

Journal of Gay & Lesbian Social Services™

eHAWORTH®

Electronic Text is provided AS IS without warranty of any kind. The Haworth Press, Inc. further disclaims all implied warranties including, without limitation, any implied warranties of merchantability or of fitness for a particular purpose. The entire risk arising out of the use of the Electronic Text remains with you. In no event shall The Haworth Press, Inc., its authors, or anyone else involved in the creation, production, or delivery of this product be liable for any damages whatsoever (including, without limitation, damages for loss of business profits, business interruption, loss of business information, or other pecuniary loss) arising out of the use of or inability to use the Electronic Text, even if The Haworth Press, Inc. has been advised of the possibility of such damages.

EDITOR

JEANE W. ANASTAS, MSW, PhD, Professor and Director, PhD Program, New York University School of Social Work, New York, NY

FOUNDING EDITOR

JAMES J. KELLY, LCSW, PhD, Associate Vice President, Extended and Continuing Education, California State University, Hayward, CA

FOUNDING HONORARY EDITOR

RAYMOND M. BERGER, PhD, Professor (retired), Department of Social Work, California State University, Long Beach, CA

EDITORIAL ADVISORY BOARD

E. MICHAEL GORMAN, PhD, MPH, MSW, Assistant Professor, College of Social Work, San Jose State University, San Jose, CA

GERALD MALLON, DSW, Assistant Professor, Hunter College School of Social Work, New York, NY

JAMES I. MARTIN, PhD, Associate Professor, New York University School of Social Work, New York, NY

WILLIAM MEEZAN, DSW, Ohio State University, College of Social Work, Columbus, OH

JULIO MORALES, PhD, Professor Emeritus, School of Social Work, University of Connecticut, West Hartford, CT

CAITLIN RYAN, ACSW, Director of Policy Studies, Research Institute on Sexuality, Social Inequality and Health, San Francisco State University, San Francisco, CA

CAROL T. TULLY, PhD, Professor, University of Louisville, Kent School of Social Work, Louisville, KY

KARINA L. WALTERS, DSW, Columbia University, School of Social Work, New York, NY

PRACTICE NOTES

MICHAEL PAUL HERNANDEZ, LICSW, BCD, PhD (cand.), Associate Professor, Simmons College School of Social Work, Boston, MA

RESEARCH NOTES

JAMES I. MARTIN, Associate Professor, New York University School of Social Work, New York, NY

BOOK REVIEW EDITOR

MARY E. SWIGONSKI, PhD, LCSW, Associate Professor and Director, BSW Program, Monmouth University, West Long Branch, NJ

VIDEO REVIEW EDITOR

LORI MESSINGER, PhD, *Assistant Professor and Director, BSW Program, School of Social Welfare, University of Kansas, Lawrence, KS*

EDITORIAL BOARD

KIMBERLY DEANNE ACQUAVIVA, PhD, MSW, *Director of Research, The Hospice of the Florida Suncoast*

STEVEN BALL, ACSW, *Private Practitioner, New York, NY*

ROY CAIN, PhD, *Professor, School of Social Work, McMaster University, Hamilton, Ontario*

THERESA CLUSE-TOLAR, MSW, PhD, *Assistant Professor of Social Work, University of Toledo, Toledo, OH*

TERESA DeCRESCENZO, MSW, *Executive Director, Gay and Lesbian Adolescent Social Services, West Hollywood, CA*

DIANE ELZE, PhD, *Associate Professor, School of Social Work, University at Buffalo (SUNY), Buffalo, NY*

LILLIAN FADERMAN, PhD, *Professor, Department of English, California State University, Fresno, CA*

EDA G. GOLDSTEIN, DSW, *Professor, Shirley M. Ehrenkranz School of Social Work, New York University*

EMMA R. GROSS, PhD, *Associate Professor, Graduate School of Social Work, University of Utah, Salt Lake City, UT*

ANN POLLINGER HAAS, PhD, *Professor of Health Services, Lehman College of the City University of New York*

PERRY N. HALKITIS, PhD, *Professor of Applied Psychology and Director, Center for Health, Identity, Behavior & Prevention Studies, Steinhardt School, New York University, New York, NY*

JOYCE HUNTER, DSW, *Research Scientist, Director, Community Liaison Program, New York, NY*

LARRY ICARD, PhD, *Associate Professor, School of Social Work, University of Pennsylvania, Philadelphia, PA*

DOUGLAS C. KIMMEL, PhD, *Department of Psychology, City University of New York*

SANDRA R. LEIBLUM, PhD, *Director, Center for Sexual and Marital Health, UMDNJ-Robert Wood Johnson Medical School, Piscataway, NJ*

BENJAMIN LIPTON, MSW, *New York University, Private Practice, New York, NY*

REBECCA A. LOPEZ, PhD, *Associate Professor, Director of Admissions, School of Social Work, University of Georgia, Athens, GA*

RONALD J. MANCOSKE, DSW, *Professor, Southern University of New Orleans, LA*

BERNARD D. MAYES, BA, MA (Honors Cantab.), *Academic Dean (ret.), University of Virginia; Fellow, Brown College, University of Virginia, Charlottesville, VA*

JOAN C. McCLENNEN, PhD, *Associate Professor, School of Social Work, Southwest Missouri State University, Springfield, MO*

BERNIE SUE NEWMAN, PhD, *Associate Professor, School of Social Administration, Temple University, Philadelphia, PA*

CHERYL A. PARKS, PhD, *Associate Professor, University of Connecticut School of Social Work, West Hartford, CT*

K. JEAN PETERSON, DSW, *Associate Professor, School of Social Welfare, University of Kansas, Lawrence, KS*

JEAN K. QUAM, PhD, *Director and Professor, School of Social Work, University of Minnesota, Minneapolis, MN*
MARGARET R. RODWAY, PhD, *Professor Emeritus of Social Work, The University of Calgary, Alberta, Canada*
CHRISTINE FLYNN SAULNIER, PhD, MSW, *University of Wisconsin*
ROBERT D. SCHOPE, PhD, *Assistant Professor, School of Social Work, University of Iowa, Iowa City, IA*
GERARD SULLIVAN, BBsc, DipEd, MA, PhD, *Faculty of Education, University of Sydney, Australia*
STEPHANIE K. SWANN, PhD, LCSW, *School of Social Work, University of Georgia, Athens, GA*
DARRELL P. WHEELER, PhD, MPH, ACSW, *Associate Professor, Hunter College School of Social Work, New York, NY*
JEROME W. WRIGHT, PhD, *Fuller E. Callaway Professor of Social Work and Anthropology, Savannah State University, Savannah, GA*
NORMAN L. WYERS, DSW, *Professor Emeritus, Graduate School of Social Work, Portland State University, Portland, OR*

Harrington Park Press Imprint Team
Imprint Coordinator: Stacey Scarba, Senior Production Editor

Senior Production Editor: Julie Ehlers
Production Editor: Jennifer Edwards
Typesetting Manager, Senior Typesetter: Roxanne Cook

<p align="center">MARKETING DIVISION</p> <p>Sandra Jones Sickels, VP, Marketing Margaret Tatich, Sales/Publicity Manager Paul Deamer, Assistant Sales/Publicity Manager/ Conferences and Exhibits Manager Beth Arnold, Library Special Services Director/ International Sales Director Becky Miller-Baum, Director, Office of Knowledge Management Christie Peterson, Assistant Advertising Manager Michelle Savory, Society Liaison Manager Micah Mellander, Director of Internet Marketing Marylouise Doyle, Cover Design Director Sue Hoyt, Foreign Rights Coordinator Janice Hoag, Art Production Manager</p>	<p>THE HAWORTH INFORMATION PRESS JOURNALS</p> <p>Shelley Brutosky, Imprint Coordinator, Senior Production Editor Arleen Dallachiesa, Senior Production Editor Tammy Enama, Production Editor Patty Zoshak, Typesetting Support, MIS Liaison</p> <p>THE HAWORTH PRESS JOURNALS THE HAWORTH MEDICAL PRESS JOURNALS</p> <p>Nancy Colpitts, Imprint Coordinator, Senior Production Editor Diane Stauffer, Senior Production Editor Stephanie Paladino, Senior Production Editor April Schaefer, Senior Typesetter Sheila Stauffer, Senior Typesetter</p>
<p align="center">PUBLICATIONS DIVISION</p> <p>Patricia Brown, Editorial Production Manager Rebecca Browne, Project Manager, Book Division Robin Hall, E-Text Production Manager Margaret Marr, Senior Book Production Editor Robert Owen, Contract Coordinator, Publications Amy Rentner, Senior Production Editor</p>	<p>THE HAWORTH PRESS JOURNALS THE HAWORTH PASTORAL PRESS JOURNALS</p> <p>Naomi Fanning, Imprint Coordinator, Senior Production Editor Barbara Paladino, Senior Production Editor Sarah Godumski, Production Editor April Schaefer, Senior Typesetter</p>
<p align="center">PRINT JOURNAL PRODUCTION</p> <p>Zella Ondrey, Vice President of Publications Karen Richardson, Journal Production Manager</p>	<p>THE HAWORTH PRESS JOURNALS THE HAWORTH HOSPITALITY PRESS JOURNALS BEST BUSINESS BOOKS JOURNALS INTERNATIONAL BUSINESS PRESS JOURNALS</p> <p>Cynthia Fedak, Imprint Coordinator, Senior Production Editor Diane Fidishin, Senior Production Editor Michael Picciano, Senior Production Editor Patty Zoshak, Typesetting Support, MIS Liaison</p>
<p align="center">CHARTER ISSUES</p> <p>Shelley Brutosky, Charter Issue Specialist, Senior Production Editor Roxanne Cook, Typesetting Manager, Senior Typesetter</p>	<p>THE HAWORTH PRESS JOURNALS HARRINGTON PARK PRESS JOURNALS ALICE STREET EDITIONS SOUTHERN TIER EDITIONS HAWORTH POSITRONIC PRESS</p>
<p align="center">JOURNAL PRE-PRODUCTION</p> <p>Linda Woolf, Pre-Production Coordinator Linda Mantush, Pre-Production Assistant Thomas J. Mayshock, Art Coordinator Debbie Gattine, Data Conversion Specialist</p>	<p>THE HAWORTH INFORMATION PRESS JOURNALS</p> <p>Stacey Scarba, Imprint Coordinator, Senior Production Editor Julie Ehlers, Senior Production Editor Jennifer Edwards, Production Editor Roxanne Cook, Typesetting Manager, Senior Typesetter</p>
<p align="center">JOURNAL ADMINISTRATION</p> <p>Danielle Wiley, Scheduling Manager, Senior Administrative Assistant Lynn Ferry, Administrative Assistant Denise Katinsky, Administrative Assistant to the Vice President Linda Pugliese, Office Coordinator</p>	<p align="center">ADMINISTRATION</p> <p>Bill Cohen, Publisher Roger Hall, Senior Vice President</p>
<p>THE HAWORTH PRESS JOURNALS THE HAWORTH MEDICAL PRESS JOURNALS PHARMACEUTICAL PRODUCTS PRESS JOURNALS FOOD PRODUCTS PRESS JOURNALS</p> <p>S. Singh, PhD, Managing Editor U. Singh, PhD, Imprint Coordinator, Senior Production Editor Jeffrey L. Wagner, Senior Production Editor Eric Kushmeder, Production Editor Christy Strohl, Senior Typesetter</p>	

Monographic Separates from the *Journal of Gay & Lesbian Social Services*TM

For additional information on these and other Haworth Press titles, including descriptions, tables of contents, reviews, and prices, use the QuickSearch catalog at <http://www.HaworthPress.com>.

- Gay Men Living with Chronic Illnesses and Disabilities: From Crisis to Crossroads***, edited by Benjamin Lipton, MSW (Vol. 17, No. 2, 2004). "Essential reading for any health or mental health practitioner or academic addressing the issue of disability and chronic illness in gay men." (Martha A. Gabriel, PhD, Associate Professor, Shirley M. Ehrenkranz School of Social Work, New York University)
- Gay and Lesbian Rights Organizing: Community-Based Strategies***, edited by Yolanda C. Padilla, PhD, LMSW-AP (Vol. 16, No. 3/4, 2004). Examines successful, tested action strategies designed to end discrimination and achieve social justice for sexual minorities.
- Community Organizing Against Homophobia and Heterosexism: The World Through Rainbow-Colored Glasses***, edited by Samantha Wehbi, PhD (Vol. 16, No. 1, 2004). A guide to using community activism to battle sexual oppression.
- Gay Men's Sexual Stories: Getting It!*** edited by Robert Reynolds, PhD, and Gerard Sullivan, PhD (Vol. 15, No. 3/4, 2003). "Fascinating. . . . Explores the diversity in gay men's sexual lives. The stories are in turn moving, funny, sexy, witty, thoughtful, painful, and delightful. They are a joy to read. . . . This book shows the many different ways there are of being sexual—and the many different ways of realizing our humanity." (Jeffrey Weeks, PhD, Professor of Sociology, London South Bank University; Author of *Making Sexual History, Same Sex Intimacies, and Sexuality and Society: A Reader*)
- Research Methods with Gay, Lesbian, Bisexual, and Transgender Populations***, edited by William Meezan, MSW, DSW, and James I. Martin, MSW, PhD (Vol. 15, No. 1/2, 2003). "Must reading for all researchers concerned about vulnerable and stigmatized groups. . . . The authors raise significant methodological and ethical issues that researchers studying any vulnerable group, especially LGBT populations, must address. An excellent supplement to any social work or social science research class." (Wynne Sandra Korr, PhD, Dean and Professor, School of Social Work, University of Illinois at Urbana Champaign)
- From Here to Diversity: The Social Impact of Lesbian and Gay Issues in Education in Australia and New Zealand***, edited by Kerry H. Robinson, PhD, MA, BA, DipEd, Jude Irwin, BSW, MA, and Tania Ferfolja, MA, BEd (Vol. 14, No. 2, 2002). "Long awaited. . . . challenges the rigid binaries that are produced and reproduced through schooling. . . . A collection that will do much to keep anti-homophobia work on the educational agenda. Required reading for educators who must take seriously their responsibility to enhance the quality of school life for sexual minority students." (June Larkin, PhD, Director of Equity Studies, University of Toronto)
- Midlife and Aging in Gay America***, edited by Douglas C. Kimmel, PhD, and Dawn Lundy Martin, MA (Vol. 13, No. 4, 2001). "Magnificent. This is a topic whose time has finally come. This book fills a gaping hole in the GLBT literature. . . . Each chapter is a gem. With its coverage of elder GLBT's who are vision impaired and HIV positive as well as an important chapter on GLBT retirement planning, it makes the literature human and integrated." (Mark Pope, EdD, Associate Professor of Counseling and Family Therapy, University of Missouri, St. Louis)
- From Hate Crimes to Human Rights: A Tribute to Matthew Shepard***, edited by Mary E. Swigonski, PhD, LCSW, Robin S. Mama, PhD, and Kelly Ward, LCSW (Vol. 13, No. 1/2, 2001). An unsparing look at prejudice and hate crimes against LGBT individuals, in such diverse areas as international law, the child welfare system, minority cultures, and LGBT relationships.
- Working-Class Gay and Bisexual Men***, edited by George Alan Appleby, MSW, PhD, (Vol. 12, No. 3/4, 2001). Working-Class Gay and Bisexual Men is a powerfully persuasive work of scholarship with broad-ranging implications. Social workers, policymakers, AIDS activists, and anyone else concerned with the lives of gay and bisexual men will find this informative study as essential tool for designing effective programs.

- Gay Men and Childhood Sexual Trauma: Integrating the Shattered Self**, edited by James Cassese, MSW, CSW (Vol. 12, No. 1/2, 2000). "An excellent, thought-provoking collection of essays. Therapists who work with gay men will be grateful to have such a comprehensive resource for dealing with sexual trauma." (Rik Isensee, LCSW, Author of *Reclaiming Your Life*)
- Midlife Lesbian Relationships: Friends, Lovers, Children, and Parents**, edited by Marcy R. Adelman, PhD (Vol. 11, No. 2/3, 2000). "A careful and sensitive look at the various relationships of [lesbians at midlife] inside and outside of the therapy office. A useful addition to a growing body of literature." (Ellyn Kaschak, PhD, Professor of Psychology, San José State University, California, and Editor of the feminist quarterly journal *Women & Therapy*)
- Social Services with Transgendered Youth**, edited by Gerald P. Mallon, DSW (Vol. 10, No. 3/4, 1999). "A well-articulated book that provides valuable information about a population that has been virtually ignored. . . ." (Carol T. Tully, PhD, Associate Professor, Tulane University, School of Social Work, New Orleans, Louisiana)
- Queer Families, Common Agendas: Gay People, Lesbians, and Family Values**, edited by T. Richard Sullivan, PhD (Vol. 10, No. 1, 1999). *Examines the real life experience of those affected by current laws and policies regarding homosexual families.*
- Lady Boys, Tom Boys, Rent Boys: Male and Female Homosexualities in Contemporary Thailand**, edited by Peter A. Jackson, PhD, and Gerard Sullivan, PhD (Vol. 9, No. 2/3, 1999). "Brings to life issues and problems of interpreting sexual and gender identities in contemporary Thailand." (Nerida M. Cook, PhD, Lecturer in Sociology, Department of Sociology and Social Work, University of Tasmania, Australia)
- Working with Gay Men and Lesbians in Private Psychotherapy Practice**, edited by Christopher J. Alexander, PhD (Vol. 8, No. 4, 1998). "Rich with information that will prove especially invaluable to therapists planning to or recently having begun to work with lesbian and gay clients in private practice." (Michael Shernoff, MSW, Private Practice, NYC; Adjunct Faculty, Hunter College Graduate School of Social Work)
- Violence and Social Injustice Against Lesbian, Gay and Bisexual People**, edited by Lacey M. Sloan, PhD, and Nora S. Gustavsson, PhD (Vol. 8, No. 3, 1998). "An important and timely book that exposes the multilevel nature of violence against gay, lesbian, bisexual, and transgender people." (Dorothy Van Soest, DSW, Associate Dean, School of Social Work, University of Texas at Austin)
- The HIV-Negative Gay Man: Developing Strategies for Survival and Emotional Well-Being**, edited by Steven Ball, MSW, ACSW (Vol. 8, No. 1, 1998). "Essential reading for anyone working with HIV-negative gay men." (Walt Odets, PhD, Author, *In the Shadow of the Epidemic: Being HIV-Negative in the Age of AIDS; Clinical Psychologist, private practice, Berkeley, California*)
- School Experiences of Gay and Lesbian Youth: The Invisible Minority**, edited by Mary B. Harris, PhD (Vol. 7, No. 4, 1998). "Our schools are well served when authors such as these have the courage to highlight problems that schools deny and to advocate for students whom schools make invisible." (Gerald Unks, Professor, School of Education, University of North Carolina at Chapel Hill; Editor, *The Gay Teen*)
- Rural Gays and Lesbians: Building on the Strengths of Communities**, edited by James Donald Smith, ACSW, LCSW, and Ronald J. Mancoske, BSCW, DSW (Vol. 7, No. 3, 1998). "This informative and well-written book fills a major gap in the literature and should be widely read." (James Midgley, PhD, Harry and Riva Specht Professor of Public Social Services and Dean, School of Social Welfare, University of California at Berkeley)
- Gay Widowers: Life After the Death of a Partner**, edited by Michael Shernoff, MSW, ACSW (Vol. 7, No. 2, 1997). "This inspiring book is not only for those who have experienced the tragedy of losing a partner—it's for every gay man who loves another." (Michelangelo Signorile, Author, *Life Outside*)
- Gay and Lesbian Professionals in the Closet: Who's In, Who's Out, and Why**, edited by Teresa DeCrescenzo, MSW, LCSW (Vol. 6, No. 4, 1997). "A gripping example of the way the closet cripples us and those we try to serve." (Virginia Uribe, PhD, Founder, *Project 10 Outreach to Gay and Lesbian Youth, Los Angeles Unified School District*)

Indexing, Abstracting & Website/Internet Coverage



Journal of Gay & Lesbian Social Services

This section provides you with a list of major indexing & abstracting services and other tools for bibliographic access. That is to say, each service began covering this periodical during the year noted in the right column. Most Websites which are listed below have indicated that they will either post, disseminate, compile, archive, cite or alert their own Website users with research-based content from this work. (This list is as current as the copyright date of this publication.)

<u>Abstracting, Website/Indexing Coverage</u>	<u>Year When Coverage Began</u>
• <i>Business Source Corporate: coverage of nearly 3,350 quality magazines and journals; designed to meet the diverse information needs of corporations; EBSCO Publishing</i> < http://www.epnet.com/corporate/bsource.asp >	2002
• <i>CAB ABSTRACTS c/o CAB International/CAB ACCESS . . . available in print, diskettes updated weekly, and on INTERNET. Providing full bibliographic listings, author affiliation, augmented keyword searching</i> < http://www.cabi.org/ >	*
• <i>CareData: the database supporting social care management and practice</i> < http://www.elsc.org.uk/caredata/caredata.htm > . . .	1993
• <i>Contemporary Women's Issues</i>	1998
• <i>Criminal Justice Abstracts</i>	1997
• <i>EBSCOhost Electronic Journals Service (EJS)</i> < http://ejournals.ebsco.com >	2002
• <i>Educational Research Abstracts (ERA) (online database)</i> < http://www.tandf.co.uk/era >	2001
• <i>Education Research Complete (EBSCO)</i> < http://ejournals.ebsco.com >	2006
• <i>Elsevier Scopus</i> < http://www.info.scopus.com >	2005
• <i>Family Index Database</i> < http://www.familyscholar.com >	1995
• <i>Family Violence & Sexual Assault Bulletin</i>	2004
• <i>GenderWatch</i> < http://www.slinfo.com >	1999

(continued)

- *GLBT Life, EBSCO Publishing*
<<http://www.epnet.com/academic/glb.asp>> 2004
- *Google* <<http://www.google.com>> 2004
- *Google Scholar* <<http://scholar.google.com>> 2004
- *Haworth Document Delivery Center*
<<http://www.HaworthPress.com/journals/dds.asp>> 1994
- *HOMODOK/“Relevant” Bibliographic Database, Documentation Centre for Gay & Lesbian Studies, University of Amsterdam (selective printed abstracts in “Homologie” and bibliographic computer databases covering cultural, historical, social & political aspects)* <<http://www.ihlia.nl/>> 1995
- *IBZ International Bibliography of Periodical Literature*
<<http://www.saur.de>> 1995
- *IGLSS Abstracts* <<http://www.iglss.org>> 2000
- *Index to Periodical Articles Related to Law*
<<http://www.law.utexas.edu>> 1994
- *Internationale Bibliographie der geistes- und sozialwissenschaftlichen Zeitschriftenliteratur . . . See IBZ*
<<http://www.saur.de>> 1995
- *(IBR) International Bibliography of Book Reviews on the Humanities and Social Sciences (Thomson)* <<http://www.saur.de>> 2006
- *Lesbian Information Service*
<<http://www.lesbianinformationservice.org>> 1994
- *Links@Ovid (via CrossRef targeted DOI links)*
<<http://www.ovid.com>> 2005
- *Magazines for Libraries (Katz) . . . (see 2003 edition)* 2003
- *National Clearinghouse on Child Abuse & Neglect Information Documents Database*
<<http://www.nccanch.acf.hhs.gov>> 1999
- *OCLC Public Affairs Information Service* <<http://www.pais.org>> . . . 1995
- *Ovid Linksolver (OpenURL link resolver via CrossRef targeted DOI links)* <<http://www.linksolver.com>> 2005
- *Psychological Abstracts (PsycINFO)* <<http://www.apa.org>> 2001
- *Referativnyi Zhurnal (Abstracts Journal of the All-Russian Institute of Scientific and Technical Information–in Russian)* <<http://www.viniti.ru>> 1994
- *Scopus (Elsevier)* <<http://www.info.scopus.com>> 2005
- *Social Services Abstracts* <<http://www.csa.com>> 1994
- *Social Work Abstracts*
<<http://www.silverplatter.com/catalog/swab.htm>> 1994
- *SocIndex (EBSCO)* 2006
- *Sociological Abstracts (SA)* <<http://www.csa.com>> 1994

(continued)

- *Studies on Women and Gender Abstracts*
 <<http://www.tandf.co.uk/swa>> 1994
- *Violence and Abuse Abstracts: A Review of Current Literature on Interpersonal Violence (VAA)* 1995

* Exact start date to come.

Special Bibliographic Notes related to special journal issues (separates) and indexing/abstracting:

- indexing/abstracting services in this list will also cover material in any “separate” that is co-published simultaneously with Haworth’s special thematic journal issue or DocuSerial. Indexing/abstracting usually covers material at the article/chapter level.
- monographic co-editions are intended for either non-subscribers or libraries which intend to purchase a second copy for their circulating collections.
- monographic co-editions are reported to all jobbers/wholesalers/approval plans. The source journal is listed as the “series” to assist the prevention of duplicate purchasing in the same manner utilized for books-in-series.
- to facilitate user/access services all indexing/abstracting services are encouraged to utilize the co-indexing entry note indicated at the bottom of the first page of each article/chapter/contribution.
- this is intended to assist a library user of any reference tool (whether print, electronic, online, or CD-ROM) to locate the monographic version if the library has purchased this version but not a subscription to the source journal.
- individual articles/chapters in any Haworth publication are also available through the Haworth Document Delivery Service (HDDS).



Publisher's Note

The Haworth Press is committed to the dissemination of ideas and information according to the highest standards of intellectual freedom and the free exchange of ideas. Statements made and opinions expressed in this publication do not necessarily reflect the views of the Publisher, Directors, management, or staff of The Haworth Press, Inc., or an endorsement by them.

For more information or to order
the **Journal of Gay & Lesbian Social Services**,
visit <http://www.haworthpress.com/web/JGLSS>

- or call (800) HAWORTH (in US and Canada) or (607) 722-5857 (outside US and Canada)
- or fax (800) 895-0582 (in US and Canada) or (607) 771-0012 (outside US and Canada)

For a list of related links,
visit <http://www.haworthpress.com/web/JGLSS>

Urge your library to subscribe today!
With your library's print subscription,
the electronic edition of the journal can
be made available campus-wide to all
of the library's users!



ALL HARRINGTON PARK PRESS BOOKS
AND JOURNALS ARE PRINTED
ON CERTIFIED ACID-FREE PAPER

Journal of
**GAY &
LESBIAN
SOCIAL
SERVICES™**

Volume 18
Number 1
2005

CONTENTS

FROM THE EDITOR	1
<i>Jeane W. Anastas</i>	
Parents' Reactions to Transgender Youths' Gender Nonconforming Expression and Identity	3
<i>Arnold H. Grossman</i>	
<i>Anthony R. D'Augelli</i>	
<i>Tamika Jarrett Howell</i>	
<i>Steven Hubbard</i>	

Fifty-five transgender youth described their gender development and expression, parents' reactions to their gender nonconformity, and initial and current mothers' and fathers' reactions to their transgender identity. All of the youth reported feeling different from others in early childhood. Forty-three of the participants' mothers and 26 of their fathers knew about their identities. The youth reported that 54% of their mothers and 63% of their fathers initially reacted negatively, and 50% of the mothers and 44% of their fathers reacted negatively at the time of the inter-

views, an average of 3 years later. The more gender nonconforming the youth, the more likely they reported that they were verbally and physically abused by their mothers and fathers. Implications of these findings for social service professionals are discussed.

KEYWORDS. Transgender, gender nonconformity, gender, youth, parent, childhood abuse

Listening to the Voices of Lesbians Diagnosed
with Cancer: Recommendations for Change
in Cancer Support Services

17

Lisa Barnoff
Christina Sinding
Pamela Grassau

This paper focuses on the operations of heterosexism and strategies to counter it in a particular service context: the context of psychosocial support services for women with cancer. The paper draws on findings from a participatory, qualitative study set in Ontario, Canada in which 26 lesbians were interviewed about their experiences of cancer diagnosis, treatment, health care and social support, and their feelings and perceptions about shifts in identity, body, sexuality and relationships. This paper focuses on findings related to the changes research participants perceived as necessary in the provision and organization of cancer support services, in order to increase access and ensure equity for lesbians with cancer and their families.

KEYWORDS. Lesbians, cancer, heterosexism, homophobia, cancer support services

The Sex Check: The Development of an HIV-Prevention Service
to Address the Needs of Latino MSM

37

Jennifer L. Katz
E. Roberto Orellana
Denise D. Walker
Luis Viquez
Joseph F. Picciano
Roger A. Roffman

The Sex Check is a brief, telephone-delivered, HIV-prevention intervention tailored for individuals who are at high risk of HIV infection or transmission but who are neither reducing their risk on their own nor seeking support for this purpose. Because the intervention is delivered on a one-to-one basis, permits anonymity, is marketed to "men who have sex with men," and is brief, it may be particularly responsive to cultural, structural, and attitudinal barriers to serving Latino MSM. Because many Latino MSM continue to engage in high risk sexual behaviors, developing and testing prevention interventions with this population is a public health priority.

KEYWORDS. HIV prevention, Latino MSM, high-risk sexual behaviors, risk reduction

- Homophobia and Use of Gay Affirmative Practice
in a Sample of Social Workers and Psychologists 51
Catherine Crisp

Researchers have previously found that social workers may be more homophobic than psychologists. This study revisits the topic and seeks to see if there are differences in the attitudes of social workers' and psychologists who are engaged in direct practice with clients. In addition, this study explores new territory by examining whether social workers and psychologists differ in their use of gay affirmative practice and discusses the impacts of these findings for gay and lesbian clients.

KEYWORDS. Gay affirmative practice, homophobia, social workers, psychologists, gay and lesbian mental health

- Not All Alike: Within-Group Differences
in Seeking Help for Same-Sex Relationship Abuses 71
Susan C. Turell
La Vonne Cornell-Swanson

Most published research regarding same-sex relationship abuse experienced by lesbian, gay, bisexual, and transgender (LGBT) people notes a need for services. However, the LGBT community is quite heterogeneous, and useful support may vary based on demographic characteristics. This research examined within group differences regarding type of support sought and its usefulness. Eighty nine percent (n = 677) of a diverse sample of LGBT people (N = 760) experienced abuse in a same-sex relationship. Of those who experienced some type of emotional, physical, and/or sexual abuse, differences in help sought and its usefulness were found based on age, income, gender, sexual orientation, and ethnicity.

KEYWORDS. Family violence, sexual assault, lesbian, gay, bisexual, transgender, social services

PRACTICE NOTES

- Breast Cancer Prevention Strategies
for Aged Black Lesbian Women 89
Thomas Alex Washington
June P. Murray

Recognizing that effective intervention must include models of treatment that "meet clients where they are," this paper describes culturally sensitive breast cancer prevention strategies that may be useful for health care providers in an effort to reach a triple-minority population: Black, lesbian women. The strategies are an adapted version of the Witnessing In Tennessee (WIT) model. WIT was developed

to increase early detection of breast cancer among Black women. The strategies have been adapted for use among Black, aged, lesbian women. This model provides practitioners with universal techniques that can be used to address various health disparities.

KEYWORDS. Lesbian issues, breast cancer prevention, community health, public health, gerontology and health

CALL FOR AUTHORS AND GUEST EDITORS

The *Journal of Gay & Lesbian Social Services* is the premier national information resource for professionals interested in the well-being of l/g/b/t people. The *Journal* publishes non-thematic issues and special issues on a wide variety of topics in the areas of programs and services; social policy; research; and direct practice with individuals, groups, families, and communities.

Call for Papers

The *Journal* seeks full-length papers from authors—social service professionals, clinicians, administrators, researchers, and policy analysts—on topics related to all areas of gay, lesbian, and bisexual social services. These areas include but are not limited to: mental health, medical services, aging, child welfare, family services, school services, juvenile and adult corrections, public welfare, social policy of relevance to l/g/b/t populations, queer theory and its application to understanding l/g/b/t identities and life experiences. The *Journal* is interested in publishing innovative papers on topics related to the needs and experiences of special populations within the gay and lesbian communities: the poor; racial and ethnic minorities; victims of domestic violence, child abuse, or hate crimes; children, adolescents, adults, and the elderly; women; persons with AIDS and other chronic illnesses or disabilities. Although theoretical papers and literature reviews that contribute to a improved understanding of l/g/b/t people and their social service needs are welcome, preference is given to submissions based on research, qualitative or quantitative. Please consult the Instructions for Authors section at the back of the issue.

Call for Brief Manuscripts

Practice Notes present discussions of timely practice issues related to social services for gay men, lesbians, bisexuals, and transgenders. Readers interested in contributing manuscripts to be considered for this section may contact Practice Notes Senior Consulting Editor, Michael Shernoff, MSW, 250 West 16th Street, #4-G, New York, NY 10011-6168 USA (e-mail: mshernoff@aol.com).

Research Notes either present short research reports or discuss methodological issues important to research on l/g/b/t populations. Authors interested in contributing manuscripts for this section may contact Editorial Advisory Board Member Dr. James I. Martin, Associate Professor, School of Social Work, New York University, 1 Washington Square North, New York, NY 10003-66541 (e-mail: james.martin@nyu.edu).

The following may be sent directly to Journal Editor, Dr. Jeane W. Anastas:

Letters to the Editor respond to issues discussed in the *Journal*.

Call for Guest Editors of Special Issues

The *Journal* has become well known for its innovative special issues. Each special issue presents a number of papers on a related theme. For example, past special issues have included the following themes: Midlife and Aging in Gay America; Gays and Lesbians in Asia and the Pacific; Violence in Gay and Lesbian Domestic Partnerships; Sexual Identity on the Job; Research Methods with Gay, Lesbian, Bisexual, and Transgendered Populations; and Gay and Lesbian Rights Organizing: Community-Based Strategies. In order to increase their dissemination, these special issues are simultaneously published and separately marketed as edited books in hard and soft cover.

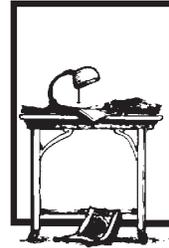
We are seeking Guest Editors for future special issues. Guest Editors assemble a group of authors and oversee completion of the special issue. Proposals for special issues address emerging or under-studied topics or ones that have not previously had the in-depth, coordinated attention that an edited series of articles can provide. Proposals for special issues, like articles, are peer-reviewed. An outline for proposing a special issue can be obtained via e-mail from the Editor.

We welcome your inquiries.

FOR FURTHER INFORMATION CONTACT:

Jeane W. Anastas, PhD
Professor
School of Social Work
The Ehrenkranz Center
New York University
1 Washington Square North
New York, NY 10003-6654
e-mail: jeane.anastas@nyu.edu

FROM THE EDITOR



This issue begins the second volume of *The Journal of Gay & Lesbian Social Services* that I have had the privilege of editing. I thank our editors for their thoughtful and insightful reviews. I also thank our contributors for their patience with our processes, but most of all for the fine scholarship that they choose to share with our readers. Articles in this and forthcoming issues in volume 18 address cancer services for lesbians, homophobia among mental health professionals, transgender youth, help-seeking for abuse in same-sex relationships, developing services for gay and lesbian people in Colombia, and some papers from an invitational conference of LGBT research in social work. Special issues on caregiving for LGBT elders and an ecological perspective on lesbian families, among others, are in the works.

I am pleased to announce that Dr. Lori Messenger of the School of Social Welfare at the University of Kansas has agreed to serve as a new column editor for this journal, a column in which we will be reviewing videos and CDs on gay, lesbian, bisexual and transgender issues that could be useful in service delivery settings and/or in educating social workers and other human service professionals. Please help us identify materials and producers of such materials who might deserve review in this new column.

Thanks to Michael Shernoff for his past work on our ongoing column, *Practice Notes*, where we continue to publish pieces that are reflections on practice issues and practice innovations serving LGBT people. Personal reasons now compel Michael to step down from this

role, and he will be missed. However, I am pleased to announce that Michael Melendez has agreed to serve as the new editor of this column. I know he will continue the fine work that has gone into this practice-oriented part of the *Journal*.

Some of you have asked why the title of this journal remains specific to “gay and lesbian” social services when there is such a need to include bisexual and transgender issues and when terms like “MSM” and “queer” are also part of our current thinking. I have in fact consulted our publisher on the matter, which has reminded me of what a complicated and difficult procedure, changing the name of a journal, in fact, requires. Most important, such a change has the potential of disrupting readership in a major way. Thus this journal will retain its current name, but please be assured that I as Editor, as well as those who review for and support this journal in other ways, want and welcome contributions that are broader in scope than the words “gay and lesbian” in the title might suggest.

Gay, lesbian, bisexual, transgender and queer people continue to face challenges in living that arise from heterosexism and sometimes even homophobia in its most classical meaning as well. Civil and human rights are still not assured, and disparities in health persist (GLMA). As long as these problems continue and as long as there are social work and other human service professionals committed to helping those affected survive and thrive in the face of them, there will be a need for this journal and its content, whatever name it bears.

Jeane W. Anastas, MSW, PhD

Parents' Reactions to Transgender Youths' Gender Nonconforming Expression and Identity

Arnold H. Grossman
Anthony R. D'Augelli
Tamika Jarrett Howell
Steven Hubbard

ABSTRACT. Fifty-five transgender youth described their gender development and expression, parents' reactions to their gender nonconformity, and initial and current mothers' and fathers' reactions to their transgender identity. All of the youth reported feeling different from others in early childhood. Forty-three of the participants' mothers and 26 of their fathers knew about their identities. The youth reported that 54% of their mothers and 63% of their fathers initially reacted negatively, and 50% of the mothers and 44% of their fathers reacted negatively at the time of the interviews, an average of 3 years later. The more gender nonconforming the youth, the more likely they reported that they were verbally and physically abused by their mothers and fathers. Implications of these findings for social service professionals are discussed. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>> © 2005 by The Haworth Press, Inc. All rights reserved.]*

The authors acknowledge the staff and volunteers of the agencies who cooperated in recruiting participants. Dr. Timothy S. O'Connell is thanked for assistance with the research design and for his management skills that helped the project begin. They also thank the study participants and the project's research staff.

This research was supported by the Research Challenge Fund of New York University.

Journal of Gay & Lesbian Social Services, Vol. 18(1) 2005
Available online at <http://www.haworthpress.com/web/JGLSS>
© 2005 by The Haworth Press, Inc. All rights reserved.
doi:10.1300/J041v18n01_02

KEYWORDS. Transgender, gender nonconformity, gender, youth, parent, childhood abuse

Girls and boys grow up in a gendered social context, and many of their psychosocial and health-related experiences are influenced by gender differences, which are linked to the compatibility of their identities and behaviors with general male and female gender roles and expectations. Those who are gender nonconforming experience many pressures, both internal (e.g., confusion, isolation) and external (e.g., rejection, discrimination, violence). These pressures increase as they reach adolescence and attempt to attain identity integration, while coping with body changes related to sexual maturation and physical growth (Burgess, 1999; Green, 2004). “When left unchecked, these pressures can lead to an array of bio-psycho-social problems, from substance abuse to self-mutilation” (Burgess, p. 36). Many social service professionals, families, schools, and peer groups are ill-equipped with accurate knowledge about these transgender youth in order to help them (Burgess, 1999; Lev, 2004). In particular, parents struggle to understand the issues facing gender nonconforming youth and their transitions. Unlike lesbian, gay, and bisexual youth, transgender youth cannot self-identify as transgender and remain hidden if they are going to achieve identity integration. They have to “re-make” themselves physically and socially in order to express the gendered selves that coincide with their transgender identities, and this process affects their parents, siblings, peers, teachers, and extended family members (Lev, 2004).

The goal of this paper is to enhance the knowledge of social service professionals about transgender youth and some of the complex familial challenges unique to their gender identities and gender expressions. It is thought that a better understanding of the issues faced by transgender youth and their families will provide social service professionals with some of the information they need to provide them with effective social service interventions. The paper focuses on transgender youth, specifically their gender expression milestones (i.e., ages of important gender developmental and sexual orientation markers), gender nonconformity as children and adolescents, and the psychosocial and health implications of parents’ reactions to their gender nonconforming youth and to learning their children’s transgender identity. As most parents have control over their children’s medical care, social services professionals play a vital role in helping parents understand the implications of their decisions affecting their children as the youth identify as transgender and transition from their assigned birth sex and gender.

GROWING UP TRANSGENDER

Transgender is an umbrella term used to describe people whose self-identification or expression breaks, goes across, or transgresses established gender categories or boundaries (Green, 2004; Sears, 2005). It includes, but is not limited to, transsexuals (individuals who identify with a gender different from their birth sex), cross-dressers (the term preferred over transvestites), and gender blenders (individuals who purposely present ambiguous gender expressions). Green (2004) described a “transgender childhood as one in which the child unconsciously (at first, and perhaps consciously later) expresses gender characteristics or behaviors that are typically associated with those of the opposite sex to the point of making other people uncomfortable or otherwise acutely aware of the dissonance” (p. 13).

Empirical data indicate that children learn about gender and gender roles very early in their development. Most two-year-olds know whether they are boys or girls; by the age of three they begin to apply gender labels of “he” and “she” when referring to men and women, respectively. They play with toys associated with their own gender and generally avoid toys associated with the other gender (Marcus & Overton, 1978). By four or five, they know that girls are more likely than boys to play with dolls, while boys are more likely than girls to play sports (Connor & Serbin, 1977; Paley, 1984). In their play, girls enact the roles of nurses, teachers, and secretaries, while boys take on the roles of doctors, firefighters, and truck drivers. Although some cultural traditions have changed, these gender stereotypes have remained in place over the last two decades. By the time children enter school at the age of five, “most children express stereotypic ideas of what each sex should do, wear, or feel, and react approvingly or disapprovingly toward each other, according to their choice of sex-appropriate toys and play patterns,” (Perrin, 2002, p. 45).

However, some boys consistently choose dolls over trucks and sports, and may state that they wish to be girls; some girls prefer aggressive play, sports and boys as playmates and state that they wish to be boys. These children tend to be gender nonconforming, and they are discovered to have gender expressions, and perhaps identities, that differ from the expectations associated with their assigned birth sex. It is their gender identities that are “in the driver’s seat” (Green, 2004, p. 8) and inform their gender expressions. “If [they] do not find a balance between [their] gender identities and [their] social interactions, [they] do not find peace in any aspect of their lives” (Green, 2004, p. 9). Their gender

nonconforming and transgender identity disclosure bring varying responses from those close to them, especially their parents. In this paper, the authors examine the gender expression milestones of transgender youth and their parents' reactions to their gender nonconformity, and both mothers' and fathers' initial and current reactions to their children's transgender identities. These reactions impact the health and well-being of this invisible population.

METHOD

The assessment procedure consisted of an interview which focused on the experiences of transgender youth as well as a questionnaire that consisted of a battery of standard measures that assessed various aspects of adjustment and mental health. The protocol was based on a previous one used in a study of lesbian, gay, and bisexual youth (D'Augelli & Grossman, in press). The earlier protocol was modified based on findings from three focus groups with transgender youth and the advice of a planning and evaluation group, which included transgender youth and professionals who had worked with them (Grossman & D'Augelli, 2006). Because seeking parental consent could put these youth at risk of exposing their gender identity or lead to harm, parental consent was waived. However, a youth advocate was available to discuss questions about the study or youths' participation in the study. The research procedures and protocols were approved by the institutional review boards on research with human subjects of New York University and of Pennsylvania State University.

Data are based on a convenience sample of male-to-female (MTF) and female-to-male (FTM) transgender youth, often so classified for research and education purposes while recognizing that some transgender people adopt identities that do not use these labels. Because transgender youth are a "hidden population," it was not possible to recruit a representative sample. The researchers recruited participants where transgender youth congregated and asked them to refer other transgender youth. They were recruited from recreational programs of two social and recreation service agencies in New York City. Using a snowball sampling technique, participants were asked to refer others to the study. The project was advertised as a study about the experiences of MTF and FTM "trans" youth. Youth were offered \$30 to participate. The authors recognize that these recruitment techniques limit the generalizability of the results and that the findings may not be characteristic of all trans-

gender youth between the ages of 15 and 21. Additionally, generalizability is not possible due to other research limitations, including the fact that a convenience sample was used, the youth self-identified as MTF and MTF transgender youth, and the youth had access to a community agency serving lesbian, gay, bisexual, and transgender youth in the New York metropolitan area or knew youth who did. Also, all data are based on self-reports.

Participants

The investigators studied a sample of 31 MTF and 24 FTM transgender youth between the ages of 15 and 21. The respective mean ages of the two groups were 17.5 ($SD = 1.6$) and 19.5 ($SD = 1.6$), a significant difference ($t [53] = 4.55, p < .001$). As to ethnicity and race, 22 were of Latino/ethnic identities, and 33 were not. Regarding race, 41 identified as White, 7 as Black/African American, 3 more than one race, 2 American Indian, 1 Asian, and one did not report race. A similar number of MTF youth (20) and FTM youth (21) identified as White. Twenty-nine youth were attending school, with 22 in college and 7 in high school. Three had graduated from high school, 21 had completed various high school grades, and 2 did not report their levels of education.

Four-fifths of the youth (79%) came from two-person households. Approximately three-fourths of the youth reported they were raised primarily by their biological mothers (42), by their grandmothers (6), or by an adoptive mother (1). There were no differences between MTF and FTM youth regarding those raised by mothers and grandmothers. Of the remaining six youth, some were raised primarily by their biological fathers (3), by a step-father (1), or by other family members (2). All parents listed by the youth as being present in their lives when they were children under the age of 13 were used in the analyses.

Assessment

Youth were assigned a trained interviewer who was a master's level clinician with experience working with transgender youth. Interviews took place in private rooms at the social and recreation agencies or in private offices at a nearby university. After giving their informed consent, the youth completed a questionnaire, and then participated in a structured interview. The interviews were conducted between 2001 and 2003.

Gender expression and presentation. The participants were asked to respond to two statements describing themselves as children under 13

years, from (0) *Never* to (6) *Always* [with (3) *Sometimes*]: (1) "I wished I had been born the sex other than my birth sex" and (2) "I liked wearing the clothes of the sex other than my birth sex." The youth were also asked the reasons they considered themselves transgender. They were asked which of the following descriptors applied to them: identify as another gender or trans, dress like another gender, plan to take hormones, take or have taken hormones, plan to have an operation to change part of their bodies, and had an operation to change part of their bodies. The participants were also asked to select the term they prefer when the interviewer referred to people who express their gender identity different from their birth sex.

Developmental milestones related to gender expression and parents' responses. The participants were asked about the ages when important milestones related to the development of their gender and sexual orientation identities occurred. They were requested to recollect if they felt different from other children while they were growing up. If their responses were affirmative, they were asked when this occurred and why they felt this way. The participants were also asked the ages at which someone else first suggested they were different from other children, and the ages when they were first called a "tomboy" or "sissy" as a child (under the age of 13) if this had occurred. They were also questioned about the age they first considered themselves transgender, and the age they first told someone else they were transgender. Additionally, they were asked if their parents told them to stop acting like a "tomboy" or "sissy" and if so, at what age. They were asked if their parents thought they needed counseling because they were lesbian, gay, bisexual, or transgender or because of their gender expression, and if so, at what age.

Perceptions of parents' reactions to gender expression. Parental psychological abuse was measured with seven verbal abuse and six physical abuse items from the Child and Adolescent Psychological Abuse Measure (Briere & Runtz, 1990); these measures have reported reliabilities from .75 to .87. The participants were asked how often seven kinds of verbal abuse items occurred when they were growing up as a child under 13 years of age. The question was, "Verbal fights and arguments can range from quiet disagreements to yelling, insulting, and more severe behaviors. When you were growing up, how often, if ever, did the following happen?" (Sample items: "yelled at," "made you feel like a bad person.") With regard to the six kinds of physical abuse, the question was, "Sometimes physical blows or violence occur between parents and their children. When you were growing up, at the worst point, how often, if ever, did the following happen?" (Sample items:

“slapped you,” “beat you,” “kicked you”). For both sets of questions, the participants answered with four options: 0 (*Never*), 1 (*Rarely*), 2 (*Sometimes*), and 3 (*Often*).

Mothers’ and fathers’ responses to becoming aware of the youth’s transgender identity were solicited separately. They were asked, “How much does your mother/father know about your being transgender, and how did she/he react?” If their parents knew, the youth were asked their age when they disclosed or their parents discovered their identity and about their parents’ first reaction and current reaction. If their parents did not know about the youths’ transgender identity, the youth were asked, “If she/he found out, what would his /her reaction be?” Parents’ reactions were rated as: 1 (*Very positive*), 2 (*Positive*), 3 (*Negative*), 4 (*Very negative*), 5 (*No reaction*).

Gender nonconformity. The participants completed a modified version of the Gender Conformity Scale (Hockenberry & Billingham, 1987) previously used by D’Augelli and his colleagues (2002) in their examination of gender atypicality among lesbian, gay, and bisexual youth. The scale contains 16 items reflecting childhood frequency of acting or thinking in a manner typically associated with males and females (sample items: “I like rough-and-tumble play,” “I like dolls,” “I preferred boys’ games”). Participants indicated the extent to which each item described them when they were under 13 years of age, with response options ranging from 0 (*Never*) to 6 (*Always*). This scale is a reliable measure of gender nonconformity; Hockenberry and Billingham reported reliabilities of .89 to .91 for different versions of the measure.

RESULTS

Of the MTF youth, only 1 reported *never* wishing to be born of the sex other than her¹ birth sex, while 26 *always* wished to be born of the sex other than their birth sex, with the other 4 using the *sometimes* points of the scale. Only 5 of FTM youth reported *never* wishing to have been born of the sex other than their birth sex as a child under 13 years, while 16 said they *always* wished to be born of the sex other than their birth sex; the other 3 used the *sometimes* point of the scale. With regard to liking to wear the clothes of the sex other than their birth sex, 25 of the MTF and 17 of FTM *always* wished to wear such clothes. When the interviewer asked the participants the term they preferred to be used when describing people who express their gender differently from their

birth sex, a majority of the youth selected “transgender,” while a few chose “queer.”

Both the MTF and FTM youth provided a number of reasons for describing themselves as transgender. The two most frequent reasons given by both groups were that they “identify as another gender or trans,” and that they “dress like another gender.” While all of MTF (31) indicated they are “taking or have taken hormones,” or “planning to take hormones,” two-thirds of the FTM youth (16) indicated doing so. Fourth-fifths of the MTF youth (25), and two-thirds of the FTM youth (15) reported “planning to have an operation to change their body” or that “they had such an operation.”

Table 1 lists eight key gender-related developmental milestones of the MTF and FTM transgender youth and the mean ages at which an event occurred for the youth who experienced the event. All of the youth reported feeling different from others in early childhood, at a mean age of 7.5. Two-thirds of both groups reported being told they were different from others in early childhood. Fourth-fifths of the MTF youth were called “sissy” and three-fourths were told to stop acting like a sissy by their parents. All but one of the FTM was called “tomboy,” and almost two-thirds were told to stop acting like a tomboy by their parents. The MTF youth first considered themselves to be transgender at a mean age of 13 and they first told someone else that they were transgender at a mean age of 14. The FTM youth first considered them-

TABLE 1. Gender-Related Developmental Milestones of Female-to-Male and Male-to-Female Transgender Youth (N = 55)

Milestone	Female to Male				Male to Female			
	<i>N</i>	<i>M</i>	<i>SD</i>	Range	<i>n</i>	<i>M</i>	<i>SD</i>	Range
Feeling different from others	24	7.5	3.1	3-12	29	7.6	3.1	1-14
Being told you were different from others	16	6.8	1.6	5-10	20	9.3	3.3	4-16
Called a “tomboy”/ “sissy” under age 13	23	6.7	2.6	3-13	25	8.3	2.4	4-12
Told by parents to stop acting like a “tomboy”/“sissy”	15	9.2	4.7	4-16	23	10.3	3.0	6-16
Parents asked/told you were gay, lesbian, bisexual, or transgender	11	13.9	1.8	11-17	21	12.0	2.0	8-15
Parents thought you needed counseling for sexual orientation or gender behavior	13	14.8	3.8	8-12	22	11.5	2.3	7-15
Considered self transgender	24	15.2	4.5	3-20	31	13.4	2.8	7-18
First told someone else transgender	24	17.0	2.7	9-20	31	14.2	2.6	8-19

selves to be transgender at a mean age of 15, and they first told someone else that they were transgender at a mean age of 17.

More than two-thirds (68%, $n = 21$) of the MTF participants reported that their parents asked or told them that they were either lesbian, gay, bisexual or transgender, and approximately one-half (46%, $n = 11$) of the FTM parents did the same. More than 70% of the MTF youth (22) had parents who thought their children needed counseling regarding their sexual orientation or gender expression, and more than 50% of the FTM youth (13) had parents who thought their children needed counseling for these reasons. Parents of MTF youth who suggested the need for counseling did so three years before the youth disclosed their transgender identities, while for the FTM youth this occurred two years before they disclosed their transgender identities.

Correlation analyses revealed that the more gender nonconforming youth were, the younger their age when they first told someone about their transgender identity ($r = -.49, p < .01$) and the younger their age when their parents asked about their sexual orientation or gender identity ($r = -.61, p < .01$). Additional correlation analyses found that more gender nonconforming the youth were, the more they reported being psychologically abused by their parents, both verbally and physically. The more gender nonconforming the youth were, under the age of 13, the more they reported being verbally abused by their parents as children, under the age of 13 ($r = .39, P < .01$). Additionally, the more gender nonconforming youth were, under the age of 13, the more they reported being physically abused by their parents as children, under the age of 13 ($r = .41, p < .01$).

Forty-three of the participants' mothers and 26 of the participants' fathers knew about their children's transgender identities. Of these mothers and fathers, they discovered the youths' transgender identity or the youth disclosed it to them at a mean age of 16 (Mother: $SD = 2.69$; Father: $SD = 3.06$). The youth reported that 54% of their mothers first reacted *negatively* or *very negatively*, while 25% first reacted *positively* or *very positively*; 21% exhibited *no reaction*. However, the mothers' reactions became generally more positive over time. At the time of the interview (an average of three years later, $SD = 2.45$), the youth reported that 50% of their mothers reacted *negatively* or *very negatively*, while 48% reacted *positively* or *very positively*. Only 2% of the mothers exhibited *no reaction*.

Of the 26 participants' fathers, the youth reported that 63% of them first reacted *negatively* or *very negatively*, while 22% first reacted *positively* or *very positively*; 15% exhibited *no reaction*. As with their moth-

ers, their fathers' reactions became generally more positive over time. At the time of the interview (an average of three years later, $SD = 2.45$), the youth reported that 44% of their fathers reacted *negatively* or *very negatively*, while 56% reacted *positively* or *very positively*; none of the fathers had *no reaction*. Youth whose parents were not aware of their transgender identities predicted that both their mothers' and fathers' reactions would be *negative* or *very negative*. The 11 participants whose mothers were not aware of their transgender identities predicted that 73% would have a *negative* or *very negative* reaction. The nine participants whose fathers were not aware of their transgender identities predicted that 78% of those reactions would be *negative* or *very negative*.

DISCUSSION

Transgender youth face many obstacles as they transition from their birth sex and gender because they transgress society's binary of two types of bodies, that is, male or female, and two types of gender expression, that is, masculine and feminine (Green, 2000, 2003). Many transgender youth live in fear of being ridiculed and rejected by family, especially their parents. As the results of this study indicate, this becomes a reality for many transgender youth. More than 59% of the participants faced initial negative reactions from their parents. Although some youth reported that both their mothers' and fathers' reactions improved over time, a large percentage of participants reported their mothers' and father's reactions were negative at the time of their interview, that is, 50% of the mothers and 44% of the fathers.

As gender nonconforming behavior is much less accepted in boys than girls, transgender males become more frequent targets of verbal and physical victimization (Ryan & Futterman, 1998). As the study reported in this paper indicates, the participants' parents not only reacted negatively to them, but they also verbally and physically abused them; the more gender nonconforming they were, the more abuse they received. As others have found, when children are abused, they either learn to protect themselves by denial, withdrawal, turning off their feelings, acting out, or self-blame (Loyola College, 2005). These coping mechanisms can have long-term consequences, such as feelings of low self-esteem and self-worth, lack of trust, problems with knowing or showing one's feelings, being easily stressed, or experiencing poor mental and emotional health, including depression, anxiety, dissociative disorders, and reactive attachment disorders. These psychological

consequences may lead to behavioral ones such as abusing alcohol or illicit drugs, or engaging in high-risk behaviors (National Clearinghouse on Child Abuse and Neglect Information, 2005). With the home not being a safe environment, other coping mechanisms used by transgender youth are running away, dropping out of school, and living on the streets, where they find themselves at risk for drug use, prostitution, and sexually transmitted diseases (Ryan & Futterman, 1998). Helping parents to learn about this invisible and vulnerable population, and not to abuse them because of who they are, is a vital task of social service professionals (Grossman & D'Augelli, in press).

As the literature indicates (Burgess, 1999; Mallon, 1999), transgender youth are misunderstood not only by their parents, but also by most social service professionals, teachers, and administrators of agencies and schools, who are uncomfortable with them. Additionally, many social service providers fail to create a safe and respectful atmosphere for transgender youth (Burgess, 1999). An affirmative environment includes being open to the youths' individual identities and giving them space to explore their gender identity. It also encompasses using the youth's choice of name and pronoun in conversations, respecting his or her privacy, and providing access to public areas (e.g., restrooms) in which youth will not be harassed. Furthermore, it means not only eradicating discrimination against and harassment of transgender youth in the social agencies, but ensuring that they have support in dealing with abuse in other situations, including those involving their parents. Consequently, it is imperative to create a place for youth not only to explore who they are, but to develop a positive self-image and sense of themselves. It is also necessary that interventions help them to develop a sense of trust, overcome feelings and conflicts in relation to their parents, and cope with feelings of hopelessness and anger when they surface.

Youth, whose parents typically make medical decisions for them or who may be too young to qualify for the few programs that help transgender youth receive care, are unable to access the medical care they need to transition from one gender to another, including counseling related to living as a gender not concordant with their birth sex, hormone therapy, and provider support. Haymes (2005) indicated that traditional programs, including housing alternatives, drug treatment programs, and health centers, are ill prepared to work with transgender youth in any kind of affirming and supportive manner. He also reported that when transgender youth are connected to a respectful outreach worker or team offering referrals, they are apt to seek social and psychosocial services from youth-serving agencies—especially when those agencies provide

services that are appropriate to their needs, respectful, and accessible on all levels, for example, at no cost, in a reachable location, and by a culturally competent staff.

In order for social service professionals to become culturally competent in working with transgender youth, they need to become transgender knowledgeable by gaining an understanding of the psychosocial issues of transgender youth, their gender expression milestones, and the contexts of their lives in a heteronormative society. As the findings of this study indicate, transgender youth learn they feel different from others when they are very young, with most being told they are different and being called a “tomboy” and “sissy.” A majority of MTF and FTM transgender youth are told by their parents to stop acting like a “sissy” or “tomboy,” respectively, when they are children, thereby being taught to feel fear and shame about who they are. All of the youth in the study considered themselves to be transgender in their early adolescence, and first told someone else about their identity within a year or two of that decision. In addition to learning that transgender youths’ gender expressions did not correspond to society’s rigid ideas about gender since they were very young, social service professionals need to understand that transgender people and gender diversity have existed at different times and places all over the world (Feinberg, 1996). In order to reduce the psychosocial stresses of transgender youth and to enhance their psychosocial function, social service professionals need to understand that each person’s gender identity is natural to that individual and that gender identity may be experienced on a continuum—not solely as male or female. Furthermore, gender identity and expression, though integral to an individual’s identity, are only two aspects of the person. Therefore, it becomes incumbent on all social service professionals to maintain a balanced perspective in understanding the multifaceted aspects of a youth’s development, not giving their transgender identities and expressions the “master status” of their lives, that is, the lens through all aspects of their lives are viewed.

NOTE

1. Gender identity self-labels are used throughout the paper, that is, “she” and “her” are used when talking about MTF, and “he” and “him” are used when talking about FTM.

REFERENCES

- Briere, J., & Runtz, M. (1990). Differential adult symptomatology associated with three types child abuse histories. *Child Abuse & Neglect*, *14*, 357-364.
- Burgess, C. (1999). Internal and external stress factors associated with the identity development of transgendered youth. In G. Mallon (Ed.), *Social services with transgendered youth* (pp. 35-47). New York: Harrington Park Press.
- Connor, J. M., & Serbin, L. A. (1977). Behaviorally-based masculine and feminine activity preference scales for preschools. *Child Development*, *48*, 1411-1416.
- D'Augelli, A.R., & Grossman, A.H. (in press). Researching lesbian, gay, and bisexual youth: Conceptual, practical and ethical considerations. *Journal of Gay and Lesbian Issues in Education*.
- D'Augelli, A. R., Hershberger, S. L., & Pilkington, N. W. (2002). Incidence and mental health impact of sexual orientation victimization of lesbian, gay, and bisexual youths in high school. *School Psychology Quarterly*, *17*, 148-167.
- Feinberg, L. (1996). *Transgender warriors*. Boston: Beacon Press.
- Green, J. (2000). Introduction to transgender issues. In P. Currah & S. Minter (Eds.), *Transgender equality: A handbook for activists and policy makers* (pp. 1-6). New York: National Center for Lesbian Rights and National Gay and Lesbian Task Force Policy Institute.
- Green, J. (2003). Centering: An alternative perspective. In J. Alexander & K. Yescavage (Eds.), *Bisexuality and transgenderism: Intersections of the others* (pp. 277-285). New York: Harrington Park Press.
- Green, J. (2004). *Becoming a visible man*. Nashville: Vanderbilt University Press.
- Grossman, A. H., & D'Augelli, A. R. (2006). Transgender youth: Invisible and vulnerable. *Journal of Homosexuality*, *51*(1), 111-128.
- Haymes, R. (2005). *Towards Healthier Transgender Youth*. Retrieved September 2, 2005, from http://www.youthsource.com/community/transphobia/being_trans/health.html.
- Hockenberry, S. L., & Billingham, R. E. (1987). Sexual orientation and boyhood gender conformity: Development of the Boyhood Gender Conformity Scale. *Archives of Sexual Behavior*, *16*, 475-492.
- Lev, A. I. (2004). *Transgender emergence: Therapeutic guidelines for working with gender variant people and their families*. New York: Haworth Clinical Practice Press.
- Loyola College (2005). Surviving Childhood Abuse. Retrieved September 4, 2005 from <http://www.loyola.edu/campuslife/healthservices/counselingcenter/abuse.html>.
- Mallon, G. (1999). Knowledge for practice with transgendered persons. In G. Mallon (Ed.), *Social services with transgender youth* (pp. 1-18). New York: Harrington Park Press.
- Marcus, D., & Overton, W. F. (1978). The development of cognitive gender constancy and sex role preferences. *Child Development*, *49*, 434-444.
- National Clearinghouse on Child Abuse and Neglect Information (2005). Long-term Consequences of Child Abuse and Neglect. Retrieved September 9, 2005, from http://nccanch.acf.hhs.gov/pubs/factsheets/long_term_consequences.cfm

- Paley, V.G. (1984). *Boys and girls: Superheroes in the doll corner*. Chicago, IL: University of Chicago Press.
- Perrin, E.C. (2002). *Sexual orientation in child and adolescent health care*. New York: Kluwer/Academic/Plenum Publishers.
- Ryan, C., & Futterman, D. (1998). *Lesbian and gay youth: Care and counseling*. New York: Columbia University Press.
- Sears, J.T. (Ed.). (2005). *Gay, lesbian, and transgender issues in education: Programs, policies, and practices*. New York: Harrington Park Press.



For FACULTY/PROFESSIONALS with journal subscription recommendation authority for their institutional library . . .

If you have read a reprint or photocopy of this article, would you like to make sure that your library also subscribes to this journal? If you have the authority to recommend subscriptions to your library, we will send you a free complete (print edition) sample copy for review with your librarian.

1. Fill out the form below and make sure that you type or write out clearly both the name of the journal and your own name and address. Or send your request via e-mail to docdelivery@haworthpress.com including in the subject line "Sample Copy Request" and the title of this journal.
2. Make sure to include your name and complete postal mailing address as well as your institutional/agency library name in the text of your e-mail.

[Please note: we cannot mail specific journal samples, such as the issue in which a specific article appears. Sample issues are provided with the hope that you might review a possible subscription/e-subscription with your institution's librarian. There is no charge for an institution/campus-wide electronic subscription concurrent with the archival print edition subscription.]

YES! Please send me a complimentary sample of this journal:

_____ (please write complete journal title here—do not leave blank)

I will show this journal to our institutional or agency library for a possible subscription.

Institution/Agency Library: _____

Name: _____

Institution: _____

Address: _____

City: _____ State: _____ Zip: _____

Return to: Sample Copy Department, The Haworth Press, Inc.,
10 Alice Street, Binghamton, NY 13904-1580

Listening to the Voices of Lesbians Diagnosed with Cancer: Recommendations for Change in Cancer Support Services

Lisa Barnoff
Christina Sinding
Pamela Grassau

ABSTRACT. This paper focuses on the operations of heterosexism and strategies to counter it in a particular service context: the context of psychosocial support services for women with cancer. The paper draws on findings from a participatory, qualitative study set in Ontario, Canada in which 26 lesbians were interviewed about their experiences of cancer diagnosis, treatment, health care and social support, and their feelings and perceptions about shifts in identity, body, sexuality and relationships. This paper focuses on findings related to the changes research participants perceived as necessary in the provision and organization of cancer support services, in order to increase access and ensure equity for lesbians with cancer and their families. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>> © 2005 by The Haworth Press, Inc. All rights reserved.]

KEYWORDS. Lesbians, cancer, heterosexism, homophobia, cancer support services

The authors want to express their sincere appreciation to the women who agreed to be interviewed for this project, and to members of the Lesbians and Breast Cancer Project Team. *Coming Out About Lesbians and Cancer*, a community research report, is available as an html file and for download in PDF at <http://dawn.thot.net/lbcp>.

This research was made possible with funding from the Canadian Breast Cancer Foundation, Ontario Chapter.

Journal of Gay & Lesbian Social Services, Vol. 18(1) 2005
Available online at <http://www.haworthpress.com/web/JGLSS>
© 2005 by The Haworth Press, Inc. All rights reserved.
doi:10.1300/J041v18n01_03

In the past two decades, as a result of dedicated activism, significant civil rights have been achieved for lesbians and gay men in Canada. This trend toward equity is also evident within social work contexts, as more social workers embrace the principles of anti-oppressive practice and re-examine the theories and practices that dominate our profession. Unfortunately, however, for the most part, mainstream social work and health care services continue to marginalize groups of people who are also marginalized within the larger society. Heterosexism (the belief that normal sexuality is heterosexuality) and homophobia (the irrational fear or hatred of non-heterosexual people) have long histories in social work and other helping professions, and continue to operate within service delivery systems today (Brotman, Ryan, & Cormier, 2003).

This paper draws from a qualitative research study about lesbians' experiences with cancer and cancer care. Elsewhere we document the heterosexism and homophobia encountered by research participants in cancer care settings (Sinding, Barnoff, & Grassau, 2004). This paper focuses on the changes research participants perceived as necessary in the provision and organization of cancer support, to increase access for lesbians with cancer and their families.

LITERATURE REVIEW

Researchers who have directly examined the experiences of lesbian and gay people with helping professionals have found heterosexism and homophobia to be pervasive within health care and social services (Barbara, Quandt, & Anderson, 2001; Faria, 1997; Saulnier, 2002; Spinks, Andrews, & Boyle, 2000; Tiemann, Kennedy, & Haga, 1997). In Canada, researchers and activists often cite Mulé's (1999) work on the provision of health and social services to sexual minorities in Ontario. In Mulé's study, 92% of research participants reported that hospital staff (including social workers) lacked knowledge and sensitivity when it came to issues facing sexual minority people. More specifically in terms of social work practice, Mulé found that 89% of respondents agreed or agreed somewhat with the statement that their therapists and counselors need to become "more knowledgeable about and sensitive to issues related to being lesbian/gay/bisexual" (p. 44).

Highlighting the diversity existing within gay, lesbian, and bisexual communities, several authors have documented the experiences of service use for people who experience heterosexism interconnected with other forms of oppression. Researchers have explored the experiences

of older gays and lesbians (Brotman et al., 2003), Two-spirited People (Brotman, Ryan, Jalbert, & Rowe, 2002a,b), lesbians of color (Stevens, 1998), and lesbians and gays diagnosed with major mental illness (Avery, Hellman, & Sudderth, 2001). These researchers have consistently found that heterosexism operates in tandem with other forms of oppression in health care and social services. Brotman et al. (2002a) for example, document the many ways in which Two-spirited people in Canada experience multiple barriers to health care both within and outside of Aboriginal communities. As another example, Stevens (1998) exposes the multiplicity of prejudices experienced by lesbians of color within health care encounters, illuminating the many ways this group of lesbians is affected not just by heterosexism but also by a series of marginalizing practices which are rooted in the intersections of heterosexism with racial, class, and gender oppressions.

Following on these findings, researchers have called for significant changes to the ways services are provided. The most commonly cited area for change is the attitudes or biases of individual service providers. It is argued that individual providers need to become more aware of their own attitudes toward gay and lesbian people, and understand how negative ideas or beliefs can manifest within the practices of even the most well-meaning social service professional (Brotman et al., 2003; Faria, 1997; Ferren, 1997; Mulé, 1999; Maccio & Doueck, 2002; Mallon, 1997; Phillips, McMillen, Sparks, & Ueberle, 1997; Rabin, Keefe, & Burton, 1986; Saulnier, 2002; Spinks et al., 2000; Stevens, 1998; Tiemann et al., 1997; Travers & Schneider, 1996). At an organizational level, researchers argue that the promotion of access and equity for gays and lesbians requires change in multiple areas, including, but not limited to organizational culture (Brotman et al., 2003; Ferren, 1997; Phillips et al., 1997); organizational policy (Ferren, 1997; Maccio & Doueck, 2002; Mulé, 1999; Phillips et al., 1997; Saulnier, 2002; Travers & Schneider, 1996); staff training and development (Barbara et al., 2001; Brotman et al., 2003; Faria, 1997; Ferren, 1997; Mule, 1999; Maccio & Doueck, 2002; Rabin et al., 1986; Travers & Schneider, 1996); hiring processes (Ferren, 1997; Maccio & Doueck, 2002; Phillips et al., 1997; Rabin et al., 1986); organizational records and other documentation (Barbara et al., 2001; Brotman et al., 2003; Tiemann et al., 1997); programs and services (Brotman et al., 2003; Ferren, 1997; Mulé, 1999; Rabin et al., 1986; Saulnier, 2002; Travers & Schneider, 1986); and outreach and advocacy (Brotman et al., 2003; Faria, 1997; Ferren, 1997; Mulé, 1999; Phillips et al., 1997; Rabin et al., 1986; Saulnier, 2002). Together, these researchers are clearly calling for programs and services

specifically designed to serve lesbians and gay men as well as for better integration of lesbian and gay issues into already existing programs.

The literature clearly confirms the existence of heterosexism across a range of service contexts, and highlights the need for change at several levels. Yet certain service contexts remain under examined, cancer care among them. Lesbians are at increased risk for some cancers (Valanis, Bowen, Bassford, Whitlock, Charney, & Carter, 2000), yet literature focused on their psychosocial and support service experiences is relatively scarce. In a 2001 study, Fobair and colleagues compared the responses of lesbians and heterosexual women newly diagnosed with breast cancer. The lesbian participants had more negative views of their care and support than heterosexual participants. Research conducted by Matthews, Peterman, Delaney, Menard, and Brandenburg (2002) also compared the experiences of lesbians and heterosexual women diagnosed with cancer, and their findings also document lesbians' lower satisfaction with health care and lower satisfaction with the availability of social support. Matthews (1998) reporting on clinical issues for lesbian cancer patients found the following: Lesbians perceived health care providers as lacking in knowledge and sensitivity to lesbian health concerns; disclosure of sexual identity was often associated with stress and conflict; lesbians relied more on "chosen family" for emotional support and expressed a strong desire for their partners to be seen as "spousal equivalents"; and lesbians of color underutilized cancer support services.

In part to address the gap in knowledge about the experiences of lesbians with cancer, and in part to contribute to the growing literature on the health and social service needs of lesbians in general, the Lesbians and Breast Cancer Project Team implemented a study to explore the experiences of lesbians diagnosed with cancer in Ontario. This paper reviews findings focused on participants' recommendations for change in service delivery systems.

METHODS

This study followed a Participatory Action Research (PAR) model. Participatory research is "systematic inquiry, with the collaboration of those affected by the issue being studied, for the purposes of education and taking action or affecting social change" (Green et al., 1995). In this model, researchers are positioned not as "separate, neutral academics theorizing about others, but rather as co-researchers or collaborators with people working toward social equality" (Gatenby & Humphries,

2000, p. 90). The study was undertaken by a Project Team comprised of lesbians directly affected by cancer, along with staff and volunteers at agencies in the cancer, queer and women's health communities. Members of the Project Team were actively involved in each aspect of the research process.

While the central focus of the study was lesbians' experiences with breast cancer, the Project Team speculated early on that lesbians with gynecological cancers might face similar issues given that they too had experienced a diagnosis of a "woman's cancer." For this reason lesbians with both breast and gynecological cancer were recruited to the study. In our promotional material, we defined lesbians as women whose "primary emotional and sexual relationships are with women."

The study was promoted across Ontario by research staff, members of the Project Team, and eventually, by some research participants as well. E-mail notices were circulated to organizations in the women's health, feminist, queer, and cancer communities, and through the Project Team's personal and professional networks. Posters advertising the study were mailed to agencies listed in a province-wide directory of lesbian and gay resources. During the process of recruiting participants, the project also attracted media attention across the province, including print, radio, and television sources. Interested potential participants were invited to contact the researchers.

Committed to ensuring the study reflected the diversity in lesbian communities (by age, socioeconomic status, race/ethnicity, geographic location, ability, family status and other such categories), the Team developed diversity targets and community-specific promotional materials (e.g., for lesbians of color and lesbians with disabilities). We involved women who were members of these communities in paid work related to promotion and recruitment of participants, hoping this might help to facilitate increased participation from these communities.

Interview topics, developed initially in consultation with the Project Team, and later in consultation with research participants, focused on participants' experiences of treatment, cancer care, and support, and their feelings and ideas about any changes in body, sexuality, identity, and relationships. Interviews were approximately one and a half hours in length and were tape recorded and transcribed. Seventeen interviews were conducted in person, at times and in locations comfortable and convenient for participants, either in their homes or at our research offices. Nine interviews were conducted over the telephone at a time convenient to participants and when they were in settings where the conversation

could happen comfortably and confidentially. A \$30 honorarium was provided to each participant.

The final sample consisted of 26 lesbians diagnosed with cancer-22 with breast cancer, 3 with gynecological cancer, and 1 with both. See Table 1 for demographic information. Participants were each asked to choose a pseudonym for use in research reports. Where participants did not select their own pseudonym, it was assigned by the researchers.

Based in large part on the Project Team's reflections on early interview transcripts but modified as the project continued to unfold, the research team developed a coding framework. Transcripts were coded using the qualitative software program NVivo (Bazeley & Richards, 2000). Both to adhere to principles of qualitative analysis (Seale, 1999) and to minimize the risk of stereotyping lesbians, we deliberately paid particular attention to negative cases. In keeping with our participatory framework, we asked eight research participants to join the Project Team for two half-day meetings to review the draft research report and

TABLE 1. Demographic Characteristics of Research Participants

Age	Average Age 50; Range = 36-72		
Time since diagnosis	Three years or more: 13; less than three years: 13		
Place of birth	Canada: 20; United States: 2; England: 1; The Philippines: 1; Jamaica: 1; Hong Kong: 1		
First language	English: 24; Cree: 1; Dutch: 1		
Race/ethnicity (self-defined) ^a	Caucasian/ White: 7; British: 2; Canadian: 2; Jewish: 2; Indigenous/Native: 2; Metis-Ukrainian: 1; Euro Canadian: 1; Polish Canadian: 1; Italian: 1; Asian: 1		
Total annual household income	100,000+ – 6	70-79,000 – 2	40-49,000 – 1
	Less than 20,000 – 1 ^b		
	90-99,000 – 1	60-69,000 – 3	30-39,000 – 4
	80-89,000 – 1	50-59,000 – 4	20-29,000 – 2
Education	University degree: 19; College diploma: 6; Secondary school diploma: 1		
Disability/health problems aside from cancer	One woman is hearing impaired; one has heart problems and arthritis and is a psychiatric survivor; one has experienced depression and has fibromyalgia; one has endometriosis		
Urban/rural (at time of treatment)	Urban: 20; semi-urban: 2; rural: 4		
Family status (at diagnosis)	Partnered: 17; single: 9; adult children: 5; young children: 1; trying to have children: 2		
Identity	Lesbian: 22; Gay: 2; Dyke: 1; Bisexual: 1		
Family doctor knew identity	Yes: 23; No: 2; Not sure: 1		

^a One woman said the question was impossible to answer as her ethnicity was "too mixed"; one did not respond.

^b Actual income – \$8000.

comment on the emerging analysis. Participants were selected for inclusion in this meeting in relation to some of the Project's diversity aims (e.g., a participant who identified as "poor" was invited, as women from low socioeconomic groups were not well represented in the research). Feedback from these meetings led to substantial revisions of the final research report.

FINDINGS

Asked what they needed and wanted at the time they were diagnosed with cancer and about the changes they would like to see implemented for lesbians with cancer now, participants offered a number of ideas, suggestions, and recommendations. Centrally, research participants expressed a desire to connect with other lesbians diagnosed with cancer, and they wanted their partners and their children to have parallel opportunities. They called for information and resource materials that integrate lesbian realities, the opportunity to meet with lesbian service providers, and program development in the form of support and wellness groups as well as one-to-one telephone support.

Opportunities for Connection with Other Lesbians Diagnosed with Cancer

The opportunity to connect with other lesbians who had been diagnosed with cancer was a dominant theme in participants' responses about what they wanted and needed when they were diagnosed.

Having other gay women to talk to, that had gone through this or have or were experiencing the same thing, would have been extremely helpful. (Laura)

I tend to think that lesbians are better handled by other lesbians. And I think that . . . when you're struggling with cancer . . . I want other lesbians around that I can talk to. (Paddy)

Many participants said they never had a chance to meet another lesbian diagnosed with cancer at any time in their journey, including up to the time of their interview. Many continue to feel that they would value contact with other lesbians with cancer.

Participants imagined a number of positive benefits that could arise in a context of connection with other lesbians diagnosed with cancer. For one, in the presence of other lesbians, participants envisioned not having to expend energy deciding if, when, how, and to whom they should reveal their sexual orientation, negotiating being “other,” or worrying about negative consequences of disclosure. One participant, for example, said she desired:

More services, more resources that lesbians can access without having to educate people, without having to feel shame when they walk in, and by thinking in your mind, what, should I take my rainbow off today? What should I do? Should I just sit there and not say anything about who I am?

Some participants suggested that among lesbians, they would have more opportunities for genuine emotional connection. “I think it would be more comfortable and more open and honest . . . and more intimate sharing, I would say. It would be more healthful” (Laura). Similarly, Jessica “always had wished . . . to have a place for us to meet, so that we know that there’s other lesbians who have cancer that we can share and gain strength from each other.”

A few participants suggested that if they had the opportunity to interact with other lesbians diagnosed with cancer, they would be better able to process the specifics related to being a lesbian with cancer:

I think that when lesbians who have cancer get together and talk, we talk about the lesbian component of having cancer, we do. And I think it’s because we can’t talk about it anywhere else or it’s not heard or it’s not understood. (Sarah)

I am isolated from other lesbians who’ve had breast cancer. And so haven’t really had a chance really to explore other issues that you know could come up that I haven’t thought of, or have gone, oh that’s happened to me too but I didn’t realize it was because I was a lesbian. (Maureen)

One participant revealed how having the opportunity to reflect on the interconnections of her cancer experience with her lesbian identity would have been beneficial not just for her, but for her entire family.

I think the fact that there wasn't a group where I could talk about that from a lesbian point of view, it was extremely difficult . . . And I really would have liked to have known other lesbians who are going through that . . . and have a chance to talk about that. I think it would help my partner too. It would've been easier for us as a couple . . . It would have [also] been easier on the kids, I think. Having somewhere to go where you could be a full person, and talk about things, would have had a really profound effect for me, and I think a ripple effect for the people in my life. (Kate)

A cancer support setting in which lesbians could bring their whole selves to the process from the beginning was also linked to wider processes of emancipation:

Some people don't have a problem with anybody not knowing that they're lesbian or that they have a woman partner, but, you know, many of us are proud of how we came from there to here and we've spent time in the closet and we're out and [as a result of the way cancer services are currently provided] some of us are going back in. (Glenda)

The seemingly simple act of enabling a woman to be "out" from the very beginning when utilizing cancer support services, was understood as critical and liberating.

Opportunities for Connection for Partners and Children of Lesbians Diagnosed with Cancer

This strong need for connection with other lesbians diagnosed with cancer which was revealed by participants, carried through into their analysis of how services could better respond to the needs of their family members as well. Participants expressed a desire for their partners to have access to opportunities to connect with other partners of lesbians diagnosed with cancer.

I mean we both pretty much gave up on the idea of support groups because there didn't seem to be anything for lesbian partners . . . All the stuff that's been written, all the groups that are out there, it's all geared toward men, and that's not very good . . . And if [there is] one thing that comes out of all these studies, "Get more help for the partners," that's what I would say. (Constance)

Interestingly, participants' statements about their partners' fears of isolation within the context of "general" groups for partners mirrored their statements about their own fears of isolation and their subsequent decisions not to attend groups based on these fears:

We did check into support groups and they were always for men, for male partners of . . . and [my partner] said "There's no way, I'm not going to those, they won't understand what I'm going through, I don't want them looking at me." She was having a hard enough time . . . she just couldn't, she just said no. (Constance)

Similarly, there was a clear expressed need for specialized services for children of lesbians diagnosed with cancer. One participant noted, "For the children in my life, for my partner, they [support groups] weren't things that were very useful. They weren't things that were open. It didn't feel like an open door was there." (Kate). She went on to say that any services that would be genuinely useful for her children would enable them to speak freely about her. This would mean that they would have to come out as children of a lesbian mom and deal with all the reactions this usually generates, and provide all the explanations it often requires. Children of lesbian parents are in this situation frequently, but as Kate suggested, when a lesbian parent has cancer, "do [my children] really want to deal with their sadness and grief and have to explain all that? No they don't. And neither did my partner." The need for connection then is clear—lesbians diagnosed with cancer want to connect with other lesbians diagnosed with cancer, and they want their partners and their children to have parallel opportunities.

Information and Resource Materials Reflecting and Integrating Lesbians' Realities

Participants noted that newly diagnosed women are often lacking information about cancer and cancer treatment experiences and saw this lack of information as a critical gap in services.

What I wanted to know was, how does it feel, you know, afterwards, what does it feel like when your hair falls out, you know, all this sort of stuff. That's in none of the literature, nobody ever writes that down and unless you know somebody who has gone through it, who do you ask? (Constance)

Further, mirroring their ideas about the importance of connections with other lesbians above, these participants desired not just the access to this kind of practical information, but more importantly, access to this knowledge within a context they defined as “safe”; in this case, that meant within the context of a relationship with other lesbians who had been diagnosed with cancer. As this participant explains:

A very meaningful thing for me would have been a program similar to [name of cancer support program] . . . They link a woman who has been through breast cancer and survived with someone who is just going through it. And they bring that person all kinds of information, they bring them a little prosthesis, a temporary prosthesis they can wear when they come out of the hospital. And . . . you can call them and talk to them and they sort of, you know, [say], “you’re just starting treatment, don’t forget to go buy your wig,” or you know, “did you feel this?” Or, “did you feel numbness here?” Or whatever. But it links you with someone that you can relate to and talk to. So it would be great, I think, if there was a program like that . . . for lesbians . . . And then you just wouldn’t feel, like, so alone all the time. (Jessica)

The glaring absence of resource materials reflecting and integrating lesbian realities was named as a serious problem. Some participants noted it was important for them to be able to access cancer resources that had been developed by lesbians themselves, both written material: “Dr Susan Love, I mean that was wonderful knowing that she wrote this wonderful book, and that she identifies as a lesbian, that was great” (Maureen), as well as stories and visual representations: “One of the helpful things was that movie, *My Left Breast* [Rogers, 2000] . . . Because it reflects my experience, which is a different experience” (Marcia). Further, participants argued that where resources were not specifically developed by lesbians, they must always be inclusive of lesbian realities. For different participants, this meant different things. For some, it meant having information available that had been compiled specifically for a lesbian audience. For others it meant seeing lesbians’ experiences within the context of “general” materials:

There’s not that word [dyke] ever used in any of the pamphlets I’ve read so far . . . not even the L word is in there. Never. Never. I’ve never seen it, never seen it. Not even the word partner is in there, you know? . . . I’m not saying that I want every example in

that pamphlet to be a lesbian. But one out of 25 would be really cool. I'm not greedy. (Sarah)

One woman spoke about the value, not only of the information itself, but of the visibility and affirmation that lesbian-specific resources imply: "I think one good thing is having pamphlets that have the word lesbian written on them in waiting rooms of breast clinics . . . It would just be sort of comforting as a lesbian to go into a clinic and see the word lesbian written somewhere." (Maureen)

Some participants also noted the diversity in lesbians' realities and life experiences, and, therefore, the need for the development of resources that could meet the needs of specific groups. One participant for example, talked about the importance of resource lists for low-income lesbians, with information about where to obtain healthy food and other basic necessities.

The development of resource material on sexuality for lesbians diagnosed with cancer was another stated need. Participants noted that basically no information was offered to them around women's sexuality in general, and certainly nothing focusing on sexuality issues that might be particularly relevant for lesbians. This is especially important for women diagnosed with a "woman's cancer," because, in these cases, as one participant put it, "sexuality and disease [now] all come in the same package" (Kate). One participant talked about the need for cancer support agencies to put together a compilation of lesbian focused resource material that could be given to lesbians who called seeking services or resources, and within this compilation.

There'd be something about sexuality. There'd be something written by a dyke about what to expect from a dyke's point of view . . . There'd be somebody somewhere, some kind of sexuality counseling person. . . . There'd be a workshop . . . that talks about, you know . . . sexual adaptation, if you'd had surgery that's affected some part of your body that you normally use for sex . . . what are other things you could do to ensure that you're, you know, you're still getting orgasms regularly, and . . . how can you bring your lover in on that. (Lilian)

Lesbian Service Providers

A number of participants expressed a wish to be able to obtain services from lesbian service providers. As Reagan said, "I wish when I'd

called, before I had to say anything, she said, ‘we have a lesbian counselor.’” In this regard, participants pointed to the need for agencies to increase diversity in their hiring practices; specifically, they wanted agencies to commit to hiring lesbian workers. This strategy for change depends not just on the willingness of agencies to hire lesbian workers, but also on the development of a workplace culture and workplace policies which can support and enable workers to be open about their sexual identity.

SUGGESTIONS FOR PROGRAM DEVELOPMENT

Support Groups

Within this discussion of lesbians’ support needs, participants named a number of programming strategies which they felt could best meet those needs. The most often mentioned programming strategy was the establishment of cancer support groups for lesbians. Given their experiences either not attending mainstream support groups, or attending and experiencing heterosexism or homophobia, it is not surprising that many participants expressed a wish for separate support groups.

I think I would have emotionally felt more surrounded, if I had a group of lesbians to talk to, you know, because you just forget all the other stuff, you know what I mean, and you just sort of focus in . . . Like you don’t need to explain . . . you just skip all that and get right to the meat and potatoes. (Sherry)

Developing their ideas further, some participants explained that they desired lesbian-specific groups which would also focus on specific topics. For example, a number of participants suggested that a group for lesbians focusing on body image issues after cancer would be beneficial:

I still feel really, really uncomfortable in this body and maybe that’s something I can give to you, maybe your people . . . could do something . . . a group for lesbians and body image after cancer. (Glenda)

Similarly, participants expressed an interest in groups focused on sexuality, and on specific kinds of cancer treatment.

Wellness Groups

As a slight variation on the support group theme, a few participants discussed their interest in groups that would be specific for lesbians, but were not traditional support groups. One participant, for example, said it would be good to have:

An exercise thing . . . lesbians who were going to go swimming, you know, once a week together, something like that, something that is health promoting and yet connecting you through that . . . where it's just not something else to do, because I feel so busy already and I don't want to be so busy. (Paula K.)

A wellness group, Paula K suggested, would meet two needs—the need for exercise, and for connection with other lesbians—simultaneously.

One-To-One Telephone Support

A number of participants suggested the establishment of a telephone support system, which would be staffed by lesbians and available to lesbians. As Sherry suggested: “I think it would definitely be helpful if there was a number, like an 800-line or something that lesbian women could call in regards to breast cancer” A telephone support system might be an especially useful option in small towns or rural areas where there are few lesbians and where a designated support group for lesbians would not be likely to draw a sufficient number of participants.

DISCUSSION

These findings reveal a pressing need to transform the ways in which cancer support services are currently provided in order to make them welcoming to lesbians and thus to enable lesbians to better meet their multiple needs. The recommendations for change put forward by research participants are wide reaching and implicate multiple aspects of service delivery systems, including individual and interpersonal levels as well as organizational structures and processes.

Participants in this research call for the creation of “safe” spaces for lesbians diagnosed with cancer, a theme well articulated in the existing literature (see for example, Brotman et al., 2002a). Key among partici-

participants' recommendations are mechanisms that foster connections among lesbians diagnosed with cancer. Various types of lesbian-specific programming requirements are suggested including multiple types of support and wellness groups as well as one-to-one telephone support and information systems. A critical need also exists to organize specific programs and services for partners and children of lesbians diagnosed with cancer. Furthermore, participants call for agencies to hire lesbian staff so they can have the choice of receiving services from lesbian providers. To this end they also recognize the need for agencies to cultivate organizational climates that are supportive to lesbian staff and institute policies and procedures necessary to ensure equity for lesbian staff members.

Existing literature echoes these recommendations. Matthews et al. (2002) found lesbians had difficulties accessing cancer support groups that met their needs, but women who were able to participate in lesbian-only groups emphasized the level of safety they felt within those settings. Fobair and colleagues (2002) note the numerous positive benefits which emerged for lesbians diagnosed with cancer as a result of being in a lesbian-only therapy group. The call for lesbian service providers is supported by Sorenson and Roberts' (1997) study, which indicates lesbians experienced more satisfaction with mental health services when the service provider was also a lesbian. Maccio and Doueck (2002) replicate this in their finding that lesbians appreciated having access to workers who were also lesbians as they perceived lesbians as being able to provide better service to them.

Beyond the importance of instituting mechanisms which foster connections and support among lesbians, participants called for resource materials that reflect and integrate lesbian realities. In some cases these should be developed by lesbians and specifically address lesbian audiences. In other cases, "lesbian content" may be integrated within more general resource materials. Participants note the positive results that could be produced for lesbians diagnosed with cancer through simply being able to see themselves reflected in the available resource materials. These participants are clearly advocating for an end to lesbian invisibility. Participants also note the diversity within lesbian communities and the need to develop specific materials for specific populations (e.g., lesbians with disabilities, or lesbians of color, or lesbians on social assistance). Resource development is yet another recommendation that resonates with the existing literature (see for example, Ferren, 1997; Matthews, 1998; Mule, 1999; Phillips et al., 1997; Travers & Schneider, 1996). More (and more appropriate) resources, along with the increased visibility of lesbians within cancer care settings (posters, books,

and magazines that highlight lesbian realities) can help create a safe and welcoming environment for lesbians diagnosed with cancer.

In this research, participants did not have a strong preference about whether new programs and services should develop out of existing mainstream cancer support agencies, or out of existing gay/lesbian community organizations. In fact, most participants argued that both of these options should be pursued. Participants noted that cancer is not especially well recognized in gay/lesbian communities. One participant for example, very succinctly stated, "Cancer has to come out of the closet in our community" (Marie). One key issue raised by participants however, revolves around resources. Gay/lesbian community organizations tend to be chronically underfunded, understaffed, and overburdened. In this way they often have a history of being unstable, and programs can be short lived. If new programs and services for lesbians diagnosed with cancer were to develop out of these organizations, the issue of sustainability will have to be addressed. Newly developed lesbian positive cancer support services must be sustainable over the long term, so that women can count on them being there when they are needed. This, of course, is not just a problem facing gay/lesbian community organizations but many small, "alternative" community agencies that have suffered from chronic underfunding and instability (Barnoff, 2002). A significant amount of advocacy work will be required in order to shift this historical pattern.

A second critical issue is the recognition that the needs of lesbians can be quite different from the needs of gay men. Some participants specifically noted they would not be attracted to services utilized by both gay men and lesbians. If gay/lesbian community organizations began to develop programs and services for people diagnosed with cancer, they should consider exploring the possibility of distinct programming for men and women.

While participants argued for change within the context of already existing organizations within gay/lesbian communities, they also very clearly held mainstream cancer services accountable for not doing enough to reflect and integrate lesbian realities. This research makes clear however, that accomplishing change in mainstream cancer support agencies will require a significant alteration in their organizational cultures. Changes in mainstream cancer support agencies ultimately rests on these agencies coming to the recognition that lesbians diagnosed with cancer do have unique needs and issues, that lesbians are not currently being adequately served by their agencies, that serving lesbians is, in fact,

their mandate, and that significant change at multiple levels will be necessary in order to accomplish the kinds of changes lesbians require.

Participants in this research point to the mistrust some lesbians have of existing services. Some indicated they would not utilize services at mainstream cancer support agencies because they would expect to encounter homophobia and/or heterosexism within these contexts. Others noted they needed to be specifically informed that an agency would be welcoming to lesbians before they would be willing to utilize its services. Given these realities, if mainstream cancer support agencies were to develop new programs or services for lesbians, they would need to engage in significant outreach activities within lesbian communities. This need for promotion and outreach is echoed in the work of Brotman et al. (2003) who argue that because of a long history of heterosexism and homophobia within service delivery systems, agencies cannot simply invite participation from sexual minorities and expect it to automatically occur. They too contend that agencies must recognize the need to build trust.

Recognizing that lesbians are not a homogeneous group, and developing mechanisms to attend to the differences existing among lesbians diagnosed with cancer is another issue requiring careful attention. Our research has shown, for example, that while lesbians as a group do have unique issues rendering their needs distinct in many ways from heterosexuals (and in some ways gay men as well), ultimately a whole range of identities and social affiliations are relevant to the needs and issues lesbians will bring to cancer support services. Our research has shown this perhaps most clearly in terms of the intersections of sexual orientation, a cancer diagnosis and the experience of living in poverty (for further discussion, see Sinding, Barnoff, & Grassau, 2004). A multiplicity of issues around what it means to be “inclusive” must be considered in relation to service delivery.

CONCLUSION

These research findings make clear that in order to develop service delivery systems that are able to effectively respond to the needs of lesbians diagnosed with cancer, change is needed in multiple areas. Some of these changes are at the level of individual service providers (e.g., attitudinal change), while others are more structural (e.g., change in the ways agencies plan, develop, and institute new programs). Some of these changes require little in terms of time or resources, while others will require a considerable commitment to restructuring the ways services are

organized. Some of these changes should be seen as the responsibility of lesbian communities, while others are clearly the responsibility of mainstream cancer care agencies. Everyone must be accountable for making this happen. If as social workers we are truly going to live up to our core values of equity, inclusion, empowerment, and social transformation, it is critical to examine our service delivery systems, and alter them where they have been shown to perpetuate discrimination and marginalization. Engaging in this work should not be seen as an option but rather, as an urgent necessity.

REFERENCES

- Avery, A. M., Hellman, R. E., Sudderth, L. K. (2001). Satisfaction with mental health services among sexual minorities with major mental illness. *American Journal of Public Health, 91* (6), 990-991.
- Barbara, A., Quandt, S. A., & Anderson, R. T. (2001). Experiences of lesbians in the health care environment. *Women and Health, 34* (1), 45-.
- Barnoff, L. (2002). *New Directions For Anti-oppression Practice in Feminist Social Services*. Unpublished Doctoral Dissertation, University of Toronto.
- Bazeley, P., & Richards, L. (2000). *NVivo Qualitative Project Book*. London: Sage.
- Brotman, S., Ryan, B., & Cormier, B. (2003). The health and social service needs of gay and lesbian elders and their families in Canada. *The Gerontologist, 43* (2), 192-202.
- Brotman, S., Ryan, B., Jalbert, Y., & Rowe, B. (2002a). Reclaiming space-regaining health: The health care experiences of two-spirit people in Canada. *Journal of Gay and Lesbian Social Services, 14* (1), 67-87.
- Brotman, S., Ryan, B., Jalbert, Y., & Rowe, B. (2002b). The impact of coming out on health and health care access: The experiences of gay, lesbian, bisexual, and two-spirit people. *Journal of Health and Social Policy, 15* (1), 1-.
- Faria, G. (1997). The challenge of health care social work with gay men and lesbians. *Social Work in Health Care, 25* (1/2), 65-72.
- Ferren, D. (1997). Making services accessible to lesbian, gay, and bisexual youth. In M. S. Schneider, (Ed). *Pride and Prejudice: Working with Lesbian, Gay, and Bisexual Youth*, pp. 239-257. Toronto: Central Toronto Youth Services.
- Fobair, P., Koopman, C., Dimiceli, S., O'Hanlan, K., Butler, L. D., Classen, C., Drooker, N., Davids, R., Loulan, J., Wallsten, D., & Spiegel, D. (2002). Psycho-social intervention for lesbians with primary breast cancer. *Psycho-Oncology, 11*, 427-438.
- Fobair, P., O (Hanlan, K., Koopman, C., Classen, C., Dimiceli, S., Drooker, N., Warner, D., Rachel Davids, H. Loulan, J., Wallsten, D., Goffinet, D., Morrow, G., Spiegel, D. (2001). Comparison of lesbian and heterosexual women's response to newly diagnosed breast cancer. *Psycho-Oncology, 10*, 40-51.
- Gatenby, B., & Humphries, M. (2000). Feminist participatory action research: Methodological and ethical issues. *Women's Studies International Forum, 23* (1), 89-105.

- Green, L. W., George, M. A., Daniel, M., Frankish, C. J., Herbert, C. J., Bowie, W. R., et al. (1995). *Study of Participatory Research in Health Promotion/Review and Recommendations for the Development of Participatory Research in Health Promotion in Canada*. Institute of Health Promotion Research, the University of British Columbia, and the B.C. Consortium for Health Promotion Research.
- Maccio, E. M., & Doueck, H. J. (2002). Meeting the needs of the gay and lesbian community: Outcomes in the human services. *Journal of Gay and Lesbian Social Services, 14* (4), 55-73.
- Mallon, G. P. (1997). Toward a competent child welfare service delivery system for gay and lesbian adolescents and their families. *Journal of Multicultural Social Work, 5* (3/4), 177-194.
- Matthews, A. K., Peterman, A. H., Delaney, P., Menard, L., & Brandenburg, D. (2002). A qualitative exploration of the experiences of lesbian and heterosexual patients with breast cancer. *ONF, 29* (10), 1455-1462.
- Matthews, A. K. (1998). Lesbians and cancer support: Clinical issues for cancer patients. *Health Care for Women International, 19*, 193-203.
- Mulé, N. (1999). Social work and the provision of health care and social services to sexual minority populations. *Canadian Social Work, 1* (1), 39-55.
- Phillips, S., McMillen, C., Sparks, J., & Ueberle, M. (1997). Concrete strategies for sensitizing youth-serving agencies to the needs of gay, lesbian, and other sexual minority youth. *Child Welfare, 76*, 393-409.
- Rabin, J., Keefe, K., & Burton, M. (1986). Enhancing services for sexual minority clients: A community mental health approach. *Social Work, 31*, 294-298.
- Rogers, G. (2000). *My left breast: An unusual film about breast cancer*. Carbonear Newfoundland: Pope Productions.
- Saulnier, C. F. (2002). Deciding who to see: Lesbians discuss their preferences in health and mental health care providers. *Social Work, 47* (4), 355-
- Seale, C. (1999). *The quality of qualitative research*. London: Sage.
- Sinding, C., Barnoff, L., & Grassau, P. (2004). Homophobia and heterosexism in cancer care: The experiences of lesbians. *Canadian Journal of Nursing Research, 36* (4), 170-188.
- Sorensen, L., & Roberts, S. J. (1997). Lesbian uses of and satisfaction with mental health services: Results from the Boston Lesbian Health Project. *Journal of Homosexuality, 33*(1), 35-49.
- Spinks, V. S., Andrews, J., & Boyle, J. S. (2000). Providing health care for lesbian clients. *Journal of Transcultural Nursing, 11*(2), 137-143.
- Stevens, P. E. (1998). The experiences of lesbians of color in health care encounters: Narrative insights for improving access and quality. *Journal of Lesbian Studies, 2* (1), 77-94.
- Tiemann, K. A., Kennedy, S. A., & Haga, M. P. (1997). Lesbians' experiences with helping professionals. *Affilia, 12* (1), 84-95.
- Travers, R., & Schneider, M. (1996). Barriers to accessibility for lesbian and gay youth needing addictions services. *Youth and Society, 27* (3), 356-378.
- Valanis, B. G., Bowen, D. J., Bassford, T., Whitlock, E., Charney, P., & Carter, R. A. (2000). Sexual orientation and health: Comparisons in the women's health initiative sample. *Archives of Family Medicine, 9*(9), 843-853.

The Sex Check: The Development of an HIV-Prevention Service to Address the Needs of Latino MSM

Jennifer L. Katz
E. Roberto Orellana
Denise D. Walker
Luis Viquez
Joseph F. Picciano
Roger A. Roffman

ABSTRACT. The Sex Check is a brief, telephone-delivered, HIV-prevention intervention tailored for individuals who are at high risk of HIV infection or transmission but who are neither reducing their risk on their own nor seeking support for this purpose. Because the intervention is delivered on a one-to-one basis, permits anonymity, is marketed to “men who have sex with men,” and is brief, it may be particularly responsive to cultural, structural, and attitudinal barriers to serving Latino MSM. Because many Latino MSM continue to engage in high risk sexual behaviors, developing and testing prevention interventions with this population is a public health priority. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>>*
© 2005 by The Haworth Press, Inc. All rights reserved.]

Address correspondence to: Roger A. Roffman, DSW, Professor, University of Washington School of Social Work, c/o IPRG, 909 NE 43rd St, Suite 304, Seattle, WA, 98105 (E-mail: roffman@u.washington.edu).

Journal of Gay & Lesbian Social Services, Vol. 18(1) 2005
Available online at <http://www.haworthpress.com/web/JGLSS>
© 2005 by The Haworth Press, Inc. All rights reserved.
doi:10.1300/J041v18n01_04

KEYWORDS. HIV prevention, Latino MSM, high-risk sexual behaviors, risk reduction

The impact of sexually transmitted Human Immunodeficiency Virus (HIV) is felt disproportionately in communities made vulnerable by social and economic inequalities and discrimination. Latino men who have sex with men (MSM) are one such group that experiences this elevated HIV risk due to cultural stigma, as well as economic, social, and legal barriers. In 2004, the most recent year for which data are available, the most prevalent mode of HIV transmission among Latino men in states with confidential, name-based reporting, was same-sex sexual activity. As many as 47% of HIV positive Latino men reported being infected in this manner. An additional 19% of HIV positive Latino men did not report a mode of transmission (CDC, 2005), but it can be assumed that at least a portion of these unknown cases involved transmission via homosexual activity. Withholding of this information may be due to stigma attached to homosexuality in Latino cultures.

Prior studies have confirmed the high prevalence of high-risk sexual behaviors, including unprotected anal intercourse (UAI), among Latino MSM which underscores the high prevalence of HIV among Latino MSM. Diaz and Ayala (2001) found an HIV prevalence estimate of 22% in a sample of gay and bisexual men at gay Latino venues in an urban setting. In a study of young Latino MSM, Dean and Meyer (1995) found an HIV prevalence of 30%, an estimate significantly greater than among white MSM. Finally, a seven-year multi-site assessment of HIV incidence among men aged 15 to 22, indicated that Latino MSM were more than twice as likely to be HIV positive as white MSM (Valleroy et al., 2000).

In addition to presenting a health risk for Latino MSM, the high prevalence of HIV also contributes to an elevated HIV risk for Latina women for whom AIDS is now the fourth leading cause of death in the United States (CDC, 2002). The most prevalent mode of HIV transmission to these women is unprotected sexual intercourse with heterosexually identified Latino men (CDC, 2003). Many of these men, however, despite their heterosexual identity, participate in same-sex sexual activity. Within many Latino cultures, heterosexually identified men can participate in same-sex sexual activity without being labeled as gay, provided that they only act as the insertive partner (Diaz, 1998). The insertive partner is then able to maintain his heterosexual identity. This construct of sexual identity has created a pervasive culture of silent Latino bisexuality, and is substantively different from cultures in which

men engaging in sexual activity with other men are considered to be bisexual or homosexual, both in their own estimation as well as that of others. This pattern underscores the importance of HIV prevention programs that target Latino MSM, including those who are gay—and bisexual-identified and those who are not.

CULTURAL, STRUCTURAL, AND ATTITUDINAL BARRIERS TO RISK REDUCTION BY LATINO MSM

The high prevalence of sexually transmitted HIV among Latino MSM is believed to be due to a variety of factors. Those who do not self-identify as gay or bisexual are less likely to benefit from normative peer supports for HIV risk-avoidance available to men in the broader gay and bisexual community. Among Latino MSM who do self-identify as gay or bisexual, many have experienced racism and ethnically driven sexual objectification that have left them disenfranchised with and disconnected from the majority white gay community (Diaz, 1998). Diaz and Ayala (2001) found that experiences of homophobia, racism, and poverty have been linked to higher rates of HIV risk among Latino gay and bisexual men. In their study of the social factors associated with HIV risk for Latino MSM, a quarter of participants reported having experienced discomfort in gay spaces due to their ethnicity, and 62% had been sexually objectified because of their ethnicity.

Barriers to healthcare may also contribute to the increased HIV risk of Latino MSM. The average household income for Latinos is nearly \$10,000 below that of Americans overall and they are nearly twice as likely to have reduced access to healthcare (U.S. Census Bureau, 2003). The result is that 21.8% of Latinos live below the poverty line, a rate nearly double the 12.1% found among the U.S. population as a whole (Proctor & Dalaker, 2002). Their limited financial resources, as well as their overrepresentation in minimum wage and non-benefit jobs, minimize Latinos' access to preventative healthcare and health treatment.

Many Latino immigrants experience additional obstacles to accessing health services. In addition to relocation into economically depressed neighborhoods with poor social service systems, the lack of social support, and a lack of information and knowledge about existing social and health services contribute to the underutilization of the healthcare system in the Latino community. Additionally, monolingual Spanish speakers experience difficulty in discovering both services which are advertised to a majority English-speaking audience, and communicating with provid-

ers who do not speak their language. This is an alarming situation given that of all reported AIDS cases among Latinos in 2000, at least 50% of infections occurred in people born outside of the United States (CDC, 2001). Many Latino immigrants have no permanent legal immigration status in the United States, and are unaware of their rights, civil and otherwise, thus fearing that seeking healthcare and other social services could lead to their deportation. Additionally, there are significant risks for undocumented immigrants with regard to HIV testing, because being HIV positive is grounds for visa refusal and deportation (Timor, 1998).

For Latino MSM with heavy employment demands and/or family obligations, participating in lengthy interventions may not be possible. Similarly, when services are delivered in in-person sessions, the need to travel to the session site at a prescribed time may be problematic. For those who are located outside urban centers, or who work multiple or late-shift jobs, this constraint can be prohibitive. A limitation of group-oriented HIV-prevention programs is the public nature of the intervention. While many benefit from developing supportive relationships in groups with other members of their community, many others prefer to maintain their anonymity. This is particularly true for those Latino MSM who do not identify as gay or bisexual or who are closeted about their sexual behavior. Additionally, when services are marketed to "gay and bisexual men," MSM who are heterosexually identified may perceive themselves as unwelcome.

A final barrier, common to MSM of all ethnic backgrounds, pertains to the ambivalence some MSM have about their HIV infection/transmission risk and whether or not to commit to consistent risk reduction behaviors. For men who hold such ambivalent attitudes, a program that is perceived as expecting that participants will be willing at the outset to commit to behavior change may be unappealing.

MODEL HIV-PREVENTION SERVICES FOR LATINO MSM

Several HIV-prevention programs have been developed that cater specifically to the needs of Latino MSM, although a review of the literature highlights the limited number of programs that specifically incorporate the social risk factors identified above into behavioral risk reduction interventions (Marin & Gomez, 1999).

Hermanos de Luna y Sol (Brothers of Moon and Sun) is a San Francisco based HIV-prevention project for Spanish-speaking Latino gay

and bisexual men. This group intervention is based on Bandura's theory of self-regulation and empowerment education to promote self-esteem, social support, sexual self-knowledge, community involvement and activism, and awareness of cultural and social factors which impact participants' lives (Diaz, 1998). The intervention is delivered through structured workshops and informal social gatherings. Program graduates are also given tools for self-monitoring to support them in maintaining their positive changes. An evaluation of 87 early participants suggest that they experienced significant behavioral change as a result of the intervention (Diaz, 2001; Marin, 2003).

Another HIV-prevention intervention specifically targeting Latino MSM was developed in Puerto Rico (Toro-Alfonso, 2002). Delivered entirely in Spanish and incorporating a number of components culturally relevant to Puerto Rican MSM, the program was designed with a particular consideration of the social and political realities that face program participants. The strongly religious Puerto Rican culture has defined MSM behaviors as immoral, and this factor has likely discouraged many men from participating in HIV-prevention interventions. To engage eligible participants, this community-based intervention was designed by and for the MSM community and was implemented by an organization with strong ties to that community. Men involved in the program attended group meetings in which discussions focused on such topics as intimacy, drug abuse, relationships, sexual behavior, HIV/AIDS, and other STDs. The intervention's design was based on concepts drawn from the Health Belief Model (Rosenstock, Strecher, & Becker, 1994). Workshops were designed to strengthen community, develop and strengthen social support networks, and increase safer sex behavior.

While these tailored programs appear to be making substantial contributions to HIV prevention among Latino MSM, remaining barriers include the burdens of time and travel imposed by in-person service delivery and lengthy programs, the disclosure threats perceived by some as a consequence of group participation, the sense of not being welcomed when programs are marketed as intended for gays and bisexuals, and a hesitation to approach risk reduction programs when one has ambivalent attitudes about committing to behavior change.

MOTIVATIONAL ENHANCEMENT TREATMENT

An adaptation of a modality first developed in the alcoholism field offered the potential of overcoming several of these barriers. The Drinker's

Check-Up (Miller, Sovereign, & Krege, 1988) was a two-session intervention that was marketed as not for alcoholics in order to reduce stigma associated with the label “alcoholism,” not being treatment in order to emphasize that participants were not expected to be committed to changing, and respectful of the individual’s right to decide whether and how to use the feedback. The Drinker’s Check-Up was tailored for individuals who were neither seeking treatment for alcohol abuse nor self-initiating change, but who had some concerns about their drinking behavior. It is the first example of a modality that has come to be known as motivational enhancement treatment (MET).

Personalized feedback drawn from an initial assessment was provided to each participant in a single individual session. The feedback included normative comparisons of the participant’s alcohol use pattern vis-à-vis that of other adults and the individual’s risk factors for the development of alcohol disorders. The clinician delivering the Drinker’s Check-Up used motivational interviewing (MI) strategies to assist clients in resolving ambivalence and increasing commitment to change. MI is a collaborative counseling style with the purpose of evoking the client’s intrinsic motivations while respecting the individual’s autonomy in making decisions related to their health (Miller & Rollnick, 2002). When evaluated, the Drinker’s Check-Up was found to have successfully recruited individuals whose drinking patterns resembled those of alcohol treatment seekers. When followed up, many participants had made significant decreases in drinking compared to a control group (Miller et al., 1988).

THE SEX CHECK

With funding from NIMH, “The Sex Check” was adapted from the Drinker’s Check-Up to provide HIV-prevention services to MSM who were at high risk of HIV transmission yet might be ambivalent about making a commitment to reducing sexual risk-taking behaviors. A number of this intervention’s features are responsive to the barriers discussed above vis-à-vis reaching and serving Latino MSM: (1) The service is brief, (2) all contacts are by telephone, (3) the intervention is one-to-one, and (4) participants have the option of retaining their anonymity. The Sex Check incorporates the following principles of motivational enhancement treatment: (1) The intervention is marketed as an opportunity to “take stock” of one’s experiences, with no pressure to change; (2) it begins with an assessment session that focuses on behav-

iors, positive and negative consequences, attitudes favoring and opposing change, and self-efficacy for change; (3) feedback is delivered by a counselor who employs motivational interviewing skills; and (4) support in setting goals and selecting change strategies is offered to those who express motivation to reduce their HIV infection or transmission risk.

Participants are recruited through a variety of methods. Advertisements are run in local print media, both mainstream and gay specific. Local agencies serving at-risk populations include listings about the Sex Check in their print and electronic bulletins, provide links on their websites, distribute brochures, and make personal referrals to potential participants. Additionally, the Sex Check employs a team of recruiters to publicize the project at local bars, bathhouses, and community events. The recruitment message emphasizes that the Sex Check is an opportunity for MSM to talk about their decisions on sexual safety in a non-judgmental space, free of pressure to change their behavior, with members of a multi-cultural and bilingual staff.

Potential participants undergo an initial risk assessment by telephone which determines their eligibility for the intervention. After deciding to participate, clients complete a self-report questionnaire by mail and a baseline assessment interview by telephone. Then, during the first session of the intervention, the counselor and participant review a personalized feedback report (PFR) that summarizes information gleaned from these initial assessments. The PFR includes information about the participant's recent sexual behaviors, HIV status, HIV status of recent partners, statistics concerning STD and HIV rates in the local MSM community, alcohol and drug use behaviors, intentions to use condoms, perceptions of the costs and benefits of condom use, confidence in practicing safer sex, and safer sex goals. The PFR serves as a guide to a detailed discussion about the participant's sexual behaviors and safety. Additionally, the PFR provides a context for examining the ways in which a participant's behavior contrasts with his stated goals and values, a process which is believed to nurture motivation for change.

Relevant STD and HIV misinformation is corrected in two ways over the course of the session. Throughout the review of the PFR, the counselor provides accurate and objective information about STDs and HIV, both at the participant's request and with permission at other relevant moments to augment or enhance a participant's knowledge base. For example, in the case of a participant who reports being HIV positive and engaging in unprotected sex with other HIV positive men, a counselor will ask, "What have you heard about re-infection?" If the participant's response indicates he might be unaware of some critical issues with

regard to this subject, the counselor will then ask for the participant's permission to provide new information: "Would you be interested in knowing how the Public Health Department is thinking about this?" A second way knowledge is transferred to participants is by reviewing the correct answers to questions to an HIV Knowledge Test that is administered to each participant during the course of the baseline assessment interview.

At the end of reviewing the PFR, the counselor asks the participant specific questions that are tailored to assess his readiness for change. If the participant expresses an interest in making alterations in his behavior, change of planning is initiated. At this time, participants can also choose to proceed with any of the following skills-training topics for the second and third feedback sessions: Setting Safer Sex Goals, Identifying Triggers for Unsafe Sex, Coping with Triggers, Action Strategies, Social Support, Assertiveness and Safer Sex, and Assertiveness and Empowerment in Relationships. These skills-training sessions are designed both to elucidate the barriers the client faces in his efforts to achieve his safer sex goals and provide him with specific tools to confront these barriers. In addition to selecting any of these modules that are relevant to his needs, participants can also choose to discuss topics that are directly related to reducing their risk of contracting or transmitting HIV/STDs (e.g., ambivalence about HIV/STD testing; obstacles to condom use). Counselors offer local resources and referrals when appropriate or requested. For participants who indicate an interest in getting tested, information concerning STD and HIV testing resources is provided and reviewed. Similarly, if the participant desires ongoing support for sexual safety issues, appropriate referrals are provided and discussed. In recognition of the relationship between risk-taking behavior and substance use and abuse, the Sex Check counselors utilize the PFR not only to review recent sexual behavior, but also to discuss the roles that alcohol and other drugs might have in the decision to engage in risky behaviors.

Throughout the conversation, motivational interviewing skills are utilized by the counselor to evoke and foster readiness to change risky sexual behavior, develop discrepancy between current and ideal behavior as identified by the participant, and strengthen the participant's self-efficacy for making behavioral changes. The Sex Check offers clients the opportunity to review their intentions to be safer, provides them with normative comparisons to contextualize their behavior, and allows each participant to select topics of discussion to guide his own counseling experience. In doing so, the Sex Check offers each participant an

opportunity to have a discussion about his life experiences and his sexual decision-making process, and provides each of these men with an experienced counselor who has been trained to utilize MI techniques to facilitate a process of identifying and building intrinsic readiness to change.

As discussed above, the structure and content of the Sex Check model has the potential for being a culturally appropriate program to address the particular prevention needs of Latino MSM. In a pilot study of this intervention, men of color were found to experience higher levels of behavior change than the overall sample, indicating that the Sex Check experience may be particularly efficacious for motivating HIV risk reduction in Latino MSM (Picciano, 2001). A randomized clinical trial to assess the efficacy of the Sex Check is currently underway to explicate these preliminary findings.

ENHANCING CULTURAL RELEVANCE FOR LATINO MSM

Particular attention was paid, prior to the start of the trial, to ensuring the cultural competency and relevance of the intervention. Two consultants were hired to identify the specific challenges that Latino MSM face, and to help develop strategies both for overcoming these challenges and for making the intervention as useful, effective, and culturally competent as possible. These consultants convened focus groups which examined and critiqued draft marketing materials, as well as offered insight into ways to increase the cultural competency of the intervention. The focus groups stressed the importance of recognizing the diversity of the Latino MSM population, and cautioned against the use of stereotypes with regard to immigration status, class, education, or religion. They stressed the idea that many Latino MSM do not self-identify as gay or bisexual, and said that they preferred the use of the term “men who have sex with men” over “gay or bisexual men” or “hombres de ambiente” (literally, “men of environment”), a term that has been used in various parts of the United States to identify Latinos who have same-sex sexual partners. Finally, the focus groups stressed the particular importance of confidentiality when working with Latino clients. The findings of the focus groups were discussed by the entire project staff to increase cultural awareness of the specific challenges facing Latino men and to facilitate the integration of the findings into the execution of the intervention.

Two of the Sex Check counselors are bilingual Latino men with extensive experience working with Latino populations. Counselors' training consisted of reading motivational interviewing literature, watching a series of training videotapes, engaging in intensive role-playing of MI techniques and the delivery of the educational and skills-building content. Each counselor completed 4-8 pilot cases and received written and verbal feedback on these sessions prior to seeing study participants. The bilingual counselors' training took place in both English and Spanish, and throughout the trial they collaboratively reviewed audiotapes of their counseling sessions and engaged in ongoing clinical consultation. All written materials were professionally translated into Spanish, including six skills-training brochures that had been written specifically for the intervention and covered a variety of themes including assertiveness, recognizing and coping with triggers, and developing change plans. Once translated into Spanish, the materials were reviewed by a team of three Spanish-speaking staff to ensure that both the tone and the content of the materials had been maintained.

The intervention protocol permits and encourages the discussion of particular topics related to Latino culture. For example, at the beginning of sessions with Latino participants, counselors reveal personal background information regarding their country of origin, how long they have lived in the United States, and their bilingual status. Latino participants are specifically asked about their background and are offered the opportunity to discuss issues related to immigration, visas, and the intersection of immigration status and HIV testing and healthcare. A common query posed to Latino participants includes, "Tell me about how being a Latino gay man is in this society. What has your experience been?" The meta-message of such questions is intended to be, "I understand that your cultural background may affect your sexual decision making. I welcome your thoughts and concerns on this." Counselors initiating discussion specifically related to the Latino experience reveal to participants a willingness and openness to engage in these topics from the beginning of the intervention and throughout.

CONCLUSION

The Sex Check offers a number of benefits that may be particularly salient for Latino MSM. As a telephone delivered intervention, it is accessible to men across a wide range of geographic areas. The establishment of a toll-free telephone number removed possible financial barriers

to service participation. By offering the sessions to individuals rather than groups and marketing it to “men who have sex with men” rather than just those who identify as gay or bisexual, the intention is to make the service accessible to men of all sexual identities. An added benefit of individual sessions is that they enable men to retain their anonymity. For closeted men in small or tight-knit communities, the disclosure associated with attending group sessions may constitute a barrier to accessing services. Additionally, rather than needing to accommodate the schedule of a group, men can arrange for individual sessions to occur at times that are most conducive to their schedules, early in the morning, late at night, or on weekends, removing an additional obstacle. Because the service is brief in design, it allows men who are unable or uninterested in participating in a long-term, high-intensity intervention to receive services without making a substantial commitment of time. For men who desire a more extensive intervention, the Sex Check counselors offer an array of referrals to existing community resources. Finally, because the counselors are familiar with both the needs of the client as well as the particular strengths and focuses of local prevention programs, this referral provision hopefully can lead to increased utilization of already established services.

In addition to the strengths outlined above, the flexible and adaptive content model of the Sex Check is designed to enable the counselors to tailor each client’s counseling experience to respond specifically to his needs. Motivational interviewing, by definition, rejects the paradigm of behavior change through judgment, confrontation and direction, and instead aims to motivate change by highlighting inconsistencies between beliefs and negative consequences of risky behaviors and resolving ambivalence. As such, it potentially offers an ideal model for a sex-positive, HIV-prevention intervention with Latino MSM. Counselors utilizing motivational interviewing employ warmth, genuineness, and empathy, qualities which are of particular importance when working with men who have experienced rejection, oppression, hostility, and discrimination from both the gay and the Latino communities.

REFERENCES

- Centers for Disease Control and Prevention. (2002). Deaths among persons with AIDS through December, 2000. *HIV/AIDS Surveillance Supplemental Report*.
- Centers for Disease Control and Prevention. (2003). Cases of HIV infection and AIDS in the United States, by race/ethnicity, 1998-2002. *HIV/AIDS Surveillance Supplemental Report*;10 (No.1), Tables 11 and 12. Atlanta: U.S. Department of Health and Human Services. Also available at: <http://www.cdc.gov/hiv/stats/hasrlink.htm>.

- Centers for Disease Control and Prevention. (2005). *HIV/AIDS Surveillance Report, 2004* (Vol. 16). Tables 20. Atlanta: U.S. Department of Health and Human Services. Also available at: <http://www.cdc.gov/hiv/stats/hasrlink.htm>.
- Dean, L., & Meyer, I. (1995). HIV prevalence and sexual behavior in a cohort of New York City gay men (aged 18-24). *Journal of Acquired Immune Deficiency Syndromes*, 8, 208-211.
- Díaz, R., & Ayala, G. (2001). *Social discrimination and health: The case of Latino gay men and HIV risk*. New York, NY The Policy Institute of the National Gay and Lesbian Taskforce.
- Díaz, R. (January, 2001). "Hermanos de Luna y Sol Program Evaluation." University of California, San Francisco, Center for AIDS Prevention Studies. Available at: <http://www.caps.ucsf.edu/capsweb/projects/hlsprogress.html>. Accessed on 07.06.2004.
- Díaz, R. M. (1998). *Latino gay men: Culture, sexuality and risk behavior*. Routledge. New York, NY.
- Marin, B. (2003). HIV prevention in the Hispanic community: Sex, culture, and empowerment. *Journal of Transcultural Nursing* 14(3):186-92.
- Marin, B., & Gomez, C. (1999). Latinos and HIV: Cultural issues in AIDS. In M.A. Sande, P. Volberding, & P.T. Cohen (Eds.), *The AIDS knowledge base: A textbook on HIV disease from the University of California, San Francisco and San Francisco General Hospital* (pp. 917-924). Philadelphia, PA: Lippincott, Williams and Wilkins.
- Miller, W.R., & Rollnick, S. (1991). *Motivational Interviewing: Preparing people to change addictive behavior*. New York: Guilford Press.
- Miller, W.R., & Rollnick, S. (2002). *Motivational Interviewing: Preparing people to change addictive behavior* (2nd ed.). New York: Guilford Press.
- Miller, W. R., Sovereign, R. G., & Krege, B. (1988). Motivational interviewing with problem drinkers: II. The Drinker's Check-Up as a preventive intervention. *Behavioural Psychotherapy*, 16, 251-268.
- Miller, W. R., Yahne, C. E., & Tonigan, J. S. (2003). Motivational interviewing in drug abuse services: A randomized trial. *Journal of Consulting and Clinical Psychology*, 71 (4), 754-763.
- Picciano, J. F., Roffman, R. A., Kalichman, S. C., Rutledge, S. E., & Berghuis, J. P. (2001). A telephone based brief intervention using motivational enhancement to facilitate HIV risk reduction among MSM: A pilot study. *AIDS and Behavior*, 5, 251-262.
- Proctor, B. D., & Dalaker, J. (2003). U.S. Census Bureau, Current Population Reports, P60-222, *Poverty in the United States: 2002*. Washington, D.C.: U.S. Government Printing Office.
- Project MATCH Research Group (1997). Matching alcoholism treatments to client heterogeneity: Project MATCH posttreatment drinking outcomes. *Journal of Studies on Alcohol*, 58, 7-29.
- Rosenstock, M., Strecher, V., & Becker, M. (1994). The health belief model and HIV risk behavior change (pp. 5-24). In R. DiClemente & J. Peterson, Eds. *Preventing AIDS: Theories, methods, and behavioral interventions*. New York: Plenum.
- Stephens, R., Roffman, R., Berghuis, J., Walker, D., & Tsuru, W. (November, 2003). *A brief motivational enhancement intervention for adolescent marijuana smokers:*

- Evaluation of the teen marijuana check-up.* Poster presented at the Association for the Advancement of Behavior Therapy, Boston, MA.
- Timour, K. (1998). *Positive Options - A Handbook for People Living With HIV.* New York, NY: Body Positive.
- Toro-Alfonso, J. (2002). Evaluation of an HIV/AIDS prevention intervention targeting Latino gay men and men who have sex with men in Puerto Rico. *AIDS Education and Prevention, 14*, 445-456.
- U.S. Census Bureau. (2003). *Current Population Survey 2003 Annual Social and Economic Supplements.* Washington, D.C.
- Valleroy, L. A., D. A. MacKellar, J. M. Karon, et al. (2000). HIV prevalence and associated risks in young men who have sex with men. *Journal of the American Medical Association, 284*, 198-204.



Homophobia and Use of Gay Affirmative Practice in a Sample of Social Workers and Psychologists

Catherine Crisp

ABSTRACT. Researchers have previously found that social workers may be more homophobic than psychologists. This study revisits the topic and seeks to see if there are differences in the attitudes of social workers' and psychologists who are engaged in direct practice with clients. In addition, this study explores new territory by examining whether social workers and psychologists differ in their use of gay affirmative practice and discusses the impacts of these findings for gay and lesbian clients. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>> © 2005 by The Haworth Press, Inc. All rights reserved.]*

KEYWORDS. Gay affirmative practice, homophobia, social workers, psychologists, gay and lesbian mental health

Several studies have examined homophobia among social workers and psychologists, although few have compared the two disciplines. Although Crisp (2002) examined the degree to which social workers and psychologists engage in methods consistent with gay affirmative prac-

Catherine Crisp, PhD, is Assistant Professor at the University of Kansas School of Social Welfare, Lawrence, KS.

Address correspondence to: Catherine Crisp, PhD, University of Kansas School of Social Welfare, 1545 Lilac Lane, Lawrence, KS 66045 (E-mail: ccrisp@ku.edu).

The author would like to thank K. Jean Peterson, PhD, and Beverly McPhail, PhD, for their very helpful reviews of this manuscript.

Journal of Gay & Lesbian Social Services, Vol. 18(1) 2005
Available online at <http://www.haworthpress.com/web/JGLSS>
© 2005 by The Haworth Press, Inc. All rights reserved.
doi:10.1300/J041v18n01_05

tice, no comparisons between the two disciplines were reported in the study. The purpose of this study was, therefore, to examine differences in social workers and psychologists on measures that assess attitudes toward gays and lesbians and affirmative practice with gay and lesbian clients. Although individuals who identify as bisexual and transgendered are clearly a group worthy of study, this study was limited to attitudes toward and practice with gay and lesbian individuals.

Homophobia was initially defined as the fear of being in close quarters with homosexuals (Weinberg, 1972), but now is generally used to refer to the broad range of negative attitudes regarding gays and lesbians (Hudson & Ricketts, 1980). To date, only two published articles have compared homophobia in social workers and psychologists. Although DeCrescenzo (1984) sampled 140 mental health professionals in the Los Angeles, California area, and found social workers to be more homophobic than psychologists, she does not indicate whether these differences were statistically significant. Other methodological problems with her study are also worth noting. Despite the existence of previously validated homophobia scales, DeCrescenzo used a measure which she developed and which did not undergo an extensive validation process, but rather was "validated" by a review by a "panel of three independent judges," who evaluated the items based on their "relevance to the research topic and in terms of adequate measurement of the identified aspect of the study" (DeCrescenzo, 1984, p. 126). In addition, caution should be taken when generalizing a sample from the Los Angeles, California, area to other areas of the United States.

The second study (Ben Ari, 2001) examined "attitudes toward homosexuality" in a sample of 235 social work, psychology, and education faculty at five universities in Israel. Using Hudson and Ricketts' (1980) Index of Homophobia (IHP), the author found statistically significant differences in the IHP scores with education faculty being the most homophobic and psychology faculty being the least homophobic and social work faculty falling in the middle. Social work faculty were significantly more homophobic than psychology faculty. Although Ben Ari's study employed the IHP, a measure that has been validated and widely used in other studies, it should not be assumed that these findings are applicable to practitioners. In addition, the results are further limited by the challenge of generalizing a sample from Israel to a sample in the United States.

Studies comparing homophobic attitudes in social work and psychology students have found no significant differences between the two groups. Smoot (1991) compared homophobia levels among 161 social

work, engineering, physical education, and psychology students. There were no statistically significant differences among the groups on the Heterosexuals Attitudes Toward Homosexuals (HATH) scale (Larsen, Reed, & Hoffman, 1980). Similar results were found in a study by Newman, Dannenfels, and Benishek (2002) that compared graduate social work and counseling students. Although social work students were found to be “slightly more accepting” than counseling students (p. 279), these differences were not statistically significant.

CONSEQUENCES OF HOMOPHOBIA FOR GAY AND LESBIAN CLIENTS

Although insight into homophobia is important, these studies tell us little about the relationship between homophobia and practice with gay and lesbian clients. Several authors claim that homophobia in social workers and other human service professionals reduces the effectiveness of the treatment provided. Travers (1998) writes: “The homophobic counselor cannot effectively meet the needs of gay or lesbian clients” (p. 6). Peterson (1996) reiterates this claim in stating, “Lesbians and gay men receive inferior treatment from providers who are homophobic” (p. xvii). Both authors suggest that the result of homophobia for gay and lesbian clients is a lower quality of services that may do more harm than good.

A review of the literature finds that gay and lesbian clients experience many negative consequences when practitioners are homophobic. These consequences include but are not limited to practitioners: (1) minimizing or exaggerating the importance of sexual orientation in clients’ lives (Messing, Schoenberg, & Stephens, 1984) and thus failing to address clients’ presenting problems, (2) changing the topic or cutting clients short when they talk about gay and lesbian issues, thus devaluing their life experiences (McHenry & Johnson, 1993), (3) viewing clients strictly in terms of their sexual behavior and/or defining them as gay or lesbian solely on the basis of their sexual behavior, denying the gay or lesbian identity of celibate individuals, and informing clients that they are not gay or lesbian because they fail to meet some arbitrary definition (Brown, 1996), and (4) perpetuating self-hatred in gay and lesbian clients (McHenry & Johnson, 1993). At its extreme, homophobia in social workers and psychologists can lead to using conversion or reparative therapies (treatment aimed at changing the sexual orientation of the gay, lesbian, or bisexual person), despite their being explicitly condemned

by the American Psychological Association (APA) and the National Association of Social Workers (NASW) (APA, 1997; NASW 2000).

Given these many negative consequences, it has historically been assumed that homophobic practitioners are ill-equipped to treat gay and lesbian clients, although this relationship has not been empirically tested using validated instruments. Each of the studies discussed earlier in this paper assumes such a relationship, yet fails to assess it. The study discussed in this paper thus moves the dialogue beyond the assumption that homophobia negatively affects practice with gay and lesbian clients by assessing the degree to which practitioners are engaged in beliefs and behaviors consistent with gay affirmative practice. In doing so, it makes a unique contribution to the research by assessing both attitudes toward and affirmative practice with gay and lesbian clients.

GAY AFFIRMATIVE PRACTICE

Gay affirmative practice “affirms a lesbian, gay, or bisexual identity as an equally positive human experience and expression to heterosexual identity” (Davies, 1996, p. 25) and is increasingly considered the preferred method by which to work with gay and lesbian clients. Though initially referred to as gay affirmative psychotherapy by psychologists, the term has been broadened to gay affirmative practice and is applicable to the many settings in which social worker and psychologists are employed (Appleby & Anastas, 1998, p. 286):

The concept of gay- or lesbian-affirmative practice is becoming the goal to which those practicing in the mental health and substance abuse fields are striving. There is no particular approach to psychotherapy or other forms of mental health treatment nor any particular modality of treatment—individual, couple, family, or group—that cannot be made useful for lesbian, gay, or bisexual people if approached affirmatively.

Appleby and Anastas (1998) describe six fundamental principles of gay affirmative practice:

1. Do not assume that a client is heterosexual.
2. Believe that homophobia in the client and society is the problem, rather than sexual orientation.
3. Accept an identity as a gay, lesbian, or bisexual person as a positive outcome of the helping process.

4. Work with clients to decrease internalized homophobia to achieve a positive identity as a gay or lesbian person.
5. Be knowledgeable about different theories of the coming out process for gays and lesbians.
6. Deal with one's own homophobia and heterosexual bias.

Other aspects of gay affirmative practice include referring clients to gay affirmative resources, looking at gay and lesbian identity as one aspect of clients' identities, using appropriate and affirming terminology, and being knowledgeable about relevant social and legal policies that affect gays and lesbians (Crisp & DiNitto, 2004; Van Den Bergh & Crisp, 2004).

Because the concept of gay affirmative practice is relatively new, the Gay Affirmative Practice Scale (GAP) (Crisp, 2002) is the first scale specifically developed and validated to assess this construct and only two articles (Crisp, in press-a; Crisp, in press-b) discuss its use and psychometric properties. Thus, little is known about social workers' and psychologists' use of gay affirmative practice.

METHODOLOGY

Sample

A total of 3,000 members (1,500 from each organization) of the NASW and APA were sampled. Because only those who provided direct practice to clients were of interest in this study, each organization was asked to specify how they identified direct practice. The NASW identified direct practitioners as those whose "function" is self-identified as "clinical/direct practice" (Beverly Young, InFocus, personal communication, December 21, 2001). The APA identified direct practitioners as those who are licensed and have "paid the special practice assessment (a mandatory fee that all members who provide/supervise mental health services must pay)" (Kyle Fennel, American Psychological Association, personal communication, December 21, 2001). The researcher requested that 1,500 members' names be randomly selected from those who met the above criteria for the respective organization.

Procedure

A survey packet was mailed to each of the individuals whose names were obtained from the APA and NASW. This packet comprised (1) the

Heterosexuals' Attitudes Toward Homosexuals Scale (HATH), Attitudes Toward Lesbians and Gay Men Scale (ATLG), and Gay Affirmative Practice (GAP) scales, (2) questions that inquired about respondents' personal characteristics such as gender, race, and sexual orientation; religious and political affiliation; training on gay and lesbian issues; feelings and contact with gays and lesbians; and social desirability; (3) a cover letter with informed consent information; and (4) a business reply envelope in which to return the questionnaire. Respondents were requested to return the packet within two weeks of the date by which they were expected to receive it.

Measures

HATH. Developed by Larsen, Reed, and Hoffman (1980), this scale assesses cognitive beliefs about gays and lesbians with a five-point Likert scale response set. The range of scores is from 20 to 100 with higher scores reflecting more positive beliefs about gays and lesbians. The HATH has been validated with college students and has a split-half reliability of 0.86, and when corrected with the Spearman-Brown prophecy formula, has a split-half reliability of 0.92 (Larsen et al.).

ATLG. Developed by Herek (1988), this scale assesses "affective responses" toward gay men and lesbians and has two subscales that assess attitudes towards lesbians and attitudes toward gay men as separate constructs. Using a 5-point Likert scale response set, the range of scores is from 10 to 50, with lower scores reflecting more positive attitudes. The ATLG has been validated with college students and members of gay and lesbian organizations and has demonstrated high internal consistency with a coefficient alpha of 0.90 (Herek, 1988).

GAP. Developed by Crisp (2002), this 30-item scale uses a 5-point Likert scale, has a scoring range of 30-150 (with higher scores reflecting more affirmative practice), and is a two-dimensional instrument that was developed specifically to assess the degree to which practitioners engage in beliefs and behaviors associated with gay affirmative practice. As such, it is the first scale that examines this construct and has been validated using several methods.

The 30-item GAP has a Cronbach's alpha of 0.95 and is evidence of its reliability. Additional support for reliability was obtained by computing the Standard Error of Measurement (SEM) which should be computed in order to compensate for differences in sample standard deviations before conclusions about reliability are drawn (Springer, Abell, & Nugent, 2002). The SEM was 1.91 for the belief domain and 2.71 for

the behavior domain, both of which are within the recommendation set by Hudson (1999) that the SEM should be less than five percent (6.0 for each of these two domains) of the possible range of scores and thus provide further evidence of the scale's reliability.

Several methods provided evidence of the validity of the GAP. Confirmatory factor analysis revealed that each item loads on its intended domain at 0.60 or greater, providing support for factorial validity. Pearson's *r*-correlation between the belief domain of the GAP and the HATH is 0.624 ($p < 0.001$), while the correlation between the behavior domain and the ATLG is .466 ($p < 0.001$). Both correlations are significant at the .001 level, are in the expected direction, and fall within the acceptable range of greater than or equal to 0.40 (Downie & Heath, 1967) and provide evidence of convergent construct validity. The correlation between the Social Desirability Scale (Crowne & Marlowe, 1960; Strahn & Gerbasi, 1972) and the entire 30-item scale was 0.021 and was nonsignificant ($p = 0.691$). This finding provides strong evidence that the GAP does not measure socially desirable responses and is evidence of its discriminant construct validity. The aforementioned reliability and validity analyses collectively suggest that the GAP does measure gay affirmative practice and that there is relationship between self-reported attitudes and practice with gay and lesbian clients. Additional information about the reliability and validity of the GAP can be found in Crisp (2002).

Data Analysis

In order to conduct the analysis, the following steps were taken using SPSS 13.0. First, *t*-tests were conducted to examine differences in NASW and APA members' interval level demographic characteristics such as the number of gay and lesbian clients and the number of years in practice. Pearson chi-square tests were conducted to examine differences in nominal level sample characteristics such as gender and sexual orientation. Next, after reviewing the above results for significant differences in APA and NASW members' responses, one way ANOVA tests and bivariate correlations were conducted to assess which variables had a significant relationship with any combination of the HATH, ATLG, and GAP and could thus be considered for use as covariates in the next stage of the analysis. Effective covariates should have some relationship with the dependent variables (Hair, Anderson, Tatham, & Black, 1995).

In the third step, multivariate analysis of variance (MANOVA) was run with organization (NASW or APA) as the fixed factor and the HATH, ATLG, and GAP scores as the three dependent measures. After

the results were analyzed, multivariate analysis of covariance (MANCOVA) was run with organization (NASW or APA) as the fixed factor and the results of step 2 as covariates to assess whether any of the sample differences found in step 2 affected the relationship between organizational membership and scores on the three measures of interest. In addition, using methods employed by Hudson and Ricketts (1980) in the development of their widely used Index of Homophobia (IHP) scale and duplicated by others (Berkman & Zinberg, 1997; Lim & Johnson, 2001; Smith, 1971), respondents' scores on the HATH, ALTG, and GAP were recoded into four groups based on respondents' scores. Respondents were categorized as having more or less positive attitudes (on the HATH and ALTG scales) and being more or less gay affirming (on the GAP) on the basis of their scores on these measures as noted in Table 1.

Pearson chi-square tests were then used to examine differences between social workers and psychologists in the response groups. Due to the small number of respondents in the least positive and least affirming categories, the four categories were combined into two categories consisting of more positive and less positive (on the HATH and ALTG scales) and more or less gay affirming (on the GAP). This analysis offers additional insight into the nature of social workers' and psychologists' attitudes toward gays and lesbians and their self-reported practice with them.

RESULTS

Sample Characteristics

Membership in the NASW and APA was fairly evenly represented with 257 (52.7%) indicating NASW membership and 220 (45.1%) indicating APA membership. Demographic characteristics and scores on the social desirability measure are presented in Tables 2 and 3. Table 2 presents the sample characteristics for the nominal level demographic

TABLE 1. HATH, ATLG, & GAP Scores from Most to Least Positive

	More Positive		Less Positive	
	Most Positive	2nd Most Positive	2nd Least Positive	Least Positive
HATH scoring range	100-80	79-60	59-40	39-20
ATLG scoring range	10-19	20-29	30-39	40-50
	More Affirming		Less Affirming	
	Most Affirming	2nd Most Affirming	2nd Least Affirming	Least Affirming
GAP scoring range	150-120	119-90	89-60	59-30

TABLE 2. Differences in NASW and APA Members' Characteristics on Nominal Level Variables

	Whole sample (N = 477)		APA (N = 220)		NASW (N = 257)		χ^2
	N	%	N	%	N	%	
Gender							19.39***
Male	120	25.2	76	34.7	44	17.1	
Female	356	74.8	143	65.3	213	82.9	
Relationship status							NS
Single	47	10.3	21	10.0	26	10.6	
Married	330	69.2	153	72.5	177	72.2	
Divorced	36	7.9	15	7.1	21	8.6	
Widowed	15	3.3	8	3.8	7	2.9	
Long-term relationship	28	5.9	14	6.6	14	5.7	
Sexual orientation							NS
Heterosexual	411	86.2	195	88.6	216	84.0	
Gay, lesbian, or bisexual	66	13.8	25	11.4	41	16.0	
Race/ethnicity							NS
Caucasian/White	439	92.0	200	90.9	239	93.0	
Other	38	8.0	20	9.1	18	7.0	
Current religious affiliation							9.87*
Protestant	110	23.1	43	20.0	67	26.5	
Catholic	77	16.1	27	12.6	50	19.8	
Jewish	72	15.1	39	18.1	33	13.0	
Other	106	22.2	52	24.2	54	21.3	
None	103	21.6	54	25.1	49	19.4	
Current political party							NS
Democrat	331	69.4	160	73.7	171	67.6	
Republican	41	8.6	20	9.2	21	8.3	
Other	71	14.9	24	11.1	47	18.6	
None	27	5.7	13	6.0	14	5.5	
Primary role at agency							7.67**
Direct practice	315	66.0	131	59.5	184	71.6	
Other	162	34.0	89	40.5	73	28.4	
Primary area of practice							12.52***
Mental health	282	59.1	149	67.7	133	51.8	
Other	195	40.9	71	32.3	124	48.2	
Degree							384.05***
Masters	238	49.9	5	2.3	233	93.2	
Doctorate	229	48.0	212	97.7	17	6.8	

* $p \leq 0.05$, ** $p \leq 0.01$, *** $p \leq 0.001$, NS = Not Significant.

TABLE 3. Differences in NASW and APA Members' Characteristics on Interval Level Variables

	Whole Sample (N = 477)		APA (N = 220)		NASW (N = 257)		t
	\bar{X}	SD	\bar{X}	SD	\bar{X}	SD	
Age	52.47	9.75	52.7	9.97	52.26	9.58	NS
Percentage of time spent in direct practice	66.543	32.91	62.46	35.54	69.99	30.15	-2.435*
Workshops attended with focus on gay or lesbian issues	1.61	3.41	1.68	3.99	1.553	2.82	NS
Workshops attended with content on gay or lesbian issues	4.24	6.52	4.31	6.96	4.17	6.13	NS
Number of gay or lesbian friends	5.80	7.57	5.95	8.26	5.66	6.92	NS
Number of gay or lesbian family members	0.61	1.04	0.48	0.94	0.72	1.11	-2.525*
Number of gay or lesbian clients	2.91	6.37	3.21	7.89	2.65	4.59	NS
Percentage of clients who are gay or lesbian	7.43	13.06	7.97	13.85	6.93	12.27	NS
Social Desirability Scale	3.57	2.24	2.78	2.02	4.22	2.23	-7.148***

* $p \leq 0.05$, ** $p \leq 0.01$, *** $p \leq 0.001$, NS = Not Significant.

variables. The samples had very similar characteristics in terms of relationship status, sexual orientation, race/ethnicity, and current political party. However, there were significant differences in NASW and APA respondents in terms of gender, current religious affiliation, primary role at agency, primary area of practice, and highest degree obtained. Most notable among these differences is that of highest degree obtained with psychologists being far more likely to have obtained a doctorate degree than social workers. However, this was expected, since the masters degree is the terminal degree for social workers, while the doctorate degree is the terminal degree for psychologists.

Table 3 presents the sample characteristics for the interval level demographic variables. The two samples had very similar characteristics in terms of age, the number of workshops respondents attended that focused on gay and lesbian issues, the number of workshops respondents attended with content on gay and lesbian issues, the number of gay and lesbian friends, the number of gay and lesbian clients, and the percentage of their clients who were gay or lesbian. However, there were significant differences in the percentage of time spent in direct practice, the number of gay or lesbian family members, and social desirability scores.

HATH, ATLG, and GAP Scores

Overall, respondents' scores on all three measures reflect very positive attitudes and affirming practice. The mean score for all respondents on the HATH was 89.67 (SD = 10.43, $\alpha = 0.93$), for psychologists was 89.48 (SD = 10.22, $\alpha = 0.92$), and for social workers was 89.82 (SD = 10.62, $\alpha = 0.93$). All three scores are within the range for the most positive attitudes towards gays and lesbians. The mean score for all respondents on the ATLG was 14.67 (SD = 5.81, $\alpha = 0.91$), for psychologists was 14.95 (SD = 5.96, $\alpha = 0.90$), and for social workers was 14.44 (SD = 5.81, $\alpha = 0.92$). As with the HATH, all three means are within the range defined as the most positive attitudes towards gays and lesbians. Comparable results for the GAP were also found. The mean score for all respondents on the GAP was 124.20 (SD = 16.37, $\alpha = 0.95$), for psychologists was 123.17 (SD = 15.09, $\alpha = 0.94$), and for social workers was 125.03 (SD = 17.32, $\alpha = 0.95$). All three means are within the range defined as the most affirming scores.

Further review of these results finds that over 80% of respondents scored in the range of the most positive attitudes for both the HATH and ATLG and almost 63% of respondents scored in the most affirming range on the GAP. For all respondents, 98.8% of respondents had scores which could be categorized as more positive on the HATH; 95.9% of respondents had scores which could be categorized as more positive on the ATLG; and 96.5% of respondents had scores which could be categorized as more affirming on the GAP. In addition, only one respondent scored in the most homophobic category on the HATH and while only four respondents scored in the most homophobic category on the ATLG. Furthermore, no respondents scored in the least affirming category on the GAP. Additional information can be found in Table 4.

Identification of Covariates

Results of the ANOVA revealed a significant relationship between (1) respondents' primary area of practice and the HATH ($F(1, 447) = 5.82, p < 0.02$) and GAP ($F(1, 364) = 13.66, p < 0.001$) and (2) respondents' religion and the HATH ($F(4, 451) = 7.49, p < 0.001$), ATLG ($F(4, 451) = 8.92, p < 0.001$), and the GAP ($F(4, 358), p < 0.05$). Results of the bivariate correlations showed a significant relationship between the number of gay and lesbian family members that respondents reported and the HATH ($r = 0.11, p < 0.05$), the ATLG ($r = -0.12, p < 0.01$), and

TABLE 4. HATH, ALTG, & GAP Scores From Most to Least Positive (Number and percent of respondents*)

Scoring range	HATH (N = 448)						ALTG (N = 461)						GAP (N = 366)					
	More Positive		Less Positive		More Positive		Less Positive		More Positive		Less Positive		More Affirming		Less Affirming			
	Most Positive	2nd Most Positive	79-80	59-60	39-20	10-19	20-29	30-39	40-50	150-120	119-90	89-60	59-30	Most Affirming	2nd Most Affirming	Least Affirming		
NASW	201 (83.4)	37 (15.4)	3 (1.2)	0 (0)	199 (81.6)	35 (14.3)	7 (2.9)	3 (1.2)	128 (65.0)	60 (30.5)	9 (4.6)	0 (0)	163 (82.7)	32 (16.2)	1 (0.5)	1 (0.5)		
Whole sample	372 (83.0)	71 (15.8)	4 (0.9)	1 (0.2)	378 (82.0)	64 (13.9)	15 (3.3)	4 (0.9)	229 (62.6)	124 (33.9)	13 (3.6)	0 (0)	229 (62.6)	124 (33.9)	13 (3.6)	0 (0)		

* Percentage is in parentheses.

the GAP ($r = 0.18, p < 0.01$). No other variables had significant relationships with the HATH, ATLG, or GAP measures.

Differences in Social Workers and Psychologists

The results of the MANOVA revealed no significant differences in NASW and APA members' scores on the HATH, ATLG, and GAP (Wilks' Lambda = 0.991, $F(3, 311) = 0.987, p = 0.399$, partial $r^2 = 0.009$). Following this analysis, MANCOVA was conducted with organization as the fixed factor and the number of gay and lesbian family members, primary area of practice, and religion as covariates. Primary area of practice was dummy coded with mental health as the reference category; religion was dummy coded into five separate variables with each religious category (Protestant, Catholic, Jewish, Other, and None) as a separate variable. No significant differences in organization were found when controlling for the aforementioned covariates (Wilks' Lambda = 0.985, $F(3, 311) = 1.559, p = 0.199$, partial $r^2 = 0.015$). This analysis indicates there are no significant differences in NASW and APA members' scores on the HATH, ATLG, or GAP when controlling for the number of gay and lesbian family members, the primary area of practice, and current religious affiliation.

In examining the covariates, there was a significant effect of the number of gay and lesbian family members (Wilks' Lambda = 0.96, $F(3, 311) = 4.17, p < 0.01$, partial $r^2 = 0.039$) and the primary area of practice (Wilks' Lambda = 0.94, $F(3, 311) = 6.72, p < 0.001$, partial $r^2 = 0.06$) on the three measures. There was no significant effect of religion. These findings indicate that social workers' and psychologists' means on the HATH, ATLG, and GAP were significantly adjusted due to differences in the groups' number of gay and lesbian family members and their primary area of practice, but not on the basis of their religion.

The chi-square analysis found no significant differences in NASW and APA members' responses on the HATH ($p = 0.822$), ATLG ($p = 0.887$), or the GAP ($p = 0.284$). Thus, the number of respondents whose scores fell in the two response categories (more positive or affirming and less positive or affirming) on the three measures is similar for both groups.

DISCUSSION

Both social work and psychology have demonstrated a commitment to gay and lesbian issues as indicated by their curriculum statements that have historically mandated content about gays and lesbians (APA,

2002b; Council on Social Work Education, 2001), their codes of ethics that support equitable treatment of gay and lesbian clients (APA, 2002a; NASW, 1996), and their statements against the use of reparative and conversion therapies (APA, 1997; NASW, 2000). Thus it would seem reasonable to expect that they would have few differences in their attitudes towards gays and lesbians and their use of gay affirmative practice, an expectation that was confirmed in this study using two different methods of analysis.

The findings in this study are in contrast with previous studies (DeCrescenzo, 1984; Ben Ari, 2001) that have found differences in social workers' and psychologists' responses to measures of homophobia. Thus the question arises as to how this study differs from previous research and why social workers and psychologists in this study are more similar in their attitudes towards gays and lesbians than has been previously reported. Though DeCrescenzo's study is frequently cited in the literature and is the first known study to examine differences in social workers' and psychologists' homophobia levels, her findings are not reported to be "statistically significant." In addition, she used a snowball sample based in the Los Angeles, California, area which leads to problems in generalizing her sample to social workers and psychologists across the United States. Ben Ari's (2001) study has similar problems with generalizability: His sample consisted of faculty in Israel, thus it is not appropriate to assume his findings are applicable to a sample of social workers and psychologists engaged in direct practice with clients and who were chosen on the basis of their membership in their two professional practice organizations. In brief, while both studies offer a valuable contribution to the literature, neither study presents findings that are generalizable to the sample of social workers and psychologists that was the focus of this study.

In addition to the findings of no significant differences between social workers' and psychologists scores on the HATH, ATLG, and GAP, other interesting findings include those that indicated that respondents' number of gay and lesbian friends and their primary area of practice mediated the relationship between organization and scores on the measures of interest. Although previous studies of correlates of homophobia in the general population have found a relationship between knowing a gay or lesbian person and lower levels of homophobia (Hansen, 1982; O'Hare, Williams, & Ezoviski, 1996), only one study examined the impact of having a gay or lesbian relative on attitudes toward gays and lesbians and it found no relationship between the two (Berkman & Zinberg, 1997). Further research into the relationship between having a gay or lesbian family mem-

ber and one's attitudes toward and practice with gays and lesbians may yield additional insight into the relationship between these variables.

The finding that mental health practitioners had more positive attitudes and engaged in more affirmative practice with gays and lesbians is also interesting and warrants further research. Given that the relationship between the three measures of interest and area of practice was significant while the relationship between organizational membership and the HATH, ATLG, and GAP was not, it may be that choosing mental health as a primary area of practice is a greater predictor of attitudes toward and practice with gays and lesbians than is membership in either the NASW or APA. Further research into characteristics of mental health practitioners and why they have more positive attitudes toward and practice with gay and lesbian clients may provide additional insight into factors that influence both attitudes toward and practice with gay and lesbian clients.

While both the number of gay and lesbian family members and primary area of practice had a significant multivariate relationship with the HATH, ATLG, and GAP, the impact of these variables was not sufficient to effect a significant difference in APA and NASW members' scores on the HATH, ATLG, and GAP. Future research should examine factors that may influence the relationships between the number of gay and lesbian family members, the primary area of practice, and attitudes toward and practice with gays and lesbians. Also warranting additional research is the difference in social desirability scores with psychologists having a greater degree of social desirability than social workers. However, because there was no significant relationship between the social desirability scores and the HATH, ATLG, and GAP measures, this difference did not have an impact on the relationship between organizational membership and respondents' scores on these three measures.

Much of the discussion has focused on the lack of significant differences in NASW and APA members' scores on the three measures. While this was focus of this study, it should be emphasized that prior to the development of the GAP, it was assumed that homophobic practitioners were less affirming in their practice with gay and lesbian clients but there was little evidence to support this assertion. The development and validation of this scale gives new insight into social workers' and psychologists' practice with gay and lesbian clients. The finding that social workers and psychologists were remarkably similar in their GAP scores has more practical significance than do the findings about homophobia, because it directly addresses the degree to which practitioners engage in beliefs and behaviors that are consistent with gay affirmative practice and suggests that the two professions are similar in their use of affirma-

tive practice methods. It is further notable that both social workers' and psychologists' mean scores on the GAP were in the most affirming fourth of the scale scores and thus reflect a high degree of gay affirmative practice. Given that gays and lesbians "have reported higher than average rates of therapy usage" (Murphy, Rawlings, & Howe, 2002, p. 183) and that they are more likely than heterosexuals to seek therapeutic services (Rudolf, 1988), current findings suggest that gay and lesbian clients can have confidence in the use of affirmative practice methods by both social workers and psychologists.

Educational interventions have frequently been targeted at changing attitudes about gays and lesbians and assumed that improving attitudes would result in improving practice with gay and lesbian clients. Development of gay affirmative practice models and the Gay Affirmative Practice Scale (Crisp, 2002) point to a need to educate both students and practitioners about components of gay affirmative practice such as those discussed earlier. In doing so, social workers and psychologists will be better prepared to work with gay and lesbian clients and provide a higher quality of services to them.

STRENGTHS AND LIMITATIONS OF THE STUDY

This study has several strengths. Chief among them are the size of the sample and the fact that the sample is randomly obtained from the single largest social work and psychology organizations. Although the response rate was low, the number of surveys returned represents one of the largest studies conducted to examine homophobia in social workers and psychologists and is the first to examine gay affirmative practice in this group. In addition, this study is limited to those engaged in direct practice with clients, thus respondents were only those who met the criteria for direct practice (as defined by the APA and NASW) and presumably not researchers or educators who may be more removed from contact with gay and lesbian clients. Furthermore, in contrast to other notable studies, this study used instruments to assess homophobia and gay affirmative practice that had undergone rigorous validation methods and had high internal consistency ($\alpha > 0.85$), defined by Springer et al. as "respectable" (2002, p. 777). A final strength of this study is the use of two different methods to examine differences in social workers' and psychologists' scores on the HATH, ATLG, and GAP. Furthermore, the use of MANCOVA reduced the probability that a significant difference in the group scores would be incorrectly found.

The most obvious limitation of this study is the low response rate. This may be partially attributable to the fact that 19% of respondents indicated they did not receive the survey until after the requested return date, a problem that may have occurred because the instrument packet was distributed shortly after members of Congress were mailed envelopes containing anthrax following the terrorist attacks on September 11, 2001 (Crisp, 2002). For those who did receive the packet on time, they may have nonetheless been reluctant to open mail from a source that was not familiar to them. Whatever the cause of the low response rate, it limits the generalizability of the current study, as it is not known to what degree the pool of respondents is representative of social workers and psychologists as a group and to what degree non-responders' view differ from responders.

The use of memberships lists from the NASW and APA to obtain the sample also limits the study's generalizability. Social workers and psychologists who are members of these organizations may hold views different from those who are not members of the NASW and APA, further limiting the generalizability of the findings to a broader group of clinicians. Given the two organizations' strong support of gay and lesbian issues, practitioners who disagree with these positions may be less likely to join these organizations, particularly since membership is not a requirement for licensure by either discipline. A study of licensed social workers and psychologists may thus yield findings that are more applicable to the broader population of social workers and psychologists who are engaged in direct practice with clients. Finally, this study is further limited by the high (92%) percentage of respondents who identified their race/ ethnicity as "Caucasian/White," shedding little light on homophobia and gay affirmative practice among people of other racial or ethnic groups.

CONCLUSION

Although previous research has found that social workers are more homophobic than psychologists, the findings presented in this study indicate that the two disciplines are remarkably similar in their attitudes toward and practice with gays and lesbians. Given that APA and NASW members were the focus of this study, it may be that practitioners who belong to these organizations have more positive attitudes and are more affirming in their practice with gay and lesbian clients than those who chose not to belong. Gay and lesbian clients may thus want to inquire

about APA or NASW membership when referred to practitioners for services. Additional research regarding correlates of homophobia and gay affirmative practice will also yield additional insight into factors that are associated with attitudes about gays and lesbians and affirmative practice with gay and lesbian clients. The findings of these studies can thus be used to give clients additional information to consider when choosing service providers and ultimately to improve social workers' and psychologists' practice with gay and lesbian clients, resulting in a higher quality of treatment for gay and lesbian clients.

REFERENCES

- Appleby, G. A., & Anastas, J. W. (1998). *Not just a passing phase: Social work with gay, lesbian, and bisexual people*. New York: Columbia University Press.
- American Psychological Association. (1997). *Resolution on appropriate therapeutic responses to sexual orientation*. Retrieved February 12, 2005, from <http://www.apa.org/pi/sexual.html>
- American Psychological Association. (2002a). *Ethical principles and psychologists code of conduct*. Retrieved February 12, 2005, from <http://www.apa.org/ethics/code2002.html>
- American Psychological Association. (2002b). *Guidelines and principles for accreditation of professional programs in psychology*. Retrieved February 12, 2005, from <http://www.apa.org/ed/G&P2.pdf>
- Ben-Ari, A. (2001). Homosexuality and heterosexism: Views from academics in the helping professions. *British Journal of Social Work, 31*, 119-131.
- Berkman, C., & Zinberg, G. (1997). Homophobia and heterosexism in social workers. *Social Work, 42*(4), 319-332.
- Brown, L. S. (1996). Preventing heterosexism and bias in psychotherapy and counseling. In E. Rothblum & L. Bond (Eds.), *Preventing heterosexism and homophobia* (pp. 36-58). Thousand Oaks, CA: Sage Publications.
- Council on Social Work Education. (2001). *Educational policy and accreditation standards*. Alexandria, VA: Author.
- Crisp, C. (2002). Beyond homophobia: Development and validation of the Gay Affirmative Practice Scale (GAP). (Doctoral dissertation, University of Texas at Austin, 2002). *Dissertation Abstracts International, 64* (07A).
- Crisp, C. (in press-a). The Gay Affirmative Practice Scale (GAP): A new measure for assessing cultural competency with gay and lesbian clients. *Social Work*.
- Crisp, C. (in press-b). Correlates of homophobia and use of Gay Affirmative Practice among social workers. *Journal of Human Behavior in the Social Environment*.
- Crisp, C., & DiNitto, D. M. (2004). Substance abuse treatment with sexual minorities. In C. A. McNeece & D. M. DiNitto, *Chemical dependency: A systems approach* (3rd Ed), (pp. 401-422). Boston: Allyn and Bacon.
- Crowne, D. P., & Marlowe, D. (1960). A new scale of social desirability independent of psychopathology. *Journal of Consulting Psychology, 24*, 349-354.

- Davies, D. (1996). Towards a model of gay affirmative therapy. In D. Davies and C. Neal (Eds.), *Pink therapy: A guide for counselors and therapists working with lesbian, gay and bisexual clients* (pp. 24-40). Philadelphia: Open University Press.
- DeCrescenzo, T. (1984). Homophobia: A study of the attitudes of mental health professionals toward homosexuality. In R. Schoenberg, R. Goldberg, & D. Shore (Eds.), *With compassion toward some: Homosexuality and social work in America* (pp. 115-136). New York: Harrington Park.
- Hair, J. F., Anderson, R. E., Tatham, R. L., & Black, W. C. (1995). *Multivariate Data Analysis (4th Ed)*. Upper Saddle River, NJ: Prentice Hall.
- Herek, G. (1988). Heterosexuals' attitudes toward lesbians and gay men: Correlates and gender differences. *Journal of Sex Research, 25*, 451-477.
- Hudson, W. W. (1999). *Measuring personal and social problems: Methods for scale development*. Unpublished manuscript.
- Hudson, W., & Ricketts, W. (1980). A strategy for the measurement of homophobia. *Journal of Homosexuality, 5*, 357-372.
- Larsen, K., Reed, M., & Hoffman, S. (1980). Attitudes of heterosexuals toward homosexuality: A Likert-type scale and construct validity. *Journal of Sex Research, 16*, 245-257.
- Lim, H. S., & Johnson, M. M. (2001). Korean social work students' attitudes towards homosexuals. *Journal of Social Work Education, 37*(3), 545-554.
- McHenry, S. S., & Johnson, J. W. (1993). Homophobia in the therapist and gay or lesbian client: Conscious and unconscious collusions in self-hate. *Psychotherapy, 30*, 141-151.
- Messing, A., Schoenberg, R., & Stephens, R. (1984). Confronting homophobia in health care settings: Guidelines for social work practice. In R. Schoenberg, R. Goldberg, & D. Shore (Eds.), *With compassion toward some: Homosexuality and social work in America* (pp. 65-74). Binghamton, NY: Harrington Park Press.
- Murphy, J. A., Rawlings, E. I., & Howe, S. R. (2002). A survey of clinical psychologists on treating gay, lesbian, and bisexual clients. *Professional Psychology: Research and Practice, 33*(2), 183-189.
- National Association of Social Workers. (1996). *Code of Ethics*. Retrieved February 11, 2005, from <http://www.socialworkers.org/pubs/code/code.asp>
- National Association of Social Workers. (2000). "Reparative" and "conversion" therapies for lesbians and gay men: Position Statement. Retrieved February 11, 2005, from <http://www.socialworkers.org/diversity/lgb/reparative.asp?back=yes>
- Newman, B. S., Dannenfelser, P. L., & Benishek, L. (2002). Assessing beginning social work and counseling students' acceptance of lesbians and gay men. *Journal of Social Work Education, 38*(2), 273-288.
- Peterson, K. J. (1996). Preface: Developing the context: The impact of homophobia and heterosexism on the health care of gay and lesbian people. In K. J. Peterson (Ed.), *Health care for lesbians and gay men: Confronting homophobia and sexism* (pp. xix-xxii). Binghamton, NY: Harrington Park Press.
- Rudolf, J. (1988). Counselors' attitudes toward homosexuality: A selective review of the literature. *Journal of Counseling and Development, 67*(3), 165-168.
- Smoot, L. R. (1991). Homophobia among college students majoring in engineering, physical education, psychology, and social work. Unpublished masters thesis. Cal State University, Long Beach.

- Springer, D. W., Abell, N., & Nugent, W. R. (2002). Creating and validating rapid assessment instruments for practice and research: Part 2. *Research on Social Work Practice, 12*(6), 768-795.
- Strahn, R., & Gerbasi, K. C. (1972). Short, homogeneous versions of the Marlowe-Crowne Social Desirability Scale. *Journal of Clinical Psychology, 28*, 191-193.
- Travers, P. (1998). *Counseling gay and lesbian clients*. Unpublished master's thesis. James Madison University, Harrisonburg, VA.
- Van Den Bergh, N., & Crisp, C. (2004). Defining culturally competent practice with sexual minorities: Implications for social work education and practice. *Journal of Social Work Education, 40*(2), 221-238.
- Weinberg, G. (1972). *Society and the healthy homosexual*. New York: St. Martin's.

**Get Articles *FAST* with
the Haworth Document
Delivery Service and Rightslink®**



To request single articles from Haworth, visit www.HaworthPress.com/journals/dds.asp. You can order single articles here directly from Haworth or through Rightslink®. We have over 40,000 articles ready for immediate delivery, and you can find articles by title, by author name, by keyword, and more!

RIGHTS LINK 
Copyright Clearance Center

Not All Alike: Within-Group Differences in Seeking Help for Same-Sex Relationship Abuses

Susan C. Turell
La Vonne Cornell-Swanson

ABSTRACT. Most published research regarding same-sex relationship abuse experienced by lesbian, gay, bisexual, and transgender (LGBT) people notes a need for services. However, the LGBT community is quite heterogeneous, and useful support may vary based on demographic characteristics. This research examined within group differences regarding type of support sought and its usefulness. Eighty nine percent ($n = 677$) of a diverse sample of LGBT people ($N = 760$) experienced abuse in a same-sex relationship. Of those who experienced some type of emotional, physical, and /or sexual abuse, differences in help sought and its usefulness were found based on age, income, gender, sexual orientation, and ethnicity.

Susan C. Turell, PhD, is Coordinator of Women's Studies and Professor of Psychology at the University of Wisconsin-Eau Claire, WI.

La Vonne Cornell-Swanson, PhD, is Assistant Professor of Social Work at the University of Wisconsin-Eau Claire. She has her Master's degree in Social Work and her PhD in Cultural and Linguistic Anthropology. La Vonne teaches ethnic sensitive social work practice, and provides clinical supervision for social work interns in family practice at the UW Eau Claire Human Development Center.

Address correspondence to: Susan C. Turell at UW-EC, Women's Studies, Eau Claire WI 54702-4004 (E-mail: turellsc@uwec.edu).

The authors want to acknowledge the work done by the Lesbian and Bisexual Task Force of the Texas Coalition against Domestic Violence, and research assistants Laurie Hart, John-Paul Parks, Dene Edmiston, and Mona Metzger. This research was sponsored by grants from the Faculty Research and Support Fund of the University of Houston-Clear Lake, Office of Sponsored Programs.

Journal of Gay & Lesbian Social Services, Vol. 18(1) 2005
Available online at <http://www.haworthpress.com/web/JGLSS>
© 2005 by The Haworth Press, Inc. All rights reserved.
doi:10.1300/J041v18n01_06

[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>> © 2005 by The Haworth Press, Inc. All rights reserved.]

KEYWORDS. Family violence, sexual assault, lesbian, gay, bisexual, transgender, social services

While initially there had been a general reluctance to acknowledge the occurrence of partner abuse within same-sex relationships, in the last decade there has been an increased attention paid to domestic abuse in same-sex relationships represented in the psychological, sociological, legal, and social work literature. One of the challenges presented in the literature is the lack of uniformity in defining domestic abuse in same-sex relationships which can lead to difficulty in comparing results (Burke & Follingstad, 1999; Potoczniak, Mourot, Crosbie- Burnett, & Potoczniak, 2003). For the purpose of this study, domestic abuse within same-sex relationships is defined as encompassing physical, verbal, or sexual acts that are experienced as a threat, invasion, or assault and that have the effect of hurting or degrading one's partner (adapted from Koss et al., 1994).

The primary research on domestic violence in same-sex relationships is exploratory in nature and has presented methodological challenges in obtaining representative samples. As a result, many of the findings are based on results from convenience samples (Brand & Kidd, 1986; Coleman, 1990; Lie & Gentlewarrior, 1991; Lie, Schlit, Bush, Montayne, & Reyes, 1991; Lockhart, White, Causby, & Issac, 1994; Loulan, 1987) or small sample sizes (Renzetti, 1992; Renzetti & Miley, 1996).

Best documented in the literature is the occurrence of same-sex relationship abuse for lesbian women (Brand & Kidd, 1986; Coleman, 1990; Lie & Gentlewarrior, 1991; Lie et al., 1991; Lockhart et al., 1994; Loulan, 1987; Renzetti, 1992; Renzetti & Miley, 1996). Fewer studies have focused on gay men exclusively (Cruz & Firestone, 1998; Cruz, 2003; Hamberger, 1996; Island & Lettellier, 1991; McClennen, Summers, & Vaughan, 2002; Merrill & Wolfe, 2000; Owen & Burke, 2004).

It is rare for research on incidence/prevalence rates to include bisexual or transgender people in same-sex relationships. In one study (Brand & Kidd, 1986), the data from bisexual participants was eliminated because of the small number of respondents. Although small, results that report findings on domestic violence in the relationships of bisexual and transgender people need to be published in an effort to begin developing a database for both populations. Although not as commonly found, studies that

span all sexual identity minority groups to include people who identify as lesbian, gay male, bisexual, or transgender have also begun to document incidence and prevalence rates of domestic violence in same-sex relationships (Bologna, Waterman, & Dawson, 1987; Kelly & Warshafsky, 1987; Renzetti, 1997; Turell, 1999, 2000; Waldner-Haugrud, Gratch, & Magruder, 1987; Waterman, Dawson, & Bologna, 1989).

Many of these studies' findings have provided preliminary information on help-seeking behaviors, types of services sought, and its usefulness. While the body of literature on help-seeking behavior of lesbian women reveals some consistent empirical data, there remains a paucity of studies reporting findings about help-seeking behavior of gay men (Cruz & Firestone, 1998; Cruz, 2003; McClennen et al., 2002; Merrill & Wolfe, 2000; Owen & Burke, 2004) and a gross underexamination and reporting of within-group differences (Kanuha, 1990; Lie & Gentlewarrior, 1991; Turell, 1999). Studies to date that examine help-seeking behavior of bisexual and transgender persons are almost non-existent (Letellier, 1996; Turell, 1999, 2000).

The first objective of this paper is to report what is known about help-seeking behaviors of lesbian, gay, bisexual, and transgender (LGBT) people experiencing some type of emotional, physical, and/or sexual abuse. Secondly, this paper reports the results of a preliminary examination of the differences within the L, G, B, and T communities regarding types of help sought and their perceived usefulness. Differences investigated were based on age, income, gender, sexual orientation, and ethnicity.

HELP-SEEKING BEHAVIORS

Literature has revealed that battered lesbians and gay men seek help following abusive incidents (Bradford, Ryan, & Rothblum, 1994; Coleman, 1990; Dutton, 1994; Eastburn & Sigrist, 1988; Hamberger, 1996; Leeder, 1994; Lie & Gentlewarrior, 1991; McClennen et al., 2002; Merrill & Wolfe, 2000; Renzetti, 1992, 1996; Scherzer, 1998; Schlit, Lie, & Montayne; 1990; Turell, 1999). According to Turell (1999) just over half (54%) of lesbians, gay men, bisexual, and transgender people have sought support related to abusive relationships. Other sources report rates as high as 83-85% (Scherzer, 1998; Merrill & Wolfe, 2000). Among battered lesbians and gay men the sources of help most frequently sought included friends, counselors, and relatives (McClennen et al., 2002; Merrill & Wolfe, 2000; Renzetti, 1992, 1996; Scherzer, 1998; Turell, 1999). Among both battered lesbians and gay men the

sources of help least utilized included police and other legal services, crisis hotlines, clergy, domestic violence agency and shelter services (Hammond, 1988; Letellier, 1994; McClennen et al., 2002; Merrill & Wolfe, 2000; Renzetti, 1992, 1996; Sherzer, 1998; Turell, 1999).

Reported Helpfulness of Services

A consistent findings has been that battered lesbians and gay men give high ratings of helpfulness of support received from friends, family, and counselors (Coleman, 1990; Dutton, 1994; Hamberger, 1996; Hammond, 1988; Leeder, 1994; Letellier, 1994; McClennen et al., 2002; Merrill & Wolfe, 2000; Sherzer, 1998; Turell, 1999). However, Merrill and Wolfe's (2000) findings also revealed that battered gay men perceived gay men's shelters, counseling, HIV services and police as helpful. They attributed the difference in their findings to the geographic location of their sample (Chicago area), where more domestic violence services for gay men are offered and that many of their respondents had been previous clients of Merrill (Merrill & Wolfe, 2000).

With the exception of Merrill and Wolfe (2000), services documented in the literature as being the least helpful fell into categories of (1) domestic violence services including agencies, shelters, and crisis lines, (2) police, (3) attorneys, and (4) clergy (Coleman, 1990; Hamberger, 1996; Letellier, 1994; McClennen et al., 2002; Merrill & Wolfe, 2000; Sherzer, 1998; Turell, 1999). The primary reasons given for why these services were perceived as least helpful had to do with perceptions of invisibility of LGBT people and homophobic reactions by service providers (Hammond, 1988; Renzetti, 1996; Turell, 1999).

Within-Group Differences

The L, G, B, and T communities comprise four distinct groups, and none of those groups is homogeneous within itself. Do multiple identities yield unique support needs related to domestic violence and sexual assault in same-sex relationships?

Within-group differences are largely unexamined in the literature; what are published are primarily position papers unsupported by empirical data (Hamberger, 1996; Kanuha, 1990; Mendez, 1996; Waldron, 1996). Over a decade ago Kanuha (1990) called lesbians and feminists to task about the unique challenges faced by lesbians of color. Kanuha (1990) discussed the impact of internalized racism, sexism, and homophobia, referred to as "triple jeopardy," thus providing a description of

the impact of domestic violence for lesbians of color. She emphasized that lesbians of color are inextricably bound to their racial community due to racism and the concomitant need for people of color to bond together against it, challenging the assumption that heterosexism and homophobia affect all lesbians the same way (Kanuha, 1990). Six years later Waldron (1996) examined the impact of homophobia and racism on lesbians of color who are abused and lesbians of color who abuse through discussions from her clinical experience and suggested that lesbians of color be treated as a community.

Sherzer's (1998) study on domestic violence in lesbian relationships reported a 44% response rate of lesbian women of color with Asian and Pacific Islander women constituting 12%, Native American 2%, Women of African Descent 10%, Latinas 10%, and women who are multi-racial 11%. She reported that there were no significant differences between ethnicity and seeking help, and that the sources considered most helpful were counselors and friends (Sherzer, 1998). Turell (1999) reported a study sample that was 25% ethnically diverse, and included men, women, and a small sample of transgender people. Of the 25% diversity, 9% were African American, 8% Latinos, 4% multi or bi-ethnic, 3% Native American, and 1% Asian American. Her findings indicated that African American participants expressed the strongest preference for help from someone of the same ethnicity (Turell, 2000). With the exception of Sherzer (1998) and Turell (1999), other studies that looked at help-seeking behaviors of both battered lesbians and gay men, or of exclusively battered gay men have not reported on ethnicity specifically, leading to the assumption that the experience of white lesbians and gay men are normative (Coleman, 1990; Hamberger, 1996; Letellier, 1994; McClennen et al., 2002; Merrill & Wolfe, 2000).

Ethnicity is not the only within-group difference that remains under-examined in the literature. An analysis on the impact of factors such as age, income, gender, and sexual orientation on help-seeking behaviors of persons experiencing same-sex relationship abuse have not been reported in the literature. Recent findings reported by Beeler, Rawls, Herdt, and Cohler (1999) and Jacobs, Rasmussen, and Hohman (1999) focused on the needs of older lesbians, gay men, and bisexuals. Neither of these studies solicited information about domestic abuse. Although the last decade has shown some improvement on the attention given to the occurrence of domestic abuse in same-sex relationships and help-seeking behaviors, further research is needed to examine the impact of different factors that exist within lesbian, gay, bisexual, and transgender communities on help-seeking behaviors.

The purpose of this research was to examine differences within the LGBT community regarding services sought and their helpfulness related to same-sex relationship abuses. Variables examined for within-group differences included gender, sexual orientation, ethnicity, age, and income.

METHOD

Instrument

Three thousand surveys were distributed over a year's time across the state of Texas, in the urban areas of Houston, Dallas, Austin, San Antonio, El Paso, and Corpus Christi. The primary author developed the survey based on behavioral checklists used by several local domestic violence (DV) agencies. Staff members of social service agencies providing both DV services and services to the LGBT community provided input regarding the items on the survey. The survey included items that obtained demographic information and a checklist of behaviors that characterized emotional, physical, and sexual abuses for both past and present relationships. The behavioral checklists were developed in coordination with local domestic violence programs, and were based on paperwork used for documentation within the programs. Information was also gathered regarding actual help sought, its perceived usefulness, perceptions of need for services, and demographic characteristics of preferred caregivers. Each survey was placed in a stamped envelope addressed to the investigator for easy return, resulting in an overall response rate of 25%.

Procedure

Members of the Lesbian/Bisexual Task Force of the Texas Coalition against Domestic Violence distributed the survey in all areas except Houston, where a research team led by the primary investigator distributed the surveys. Surveys were distributed to social, political, religious, and community groups with LGBT membership. In addition, surveys were handed out at LGBT events, such as during Pride parades and picnics. When possible, the person distributing the survey attended the groups' meetings, giving a brief explanation regarding the research, emphasizing power, and control dynamics, but not mentioning violence specifically. Participants then self-selected to complete the survey. Surveys were placed for pick-up at local bookstores, community centers, and women's centers. Also, several medical, legal, and mental health care professionals

agreed to distribute surveys to any interested patients/clients. Finally, surveys were distributed at local bars.

Analysis of Support Data

Participants were asked about seeking help and support from a variety of sources. These included counselors, police, DV shelters, domestic violence agencies, friends, parents, family members, crisis hotlines, medical doctors, legal assistance, and religious/ministers. They were also asked whether the help and support they received was useful or not. To examine within-group differences for both help sought and its usefulness, Kruskal-Wallis analyses were conducted separately regarding each support category and the demographic characteristics of ethnicity (Table 1), gender (Table 2) and sexual orientation (Table 3). Point bi-serial correlations were also calculated for each category of support and the age and income of the participants.

TABLE 1. Differences in Help-Seeking By Ethnicity

Item	Chi-Square	df	Sig
1. Sought help for relationship abuses	10.056	5	.07
2. Sought counseling	9.792	5	.08
3. Found counseling helpful	6.459	5	.26
4. Sought police assistance	7.304	5	.20
5. Found police helpful	6.396	5	.27
6. Sought shelter	9.877	5	.08
7. Found shelter helpful	4.625	5	.46
8. Sought help at DV agency	27.067	5	.000**
9. Found DV agency helpful	2.071	5	.84
10. Sought support from friend	8.385	5	.14
11. Found friend helpful	5.594	5	.35
12. Sought support from parent	5.977	5	.31
13. Found parent helpful	1.631	5	.90
14. Sought support from family member	6.106	5	.30
15. Found family member helpful	3.527	5	.62
16. Used crisis hotline	3.878	5	.57
17. Found crisis hotline helpful	5.619	5	.35
18. Sought help from medical doctor	12.050	5	.03*
19. Found MD helpful	3.646	4	.46
20. Sought legal assistance	2.882	5	.72
21. Found legal assistance helpful	2.406	4	.66
22. Sought assistance from clergy	2.051	5	.84
23. Found clergy helpful	4.279	5	.51

*p < .05

**p < .001

TABLE 2. Differences in Help-Seeking by Gender

Item	Chi-Square	df	Sig
1. Sought help for relationship abuses	7.964	2	.02*
2. Sought counseling	7.630	2	.02*
3. Found counseling helpful	3.761	2	.15
4. Sought police assistance	4.104	2	.13
5. Found police helpful	1.680	2	.43
6. Sought shelter	4.616	2	.10
7. Found shelter helpful	3.500	2	.17
8. Sought help at DV agency	2.678	2	.26
9. Found DV agency helpful	4.964	2	.08
10. Sought support from friend	4.238	2	.12
11. Found friend helpful	.303	2	.86
12. Sought support from parent	.341	2	.84
13. Found parent helpful	1.853	2	.40
14. Sought support from family member	1.271	2	.53
15. Found family member helpful	2.266	2	.32
16. Used crisis hotline	1.417	2	.49
17. Found crisis hotline helpful	.768	2	.68
18. Sought help from medical doctor	.824	2	.66
19. Found MD helpful	.322	2	.85
20. Sought legal assistance	1.078	2	.58
21. Found legal assistance helpful	1.096	2	.29
22. Sought assistance from clergy	5.808	2	.05*
23. Found clergy helpful	4.451	2	.11

*p < .05

RESULTS

Participants

Of all those returning surveys (n = 760), 89% (n = 677) reported experiencing at least one behavior indicative of emotional, physical, or sexual abuse. The data from participants of this subsample were used for analysis of within-group differences for services sought; their characteristics are described below.

The ages of the participants from this subsample (n = 677) ranged from 16 to 78, with a mean age of 37.7 (SD = 10.2) and a median age of 37. While 40% identified as male, 59% identified as female, and 1% as transgender. The subsample self-identified with the following ethnicities: Caucasian (76%), Latino (9%), African American (7%), bi- or multi-ethnic (4.5%), Native American (3%), and Asian (0.6%).

TABLE 3. Differences in Help-Seeking By Sexual Orientation

Item	Chi-Square	df	Sig
1. Sought help for relationship abuses	15.336	4	.004**
2. Sought counseling	10.937	4	.03*
3. Found counseling helpful	1.919	4	.75
4. Sought police assistance	4.074	4	.40
5. Found police helpful	1.827	4	.77
6. Sought shelter	15.691	4	.003**
7. Found shelter helpful	4.469	4	.346
8. Sought help at DV agency	4.417	4	.35
9. Found DV agency helpful	5.822	3	.12
10. Sought support from friend	7.433	4	.16
11. Found friend helpful	2.297	4	.68
12. Sought support from parent	2.014	4	.73
13. Found parent helpful	5.334	4	.26
14. Sought support from family member	4.771	4	.31
15. Found family member helpful	8.125	3	.04*
16. Used crisis hotline	1.547	4	.82
17. Found crisis hotline helpful	2.158	4	.71
18. Sought help from medical doctor	1.378	4	.85
19. Found MD helpful	3.045	4	.56
20. Sought legal assistance	1.970	4	.74
21. Found legal assistance helpful	2.710	4	.61
22. Sought assistance from clergy	2.006	4	.74
23. Found clergy helpful	2.602	4	.63

p < .05
p < .01

The subsample identified with the following sexual orientations at the time of the survey with 44.7% lesbian, 10.8% gay woman, 37% gay man, 5.9% bisexual, and 1.5% heterosexual. (Women who partner with women often have strong preferences regarding their self-label; therefore, they were given the option of choosing between lesbian and gay woman.) Their annual incomes ranged from none to \$300,000, with a mean income of \$34,782 (SD = \$27,978) and a median income of \$30,000.

Seeking Support

Gender and sexual orientation influenced whether or not the participants sought support for same-sex relationship abuses (see Tables 1 and 2). Women were significantly more likely to seek help for relationship abuses than men were (Mann-Whitney U = 42586.0, p < .005). Also, women who identified as lesbian were more likely than gay men

(Mann-Whitney $U = 29311$, $p = .001$), gay women (Mann-Whitney $U = 8366.0$, $p = .013$) and bisexual people (Mann-Whitney $U = 4264$, $p = .016$) to ask for assistance.

Sources of Support

Mental health professionals. There was a statistically significant difference in the use of mental health professionals by gender (Table 2) and by sexual orientation (Table 3). Women were more likely than men to seek counseling (Mann-Whitney $U = 42586.0$, $p = .01$). Mirroring the gender differences, lesbians were more likely to seek counseling than gay men (Mann-Whitney $U = 33053$, $p = .004$). There was no statistically significant difference in seeking counseling based on income, age, or ethnicity. Also, there were no statistically significant differences regarding helpfulness of counseling within the sample for any subgroup.

Medical doctors. The only statistically significant difference found regarded ethnicity (see Table 1). Native Americans were statistically more likely to seek medical help than Latinos (Mann-Whitney $U = 645.5$, $p = .007$), African Americans (Mann-Whitney $U = 348$, $p < .009$), and Caucasians (Mann-Whitney $U = 3964$, $p = .004$). Again, there was no statistically significant difference found regarding helpfulness of medical personnel within any subgroup of the sample. No statistically significant differences were found regarding gender, sexual orientation, age, or income.

Police. No statistically significant differences across gender, sexual orientation, ethnicity or income emerged between groups regarding likelihood of reporting the abuses to the police. However, the correlation between seeking help from law enforcement and age was statistically significant, with age being inversely related. Older LGBT people were more likely to report abuse to the police than those who were younger ($r = -.310$, $p = .012$).

DV agencies. Seeking support from DV agencies yielded differences regarding only ethnicity (see Table 1). Asian people were more likely to use a DV agency for services than people from all other ethnic groups [Caucasians (Mann-Whitney $U = 546$, $p < .001$), African Americans (Mann-Whitney $U = 49$, $p < .001$), Native Americans (Mann-Whitney $U = 21$, $p = .018$), Latinos (Mann-Whitney $U = 63$, $p < .001$), Bi-/Multi-Ethnic (Mann-Whitney $U = 34$, $p = .013$). No statistically significant differences in utilization were found regarding age, income, or gender. There were no statistically significant differences in ratings of usefulness of these services.

DV shelters. The only statistically significant difference for use of DV shelters related to sexual orientation (see Table 3). Heterosexual people were significantly more likely to use this resource than lesbian women (Mann-Whitney $U = 1253$, $p = .004$), gay women (Mann-Whitney $U = 297$, $p = .003$), gay men (Mann-Whitney $U = 1015$, $p < .001$) and bisexual people (Mann-Whitney $U = 195$, $p = .039$). No differences were found regarding gender, ethnicity, age, or income, nor were there any differences found regarding who found this service useful.

Parents. Younger age ($r = .211$, $p < .001$) and having less income ($r = .115$, $p = .004$) were both related to seeking support from parents at a statistically significant level, although the correlation for each was weak. No differences were found related to gender, sexual orientation, or ethnicity. Also, there were no differences found in usefulness of seeking parental help.

Family members. Mirroring the results found for seeking help from parents, those who were younger ($r = .127$, $p < .001$) and having less income ($r = .119$, $p < .003$) were more likely to seek help from family members. Again, the correlation for each was weak but statistically significant. No differences were found regarding gender, sexual orientation, or ethnicity.

Some within-group differences did emerge regarding the usefulness of seeking help from family. People with higher incomes were more likely to find family member support useful ($r = -.201$, $p = .03$). Also, differences in sexual orientation arose regarding usefulness of family member support (see Table 3). Gay men found family members significantly more than bisexuals (Mann-Whitney $U = 113$, $p = .05$).

Friends. Similar to the results found for parents and family members, those who were younger ($r = .094$, $p = .015$) and who had less money ($r = .121$, $p = .002$) were more likely to use friends as a source of support. Although the correlations were statistically significant, they were once again quite weak. No differences in seeking help from friends were found related to gender, sexual orientation, or ethnicity. Also, no differences were found in the usefulness of friends' support.

Religious resources. Gender differences were the only ones that emerged regarding the utilization of religious resources (see Table 2). Transgender people were statistically more likely to seek support from clergy than either men (Mann-Whitney $U = 655$, $p = .021$) or women (Mann-Whitney $U = 973.5$, $p = .016$).

Crisis hotlines and legal assistance. There were no statistically significant differences for either support sought or usefulness for any of these resources within the sample based on any of the demographic variables.

DISCUSSION

Because the previous literature underexamined within-group differences, including gender, sexual orientation, ethnicity, age, and income, this study performed a more thorough analysis. Importantly, more similarities than differences emerged in the results of this study. That is, people in subgroups within the LGBT communities appear to be more similar than different, regarding both support sought for same-sex domestic violence and/or sexual assault and in the perceived helpfulness of the support. While this is consistent with the most of the previously published literature, the differences that do emerge are critical to consider, and have practical implications for treating a heterogeneous population of persons experiencing domestic violence in same-sex relationships. Lesbians were more likely than gay men, gay women, and bisexual people to seek help for same-sex relationship abuses. Lesbians have long been involved in the domestic violence and sexual assault movements, which have roots in feminism. Perhaps a lesbian identity is more likely to create an awareness of a feminist analysis and/or access to resources, making it more likely for these women to seek help.

The previous literature yielded common patterns regarding help-seeking behaviors of people who had experienced domestic violence in same-sex relationships. Both battered lesbians and gay men most frequently sought support from friends, counselors, and relatives (McClennen et al., 2002; Merrill & Wolfe, 2000; Renzetti, 1992; Renzetti & Miley, 1996; Scherzer, 1998; Turell, 1999). Of the services sought, services received from friends, family, and counselors were considered the most helpful (Coleman, 1990; Dutton, 1994; Hamberger, 1996; Hammond, 1988; Leeder, 1994; Letellier, 1994; McClennen et al., 2002; Merrill & Wolfe, 2000; Sherzer, 1998; Turell, 1999). This study supported these previously found general patterns.

Gender differences emerged in this study about seeking counseling services. Consistent with utilization of counseling in the general population, women were more likely to seek counseling than men. These results are consistent with and explain why lesbians were more likely than gay men to seek counseling.

The data regarding seeking support from family and friends yielded some within-group differences: LGBT people who were younger and those who had less money were more likely to use these populations as resources. These results may be describing some of the same people. A further analysis of the sample revealed that the age and income for this sample was significantly correlated ($r = .208, p < .01$). While there is

some overlap, the correlation is a relatively weak one. Perhaps a combination of limited economic resources and/or lack of knowledge about other community resources (due to age or decreased access) contribute to these findings.

While people with less money sought family and friends for support, ironically those with more money found family to be a more useful resource, as did gay men, closely followed by women who identified as gay women (rather than lesbian). Bisexuals were the least likely to find family a useful resource. Since bisexual people may have relationships with both same and other-sex partners, perhaps they receive more support from family members when they are paired with other-sex partners, as family members may not be as understanding of their same-sex relationships in general, and about abuse experienced in them specifically.

The interaction between income or sexual orientation and helpfulness of family members regarding same-sex relationship abuse cannot be definitively answered by this study's data. One can speculate about these results. Does having a higher income improve family relationships in general? Or does having a lower income relate in some way to poor relationships with one's family of origin? Gay men and (self-identified) gay women were similar in their ratings of helpfulness of family. What characteristics might these groups have in common, that differentiate them from women who identify as lesbian? Further analyses related to income indicated this may be an intervening variable. Two-tailed t-tests analyzing income indicated that women who identify as lesbian earned less per year than women who identified as gay women, although this was not a statistically significant difference [\$31,451 (SD = 20,757), compared with \$35,904 (SD = 26,630; $p < .15$)]. Women who identified as lesbian did earn significantly less statistically than gay men on average [\$31,451 (SD = 20,757) compared with \$38,720 (SD = 29,890); $p < .001$]. There was little difference in average yearly income for gay men and women who identified as gay. Perhaps occupation, income, and sexual orientation identity interact with family relations in ways that impact more than relationship abuses.

In general, this study supported the contentions of Kanuha (1990) and Waldron (1996) that concerns about racism do impact help-seeking behaviors of LGBT people of color. Where ethnic differences were statistically significant, African American and Latino people utilized the services the least, with less than 5% seeking medical help. It is unlikely that African American and Latino people are less commonly physically injured in same-sex relationships. More likely reasons for the difference in seeking help from medical professionals include issues of access and

perceptions of double or triple jeopardy (Kanuha, 1990; Waldron, 1996). Fears of encountering homophobia and racism by medical professionals may limit African American and Latino LGBT people from going to medical professionals. Also, homophobia within these communities of color may make it less likely that they are willing to disclose their sexual orientation by going to a medical professional and acknowledging the injury was a result of same-sex relationship abuse (Greene, 1994; Kanuha, 1990).

Native American participants were most likely, when compared across ethnic groups, to seek medical attention. Future research is needed to determine if these results are replicable, and if so, what might be the possible reasons for this difference. Additionally, this sample included only urban Native Americans, and did not include Native Americans who lived on tribal land. These results may not apply to the latter group, as there may be differences regarding accessibility.

Ethnic differences also were significant related to seeking help from a domestic violence agency. Again, both African-American and Latino LGBT people were least likely to use this resource. Despite efforts by DV agencies to meet the needs of ethnically diverse people, it appears that, at least for these two ethnic groups, DV agencies are not viewed as places to seek help for same-sex relationship abuses. As with seeking help from medical professionals, these results raise questions about accessibility issues, perceptions of possible racist treatment, and concerns about being "outed" by the agency to one's community of color (Kanuha, 1990). Not seeking services from these sources may also be a result, at least for African-American people, of a preference for African American service providers (Turell, 1999).

The participants most likely to seek help from DV agencies were those who identify as Asian-American. More definitive explanations for such ethnic differences cannot be deduced from this data, as the sample of Asian LGBT people was quite small. These results must be interpreted with caution and therefore must not be replicated before we can assume these findings are accurate. More research is needed to further explore these inter-ethnic differences in sources of support for same-sex relationship abuses.

The differences found related to utilization of domestic violence shelters and sexual orientation make intuitive sense. Currently identified heterosexuals were more likely to seek shelter, even for previous same-sex relationships. If people maintain a heterosexual identity, even when in a same-sex relationship, it may make it easier to negotiate the heterosexist biases of a DV shelter. Also, gay men were the least likely to use this resource. Shelters are often only available for women resi-

dents; therefore, this would not even be a resource for gay men. Also, gay men may be seeking emotional support through agencies providing support for HIV + status rather than private psychotherapy, as noted by Merrill and Wolfe (2000).

In looking at support and services for same-sex relationship abuses, there appears to be two broad categories: personal and professional. The personal sources of support often come from within the L, G, B and T communities, or from family members. Education efforts within the LGBT community about DV/SA are strongly supported by this study. And while needing to be inclusive of all, LGBT community education efforts would be well advised to note the within-community reliance of younger and lower income members for support. Also, professional service providers might need to look at cost or accessibility issues to reach younger people or people with less income.

The results of this study strongly support the notion of double or triple jeopardy in seeking services for LGBT people of color. If wanting to provide services to LGBT people of color, the professional service providers, such as DV agencies and medical/legal personnel, must deal with the perceptions and realities of the interaction of homophobia/heterosexism and racism, as well as the homophobia within ethnic groups.

Finally, these results should not be read as a call for shelter for LGBT people. Focus on shelter should not be viewed as the only or most important need for services. This is not unusual, as only small percentages of heterosexuals in abusive relationships utilize shelter. Resources and energy might be better spent on ongoing and thorough anti-homophobia/anti-heterosexism trainings for staff and volunteers, coupled with anti-racism trainings, or trainings that address the intersections of oppressions. Trainings with service providers, concurrent with educational efforts targeted within the LGBT communities, appear both necessary and warranted.

LIMITATIONS

Because the data gathered in this study were largely from urban areas, the results may not be applicable to LGBT people who live in rural areas. As with most research with LGBT people, the sample is not a random one, relying on collection of data from those who are identified in some way with the LGBT community through attendance at events, membership in organizations, and/or clients of LGBT identified caregivers. Care should be taken in generalizing these results to those LGBT

people who remain uninvolved in such groups, or who remain isolated from the LGBT community. Also, the conclusions about the results involving Asian American and transgender participants should be viewed as, at best, preliminary, warranting replication in future studies.

CONCLUSION

This preliminary study raised more questions than it answered. Though progress is being made, studies that seek to better understand domestic violence in same-sex relationships are still needed. This understanding will not be complete unless future research considers within-group differences in recruiting their study participants, and analyzing and reporting their data. Specific questions that are designed to better understand how such factors as age, income, sex, gender, and ethnicity influence seeking help for same-sex relationship abuses are needed. However, this exploration of within-group differences is complex, and must be understood in the context of the preponderance of similarities for LGBT people regarding support sought and its helpfulness.

In addition, rigorous qualitative studies that are designed to document the voices from insider's perspectives could enhance what the statistics are telling us about help-seeking experiences. Hearing from the victim/survivors themselves can provide insight into how to better educate and train service providers on all levels, as well as members of the LGBT community as to what is needed regarding support of one's peers. Continuing to address the pervasiveness of oppression that occurs as a result of homophobia, racism, ageism, sexism, anti-Semitism, and ableism appears to be central to providing successful education and intervention about violence in same-sex relationships.

REFERENCES

- Beeler, J., Rawls, T., Herdt, G., & Cohler, B. (1999). The needs of older lesbians and gay men in Chicago. *Journal of Gay & Lesbian Social Services, 9*(1), 31-49.
- Bologna, M., Waterman, C., & Dawson, L. (1987). *Violence in gay male and lesbian relationships: Implications for practitioners and policy makers*. Paper presented at the Third National Conference for Family Violence Researchers, Durham, NH.
- Bradford, J., Ryan, C., & Rothblum, E. D. (1994). National lesbian health care survey: Implication for mental health care. *Journal of Consulting and Clinical Psychology, 63*, 228-242.
- Brand, P., & Kidd, A. (1986). Frequency of physical aggression in heterosexual and female homosexual dyads. *Psychological Reports, 59*, 1307-1313.

- Burke, L., & Follingstad, D. (1999). Violence in lesbian and gay relationships: Theory, prevalence, and correlational factors. *Clinical Psychology Review, 19*, 487-312.
- Coleman, V. (1990). Violence in lesbian couples: A between group comparison. [CD-ROM]. Abstract from: Silver Platter File: Psych Lit: Dissertation Abstracts Item: 9109022.
- Cruz, J. M. (2003). Why doesn't he just leave? Gay male domestic violence and the reasons victims stay. *Journal of Men's Studies, 11*(3) 309-319.
- Cruz, J. M., & Firestone, J. M. (1998). Exploring violence in gay male relationships. *Violence and Victims, 13*, 159-173.
- Dutton, D. (1994). Patriarchy and wife assault: The ecological fallacy. *Violence and Victims, 9*, 167-182.
- Eastburn, J., & Sigrist, S. (1988). Lesbian battering: An exploratory study. Unpublished thesis, CA State University, Sacramento.
- Greene, B. (1994). Lesbian women of color. In Comas-Diaz, L & Greene, B.(Eds.). *Women of color* (pp. 389-427). New York, NY: Guilford Press.
- Hamberger, L. K. (1996). Intervention in gay male intimate violence requires coordinated efforts on multiple levels. *Journal of Gay & Lesbian Social Services, 4*, 83-91.
- Hammond, N. (1988). Lesbian victims of relationship violence. *Women and Therapy, 8*, 89-105.
- Hart, B. J. (1986). Lesbian battering: An examination. In K. Lobel (Ed.) *Naming the violence*. Seattle, WA: Seal Press.
- Island, D., & Letellier, P. (1991). *Men who beat the men who love them: Battered gay men and domestic violence*. New York: Haworth Press.
- Jacobs, R., Rasmussen, L., & Hohman, M. (1999). The social support needs of older lesbians, gay men, and bisexuals. *Journal of Gay & Lesbian Social Services, 9*(1), 1-30.
- Kanuha, V. (1990). Compounding the triple jeopardy: Battering in lesbian of color relationships. *Women and Therapy, 9*, 169-184.
- Kelly, E., & Warshafsky, L. (1987). *Partner abuse in gay male and lesbian couples*. Paper presented at the Third National Conference of Family Violence Researchers, Durham, NH.
- Koss, M., Goodman, L., Browne, A., Fitzgerald, L., Keita, G., & Russo, N. (1994). *No safe haven: Male violence against women at home, at work, and in the community*. Washington D.C.: American Psychological Association.
- Leeder, E. (1994). *Treating abuse in families: A feminist and community approach*. New York: Springer Publishing.
- Letellier, P. (1994). Gay and bisexual male domestic violence victimization: Challenges to feminist theory and responses to violence. *Violence and Victims, 9*, 95-106.
- Lie, G-Y., & Gentlewarrior, S. (1991). Intimate violence in lesbian relationships: Discussion of survey findings and practical implications. *Journal of Social Service Research, 15*, 41-59.
- Lie, G-Y., Schilit, R., Bush, J., Montagne, M., & Reyes, L. (1991). Lesbians in currently aggressive relationships: How frequently do they report aggressive past relationships? *Violence and Victims, 6*, 121-135.
- Lockhart, L., White, B., Causby, V., & Isaac, A. (1994). Letting out the secret: Violence in lesbian relationships. *Journal of Interpersonal Violence, 9*, 469-492.

- Loulan, J. (1987). *Lesbian passion: Loving ourselves and each other*. San Francisco: Spinsters Books.
- McClennen, J., Summers, A., & Vaughan, C. (2002). Gay men's domestic violence: Dynamics, help seeking behaviors, and correlates. *Journal of Gay & Lesbian Social Services, 14*(1), 23-49.
- Mendez, J. M. (1996). Serving gays and lesbians of color who are survivors of domestic violence. In C. Renzetti & C. Miley (Eds). *Violence in gay and lesbian domestic partnerships*. New York: Haworth Press.
- Merrill, G., & Wolfe, V. (2000). Battered gay men: An exploration of abuse, help seeking, and why they stay. *Journal of Homosexuality, 39*(2), 1-30.
- Owen, S. S., & Burke, T. W. (2004). An exploration of prevalence of domestic violence in same-sex relationships. *Psychological Reports, 95*(1), 129-132.
- Potoczniak, M. J., Mourot, J. E., Crosbie-Burnett, M., & Potoczniak, D. J. (2003). Legal and psychological perspectives on same-sex domestic violence: A multisystemic approach. *Journal of Family Psychology, 17*(2), 252-259.
- Renzetti, C. (1992). *Violent betrayal: Partner abuse in lesbian relationships*. Newbury Park, CA: Sage.
- Renzetti, C. (1996). The poverty of services for battered lesbians. *Journal of Gay & Lesbian Social Services, 4*, 61-68.
- Renzetti, C. (1997). Violence and abuse among same-sex couples. In A. P. Cardarelli (Ed), *Violence between intimate partners: Patterns, causes and effects* (pp. 70-89). Needham Heights, MA: Allyn & Bacon.
- Renzetti, C., & Miley, C. (Eds.) (1996). *Violence in gay and lesbian domestic partnerships*. New York: Haworth Press.
- Scherzer, T. (1998). Domestic violence in lesbian relationships: Findings of the lesbian relationships research project. *Journal of Lesbian Studies, 2*(1), 29-47.
- Schilit, R., Lie, G-Y., & Montagne, M. (1990). Substance use as a correlate of violence in intimate lesbian relationships. *Journal of Homosexuality, 19*, 51-65.
- Turell, S. C. (1999). Seeking help for same-sex relationship abuses. *Journal of Gay & Lesbian Social Services, 10*(2), 35-49.
- Turell, S. C. (2000). A descriptive analysis of same-sex relationship violence in an ethnically diverse sample. *Journal of Family Violence, 15*, 281-293.
- Waldner-Haugrud, L., Gratch, L., & Magruder, B. (1997). Victimization and perpetration rates of violence in gay and lesbian relationships: Gender issues explored. *Violence and Victims, 12*, 173-184.
- Waldron, C. (1996). Lesbians of color and the domestic violence movement. In C. Renzetti, & C. Miley (Eds.). *Violence in gay and lesbian domestic partnerships*. New York: Haworth Press.
- Waterman, C., Dawson, L., & Bologna, M. (1989). Sexual coercion in gay male and lesbian relationships: Predictors and implications for support services. *Journal of Sex Research, 26*, 118-124.

PRACTICE NOTES

Breast Cancer Prevention Strategies for Aged Black Lesbian Women

Thomas Alex Washington
June P. Murray

ABSTRACT. Recognizing that effective intervention must include models of treatment that “meet clients where they are,” this paper describes culturally sensitive breast cancer prevention strategies that may be useful for health care providers in an effort to reach a triple-minority population: Black, lesbian women. The strategies are an adapted version of the Witnessing In Tennessee (WIT) model. WIT was developed to increase early detection of breast cancer among Black women. The strategies have been adapted for use among Black, aged, lesbian women. This model provides practitioners with universal techniques that can be used to address various health disparities. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>> © 2005 by The Haworth Press, Inc. All rights reserved.]*

Thomas Alex Washington, PhD, LGSW, is a Research Fellow and Assistant Professor, Department of Social Work, Morgan State University, Baltimore, MD. Dr. Washington is also an independent psychotherapist, licensed in the state of Maryland. He has practiced medical social work in an ambulatory care setting in Memphis, Tennessee.

June P. Murray, PhD, LCSW-C, is Director of the Gerontology Program, Department of Social Work, Morgan State University, Baltimore, MD. Additionally, Dr. Murray is a Licensed Clinical Social Worker in the state of Maryland.

Journal of Gay & Lesbian Social Services, Vol. 18(1) 2005
Available online at <http://www.haworthpress.com/web/JGLSS>
© 2005 by The Haworth Press, Inc. All rights reserved.
doi:10.1300/J041v18n01_07

KEYWORDS. Lesbian issues, breast cancer prevention, community health, public health, gerontology and health

Breast cancer is the second leading cause of cancer death among Black women and the leading cause of cancer death among women 40-55 years of age (American Cancer Society, 2003; Belin, Washington, & Greene, 2006). Black lesbians have a greater risk of breast cancer death because of dual health care challenges and disparities, such as limited access to quality health care for ethnic and sexual minorities. Moreover, the higher breast cancer mortality rate for Black lesbians is partially related to the fact that a larger percentage of their breast cancers are diagnosed later, at a less treatable stage (American Cancer Society, 2003; Phillips, 1995).

According to the Centers for Disease Control and Prevention (CDC) (2004), except for skin cancer, breast cancer is the most commonly diagnosed cancer among women in the United States. Furthermore, the burden and consequences of cancer have increased over the past 25 years (CDC, 2002). Thus, cancer control activities are needed that include programs designed to increase the availability and use of breast and cervical cancer screening. Additionally, follow-up care by health providers is needed for hard-to-reach populations, such as older ethnic-minority lesbians who have had negative experiences with health care providers whose practices may not be culturally sensitive to the needs of the sexual minority community (Dibble et al., 2002). Likewise, cancer control activities are needed for Black lesbians who are economically deprived, have limited education and access to educational resources (American Cancer Society, 2003; CDC, 2002).

The CDC Healthy People 2010 Report highlights the need for strong, cohesive, and integrated educational and community-based programs for racial/ethnic and sexual minorities. In addition, it emphasizes the use of interventions specifically designed to meet the age, developmental levels, and cultural, linguistic, and other learning needs of diverse target audiences. There is a need to increase partnerships between planned community health promotion programs and community organizations (CDC, 2002; Dibble et al., 2002).

To improve the survival rate of Black lesbians with breast cancer, breast health education that is sensitive to racial and sexual minority women is needed in an effort to increase their participation in breast cancer screening (Belin, Washington, & Greene, 2006; Brown & Williams, 1994; Goelitz, 2001; Moormeier, 1996). The information needed includes basic facts about normal breast changes, breast cancer, and early detection methods (Brown, 1994; Moormeier, 1996). These educational

measures can also help to alleviate stigma and negative attitudes regarding breast cancer (Brown, 1994). Pamphlets, instructional sessions, films, health fairs, and speakers at women's gatherings can be used to increase knowledge and awareness of breast cancer screening practice. In addition, educational methods and materials should be evaluated for ethnic and cultural sensitivity. The presentation and writing of these materials should be conducive for those who may read at a low functioning level (Belin, Washington, & Greene, 2006; Brown, 1994).

According to the American Cancer Society (ACS) (2003), there is a definite need to reach lesbian women in impoverished and/or underserved areas in the United States, particularly in the Black lesbian communities. Previous research suggests that past negative experiences with providers may cause lesbians and bisexual women to wait too long before seeking health care; hence, breast cancer goes undiagnosed at early stages (ACS, 2003). Moreover, according to Cochran et al. (2001), lesbians have fewer mammograms and pelvic exams than the heterosexual population. Similarly, another study's findings suggest that lesbians have less frequent pap tests than their heterosexual counterparts (Marrazzo et al., 2001).

One challenge is that it is very difficult to reach Black lesbian community leaders, the key informants, and the women in the target population who need the education and services. In addition, according to CDC (2002), there is an urgency for health educators to take full advantage of opportunities to reach target audiences during "teachable moments" in a variety of settings and sites through all appropriate providers and intermediaries. Community-based programs must assure that participants have not just the knowledge, but also the attitudes regarding optimal health, and the training necessary to continue the program's efforts, even after the public health social workers have discontinued their involvement (Belin, Washington, & Greene, 2006; CDC, 2002; Chen & Ma, 2004; Magen & Glajchen, 1999). Even though some programs, such as the Cancer Outreach Services (COS) of Thompson Cancer Survival Center in Knoxville, Tennessee, have been capable of performing the needed screening services among white, heterosexual women, the staff of COS stressed that the most important factor was the need for an effective intervention and method of delivery to Black heterosexual and lesbian women in East Tennessee.

This paper describes a culturally sensitive breast cancer prevention model for Black lesbian communities (CPMBLC). CPMBLC is described, by participants, as a "Saving Grace" for Black women who have experienced early detection of breast cancer and received preventable

treatment that has saved their lives. The Witnessing In Tennessee (WIT) model has been a success. In fact, the model has been adapted for use among Black men to prevent prostate cancer. Additionally, the model is individually focused, acknowledge that learning occurs at various levels, and that people optimally learn when their cultural and social beliefs are understood and respected (Belin, Washington, & Greene, 2006).

Cancer Prevention Model for Black Lesbians

CPMBLC was tailored after the original Witness Project and the Witnessing In Tennessee (WIT) program, which was implemented to provide participants with the knowledge and skills necessary to increase screening practices among Black women (Belin, Washington, & Greene, 2006; Erwin et al., 1996). CPMBLC was developed to increase breast-self examination, clinical breast examination, and mammography use among Black lesbians.

As shown in Figure 1, the first step in developing the program is to build a partnership with a local Cancer Center that provides cancer outreach services. The partnering organization should have the capability to provide mammograms for the population the program is trying to reach. Grant funding should be solicited from local, state, or federal organizations (e.g., Thompson Foundation, the Susan G. Komen Foundation, CDC, NIMH, Buddy's Race for the Cure).

CPMBLC programs should be held during regularly scheduled activities at churches (i.e., open and GLBT-affirming churches), GLBT community centers, and bars with a predominately lesbian clientele. The programs should follow the 4MAT System, which presented educational material sequentially to address four distinct learning styles. The 4MAT System allows breast cancer information to be presented in a very simple style and allows the women to process the information according to their learning styles (McCarthy & Glajchen, 1992; Spatz, 1991). The intervention consists of having a team of Black lesbian breast cancer survivors speak in groups of two to five at the programs scheduled at the host sites (e.g., churches, bars, GLBT community centers).

Involvement of Affirming GLBT Organizations

As a way to ensure that minority, lesbian, underserved women receive education on the importance of mammography as an early breast cancer detection tool, a CPMBLC program coordinator and staff member collaborates with GLBT-affirming organizations, such as churches

FIGURE 1. Steps to Develop Cancer Prevention Model for Black Lesbians

- Step 1. Partnering:** Link with cancer health providers and funding sources.
- Step 2. Collaboration:** Involve GLBT churches and community organizations.
- Step 3. Education:** Select or design culturally sensitive material related to cancer prevention, health resources, referral sources, and provide training that is sensitive to the target population.
- Step 4. Recruitment:** Recruit Black lesbian cancer survivors who are willing to participate as a Role Model (RM) and a Layhealth Advisor (LHA).
- Recruitment is done at church programs, GLBT centers, and advertising
 - Training sessions are scheduled as 1-day (8-hour) programs
 - LHAs and RMs meet together for the first 2 hours, then separate into groups for specialized training
 - LHAs learn cancer facts and early detection; RMs develop narratives
- Step 5. Witnessing:** RM and LHA do the following:
- Answer questions about their cancer experiences, fears, and concerns
 - Their presence as survivors is seen as a blessing and proof that cancer is not a death sentence
 - Encourage women to talk about cancer and to take care of themselves
 - Discuss the importance of mammography, breast self-examination
 - Invite other cancer survivors to become LHAs and RMs

(i.e., Pastors and Church Board Members) in the area to bring breast health outreach to the at-risk populations in the community. The GLBT-affirming church has been for decades a place where people witnessed through testimonials of how lives have been changed, disrupted, or even in some cases, “saved.” Therefore, these churches are a great starting point to bring breast health outreach to at-risk populations. Church officials are asked to schedule breast cancer screening programs at their

churches and allow the CPMBLC program director to announce a date that the CPMBLC program would visit their church.

Some members of CPMBLC should themselves be involved in the GLBT-affirming churches and should be breast cancer survivors who teach other women the importance of early detection by verbally sharing their cancer experience. In addition to talking about their cancer experience, the CPMBLC members should inform the women attending the programs about the services available through the Cancer Center, which involves a state-of-the-art software tracking system that ensures women who visit the Center that they would receive breast cancer screening and follow-up care.

Moreover, the women are carefully monitored and tracked, and measures are set up to keep them from falling through the cracks. Similarly, GLBT community centers and bars have been for decades a place where lesbians have garnered support and shared experiences of how lives have been changed, disrupted, or even in some cases, educated. GLBT community centers are a great resource for reaching Black lesbians and implementing a CPMBLC program.

PEER LESBIAN CANCER SURVIVOR

The motivation for the CPMBLC program is clear, "What you don't know might kill you!" With this statement as a focus for prevention, the CPMBLC program staff works with the following premises: (1) African-American lesbians can reach other Black lesbians better than anyone else can; (2) The Black and lesbian community are close-knit caring communities where members nurture each other and can learn to nurture themselves; (3) The program specifically targets Black lesbians for breast and cervical cancer education screening, and uses the church to connect to the community.

According to Belin, Washington, and Greene (2006), the WIT program had participants with five or six children who had never had a pap smear, and 50, and 60-year-old women who had never had a mammogram. It is important to note that a participant in the WIT program understands, first-hand, why programs like CPMBLC is needed, she states:

When I received my mammography results showing cancer, I couldn't reach family to turn to. The Lord . . . guided me . . . by putting WIT in my life. Now I am happy to take on the same role as a cancer survivor . . . I go out to churches . . . to share my testimony with the hope of reaching Black women and help save lives.

DISCUSSION

This paper provides an example of a community-based breast cancer prevention and education program targeted to Black lesbian women. Whereas previous research clearly has shown that early detection of breast cancer can save lives, and that higher breast cancer mortality rate for Black women is partially due to late diagnosis at a less treatable stage, this paper provides a description of a program that includes a protocol to increase cancer screening, education, and follow-up care for hard-to-reach populations, such as older Black lesbians who are poor and have limited education. Taking CPMBLC programs to the GLBT-affirming churches, community centers, and bars, with an understanding that peer-education, shared experiences, and support are very important in the Black and lesbian community, these organizations are an excellent place to reach Black lesbians to share lifesaving breast cancer information.

The CPMBLC service delivery model has several key implications for practice that social workers and other health care professionals should consider when working with hard-to-reach populations, particularly Black lesbians. The following points are crucial for practice: (1) Alleviate barriers that impede intervention by effectively identifying and accessing key support systems within the community; (2) Relate to individuals in clear and concise language that is sensitive to various educational levels and cultural differences; (3) Healthcare providers must become comfortable asking questions about sexual orientation and behavior; (4) Recognize that the client's point of reference not only addresses where the client is emotionally, but physically and spiritually as well. Thus this model provides practitioners with universal techniques that can be used to address various health disparities.

REFERENCES

- American Cancer Society. (2003). *Health information seekers: Statistics, prevention and early detection*. Online resource. [www.cancer.org].
- Belin, P., Washington, T. A., & Greene, Y. (2006). Saving Grace: A breast cancer prevention project for African American women. *Health and Social Work, 31*(1), 73-76.
- Brown, L. W., & Williams, R. D. (1994). Culturally sensitive breast cancer screening programs for older Black women. *Nurse Practitioner, 19*(3), 21, 25-26, 31 passim.
- Centers for Disease Control & Prevention. (2002). *Healthy People 2010 Report*. Atlanta, GA: Online resource. [www.cdc.gov.]

- Centers for Disease Control & Prevention. (2004). *The national breast and cervical cancer early detection program 2004/5 Fact Sheet*. Atlanta, GA: Online resource. [www.cdc.gov/cancer].
- Chen, M. F., & Ma, F. C. (2004). Symptom distresses and coping strategies in breast cancer women with mastectomy. *Hu li za zhi The Journal of Nursing*, 51(4), 37-44.
- Cochran, S. D., Mays, V. M., Bowen, D., Gage, S., et al. (2001). Cancer-related risk indicators and preventive screening behaviors among lesbians and bisexual women. *American Journal of Public Health*, 91(4), 991-998.
- Dibble, S. L., Roberts, S. A., Robertson, P. A., & Paul, S. M. (2002). Risk factors for ovarian cancer: Lesbian and heterosexual women. *Oncology Nursing Forum*, 29(1), E1-7.
- Erwin, D., Spatz, T., Stotts, C., Hollenberg, J., & Deloney, L. (1996). Increasing mammography and breast self-examination in Black women using the Witness Project model. *Journal of Cancer Education*, 11, 210-215.
- Goelitz, A. (2001). Nurturing life with dreams: Therapeutic dream work with cancer patients. *Clinical Social Work Journal*, 29(4), 375-385.
- Magen, R. H., & Glajchen, M. (1999). Cancer support groups: Client and the context of group process. *Research on Social Work Practice*, 9(5), 541-554.
- Marrazzo, J., Koutsky, L. A., Kiviat, N. B., Kuypers, J. M., & Stine, K. (2001). Papanicolaou test screening and prevalence of genital human papillomavirus among women who have sex with women. *American Journal of Public Health*, 91(6), 947-953.
- McCarthy, B., & Morris, S. (1992). *The 4MAT System*. Chicago: Excel, Inc.
- Moormeir, J. (1996). Breast cancer in Black women. *Annual of Internal Medicine*, 124(10), 897-905.
- Phillips, J. M. (1995). Adherence of breast cancer screening guidelines among African American women of differing employment status. *Cancer Nursing*, 18(4), 258-269.
- Spatz, T. S. (1991). Improving breast self-examination training by using the 4MAT Instructional model. *Journal of Cancer Education*, 6(3), 179-183.

Journal Ordering, Copyright, and Document Delivery Information

- 1) **JOURNAL OF GAY & LESBIAN SOCIAL SERVICES**TM (Print ISSN: 1053-8720; Electronic ISSN: 1540-4056) is published at Harrington Park Press® (an imprint of The Haworth Press, Inc.), 10 Alice Street, Binghamton, NY 13904-1580 USA.

The *Journal of Gay & Lesbian Social Services* aims to promote the well-being of homosexuals and bisexuals in contemporary society through disseminating information on innovative approaches to the design, evaluation, and delivery of social services to lesbians and gays. The journal will provide positive influence in the development of public and social policy, programs and services, and practice with individuals, couples, families, and communities.

Focusing on and supporting services geared for lesbians and gays, the *Journal of Gay & Lesbian Social Services* will publish articles to assist public, nonprofit, and for-profit services and organizations. Mental health services, family services, foster care, school services, health and medical services, juvenile and adult corrections, aging, and child welfare agencies will be able to better meet the needs of special populations within the gay community such as ethnic and racial minorities; children, adolescents, and senior adults; women; and victims of special social problems such as poverty, hate crimes, domestic violence, and physical and medical disabilities.

- 2) **BUSINESS OFFICE:** Except for overseas sales representatives, all subscriptions and advertising inquiries should be directed to The Haworth Press, Inc., 10 Alice Street, Binghamton, NY 13904-1580 USA. Telephone (607) 722-5857.
- 3) **SUBSCRIPTION CYCLE:**
- Academic year basis (first issue in each volume begins in September or Fall season)
 - Calendar year basis (first issue in each volume begins in January or Spring season)
 - Irregular (first issue in each new volume will be published on a to-be-announced date after publication of the final issue of the preceding volume)
- 4) **FREQUENCY:**
- Quarterly (4 issues per volume)
 - Triannual (3 issues per volume)
 - Biannual (2 issues per volume)

Additional volumes in any subscription year may be issued; these will be noted on renewal notices. This journal frequently publishes two volumes a year.

- 5) **SUBSCRIPTION INFORMATION:** Subscriptions are on a per volume basis only. The following prices are for the current volume only for the USA. Subscriptions must be prepaid.
- US\$: 50.00 Volume 17 individuals (paid by personal check);
 - US\$: 90.00 Volume 17 institutions (examples: corporations, departments, institutes, social & health service agencies/hospitals);
 - US\$: 225.00 Volume 17 libraries and subscription agencies (e.g., whenever purchased either directly or through a subscription agency).
- 6) **CANADIAN ORDERS:** Price of journal is 35% above domestic USA rate; Canadian G&S Tax of 7% must then be added (GST# R129786984), plus an additional 8% province tax in these four Canadian provinces: Newfoundland, Nova Scotia, New Brunswick, and Labrador.
- 7) **PAYMENT:** U.S. and Canadian funds accepted; please add in current exchange rate if paying by Canadian check or money order.
- 8) **OUTSIDE USA AND CANADA:** Price of journal is 45% above domestic USA rate.
- 9) **POSTAGE & HANDLING:** 10% postage & handling charge is included in journal subscription rates. Journals are mailed via consolidated air mail outside the USA and Canada.
- 10) **BACK VOLUMES:** 40% above the current subscription rate.
- 11) **SUBSCRIPTIONS THROUGH AGENCIES:** Subscriptions through any subscription agency subject to publisher's credit check of subscription agency and payment record history of subscription agency. Renewals through agents must be prepaid 60 days prior to renewal cycle of journal, which is: November 1 for calendar-year journals and July 1 for academic-year journals. Library subscribers will be notified if subscription agent does not remit renewal payments on this schedule. All cancellations requiring refunds are subject to a 25% processing fee.

Journal ordering, copyright, and document delivery information continued

- 12) **CHANGE OF ADDRESS:** Please notify the Subscription Department, The Haworth Press, Inc., 10 Alice Street, Binghamton, NY 13904-1580 USA of address changes. Please allow six weeks for processing; include old and new addresses, as well as both zip codes.
- 13) **COPYRIGHT** © 2005 by The Haworth Press, Inc. All rights reserved. No part of this work may be reproduced beyond limits set by fair use, or utilized in any form or by any means, electronic or mechanical, including photocopying, microfilm and recording, or by any information storage and retrieval system, without permission in writing from the publisher. See also paragraphs 14 and 15 for obtaining photocopies. Printed in the United States of America.
- 14) **LOCAL PHOTOCOPYING, DOCUMENT DELIVERY, FAIR USE, ANTHOLOGY PUBLISHING:**
- LOCAL PHOTOCOPYING may be done at no charge for classroom/educational/interlibrary-loan use within the limits allowed by fair use statutes.
 - DOCUMENT DELIVERY is provided by the Haworth Document Delivery Service, 10 Alice Street, Binghamton, NY 13904-1580. Telephone orders and all major credit cards accepted. The Haworth Press, Inc. has not licensed any document delivery service, firm, library, or organization for the preparation of photocopies for the purpose of document delivery. Sole exception is the Original Article Tear-sheet Service of the Institute for Scientific Information (ISI). ISI's right to prepare photocopies cannot be sold or licensed to a third party.
 - BEYOND FAIR USE photocopying requires a rights & permissions fee of \$2.50 per copy, per article or portion thereof with a minimum \$25.00 rights & permissions fee on each request for services, payable directly to the Publisher.
 - ANTHOLOGY PUBLISHING fees may be obtained from RuthAnn Heath, Rights & Permissions, The Haworth Press, Inc., 10 Alice Street, Binghamton, NY 13904-1580.
- 15) **SUB-LICENSING:** The Haworth Press, Inc. can provide all photocopies of its materials through its own Haworth Document Delivery Service. Official Sub-Licensee for Article Photocopies: Institute for Scientific Information (ISI)/Research Alert, 3501 Market Street, Philadelphia, PA 19104-3302 (USA) and all allied ISI services.
- 16) **CLAIMING:** The Publisher will, at no charge, replace any missing issue within one year of the original mailing date.
- 17) **GRACING:** Journal issues are not "graced"; i.e., the first issue of a new volume is not mailed until payment is received.
- 18) **DISCLAIMER:** The development, preparation, and publication of this work has been undertaken with great care. However, the publisher, employees, editors, and agents of The Haworth Press and all imprints of The Haworth Press, Inc., including The Haworth Medical Press® and Pharmaceutical Products Press®, are not responsible for any errors contained herein or for consequences that may ensue from use of materials or information contained in this work. Opinions expressed by the author(s) are not necessarily those of The Haworth Press, Inc. With regard to case studies, identities and circumstances of individuals discussed herein have been changed to protect confidentiality. Any resemblance to actual persons, living or dead, is entirely coincidental. Offers by Advertisers in Haworth Press journals are made by the Organization named therein and not by The Haworth Press, Inc. The Haworth Press, Inc. disclaims any responsibility on its part for the fulfillment or performance of any such offer. All inquiries with respect to such offer should be made directly to the Advertiser. The publisher and its editorial staff do not endorse and make no warranty, express or implied, with respect to any third-party products, services or offerings advertised in this journal.
- 19) **LIBRARY PHOTOCOPYING:** ATTENTION LIBRARIANS: If your library subscribes to this journal, Haworth® **waives** all photocopying fees or any royalty payments for multiple internal library use. By "internal library use" we mean:
- photocopying multiple copies of any article for your reserve room or reference area
 - photocopying of articles for routing to either students or faculty members
 - multiple photocopying by students for coursework
 - multiple photocopying by faculty members for passing out to students at no charge or for their own files
 - other traditional internal library multiple use of journal articles