat disagree	16% (n=136)
Strongly disagree	3% (n=28)
I am confident that I could deal efficiently with unexpected events (N=824)	
Strongly agree	52% (n=432)
Somewhat agree	40% (n=326)
Somewhat disagree	6% (n=50)
Strongly disagree	2% (n=16)
I can solve most problems if I invest the necessary effort (N=824)	
Strongly agree	60% (n=498)
Somewhat agree	35% (n=288)
Somewhat disagree	3% (n=25)
Strongly disagree	2% (n=13)
How would you rate your self-esteem? (N=826)	
Very good	37% (n=306)
Good	42% (n=347)
Could be better	19% (n=158)
Poor	2% (n=15)

Gender Conformity

Gender nonconformity—or variance from social norms related to how males and females are expected to act and look—has been associated with parental and peer rejection in childhood[47,48] and suicidality and poor adjustment in adolescence.[49,50] In adulthood, gender nonconformity has been associated with psychological distress among gay and bisexual males[51,52] and anti-gay prejudice and discrimination.[53]

However, the relationship between gender identity and adjustment has been shown to vary across racial/ethnic groups, and more needs to be known about how the meaning of gender is constructed in different cultures.[54]

Key Findings from Speak Out 2009 Related to Gender Conformity:

- More than half of all Speak Out 2009 respondents (52%) said they often or always tried to conform to social expectations about gender growing up; only 14% said they often or always try to conform currently.
  - Transgender (64%) and male (57%) respondents were significantly more likely to report always or often trying to conform to gender norms when growing up ($p = .004$).
- 37% of respondents experienced harassment always or often while growing up because of acting "too masculine or too feminine;" about 5% currently experience harassment always or often for this reason.
- There were significant differences by gender and sexual orientation related to gender-based harassment growing up:
  - Females reported, by far, the least amount of harassment (27%) compared to 41% of males, 56% of transgender respondents, and 62% of genderqueer respondents ($p < .001$).
  - Bisexuals (18%) reported significantly less harassment than gay men and lesbians (38%) or queer-identified respondents (40%) ($p < .001$).

Table 7. Experiences with Gender Conformity while Growing Up and Currently

Question/Variable	% (n)	% (n)
In terms of your physical appearance, how masculine or feminine are/were you?	**Growing Up N=811**	**Currently N=801**
Very Masculine or Feminine	18% (n=146)	26% (n=210)
Somewhat Masculine or Feminine	63% (n=510)	58% (n=467)
Androgynous	19% (n=151)	16% (n=124)
Did/do you try to change your behavior and/or appearance to conform to social expectations for boys or girls?	**Growing Up N=805**	**Currently N=805**
Never	13% (n=103)	37% (n=294)
Rarely	36% (n=291)	50% (n=402)
Often	42% (n=334)	12% (n=94)
Always	10% (n=77)	2% (n=15)
Harassed for acting too masculine or feminine?	**Growing Up N=806**	**Currently N=805**
Never	24% (n=192)	52% (n=417)
Rarely	40% (n=323)	43% (n=348)
Often	31% (n=247)	5% (n=39)
Always	6% (n=44)	<1% (n=1)

V. Access to Medical Care

Access to culturally competent, high quality medical care and preventive health services is essential to improving health equity, quality of life, and longevity. Many people in the United States, including LGBTQI individuals, have difficulty accessing medical care because they lack health insurance or the financial resources to pay for medical visits or procedures. In addition, LGBTQI individuals may face additional barriers due to discrimination, stigma, and/or care that is not culturally proficient. A 2009 study conducted in Washington State found that lesbian and bisexual women had poorer access to health care than their heterosexual peers,[2] a finding consistent with previous studies of sexual minority and heterosexual women.[55] A large national study using pooled data from more than 90,000 individuals also found that women in same-sex relationships were significantly less likely than women in opposite-sex relationships to have health insurance coverage, to have seen a medical provider in the previous 12 months, and to have a usual source of health care, and they were more likely to have unmet medical needs due to cost.[56] In contrast, the same study found that health care access among men in same-sex relationships was equivalent to or greater than access among men in opposite-sex relationships.

Transgender people face significant barriers to accessing healthcare, both for general medical care and for transition-related services. Needs assessments in Virginia and Philadelphia found that almost 25% of the respondents experienced discrimination by healthcare providers, including being denied healthcare altogether.[4,57] Institutional barriers such as poorly designed and/or non-inclusive intake forms, medical staff using incorrect pronouns, and binary gendered bathrooms also create difficulties for transgender people in accessing appropriate healthcare.[58,59,60]

Key Findings from Speak Out 2009 Related to Access to Medical Care:

- Most respondents (83%) reported having some kind of health insurance or health care coverage, similar to the overall Oregon adult population (84%).
  - However, health insurance coverage varied significantly by gender: males were most likely to have coverage (90%); transgender respondents were least likely (68%).
  - Few transgender and genderqueer respondents (12%) reported having insurance that covers trans-specific healthcare, such as hormone therapy and/or gender-confirmation surgery.[b]
- Despite high overall rates of health care coverage, almost 1 in 3 respondents (30%) reported needing health care in the past year, and not being able to access it because of cost.
  - Financial barriers to health care varied significantly by gender, with half of transgender respondents experiencing financial barriers compared to about 1 in 3 female and genderqueer respondents and about 1 in 5 males.

[b] The survey question did not ask about comprehensive coverage of trans-specific health care needs, so we don't know what level of trans-specific health services the 12% of respondents are able to receive through their insurance plans.

- Almost 1 in 10 respondents (9%) said they couldn't get needed health care in the past year because they feared discrimination.
  - Transgender and genderqueer individuals were three and five times more likely, respectively, than their male and female counterparts to avoid needed health care because they feared discrimination by a health care provider.

Table 8a: Overall Access to Health Care

Question / Variable	% (n)
Have health insurance/health care coverage	83% (679/821)
Needed health care past 12 months, but couldn't get it because of cost/lack of insurance	30% (243/823)
Needed health care past 12 months, but couldn't get it because of fear of discrimination	9% (70/823)
Access to queer-friendly health care*	74% (586/795)
Have insurance that covers trans health care (trans/genderqueer respondents only)	12% (12/100)

*this constructed variable includes people who have health insurance/health care coverage and are out about their orientation to their health care provider.

Transition-Related Medical Care

Transition-related medical care can be essential for the safety and well-being of transgender individuals, and typically includes hormone therapy and/or surgical procedures. Access to appropriate transition-related medical care has been associated with increased quality of life and improved mental health status.[61,62,63] Transgender people face multiple barriers to accessing transition-related medical care, perhaps most significantly financial barriers, including insurance exclusions. There is increasing acceptance that these services are medically necessary and should not be considered cosmetic in nature, including a resolution passed by the American Medical Association[64] and a recent ruling in federal tax court that transition costs are deductible as necessary medical expenses.[65] Despite this progress, only 6% of Fortune 500 companies offered transgender-inclusive insurance policies in 2008.[66] Transition-related medical needs and barriers for genderqueer individuals are unknown.

Key Findings from Speak Out 2009 Related to Transition-Related Medical Care:

- Most transgender respondents (80%) are either taking hormones or have had gender-related surgery.
- While only 6 % of genderqueer respondents have used hormones or had surgery, 38% desired some form of body modification.
- Of those respondents with a need or desire for body modification, 93% of transgender (37 of 40) and 52% of genderqueer respondents (11 of 21) face financial barriers to accessing those services, which are not covered by health insurance for the vast majority of respondents.

Table 8b: Medical Transition Status of Transgender (N=50) and Genderqueer Respondents (N=55)

Variable	Transgender % (n)	Genderqueer % (n)
Currently take hormones		
Yes	80% (n=40)	4% (n=2)
No	20% (n=10)	96% (n=53)
Have sex reassignment (SRS)/gender confirmation surgery		
Yes	52% (n=26)	6% (n=3)
No	48% (n=24)	95% (n=52)
Desire body modifications		
Yes	80% (n=40)	38% (n=21)
No	20% (n=10)	62% (n=34)
Want but can't afford surgery or body modifications		
Yes	74% (n=37)	20% (n=11)
No	26% (n=13)	80% (n=44)

VI. Health Behaviors

Physical Activity and Nutrition

Physical activity and good nutrition are two of the most important things people can integrate into their lives in order to prevent obesity and chronic diseases like diabetes, heart disease, and stroke. The Surgeon General recommends that people of all ages engage in 30 minutes of moderately intense exercise like brisk walking on most, if not all, days of the week, and encourages more vigorous intensity or physical activity of longer duration for even greater health benefits.[67] Most adults should also eat 4 ½ cups of fruits and vegetables per day for optimal health, which is the equivalent of about 10 servings.

Few studies have looked at physical activity and nutrition among LGBTQI populations. One population-based, national study examined differences in nutritional habits among women by sexual orientation, but found no significant differences between sexual minorities and heterosexuals.[68]

Key Findings from Speak Out 2009 Related to Physical Activity and Nutrition:

- LGBTQI respondents need to increase their fruit and vegetable consumption. Only 16% of Speak Out respondents reported eating five or more servings per day. This proportion is much lower than the current recommendation, and lower than Oregon adults overall (27%).
- About 2 in 3 LGBTQI respondents (65%) reported getting an average of at least five days per week of moderate exercise.
- Compared with the Oregon BRFSS, which uses a different measure for levels of physical activity, Speak Out respondents appear to be more physically active, with only 2% reporting engaging in <u>no</u> moderate physical activity on a weekly basis.
- There were no significant differences by gender or sexual orientation related to consumption of fruits and vegetables or levels of physical activity.

Table 9: Physical Activity and Nutrition

Question/Variable	% (n)
Typical number of daily servings of fruits & vegetables (N=816)	
None (0 servings)	1% (n=9)
1-2 servings a day	44% (n=362)
3-4 servings a day	39% (n=318)
5+ servings a day	16% (n=127)
Typical days per week of moderate physical activity (N=814)	
0 days	2% (n=17)
1-2 days	9% (n=72)
3-4 days	25% (n=198)
5+ days	65% (n=527)
Typical days per week of vigorous physical activity (N=814)	
0 days	17% (n=139)
1-2 days	31% (n=249)
3-4 days	31% (n=256)
5+ days	20% (n=170)

Substance Use, Including Tobacco, Alcohol & Other Drugs

Use of alcohol and other drugs is frequently measured in LGBTQI communities. Studies have found increased use of alcohol among LGB individuals compared to heterosexuals, particularly among lesbians and bisexual women.[69,70,71,72] Increased rates of substance abuse in transgender communities have also been documented.[7, 57] A 2009 study using a large national sample found considerable variation in substance use outcomes across sexual orientation dimensions, and these variations were more pronounced among women than among men.[73] This indicates that risks of alcohol use and dependence among lesbians, gay men, and bisexuals (LGB) appear to vary based on gender and how sexual orientation is defined, and prevention efforts and other programming should consider these differences when designing interventions for LGB populations. Furthermore, some findings suggest that disparities in alcohol use among youth with a minority sexual orientation emerge in early adolescence and persist into young adulthood,[74] indicating that prevention should start early.

Lesbian, gay, and bisexual individuals have been found in numerous studies to have smoking rates that are about twice as high as heterosexuals,[75,76,77, 78] likely due, in part, to excessive marketing of cigarettes to LGB populations by the tobacco industry.[79] Despite a disparity in smoking rates, LGB populations in the Pacific Northwest have been found to have similar knowledge, attitudes, and behaviors related to tobacco control, such as quit attempts or knowledge of secondhand smoke dangers.[80] Research on the use of other recreational drugs among LGB populations has also found high rates of use.[81,82] For example, a population-based study conducted in 2009 found rates of marijuana use among LGB respondents to be three to five times higher than among exclusively heterosexual respondents.[83]

Key Findings from Speak Out 2009 Related to Use of Alcohol, Tobacco, and Other Drugs:

- LGBTQI respondents reported higher alcohol and tobacco use than the overall Oregon adult population, and marijuana use was also common.
- 78% LGBTQI reported drinking alcohol in the past 30 days compared to 60% of Oregon adults. Just over 1 in 4 (27%) LGBTQI respondents reported drinking every day or every other day.
- 29% LGBTQI reported smoking cigarettes in the past 30 days compared to 17% of Oregon adults.
- 1 in 4 Speak Out respondents smoke marijuana;[c] about one-third of current marijuana smokers smoke daily or every other day.
  - Queer respondents were significantly more likely to smoke tobacco ($p = .02$) and marijuana ($p < .001$) compared to bisexual or gay/lesbian respondents.
  - There were no differences by gender.
- Use of other drugs was less commonly reported: 7% used one or more of a range of drugs including stimulants or heroin, and 1% used methamphetamine.
  - Males were significantly more likely ($p < .001$) to report using Ecstasy, GHB, poppers, cocaine, or heroin than respondents of other genders. For example,

[c] The survey did not differentiate between recreational marijuana use and medicinal marijuana use by registered Oregon Medical Marijuana cardholders.

14% of males reported use in the past 30 days compared to 6% of genderqueer respondents, who reported the next highest us

Table 10: Use of Alcohol & Other Drugs, Past 30 Days

Question/Variable	% (n)
Used alcohol, including beer, wine, hard liquor/mixed drinks? (N=818)	78% (n=638)
If yes, how often?* (N=638)	
Very often	27% (n=169)
Somewhat often	40% (n=252)
Rarely	34% (n=217)
Used cigarettes/tobacco? (N=817)	29% (n=237)
If yes, how often?* (N=237)	
Very often	55% (n=130)
Somewhat often	19% (n=44)
Rarely	27% (n=63)
Used marijuana? (N=812)	25% (n=203)
If yes, how often?* (N=203)	
Very often	32% (n=64)
Somewhat often	27% (n=54)
Rarely	42% (n=85)
Used Ecstasy, GHB, Poppers, Cocaine, Heroin? (N=771)**	7% (n=54)
If yes, how often?* (N=54)	
Very often	4% (n=2)
Somewhat often	24% (n=13)
Rarely	72% (n=39)
Used methamphetamines or crystal? (N=600)**	2% (n=12)
If yes, how often?* (N=12)	
Very often	8% (n=1)
Somewhat often	17% (n=2)
Rarely	75% (n=9)

*Scale used defined as: very often= daily/every other day; somewhat often=1 to 2 times per week; rarely = a few times per month

**Readers should view items with large amounts of missing data with healthy skepticism.

Sexual Behavior

Early sexual initiation and risky sexual behavior in adolescence has been shown to be more common in LGB adolescents compared to those who define themselves as heterosexual or mostly heterosexual.[84,85] Unprotected vaginal or anal sex, particularly with multiple partners, is associated with the spread of sexually transmitted infections, including HIV. Some behaviors may contribute to sexual risk, such as having sex while drunk or high or trading sex for drugs or money. Other behaviors may help reduce sexual risk, such as use of latex barriers, mutually monogamous sex or clear communication with sexual partners about sexual health.

We asked questions about sexual attraction and experiences, as well as a range of sexual behaviors.

Key Findings from Speak Out 2009 Related to Sexual Attraction and Experiences:

- Data on sexual attraction and experiences were similar, but not identical, demonstrating the importance of distinguishing between behavior, attraction, and identity as distinct components of sexuality.

Table 11a. Sexual Attraction and Experiences

Question/Variable	% (n)	% (n)
Sexual attraction and experiences	**Sexual Attraction (N=802)**	**Sexual Experiences (N=803)**
One gender (male or female) only	23% (n=188)	24% (n=194)
Predominantly male or female, but at least once to/with the other gender	52% (n=414)	54% (n=430)
Equally to males and females	10% (n=79)	11% (n=90)
People across the gender spectrum	15% (n=120)	10% (n=83)
Never felt sexually attracted/had sexual experience with anyone	<1% (n=1)	<1% (n=6)

Key Findings Related to Sexual Behavior:

- More than half of respondents (56%) reported zero or one sexual partner in the past year, but these data varied significantly by gender, with males reporting significantly more partners:
  - 32% of males reported five or more past-year partners compared to 16% of transgender respondents, 15% of genderqueer, and 2% of females ($p < .001$).
- About half of respondents (49%) had known their last sexual partner for more than one year.
  - However, almost 1 in 3 males (29%) reported their last sexual encounter to be with someone they had known less than 24 hours compared to 8% of transgender, 6% of genderqueer, and 2% of female respondents ($p <.001$).
- People who had known their last sex partner for a longer amount of time reported significantly higher physical pleasure and emotional satisfaction ($p < .001$)

Table 11b. Sexual Health Behavior

Question/Variable	% (n)
Number of past-year sexual partners (N=797)	
0	14% (n=109)
1	42% (n=338)
2-5	29% (n=230)
6-10	8% (n=61)
11-20	4% (n=30)
21+	4% (n=29)
In your most recent sexual encounter, how long did you know the person before having sex? (N=688)	
Less than 24 hours	13% (n=87)
A few days	7% (n=46)
A few weeks/months	22% (n=153)
6 -12 months	10% (n=66)
More than 1 year	49% (n=336)
How physically pleasurable was your most recent sexual encounter? (N=688)	
Extremely	38% (n=258)
Very	35% (n=243)
Moderately	17% (n=118)
Not Very	8% (n=55)
Not at All	2% (n=14)
How emotionally satisfying was your most recent sexual encounter? (N=688)	
Extremely	33% (n=225)
Very	29% (n=198)
Somewhat	20% (n=138)
Not Very	11% (n=73)
Not at All	8% (n=54)
Potentially risky sexual behaviors	
Had sex while drunk or high	42% (280/670)
Had sex with someone you just met	29% (195/670)
Had sex with someone you met on the Internet	21% (142/672)
Traded sex for money	2% (13/669)
Traded sex for drugs or something else of value	2% (14/670)
Sexual harm reduction	
Had sex with one person who you believe is monogamous	50% (335/670)
Always talked with new partners about sexual health histories	52% (333/646)

VII. Health Outcomes

Overall Physical and Mental Health Status, Including Chronic Conditions

Existing data suggest that important health disparities exist between LGBTQI people and their heterosexual and non-transgender peers. A 2009 population-based study from Washington State found that lesbian and bisexual women were more likely than heterosexual women to have poor physical and mental health, asthma, and—for bisexuals only-- diabetes. They also reported poorer access to health care and less frequent use of preventive services. Gay and bisexual men were more likely than heterosexual men to have poor mental health, and were more likely to report having to limit their activities because of poor health. Bisexuals of both genders reported the greatest number and magnitude of health disparities compared to heterosexuals.[86] Other studies have found similarly elevated chronic disease risks among LGB populations, particularly among lesbians and bisexual women.[87, 88]

Mental health disparities have also been demonstrated among LGBTQ populations, including increased rates of depression, anxiety, and suicidal thoughts and attempts.[89,90,91,92] How sexual and gender minority status and poor mental health are associated is not well-understood. However, a 2009 meta-analysis, while confirming the high prevalence of mental health conditions among LGB populations, found that rates varied from place to place, leading the author to conclude that policy regimes, health programming, and the ways in which sexual minority status is viewed in different nations and regions all contribute to mental health outcomes;[93] in other words, mental health disparities may be at least partially socially constructed.

Key Findings from Speak Out 2009 Related to Physical and Mental Health Status:

- 9 in 10 respondents rated their overall health as good (30%), very good (40%) or excellent (20%). These proportions are similar to those reported by the Oregon adult population.
- A lower proportion of LGBTQI respondents reported zero days of mental (35% LGBTQI vs. 67%) and physical (41% vs. 63%) disability than Oregon adults overall.
  - Days of mental and physical disability varied significantly by gender ($p < .01$), with transgender respondents reporting the most days of disability, followed by gender queer, female, and male respondents.
  - Transgender individuals reported about twice as many days of each type of disability as males.
- There were high rates of diagnosed mental health conditions like depression (56%), anxiety (50%), and post-traumatic stress (21%) among respondents overall.
  - Transgender respondents reported the highest rate of diagnosed depression by far: 72% compared to 60% of females, 58% genderqueer, and 47% of males ($p < .001$).

- Transgender and female respondents were significantly more likely to report a diagnosis of anxiety (58% for each group) compared to 54% of genderqueer and 36% of males ($p < .001$).
- Bisexuals and queers were significantly more likely to report a diagnosis of anxiety and depression than gay/lesbian respondents ($p < .001$).
- The pattern related to post-traumatic stress (PTSD) diagnosis varied slightly for gender, with 28% of female, 26% of genderqueer, and 24% of transgender respondents reported diagnosed post-traumatic stress compared to 11% of males ($p < .001$).
- Queer and bisexual respondents reported higher rates of PTSD diagnosis than gay/lesbian respondents ($p = .04$).

- The current prevalence of mental health conditions may be somewhat higher or lower, given the survey question asked about conditions that have been diagnosed by a health care provider. It is likely that some people with these conditions have not had a formal diagnosis. On the other hand, some respondents may be managing their conditions effectively, and would not currently report problems related to the diagnosed condition.

Table 12: Physical and Mental Health Status

Question/Variable	% (n)
How would you rate your overall health? (N=823)	
Excellent	20% (n=162)
Very good	40% (n=331)
Good	30% (n=248)
Fair	9% (n=72)
Poor	1% (n=10)
Number of days in past 30 days that physical health was not good (N=803)	
0 days	41% (n=326)
1-14 days	54% (n=431)
15-29 days	4% (n=34)
30 days	2% (n=12)
Number of days in past 30 days that mental health was not good (N=799)	
0 days	35% (n=278)
1-14 days	53% (n=425)
15-29 days	10% (n=78)
30 days	2% (n=18)
Ever had the following conditions, diagnosed by health care provider:	
Depression	56% (456/816)
Anxiety	50% (402/812)
Asthma	23% (189/808)
Post traumatic stress	21% (174/812)
High cholesterol	21% (169/811)
Heart/cardiovascular disease or high blood pressure	18% (146/808)
Gender identity dysphoria/disorder	7% (60/808)
Diabetes	6% (50/808)
Cancer	6% (50/807)
Hep B	4% (34/805)
Hep C	2% (19/804)

Sexual Health

Men who have sex with men (MSM), regardless of how they define their sexual orientation, bear a disproportionate burden of HIV infection in Oregon.[94] National projections indicate that HIV will adversely affect the health of gay male communities for decades to come; a 2009 study calculated a mean incidence rate of 2.39% for MSM in the United States, which if sustained within a cohort of MSM would yield HIV prevalence rate of approximately 40% at age 40.[95] Previous studies have shown very high HIV prevalence rates among transgender women: a recent meta-analysis showed 28% of MTF respondents tested positive for HIV (4 studies) and 12% self-reported a positive HIV status (18 studies).[96] When interpreting these high prevalence rates, it is important to remember that most of these studies were conducted through HIV prevention organizations and focus on trans women engaging in high-risk activity, primarily sex work and survival sex. Although transgender men in two needs assessments have had lower rates of HIV at 2-3%,[7,9] most studies on HIV prevalence among transgender people have excluded this population. Transgender men may be more likely to engage in high risk sexual activity[97] and have lower testing rates and knowledge of HIV than transgender women.[98] Transgender men who have sex with men (TMSM) may be at a particularly high risk and programs in Ontario[99] and San Francisco[100] have begun to explore the HIV prevention needs of this population.

Gonorrhea and chlamydia are common sexually transmitted infections (STI); in Oregon, rates are highest among African Americans, younger age groups, and women. Syphilis is less common in Oregon, but increased to a rate of about 1.5/100,000 in 2002, and has remained relatively close to that rate ever since. Most syphilis cases in Oregon are among MSM, and a large proportion of MSM cases are also HIV-positive.[101]

Key Findings from Speak Out 2009 Related to Sexual Health:

- The overall proportion of the Speak Out population who had ever been diagnosed with syphilis, gonorrhea, chlamydia or HIV was higher than the overall population. However, males accounted for most of these infections (75% of STIs and 93% of HIV). Overall:
  - 25% of males reported a history of syphilis, gonorrhea or chlamydia compared to 9% of genderqueer, 4% of transgender, and 2% of females ($p < .001$).
  - 18% of males were HIV positive compared to 4% genderqueer, <1% women, and no transgender respondents ($p < .001$).

Table 13: Sexual Health Conditions

Question/Variable	% (n)
Have the following conditions, diagnosed by health care provider:	
Syphilis/Chlamydia/Gonorrhea	12% (93/793)
What is your HIV status? (N=818)	
Positive	7% (n=56)
Negative	85% (n=692)
I don't know	9% (n=70)

Intimate Partner Violence[d]

National BRFSS data from 18 states and territories, including Oregon, found that 24% of women and 12% of men reported physical or sexual violence by an intimate partner at some point in their lives; 1.5% of women and .7% of men reported intimate partner violence (IPV) in the past 12 months.[102] IPV has been associated with poor health outcomes. Specifically, a 2008 study found that women and men who reported IPV victimization during their lifetime were more likely to report joint disease, current asthma, activity limitations, HIV risk factors, current smoking, heavy/binge drinking, and not having had a checkup with a doctor in the past year.[103]

Existing data suggest that the prevalence of IPV among people in same-sex relationships is high, although it is unclear whether the prevalence is higher, lower or about the same for heterosexual couples, same-sex male couples, and same-sex female couples.[104,105,106]

Key Findings from Speak Out 2009 Related to Intimate Partner Violence:

- Both lifetime and past-year prevalence of IPV appear to be elevated among Speak Out respondents compared to Oregon residents overall.
- 4 in 10 respondents reported experiencing IPV, defined as physical violence or unwanted sex with an intimate partner, at some point in their lives. Prevalence of IPV varied significantly by gender and sexual orientation:
  - Genderqueer respondents reported lifetime IPV most often (56%), followed by transgender (50%), women (44%), and male (28%) respondents ($p < .001$).
  - Queer (58%) and bisexual (53%) respondents reported a higher proportion of lifetime IPV than gay/lesbian (31%) respondents ($p < .001$).
- About 4% of LGBTQI respondents reported IPV in the past year.
- We do not know how much of the lifetime and past-year IPV occurred within same-sex relationships because the questions did not ask about the perpetrator's identity.

Table 14: Intimate Partner Violence (N=814)

Question/Variable	% (n)
Lifetime experiences of intimate partner violence	40% (n=322)
Past-year experiences of intimate partner violence	4% (n=31)

[d] Intimate partner violence (IPV) is most broadly defined as emotional, physical, and/or sexual violence between two people who are or have been romantically or sexually linked, such as current or former partners, dates or spouses. Some definitions of IPV may include other forms of violence like economic control or threats of violence. IPV is a more specific term than 'domestic violence.'

VIII. Predictors of Health Behaviors and Health Outcomes

Relationships between Social Determinants, Demographic Factors and Health Outcomes

As noted in previous sections, studies among LGBTQ populations have found relationships between negative experiences (e.g., stigma, discrimination, and rejection), negative health behaviors (e.g., alcohol and drug use, risky sex) and poor health outcomes (e.g., depression, poor physical health). Because we collected a substantial amount of data related to protective factors like positive childhood experiences and formal recognition of relationships, we wanted to expand our perspective to explore the relationship between protective factors and health outcomes.

We used forward stepwise logistic regression to examine the relationship between the predictive variables listed below and the outcomes of depression, anxiety, and overall physical health. We controlled for age, race/ethnicity, and education in each model.

Predictive variables were chosen based on associations at the bivariate level and variables of interest (e.g., gender, sexual orientation). Factor analysis was used for data reduction. New variables (factors) were created based on theory and the results of the factor analysis; for example, a scale variable measuring social isolation growing up was created representing three original variables. These new multiple-scale variables were used in the logistic regression. Predictive variables included:

- Isolation growing up (three-item scale variable that included hiding sexual orientation, teased about orientation, not fitting in at school)
- Support growing up (three-item scale variable that included unconditional love from family, peer confidante, adult confidante)
- Current community connection (five-item scale)
- Self-efficacy (four-item scale)
- Out about sexual orientation and fully supported by family
- Gender
- Sexual orientation

Key Findings from Speak Out 2009 Related to Physical Health Outcomes:

The following factors were associated with better overall physical health:

- Being out and fully supported by family
- Having stronger community connections
- Having higher self-efficacy
- Having fewer experiences of social isolation and teasing growing up

In addition, higher education, younger age, male gender, and non-Hispanic ethnicity were also associated with better overall physical health.

Key Findings from Speak Out 2009 Related to Mental Health Outcomes:

The following personal and interpersonal factors were associated with a lower likelihood of having depression and anxiety:

- Having fewer experiences of social isolation and teasing growing up
- Having social support growing up (depression only)
- Having higher self-efficacy (anxiety only)

In addition, gay and lesbian respondents were significantly less likely to report depression or anxiety than bisexual or genderqueer respondents. Males were also significantly less likely to report poor mental health outcomes compared to females, transgender or genderqueer (for anxiety only) respondents. Finally, although subgroup numbers were small, Native Americans may be less likely to report depression and Asian/Pacific Islanders less likely to report anxiety.

IX. Epilogue: Making Life Better for LGBTQI Individuals in the Portland Area

More than three-fourths of respondents (76%, n=644) volunteered at least one open-ended answer to the question: "What two things would make life better for you as a LGBTQI individual?" These short, open-ended answers were analyzed and coded into themes, which represent the views of multiple individuals; numbers and percents are given to show how frequently the theme was mentioned. Quotes illustrating the major themes are included in italics. These quotes provide good examples of the theme, but are not exhaustive.

Speak Out respondents identified four major things that would make life better for LGBTQI people: increased awareness and education related to LGBTQI issues; equal rights; health care and social services; and social opportunities.

Twenty-six percent of respondents who provided an answer (n=166) said that increased awareness and education of LGBTQI issues would improve life for LGBTQI people. Responses focused on teaching respect; increasing understanding, tolerance, and acceptance; decreasing discrimination; and putting an end to labeling. Of those, some people focused on increased awareness within specific communities, including the LGBTQI community (n=15), the straight or heterosexual community (n=11), faith communities (n=8), the police department (n=7), and health care providers (n=4).

- *We need more positive public LGBT adult role models for kids growing up, especially in more rural areas and areas outside of the heart of the Metro area.*
- *Inclusiveness: there's too much segregation between the L's, G's, B's, T's, Q's and I's.*
- *Ongoing education for the straight community to improve awareness of issues and increase comfort level for gender and relational diversity.*
- *Community-wide understanding of the challenges facing the LGBT population.*

Twenty-five percent of people who responded to the open-ended questions (n=164) identified equal rights as something that would improve life for them. Responses covered an array of topics, including better legal protections, improved enforcement of hate crime laws, and equal opportunity in general. The most common sub-category within the theme of equal rights, mentioned by 96 people (15%), was having an equal right to marriage.

- *Having the right to marry, and having equal rights under the law*
- *Right to marry, serve in military, equal to heterosexuals*
- *Freedom from being fired/[prevent] employment discrimination*

Thirteen percent of respondents (n=86) mentioned the importance of health care and social services, specifically access to LGBTQI-appropriate care across the treatment spectrum (e.g., primary medical care, mental health services, and alcohol and drug

treatment), health insurance, and increasing the number of LGBTQI providers of health care and social services.

- *Access to affordable health care*
- *Queer-specific advocates in all realms of social services, especially in the domestic and sexual violence programs*

Nine percent of respondents (n=59) said that increased social opportunities would improve their lives, including LGBTQI-focused social events that do not involve drugs or alcohol, more places to congregate (e.g., community center), and more social and community events.

- *More queer-friendly events/places to go*
- *Better social opportunities outside of bars*
- *More inclusive events with all ranges of sexual orientation*

X. Next Steps

This report was the first local collection of LGBTQ health and wellness data. As such we want to make effective use of the information and hope that readers can do the same. We encourage you to share this report with your friends and colleagues, talk to elected officials and policy makers about LGBTQ health, and become involved in the community to support health and wellness.

The survey results will be used to continue building momentum to document and address local LGBTQ health disparities. A coalition of committed organizations that includes The Quest Center for Integrative Health, Outside In, the Q Center, Basic Rights Oregon, Cascade AIDS Project and the Multnomah County Health Department are seeking additional funding to conduct a Community Based Participatory Research process to gather additional information on LGBTQ Health, particularly from people who were underrepresented in this initial survey (e.g., older LGBTQ, intersex individuals, people of color), and to develop and prioritize a social service and policy agenda to address LGBTQ health inequity.

In addition, further analyses of these data will include additional examination of relationships between protective factors and health behaviors and outcomes, and additional subgroup analysis.

References

[1] Gay & Lesbian Medical Association. Healthy People 2010 Companion Document for Lesbian, Gay, Bisexual and Transgender Health. San Francisco, CA: Gay & Lesbian Medical Association, 2001.

[2] Dilley J, Wynkoop Simmons K, Boysun M, Pizacani B, Stark M. 2009. Demonstrating the importance and feasibility of including sexual orientation in public health surveys: Health disparities in the Pacific Northwest. Am J Public Health; 99 (10):1-8.

[3] Johnson CV, Mimiaga MJ, & Bradford J. 2008. Health care issues among lesbian, gay, bisexual, transgender and intersex (LGBTI) populations in the United States: introduction. *Journal of Homosexuality*. 54(3):213-224.

[4] Carson L. 2009. Physical and emotional health needs of transgender individuals in Philadelphia: Summary of key findings, Report. Pennsylvania Department of Public Health, Commonwealth Universal Research Enhancement (CURE) Program.

[5] JSI Research and Training Institute. 2000. Access to health care for transgendered persons in greater Boston, Report. *Transgender Health Care.*

[6] Kenagy GP. 2005. Transgender health: Findings from two needs assessment studies in Philadelphia. *Health & Social Work.* 30(1):19-26.

[7] Xavier J. 2000. The Washington, DC Transgender Needs Assessment Survey: Final report for phase II. Funded by the Administration for HIV/AIDS of the District of Columbia Government.

[8] Kenagy, GP, Bostwick, WB. (2005). Health and social service needs of transgender people in Chicago. *International Journal of Transgenderism*. 8(2/3)57-63.

[9] Clements-Nolle K, Marx R, Guzman R, Katz M. 2001. HIV prevalence, risk behaviors, health care use, and mental health status of transgender persons: Implications for public health intervention. *American Journal of Public Health.* 91(6):915-921.

[10] AL Zimmerman and P Geist-Martin. 2006 The hybrid identities of genderqueer: Claiming neither/nor, both/and. *Intercultural communication: A reader* (11th ed).

[11] Factor RJ & Rothblum E. 2008. Exploring gender identity and community among three groups of transgender individuals in the United States: MTFs, FTMs, and genderqueers. *Health Sociology Review*, 17 (3): 235-253.

[12] http://www.statisticssolutions.com/general-self-efficacy-schwarzer

[13] Pitts M, Smith A, Mitchell A, Patel S. 2006. *Private lives: A report on the health and well-being of LGBTI Australians.* Melbourne: Australian Research Centre in Sex, Health and Society.

[14] Bowen DJ, Bradford J, & Powers D. 2006. Comparing sexual minority status across sampling methods and populations. *Women & Health*. 44(2):121-34.

[15] Marcus U, Schmidt AJ, Hamouda O, & Bochow M. 2009. Estimating the regional distribution of men who have sex with men (MSM) based on Internet surveys. *BMC Public Health*. 9:180-191.

[16] Mayer KH, Bradford JB, Makadon HJ, Goldhammer H, & Landers S. 2008. Sexual and gender minority health: what we know and what needs to be done. *American Journal of Public Health*. 98(6):989-95.

[17] Meyer IH & Colten ME. 1999. Sampling gay men: random digit dialing versus sources in the gay community. *Journal of Homosexuality*. 37(4):99-110.

[18] Herek GM. 2008. Hate crimes and stigma-related experiences among sexual minority adults in the United States: prevalence estimates from a national probability sample. *Journal of Interpersonal Violence*. 24(1):54-74.

[19] D'Augelli AR, Grossman AH, & Starks MT. 2006. Childhood gender atypicality, victimization, and PTSD among lesbian, gay, and bisexual youth. 2006. *Journal of Interpersonal Violence*. 21(11):1462-82.

[20] Gordon AR & Mayer IH. 2008. Gender nonconformity as a target of prejudice, discrimination, and violence against LGB individuals. *Journal of LGBT Health Research*. 3(3):55-71.

[21]National Center for Transgender Equality & National Gay and Lesbian Task Force. 2009. *Preliminary findings: National Transgender Discrimination Survey*. Washington, DC.

[22] St. Pierre E. 2009. *Transgender death statistics 2009*. Retrieved from: http://www.transgenderdor.org.

[23] Moser B. 2003. Disposable people. *Intelligence Report, 112*. Retrieved from: http://www.splcenter.org.

[24] Burgess D, Lee R, Tran A, & van Ryn M. 2007. Effects of perceived discrimination on mental health and mental health services utilization among gay, lesbian, bisexual and transgender persons. *Journal of LGBT Health Research*. 3(4):1-14.

[25] Factor RJ, Rothblum ED. 2007. A study of transgender adults and their non-transgender siblings on demographic characteristics, social support, and experiences of violence. *Journal of LGBT Health Research*. 3(3):11-30.

[26] Clements-Nolle K, Marx R, & Katz M. 2006. Attempted suicide among transgender persons: the influence of gender-based discrimination and victimization. *Journal of Homosexuality*. 51(3):53-69.

[27] Diaz RM, Ayala G, & Bein E. 2004. Sexual risk as an outcome of social oppression: data from a probability sample of Latino gay men in three U.S. cities. *Cultural Diversity and Ethnic Minority Psychology*. 10(3):255-267.

[28] Hatzenbuehler ML, Keys KM, Hasin DS. 2009. State-level policies and psychiatric morbidity in lesbian, gay, and bisexual populations. *American Journal of Public Health*. 99(12):2275-81.

[29] Saewyc EM, Homma Y, Skay CL, Bearinger LH, Resnick MD, Reis E. 2009. Protective factors in the lives of bisexual adolescents in North America. *American Journal of Public Health.* 99:110-117.

[30] Ryan C, Huebner D, Diaz R, Sanchez J. Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual young adults. Pediatrics 2009; 123:346-352.

[31] Birkett M, Espelage DL, & Koenig B. 2009. LGB and questioning students in schools: the moderating effects of homophobic bullying and school climate on negative outcomes. *Journal of Youth Adolescence*. 38:989-1000.

[32] Bontemp DE, & D'Augelli AR. 2002. Effects of at-school victimization and sexual orientation on lesbian, gay, or bisexual youths' health risk behavior. *Journal of Adolescent Health*. 30:364-374.

[33] Dube SR, Anda RF, Whitfield CL, Brown DW, Felitti VJ, Dong M, & Giles WH. 2005. Long-term consequences of childhood sexual abuse by gender of victim. *American Journal of Preventive Medicine*. *28*(5):430-8.

[34] Brown DW, Anda RF, Tiemeier H, Felitti VJ, Edwards VJ, Croft JB, & Giles WH. (2009). Adverse childhood experiences and the risk of premature mortality. *American Journal of Preventive Medicine*. *37*(5):389-96.

[35] Austin SB, Hee-Jin J, Jackson B, Spiegelman D, Rich-Edwards J, Corliss H, & Wright R. 2008. Disparities in child abuse victimization in lesbian, bisexual, and heterosexual women in the nurses health study II. *Journal of Women's Health*. 17(4):597-606.

[36] Balsam KF, Rothblum, ED, Beauchaine, TP. 2005. Victimization over the life span: a comparison of lesbian, gay, bisexual and heterosexual siblings. *Journal of Consulting and Clinical Psychology*. 73(30):477-487.

[37] Corliss HL, Cochran SD, & Mays VM. 2002. Reports of parental maltreatment during childhood in a United States population-based survey of homosexual, bisexual and heterosexual adults. *Child Abuse and Neglect*. 26(11):1165-1178.

[38] Tomeo ME, Templer DI, Anderson S, Kotler D. 2001. Comparative data of childhood and adolescence molestation in heterosexual and homosexual persons. *Archives of Sexual Behaviors.* 30(5):535-541.

[39] Feldman MB & Meyer IH. 2007. Childhood abuse and eating disorders in gay and bisexual men. *International Journal of Eating Disorders*. 40(5):418-23.

[40] Arreola S, Neilands T, Pollack L, Paul J, & Catania J. (2008). Childhood sexual experiences and adult health sequelae among gay and bisexual men: defining childhood sexual abuse. *Journal of Sex Research*. 45(3):246-252.

[41] Brennan DJ, Hellerstedt WL, Ross MW, & Welles SL. 2007. History of childhood sexual abuse and HIV risk behaviors in homosexual and bisexual men. *American Journal of Public Health*. 97(6):1107-12.

[42] Cornwell EY, & Waite LJ. (2009). Measuring social isolation among older adults using multiple indicators from the NSHAP study. *The Journals of Gerontology. Series B, Psychological Sciences and Social Sciences*. *64.*i38-46.

[43] Hwang SW, Kirst MJ, Chiu S, Tolomiczenko G, Kiss A, Cowan L, & Levinson W. (2009). Multidimensional social support and the health of homeless individuals. *Journal of Urban Health: Bulletin of the New York Academy of Medicine*. *86*(5):791-803.

[44] Simoni JM, Huh D, Frick PA, Pearson CR, Andrasik MP, Dunbar PJ, & Hooton TM. (2009). Peer support and pager messaging to promote antiretroviral modifying therapy in Seattle: a randomized controlled trial. *Journal of Acquired Immune Deficiency Syndromes*. *52*(4):465-473.

[45] Protopopescu C, Raffi F, Roux P, Reynes J, Dellamonica P, Spire B, Leport C, & Carrieri MP. (2009). Factors associated with non-adherence to long-term highly active antiretroviral therapy: a 10 year follow-up analysis with correction for the bias induced by missing data. *The Journal of Antimicrobial Chemotherapy*. *64*(3): 599-606.

[46] Rosario M, Schrimshaw EW. 2009. Disclosure of sexual orientation and subsequent substance use and abuse among lesbian, gay, and bisexual youths: Critical role of disclosure reactions. *Psychology of Addictive Behaviors.* 323(8):175-184.

[47] Landolt MA, Bartholomew K, Saffrey C, Oram D, & Perlman D. 2004. Gender nonconformity, childhood rejection, and adult attachment: a study of gay men. *Archives of Sexual Behavior*. *33*(2), 117-28.

[48] Rieger G, Linsenmeier JA, Gygax L, & Bailey JM. 2008. Sexual orientation and childhood gender nonconformity: evidence from home videos. *Developmental Psychology*. *44*(1), 46-58.

[49] Friedman MS, Koeske GF, Silvestre AJ, Korr WS, & Sites EW. 2006. The impact of gender-role nonconforming behavior, bullying, and social support on suicidality among gay male youth. *The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine*. *38*(5), 621-3.

[50] Yunger JL, Carver PR, & Perry DG. 2004. Does gender identity influence children's psychological well-being? *Developmental Psychology*. *40*(4), 572-82.

[51] Sandfort TG, Melendez RM, & Diaz RM. 2007. Gender nonconformity, homophobia, and mental distress in latino gay and bisexual men. *Journal of Sex Research*. *44*(2), 181-9.

[52] Skidmore WC, Linsenmeier JA, & Bailey JM. 2006. Gender nonconformity and psychological distress in lesbians and gay men. *Archives of Sexual Behavior*. *35*(6), 685-97.

[53] Gordon AR, & Meyer IH. 2007. Gender nonconformity as a target of prejudice, discrimination, and violence against LGB individuals. *Journal of LGBT Health Research*. *3*(3), 55-71.

[54] Corby BC, Hodges EV, & Perry DG. 2007. Gender identity and adjustment in black, Hispanic, and white preadolescents. *Developmental Psychology*. *43*(1), 261-6.

[55] Bowen, DJ, Bradford JB, Powers D, McMorrow P, Linde R, Cody Murphy B, Han J, & Ellis J. 2004. Comparing women of differing sexual orientations using population-based sampling. *Women & Health*. 40(3):19-34.

[56] Heck JE, Sell RL, & Gorin SS. 2006. Health care access among individuals involved in same-sex relationships. *American Journal of Public Health*. 96(6):1111-8.

[57] Xavier, J, Honnold JA, Bradford, J. 2007. The health, health-related needs, and life-course experiences of transgender Virginians. Virginia HIV Community Planning Committee and Virginia Department of Health. http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/document/pdf/THISFINALREPORTVOL1.pdf

[58] Dutton L, Koenig K, Fennie K. 2008. Gynecologic care of the female-to-male transgender man. *Journal of Midwifery Women's Health.* 53:331-337.

[59] Bockting W, Robinson B, Benner A, Scheltema K. 2004. Patient satisfaction with transgender health services. *Journal of Sex and Marital Therapy.* 30:277-294.

[60] Lombardi E. 2001. Enhancing transgender health care. *American Journal of Public Health.* 91(6):869-872.

[61] Newfield E, Hart S, Dibble S, Kohler L. 2006. Female-to-male transgender quality of life. *Quality of Life Research.* 15:1447-1457.

[62] Murad, MH, Elamin, MB, Garcia, MZ, Mullan, RJ, Murad, A, Erwin, PJ, Montori, VM. 2010 Hormonal therapy and sex reassignment: a systematic review and meta-analysis of quality of life and psychosocial outcomes. Clinical Endocrinology. 72(2):214-231

[63] Smith YS, Van Goozen SHM, Kuiper AJ, Cohen-Kettenis PT.(2005). Sex reassignment: outcomes and predictors of treatment for adolescent and adult transsexuals. *Psychological Medicine,* 35 , pp 89-99

[64] American Medical Association, GLBT Advisory Committee, 2008. "Removing Barriers to Care for Transgender Patients," H-185.950.

[65] Rhiannon G. O'Donnabhain v. Commissioner of Internal Revenue. 2010. 134 T.C. 4.

[66] Human Rights Campaign Foundation. 2009. *The state of the workplace for lesbian, gay, bisexual, and transgender Americans 2007-2008*. Washington, DC.

[67] U.S. Department of Health and Human Services. *The Surgeon General's Vision for a Healthy and Fit Nation.* Rockville, MD: U.S. Department of Health and Human Services, Office of the Surgeon General, January 2010.

[68] Bowen, DJ, Bradford JB, Powers D, McMorrow P, Linde R, Cody Murphy B, Han J, & Ellis J. 2004. Comparing women of differing sexual orientations using population-based sampling. *Women & Health*. 40(3):19-34.

[69] Amadio D. 2006. Internalized heterosexism, alcohol use, and alcohol-related problems among lesbians and gay men. *Addictive Behaviours*. 31:1153-62.

[70] Cochran SD, Keenan C, Schober C, & Mays VM. 2000. Estimates of alcohol use and clinical treatment needs among homosexually active men and women in the U.S. population. *Journal of Consulting and Clinical Psychology*. 68(6):1062-1071.

[71] King M, Semlyn J, Tai SS, Killaspy, Osborn D, Popelyuk D, & Nazareth I. 2008. A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. *BMC Psychiatry*. 8:70.

[72] Hughes TL. 2005. Alcohol use and alcohol-related problems among lesbians and gay men. *Annual Review of Nursing Research*. 23:283-325.

[73] McCabe SE, Hughes TL, Bostwick WB, West BT, & Boyd CJ. 2009. Sexual orientation, substance use behaviors and substance dependence in the United States. *Addiction*. 104(8):1333-1345.

[74] Corliss HL, Rosario M, Wypij D, Fisher LB, & Austin B. 2008. Sexual orientation disparities in longitudinal alcohol use patterns among adolescents: findings from the Growing UP Today Study. *Archives of Pediatric and Adolescent Medicine*. 162(11):1071-1078.

[75] Ryan H, Wortley PM, Easton A, Pederson L, Greenwood G. 2001. Smoking among lesbians, gays, and bisexuals- A review of the literature. *Am Journal of Preventive Medicines.* 21(2):142-149.

[76] Gruskin EP, Gordon N. Gay/lesbian sexual orientation increases risk for cigarette smoking and heavy drinking among members of a large Northern California health plan. BMC Public Health 2006; 6: 241.

[77] Dilley J, Maher J, Boysun M, Pizacani B, Mosbaek C, Rohde K. 2005. Response letter to Tang et al. Cigarette smoking among gays, lesbians, and bisexuals: How serious a problem? *Cancer Causes & Control*. 16:1133-34.

[78] Greenwood GL, Paul JP, Pollack LM, Binson D, Catania JA, Chang J, Humfleet G, Stall R. Tobacco use and cessation among a household-based sample of US urban men who have sex with men. *Am J Publ Health* 2005; 95:145-151.

[79] Dilley JA, Spigner C, Boysun MJ, Dent CW, & Pizacani BA. 2008. Does tobacco industry marketing excessively impact lesbian, gay and bisexual communities? *Tobacco Control*. 17(6):385-90.

[80] Pizacani BA, Rohde K, Bushore C, Stark MJ, Maher JE, Dilley JA, Boysun MJ. 2009. Smoking-related knowledge, attitudes and behaviors in the lesbian, gay, and bisexual community: A population-based study from the U.S. Pacific Northwest. *Preventive Medicine*. 48:555-561.

[81] Stall R, Paul JP, Greenwood G, Pollack LM, Bein E, Crosby GM, et al. 2001. Alcohol use, drug use and alcohol-related problems among men who have sex with men: The Urban Men's Health Study. *Addiction.* 96:1589-1601.

[82] Reed E, Prado G, Matsumoto A, Amaro H. 2010. Alcohol and drug use and related consequences among gay, lesbian and bisexual college students: Role of experiencing violence, feeling safe on campus, and perceived stress. *Addictive Behaviors.* 35:168-171.

[83] Trocki KF, Drabble LA, Midanik LT. 2009. Tobacco, marijuana, and sensation seeking: Comparisons across gay, lesbian, bisexual, and heterosexual groups. *Psychology of Addictive Behaviors.* 23(4):620-633.

[84] Saewyc EM, Bearinger LH, Blum RW, Resnick MD. 1999. Sexual intercourse, abuse and pregnancy among adolescent women: Does sexual orientation make a difference? *Family Planning Perspectives.* 31(3):127-131.

[85] Saewyc EM, Skay CL, Richens K, Reis E, Poon C, Murphy A. 2006. Sexual orientation, sexual abuse, and HIV-risk behaviors among adolescents in the Pacific Northwest. *American Journal of Public Health.* 96(6):1104-1110.

[86] Dilley J, Wynkoop Simmons K, Boysun M, Pizacani B, Stark M. Demonstrating the importance and feasibility of including sexual orientation in public health surveys: Health disparities in the Pacific Northwest. Am J Public Health 2009; 99 (10): 1-8.

[87] Cochran SD, Mays VM, Bowen D, Gage S, Bybee D, Roberts SJ, Goldstein RS, Robison S, Rankow EJ, & White J. 2001. Cancer-related risk indicators and preventive screening behaviors among lesbians and bisexual women. *American Journal of Public Health*. 91(4): 591-7.

[88] Cochran SD, & Mays VM. 2007. Physical health complaints among lesbians, gay men, and bisexual and homosexually experienced heterosexual individuals: results from the California Quality of Life Survey. *American Journal of Public Health*. 97(13):2048-55.

[89] King M, Semlyn J, Tai SS, Killaspy, Osborn D, Popelyuk D, & Nazareth I. 2008. A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. *BMC Psychiatry*. 8:70.

[90] Grossman AH & D'Augelli AR. 2007. Transgender youth and life-threatening behaviors. Suicide and Life-Threatening Behaviors. 37(5):527-37.

[91] Matthews AK, Hughes TL, Johnson T, Razzano LA, & Cassidy R. 2002. Prediction of depressive distress in a community sample of women: the role of sexual orientation. *American Journal of Public Health*. 96(7):1131-9.

[92] Silenzio VMB, Pena JB, Duberstein PR, Cerel J, Knox KL. 2007. Sexual orientation and risk factors for suicidal ideation and suicide attempts among adolescents and young adults. *American Journal of Public Health.* 97(11):2017-2019.

[93] Lewis NM. 2009. Mental health in sexual minorities: recent indicators, trends, and their relationships to place in North America and Europe. *Health & Place*. 15(4):1029-1045.

[94] Oregon Department of Human Services, Public Health Division. Oregon HIV Epidemiological Profile 2008. Oregon DHS: Portland, OR.

[95] Stall R, Duran L, Wisniewski SR, Friedman MS, Marshal MP, McFarland W, et al. 2009. Running in place: Implications of HIV incidence estimates among urban men who have sex with men in the United States and other industrialized countries. *AIDS Behav.* 13:615-629.

[96] Herbst JH, Jacobs ED, Finlayson TJ, McKleroy VS, Neumann MS, Crepaz N. 2008. Estimating HIV prevalence and risk behaviors of transgender persons in the United States: A systematic review. *AIDS Behav.* 12:1-17.

[97] Kenagy GP, Hsieh CM. 2005. The risk less known: Female-to-male transgender persons' vulnerability to HIV infection. *AIDS Care.* 17(2):195-207.

[98] Kenagy GP. 2002. HIV among transgendered people. *AIDS Care.* 14(1):127-134.

[99] Ontario Gay Men's HIV Prevention Strategy, Gay/Bi/Queer Trans Men Working Group. 2010. www.queertransmen.org.

[100] San Francisco HIV Prevention Planning Council. 2010. *2010 San Francisco HIV prevention plan.* San Francisco, CA: Harder and Company Community Research.

[101] Oregon Public Health Division HIV/STD/TB Program Website. Available at: http://www.oregon.gov/DHS/ph/std/annrep.shtml. Accessed February 22, 2010.

[102] Breiding MJ, Black MC, & Ryan GW. (2008). Prevalence and risk factors of intimate partner violence in eighteen U.S. states/territories, 2005. *American Journal of Preventive Medicine*. *34*(2):112-8.

[103] Breiding MJ, Black MC, & Ryan GW. (2008). Chronic disease and health risk behaviors associated with intimate partner violence-18 U.S. states/territories, 2005. *Annals of Epidemiology*. *18*(7):538-44.

[104] Tjaden P, Thoennes N, Allison CJ. 1999. Comparing violence over the life span in samples of same-sex and opposite-sex cohabitants. *Violence and Victims.* 14(4):413-425.

[105] Burke LK, & Follingstad DR. 1999. Violence in lesbian and gay relationships: theory, prevalence, and correlational factors. *Clinical Psychology Review*. 19(5):487-512.

[106] Greenwood GL, Relf MV, Huang B, Pollack LM, Conchola JA, & Catania JA. 2002. Battering victimization among a probability-based sample of men who have sex with men. *American Journal of Public Health*. 92(12):1964-9.