

Health Disparities in Michigan's Lesbian, Gay, Bisexual, and Transgender Community

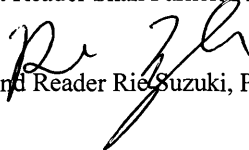
Andrea L. Smith

Presented to the Health Education Faculty
at the University of Michigan-Flint
in partial fulfillment of the requirements for the
Master of Science in Health Education

January 20, 2014



First Reader Shan Parker, Ph.D.



Second Reader Rie Suzuki, Ph.D.

Table of Contents

Abstract.....	3
Glossary of Terms.....	5
Statement of Purpose.....	6
Research Questions.....	6
Literature Review	10
Methodology	18
Presentation of Results	21
Discussion and Conclusions.....	29
References	38
Appendix A – Recruitment	41
Appendix B – Informed Consent	42
Appendix C – Survey Tool	43

Abstract

The purpose of the research was to illustrate how the health of LGBT persons are affected by stigma, discrimination, and bias within the state of Michigan. It will be researched through answering these questions: Statement about the health of the LGBT population. Did the LGBT person feel they were treated worse than other sexual identities? How did their experiences differ when seeking health care? Had they experienced physical symptoms as a result of how they were treated? Research in the area of LGBT health states that there is a lack of access to health care, there is discrimination and bias when they received care and that there was an increased need of mental health services.

Methods: This study utilized a cross sectional design to via an anonymous online survey for LGBT people over the age of 18 living in the state of Michigan. The survey was implemented Qualtrics Software, took about 30 – 45 minutes to complete, and was advertised through email, a Facebook event, and word of mouth. It was a cross-sectional study and a descriptive analysis was performed using the same Qualtrics software and SPSS Statistics 17.0.

Results: Respondents were predominately white women with higher education and who identified as heterosexual. Thus the sample size for comparison was small giving a limited scope of health and health experiences for LGBT people in Michigan. Future research should include a filter question to make sure that the majority of people who fill out the survey are in fact LGBT. For the next survey using self identification instead of predetermined categories will allow for more information gathering from subjects about gender identity and sexual orientation. Questions with regard to health outcomes would be beneficial. Having a larger sample size is necessary.

Conclusions: Access to care was not a problem which is inconsistent with what the literature review stated. Respondents did not rate their physical health as poor or bad. They stated that they did not feel they were having different experiences than heterosexuals while receiving care. The majority stated that they did not experience physical symptoms based on their treatment but they did experience more negative events daily than their heterosexual counterparts. These negative experiences add stress to their everyday lives. Finally, respondents did engage in smoking and drinking alcohol at a higher rate than their heterosexual counterparts but at a lower rate than was reported for Genesee County in their 2010 Speak to Your Health Survey. Overall the experience of the LGBT population surveyed was similar to that of the heterosexual population which is inconsistent of what the literature review suggested. Future health interventions with this population should then not necessarily be focused on the care provider but on mental health including stress management and dealing with stressful situations. This was consistent with the literature.

Glossary of terms

All terms for this glossary came from the LGBTQIA Glossary of UC Davis Lesbian, Gay, Bisexual, Transgender Resource Center.

Bisexual: A person whose primary sexual and affectional orientation is toward people of the same and other genders, or towards people regardless of their gender.

FTM (F2M): Female-to-male transsexual or transgender person. Someone assigned female at birth who identifies on the male spectrum.

Gay: A person (or adjective to describe a person) whose primary sexual and affectional orientation is toward people of the same gender; a commonly-used word for male homosexuals.

Gender Identity: A person’s internal sense or self-conceptualization of their own gender. Used to call attention to the self-identification inherent in gender. Cisgender, transgender, man, woman, genderqueer, etc. are all gender identities.

Heterosexuality: A sexual orientation in which a person feels physically and emotionally attracted to people of the “opposite” gender.

Homophobia: The irrational hatred and fear of homosexuals or homosexuality. In a broader sense, any disapproval of homosexuality at all, regardless of motive. Homophobia includes prejudice, discrimination, harassment, and acts of violence brought on by fear and hatred. It occurs on personal, institutional, and societal levels, and is closely linked with transphobia, biphobia, and others.

Homosexuality: A sexual orientation in which a person feels physically and emotionally attracted to people of the same gender. This term originated within the psychiatric community to label people with a mental illness, and still appears within the current discourse, but is generally thought to be outdated.

Lesbian: A woman whose primary sexual and affectional orientation is toward people of the same gender.

LGBT: Abbreviation for Lesbian, Gay, Bisexual, and Transgender. An umbrella term that is used to refer to the community as a whole.

MTF (M2F): Male-to-female transsexual or transgender person. Someone assigned male at birth who identifies on the female spectrum.

Sexual orientation: an enduring emotional, romantic, sexual, and/or affectional attraction. Terms include homosexual, heterosexual, bisexual, pansexual, non-monosexual, queer, and asexual, and may apply to varying degrees. Sexual orientation is fluid, and people use a variety of labels to describe their own. Sometimes sexual preference is used but can be problematic as it implies choice.

Straight: A person (or adjective to describe a person) whose primary sexual and affectional orientation is toward people of the “opposite” gender.

Transgender: Used most often as an umbrella term, and frequently abbreviated to “trans” or “trans*” (the asterisk indicates the option to fill in the appropriate label, ie. Transman). It describes a wide range of identities and experiences of people whose gender identity and/or expression differs from conventional expectations based on their assigned biological birth sex.

Chapter 1: Introduction

Overall LGBT people are not as healthy as heterosexual people. Health for LGBT people is affected by stigma, discrimination and bias which undoubtedly causes them to experience lower levels of health both physically and emotionally. It is also affected by a heterosexist society and health system. These factors all create health disparities for LGBT people when compared to the straight population. However, there is no central database of health information regarding the LGBT community it is hard to pinpoint which of the above mentioned social problems is the main cause for the differences. Furthermore, of the few studies that do exist relating to the problems facing LGBT people's health, none of them include a large enough sample size or are thorough enough to shed light on the issue. The surveys that do exist are small and do illuminate some of the issues at hand but the scope is lacking. As such this study endeavors to try to fill the gaps for LGBT people in Michigan. While the social problems mentioned are decreasing in reference to sexual orientation there are still a lot of barriers to be faced. The main issues fueling the disparity are stigma, discrimination and bias by medical practitioners, psychological health professionals, and the society at large.

As with any issue, understanding the cause of the problem is the way in which to provide solutions. Unfortunately, throughout our history little funding has been devoted to understanding the complexities of LGBT health. In fact, the largest portion of research was funded solely due to the AIDS epidemic of the 1980s, not in reaction to the desire to understand more about the overall health of LGBT people. Even with AIDS raging through the community, there was naught but brief support for research and that which was done only concerned the men who have sex with men community. This is a striking illumination of the overall lack of priority that the LGBT community has received in response to their health concerns.

In response to this lack of baseline information for assessing the needs of LGBT people, the United States Health and Human Services Department surveyed a portion of the LGBT population in 2012 and found that they smoke and drink more, engage in higher risk taking activities and have overall poorer health outcomes than their straight counterparts. Studies in 2009 by Ungavarski and Grossman found that gay men have high rates of cigarette smoking and alcohol use which put them at an increased risk for secondary diseases such as lung cancer and heart disease. Studies done in 2000 and 2001 found that lesbians also smoke and drink at an increased rate when compared to heterosexual women (Harcourt, 2006). Lesbians are also more likely to be at risk for cancers because they engage in behavioral risk factors such as smoking and heavy drinking. Though there are not studies that can provide concrete data as to assess why these behaviors are more prevalent in the LGBT community, there are different theories being discussed.

Beyond engaging in what can be described as poor health choices such as drinking and smoking, Harcourt further revealed that lesbians are less likely to access preventative care such as pap smears, breast exams, and mammograms; this is partly due to not having open communication about these risk factors with their primary care provider. Patients are afraid of judgment and treated poorly. The care provider assumes that the patient desires to have sex with men when the patient she doesn't in fact participate in that type of sexual activity, or the care provider assumes that they are not sexually active and therefore are not at risk for certain conditions. The patient, fearing judgment, does not go further to disclose their sexuality and an opportunity is missed to discuss preventative care (Steele, Timmouth, & Lu, 2006). This lack of preventative health care can ultimately lead to much more serious complications such as certain cancers, STIs, and other maladies.

Though some health care providers attempt to be sensitive to their patients' individual issues, most are unaware of the unique needs of their LGBT patients. These unique needs can include examinations of infection of the anal canal, pain management after genital reassignment surgery, and fertilization therapies for lesbian and bisexual women (Dean et al., 2000). This lack of education and even just simple awareness, breeds ignorance and can further detract from a patient's overall health experience. In response to the information about lack of care the Health and Human Services department has developed specific goals in their Healthy Communities 2020 initiative to address improving health outcomes for LGBT community including cultural competency training for health professionals, outreach to medical professionals who are LGBT, and addressing discrimination, harassment and violence.

Transgender people face even more unique circumstances because of even less support and research. For instance some doctors refuse to treat transgender patients because of misinformation and fear-based bias. As a direct result of this discrimination many transgender people go without any medical care at all. Even when care is possible, transgender people's insurance often exclude transition-related care despite the American Medical Association stating that care related to transition is medically necessary (Molon, 2012). Although some lesbian, gay, and bisexual people may face discrimination, nearly all transgender people do and are more likely to have poorer health outcomes because they have no options when it comes to health care.

In reaction to all these startling facts, the purpose of this thesis is to illustrate how the health of LGBT persons is affected by stigma, discrimination, and bias within the LGBT community. This study addresses the following research questions:

- How was the LGBT person treated differently than other heterosexual people?

- What were the health outcomes as an LGBT person? Were they more negative because of the stressors of being LGBT?
- What maladaptive behaviors do LGBT people engage in?

In doing this study the results will illuminate the current status of LGBT people within the health care system. Their experiences will provide the groundwork for addressing the problems inherent with the care or lack thereof they are receiving.

Chapter 2: Literature Review

Research regarding health disparities suggests that there are several factors that can affect LGBT health outcomes. These include stigma, lack of a primary care provider, maladaptive behaviors and heterosexist bias within the health care setting. To look at these factors more in depth takes a deeper look into the current landscape of LGBT health and to be able to make the most improvements possible to everyday life.

Discrimination and Bias through Health Care Practice and Treatment

People who do not meet expectations of traditional sex and gender presentation are likely to have elevated risk for health problems including discrimination when seeking treatment (Lombardi, 2001). Routine care and screenings are not being offered. If a patient is a lesbian it does not mean that they do not need to have routine pap screens and STI testing. Issues come into stark relief for transgender patients and how much of their routine care may be ignored due to discomfort of the medical professional and the patient not knowing to advocate for themselves or feeling comfortable to do so. LGBT patients may feel increased discomfort or stress when being in an examination depending on if their provider is open and non-judgmental, what questions they are being asked, and state of dress depending on the type of examination (Kimmel, 2003). When LGBT people feel like active decision makers and that their health care provider is non-judgmental of their sexual identity they receive better care.

Bias within health insurance and public entitlements afforded to heterosexuals are significant barriers keeping LGBT people from accessing health care. This bias prevents coverage for LGBT partners and does not provide any reimbursement for procedures that are needed by this population; such as fertility services or surgical procedures (Dean et al, 2000). Relationships are not recognized unless the partners are married in most cases. In most cases

LGBT people are not legally allowed to marry, and that domestic partner benefits are only available to some same-sex couples and this prevents inclusion on each other's insurance.

Gender and Sexual Self-Identification and Impact on Health Services

Gender and sexual self-identification are important when working with a health care provider in order to receive the best care possible. It is important to share all health history in order for the provider to have the most information possible to make the best health decisions for the patient. However, as previously explored, there are reasons why patients would not feel comfortable sharing gender expression and identity information with their health care provider.

Gender identity and expression takes many forms. Sometimes a person identifies as transgender. Being transgender has many different forms and each person has very different experiences. These differences in gender expression mean that the needs of transgender patients are going to be different than those of a heterosexual population.

Sharing gender and sexual identification help a health care provider tailor to an LGBT patient's specific health requirements. A lesbian patient may need to be counseled differently on pregnancy services. Having a patient who is transitioning from a man to a woman may require more information about breast cancer and drug interactions than the average patient needs. Not every patient has the knowledge to inquire about different screening needs. While the medical field has lack of information about transgender people need there are even misconceptions among transgender people. An example from researchers, Dhand and Dhaliwal's study of transgender people in 2009 illustrates the cognitive disconnect between body representation and health needs. They found that the "...patient displayed a complex identity construction. Her social identity was feminine highlighted by her preference for a female name and female body signifiers, including her silicone breasts, hip padding, and choice of clothing. At the same time,

she self-identified her chest as a “male chest” that she believed provided immunity against breast cancer. Therefore her female social identity and her male biological identity were dissociated when the patient was evaluating her risk for breast cancer.” This shows that even transgender individuals are unsure of what their risk is and what preventative care applies to them. This is not just an area of informational need for medical providers but also people themselves. There is a lack of research on self-identification and its implications on health which is why more research is necessary.

Stigma and its Impact on Mental Health

The effect that societal stigma has on people has been researched in regards to how it manifests itself in mental health, substance abuse, and pursuit of medical assistance of the LGBT population. Stigmatization and marginalization from the culture as a whole can affect LGBT peoples' health because of violence, psychologically, and physically due to stress in everyday living and services available to this population are constrained (Bettcher & Lombardi, 2002). The majority of the research highlights that stigma prevents the pursuit of assistance with mental health. LGBT people fear that they will have a negative experience and or that they will be judged for their sexual orientation or gender identity fuels their fear of obtaining necessary services.

Homosexuality as a mental disorder was removed from the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) in 1973 (Dean et. al 2000). The DSM-IV still classifies transgenderism and transsexualism as a gender identity disorder. Separation into clinical otherness facilitates a lack of trust between patients and professionals. This is extended not only to relationships between patients and professionals but also to interactions through everyday life, such as maintaining a job or going to school. Ninety-seven percent of transgender people report

mistreatment at work as a result of their gender identity or expression according to a study by the National Gay and Lesbian Task Force (Krehely, 2009). The stress associated with everyday existence as a person who does not follow the heterocentrist paradigm has been shown to increase suicide risk, increase substance abuse, and an increase in mental health issues. This has been substantiated by several studies ranging from the 1980s through the 1990s. The United States Office of Health and Human Services issued the following statements about how they plan to address disparities in LGBT health.

- Encouragement of new and updated training for health professionals which will include behavioral health programs and LGBT cultural competency.
- Create professional groups to represent LGBT health providers and students to identify opportunities and challenges for those LGBT trainings.
- Develop LGBT cultural competency goals.
- Continuing to address discrimination, harassment, and violence against LGBT individuals with both domestic violence and other violence programming.
- Create stronger focus on LGBT youth with all anti-bullying initiatives and make resources to schools more available and accessible.

Having updated training materials for health care professionals with regards to behavior and cultural competency will help to eliminate misinformation and negative attitudes about working with LGBT patients and families. This will help to eliminate stigma and the association of the LGBT community with some illnesses and behaviors. With the removal of stigma there will be a lessening of stress on people who are part of the LGBT community. Lessening of stress will lead to better mental health outcomes and it will decrease the dependence on maladaptive behaviors in order to cope with everyday living.

Heterosexual Bias in Health Care Services

Through survey data from the Gay and Lesbian Medical Association it has been shown that doctors are uncomfortable with sexually diverse patients and do not understand that medical history documents, new patients forms, and other paperwork need to include options for gender as well as information about sexual orientation. This paperwork sets the tone for how the patient feels in regards to that doctor's medical facility. The lack of inclusiveness and heterosexist bias within intake forms can keep patients from coming out to their medical professional and not getting the preventative treatment and screening they need. Self identification by the patient gives more information than simple check box intake forms that separate male and female. With complete knowledge of their unique needs, a doctor can recommend proper preventative services. Some authors have noted the importance of the doctor-patient relationship in aiding the care of sexually diverse people, and they have found that keeping confidentiality leads to a more trusting relationship. When working with sexually diverse people, professionals should be aware that LGBT people have contributing factors to their poorer health outcomes; they need to provide support as well as health care.

A survey of members of the Gay and Lesbian Medical Association (GMLA) found that 67% of respondents believed LGBT patients were receiving unequal care because they had not shared their sexual orientation with their medical provider. Reports made by lesbians and gay men state that their doctors lack knowledge and sensitivity regarding the health risks and needs of the LGBT population.

Reviewing this section illustrated the issues of not having education on dealing with issues associated with LGBT patients, and how because of this lack of education and information gaps in care start to emerge. Heterosexual bias also keeps LGBT people from having their loved

ones with them in the hospital and making their medical decisions because they are not seen as important.

Discrimination toward Partners in Health Care

People who identify as lesbian, gay, bisexual, and transgender along with their partners are at an increased risk of secondary victimization, which is when a partner of the patient is denied services or courtesies that a heterosexual partner would have. This includes hospital visitation and lack of recognition from social workers or victim assistance programs. This treatment only emphasizes for the couple their difference and lack of support within the health care and social work systems (Garnets, Herek, & Levy, 2003). In response to these issues, the Health and Human Services Department has created new policy for partners seeking to support each other in the hospital and the Centers for Medicare and Medicaid Services (CMS) has increased enforcement of same-sex couples rights. They have clarified that same-sex couples have the same rights as their heterosexual counterparts, including hospital visitation and naming representatives to make medical decisions on a patient's behalf ("Equal Rights for LGBT Americans," n.d., para. 2). Partners of people on Medicaid or Medicare will have the ability to have visitation and allow for power of attorney in making medical decisions. It is the hope that with the laws of domestic partnership and marriage for same-sex partners that recently passed in Vermont as well as a few other states that there will be protections for partners, and people of other LGBT identities. A heterosexual couple that has been married for a few days have more rights for visitation and medical decision making than a homosexual couple that has been in a committed relationship for 50 years.

Discrimination and Bias Connected to Maladaptive Behaviors

The Center for American Progress found that high stress from harassment and discrimination, low rates of insurance coverage, and lack of cultural competency, all put LGBT people at an increased risk for health issues and maladaptive behaviors. They are more likely to drink alcohol, smoke, use recreational drugs (HIV, 1997). Research suggests that drinking alcohol and smoking cigarettes are the most common sources stress relief for LGBT people. Northeastern University's Institute on Urban Health Research did a study in 3000 and found that gay men and women were more likely to be current smokers compared to their heterosexual counterparts.

Health Belief Model – Barriers to Accessing Care

The health belief model is a system used to suggest why a person would or would not access health care. It is made up of four different parts: severity of potential illness, susceptibility of contracting that illness, the benefits of engaging in preventative action/care, and barriers preventing that action. This model helps to explain why LGBT people would not receive preventative care for illness; barriers to access care are too high to overcome.

As previously discussed there are many barriers to care for LGBT people; discrimination and bias, stigma, as well as gender identity and sexual identity. Lack of doctors willing to work with transgender and homosexual couples and fear of judgment prevent LGBT people from wanting to go in to receive care. (Citation) There has been shown that there is a lack of cultural competency with regards to the LGBT population. This is a significant barrier to accessing preventative care. If, as most people believe, they have little susceptibility to illness and there are the large barriers to accessing care the benefits to accessing that care seems minimal in relation to the large barriers that will have to be overcome.

For example the perceived risk of cervical cancer for a male to female (MTF) patient would be low. The patient believes that because they are not living as a man, their prostate cancer risk would be minimal. The doctor, if unaware of the patient's history, would suggest a cervical screening, a test that would be unsuccessful. A MTF patient having undergone a vaginoplasty and because they are woman would not necessarily think of needing a prostate screening. These patients are not considering themselves as risk because those conditions do not connect with their physical presentation. They are still at risk for these issues because they still have the biology to make these health conditions possible. This is also convoluted by body dysmorphia and the possibility of routine screenings to be psychologically traumatic for the patient.

The example above is for a transgender patient but barriers exist for all LGBT people. "Barriers to care for LGBT people include systemic bias in health insurance and public entitlements, which routinely fail to cover gay and lesbian partners or to provide reimbursement for procedures of particular relevance to LGBT populations (e.g., fertility services to lesbians, surgical procedures required by transsexuals)" (Dean *et al.*, 2000). Currently the barriers outweigh the benefits of accessing care for LGBT people.

The hope is that after addressing barriers such as stigma, bias, discrimination, and lack of self-identity that the barriers will become minimal and that there will be an increase in access to care, especially for preventative measures.

Chapter 3: Methodology

Subjects:

There were 156 respondents to the survey conducted. Respondents to the survey were all adults over the age of 18, median age being the 25 – 34 age bracket with 47% (n=74).

Respondents were recruited from the state of Michigan. The study was approved for human subjects by University of Michigan-Flint's Internal Review Board. Eligibility criteria included being at least 18 years of age, and consent to participating in the survey.

Recruitment:

Survey respondents were found through a variety of sources. They were invited to participate in the study through word of mouth, email, and through a Facebook event. An email was sent out to LGBT organizations and the students of University of Michigan-Flint. In the email there was a link to the survey which led through to consent page. These methods were used because LGBT people are not a static category. The information wanted was regarding the entire LGBT population of Michigan. The speed of electronic mail and social media was needed in collecting data of the target population.

Design:

The design was a cross sectional study. The limitations of a cross sectional studies are that it is just a snapshot in time. It does not allow for a life history of the respondent. The lack of life history of a respondent means there is no data for comparison for the same question at different times in that respondent's life. The sample was a sample of convenience. An anonymous online survey was utilized.

Survey Development:

The questions on the survey were a conglomeration of different surveys. such as The Behavioral Risk Factor Surveillance (BRFSS), National Co-morbidity Survey and Epidemiologic Catchment Area (NCSECA), were combined to provide the most detailed picture possible of what was lacking and what issues were apparent in LGBT health care services. The survey asked a variety of questions related to physical, mental, and emotional health and how those areas manifested themselves in behaviors and what coping mechanisms, if any, were used. The survey was posted using the Qualtrics program available for use by University of Michigan students. Qualtrics is a program that allows for the survey to be completed online after the respondents provide informed consent. Subjects were assured during informed consent that their responses would remain confidential and anonymous in order to get the most information possible.

The criteria for filling out the survey were that the participant must be a resident of Michigan and be at least 18 years old or older. Due to time and budget constraints, a snowball sample was used utilizing LGBT centers and communities at universities because they are a static group and are easily contactable. Students at Michigan colleges and universities also had the opportunity to spread the survey to friends and other people they know through social media outlets (e.g. Facebook, Twitter, and email). The way in which the survey was dispersed was not meant to prevent people older than traditional college age (18 – 23) from filling out the survey, rather, it was a sample of convenience. The survey was not limited only to LGBT respondents because of the trouble of getting information from people who do not self identify as LGBT but engage in same sex relationships and sexual encounters.

The IRB application was accepted in March 2011 after edits were made to the recruitment letter. The survey was left open for two months, the end of April to the end of June,

to allow for the most possible responses. The responses were then analyzed using Qualtrics software. The information obtained from that analysis can be found in the presentation of the data.

Analysis:

After closing the survey to responses the information was collected and analyzed using the program used to create the survey, Qualtrics, provided by eResearch at the University of Michigan – Flint. Qualtrics is an online survey platform that allows you to collect information anonymously. The system was chosen for its ability to give an initial report of the data. A descriptive summary of the data was used looking specifically at experiences at the doctor, self identification, physical symptoms of stress, and maladaptive behaviors. The descriptive data was summarized and frequencies were looked at for comparison. Answers to questions were also compared to each other to see the incidence of complaints, such as with negative health experiences at the doctor or negative physical symptoms of stress. Though this process was the best choice it does have some of the limitations of using only descriptive summaries; are mainly, that it can't be compared to national data. The survey also didn't have enough of a minority sample. Also the number of responses was small. Data collected about smoking and drinking behaviors were compared with national LGBT data as well as Genesee County data.

Chapter 4: Presentation of Results

Demographics

There were 157 respondents; one was eliminated because they were under the age of consent. There was a wide age range but the majority of respondents were ages 25 – 44. Most of the surveyed, 32% (n=50), stated that they had some college. Eleven percent of the subjects had completed a 2-year degree, 31% (n=49) completed a 4-year college degree and 18% (n=29) earned a Master’s degree. Ninety-four percent (n=147), were from Michigan. Of the total subjects, N=156, thirty three percent (n=51) made less than \$30,000/year. Other responses were 12 – 13% for \$30,000 – \$100,000 or more (n=56). Subjects identified as white 94%; (n=147). African American and Hispanic subjects were tied with 4% (n=7), respectively. There was one subject who identified as Asian (1%), 4 who identified as Native American (3%), two as Pacific Islander (1%), and 3 who specified other (2%). The overwhelming majority of subjects self-identified as female, 75% (n=118) with the second most being male at 18% (n=29) and 17% of respondents self-identified as another form of gender presentation.

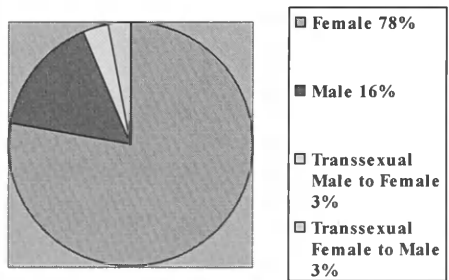
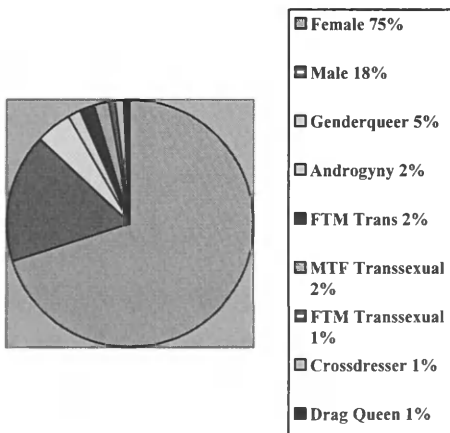


Figure 1 – Current Gender Self-Identification Figure 2 – Current Gender, Categories Predefined

Comparing Figure 1 Current Gender Self-Identification and Figure 2 – Current Gender, Categories Predefined, the question asked with predetermined categories is compared to the answers when the respondents were given the ability to self-identify. When the option to self-identify is taken away additional data is lost about the respondents. When the option to self-identify is available more information is presented for their health practitioner. The total percentage now adds up to more than 100 percent because respondents are able to identify themselves with multiple categories. For example, a person could identify as a transgender male to female who is also identifies as straight in terms of their sexual orientation.

Sexual Orientation

Respondents were asked the gender of their sexual partners. Of responses 45% (n=70) stated only men, 34% (n=54) stated only women, and 21% (n=33), stated both men and women. The next question asked whether the surveyed population ever engaged in same-sex/same-gender sexual behaviors. The majority, 68% (n=107), responded with yes, and 32% (n=50) indicated that they did not engage in same-sex/same-gender behaviors. Respondents were asked if they were currently engaged in same-sex/same-gender behaviors, this changed the way information was divided. Respondents stated yes at 43% (n=68) and 57% (n=89) stating no, they were not currently engaged in same-sex/same-gender sexual activities. Finally the last question in the series asked whether they had engaged in sexual behaviors at all in the last year. The majority said that yes, they had. Table 1 reviews how people identified themselves using predetermined categories to express their sexual orientation.

Table 1 – Sexual Orientation Identity

	Sexual Identity	Response	%
1	Gay	17	11%
2	Straight/Heterosexual	69	44%
3	Lesbian	36	23%
4	Queer	19	12%
5	Bisexual	34	22%
6	Other, please specify	8	5%

Respondents were asked to mark all identities that applied. This is why the percentages add up to more than 100%.

Sexual Orientation, Day-to-Day Life and Health Care

The next questions examined how sexual orientation actually affects experience either in health care. Respondents were asked whether or not they believed that they were treated worse or the same in a health care setting because of their sexual identity. When looking at sexualities other than straight, those who felt they were treated worse than other identities totaled 26% (n=24), the same as other sexual identities totaled 33% (n=31), better than other sexual identities totaled 12% (n=11), and I don’t know or I’m unsure totaled 28% (n=26). Comparing this to how heterosexuals felt 1.5% (n=1) heterosexual felt they were treated worse than other identities, 64% (n=42) felt that they were treated the same or better and 33% (n=22) didn’t know or were unsure. This question did show that a significant percentage felt that they were treated worse than other patients because of their sexual identity.

Additionally non-heterosexual respondents were asked whether they experienced physical symptoms (physical symptoms were defined as headache, upset stomach, tensing of muscles, or increased heart rate) based on their treatment because of their sexual identity; 56% (n=52) of respondents answered “never”, less than once a month 22% (n=20), once a month 7% (n=6), 2 – 3 times a month 8% (n=7), once a week 1% (n=1), 2 – 3 times a week 5% (n=5), and

finally daily 1% (n=1). Eighty-six percent of heterosexual respondents stated that they never experienced and physical symptoms as a result of their treatment.

Taking this information into account, non-heterosexual subjects stated that their health status in general was bad or poor (7%; n=7), neither good nor bad (9%; n=8), fair (20%; n=18), good (45%; n=41), very good (19%; n=17).

Finally they were asked about the experiences they had because of their sexual identity, this is everyday day experiences and not experiences in a health care setting. Fifty-eight percent of LGBT people stated they had been insulted or humiliated more than once, seven stated they had experienced sexual assault more than once. Most stated they had never been hit, pushed, or assaulted 48% (n=75) nor had they had their property damaged 43% (n=67). Seventy-nine percent (n=124) stated that they had never been the victim of a sexual assault or rape (see table 2).

Table 2 - Negative every day experiences based on sexual orientation, checked all that applied

Experienced at least once	Heterosexual Respondents	LGBT Respondents
Violence/Intimidation	7% (n=11)	24% (n=37)
Physical Violence	3% (n=5)	10% (n=16)
Threats of physical violence	5% (n=7)	19% (n=30)
Verbal abuse/name calling	10% (n=15)	42% (n=66)
Sexual Assault	6% (n=9)	11% (n=17)
Property Damage	2% (n=3)	15% (n=23)

Gender Identity Health Care Experience

Respondents were asked if they felt they had better, same, or worse experiences with health care because of their gender identity. Now thinking about seeking health care, do you feel your experiences were worse than, the same as, or better than people of other gender identities? Most respondents stated they either felt they had better experiences, 38% (n=59) or didn't know/weren't sure about how their experiences rated compared to others, 31% (n=49). When

asked how many days they felt any physical symptoms as a result of how they were treated based on their gender identity 76% (n=120) stated that they never had felt physical symptoms as a result of how they were treated (see table 3).

Table 3 – Health Care experience because of gender identity

#	Answer	Response	%
1	Worse than other gender identities	18	12%
2	The same as other gender identities	30	19%
3	Better than other gender identities	59	38%
4	Don't know/Not sure	49	31%
	Total	156	100%

Health Conditions: Mental Health and Physical Symptoms

Of the respondents only 9% (n=13) experienced physical symptoms weekly or had more negative occurrences because of experiences connected to mistreatment regarding gender identity. 76% (n=120) of subjects reported never having any occurrence of physical symptoms based in their experience and treatment because of their gender identity. The majority of respondents were heterosexuals.

LGBT respondents were asked about their mental health in the past 30 days and to state how many days would they say that their mental health was not good. Mental health includes stress, depression and problems with emotions. The range of responses went from 1 – 2 days 16% (n=15), 3 – 4 days 19% (n=17), 5 or more days 42% (n=39), don't know/not sure 1% (n=1) and finally my mental health was good during the past 30 days 26% (n=18). Another question requested information about how many days in the last month was their physical health was rated not good? This was LGBT respondents. The majority of answers were either 1 – 2 days (n=53) 34% or my physical health was good in the past 30 days (n=51) 32%. Three to four days was at

13% (n=20) and five or more was 17% (n=27), don’t know or unsure had the fewest responses with 4% (n=6).

Maladaptive Behaviors, Alcohol and Cigarette Use

Table 4 – Drinking Behaviors by Sexual Orientation

Number of drinks in the past 30 days	Heterosexual Respondents	LGBT Respondents
No drinks	12% (n=8)	15% (n=14)
1 – 2	39% (n=26)	35% (n=32)
3 – 4	32% (n=21)	31% (n=28)
5 or more	17% (n=11)	19% (n=17)

Alcohol consumption is one of the ways people choose to self medicate as a response to stress; this was discussed earlier in the section dealing with discrimination and stigma. The numbers are comparable between heterosexuals and LGBT respondents. Of the heterosexual subjects responding to this survey, 17% (n=11) said that they had 5 or more drinks in the past 30 days; 32% (n=21) stated having 3 -4, and 39% (n=26) stated having 1 – 2. Comparing these numbers for those of the LGBT population 19% (n=17) said that they had 5 or more drinks in the past 30 days; 31% (n=28) stated having 3 -4, and 35% (n=32) stated having 1 – 2. These numbers disagree with what the literature review suggested. A smaller percentage of LGBT individuals drank compared to the heterosexuals surveyed. Of the heterosexual subjects, 12% (n=8) stated not having a drink at all in the past 30 days and 15% (n=14) of the LGBT population had not ingested alcohol. These numbers are pretty comparable.

Another coping behavior explored is smoking cigarettes. The number of heterosexual subjects that stated that they smoke is 11% (n=7) while 24% (n=22) LGBT respondents indicated that they currently smoke. Respondents were also asked about the last time they smoked regularly to see if they had recently quit smoking or if it had never been a maladaptive behavior

they engaged in. Eleven percent (n=7) of the heterosexual respondents stated that they had tried to quit smoking in the past month while 20% (n=18) of the LGBT respondents had tried to quit. For both groups the data was similar.

Routine Health Care and Health Insurance

LGBT subjects were asked how long it had been since they had received a routine check up or exam. The reason it was asked was to surmise whether there was not a routine check up because of lack of access due to lack of health insurance or because the respondents did not have a doctor to see.

Table 5 – Health Care Coverage

Have Health Care Coverage	Heterosexual Respondents	LGBT Respondents
Yes	37% (n=58)	47% (n=73)
No	4% (n=7)	11% (n=17)
Unsure	0% (n=0)	1% (n=1)

Missing data of 3 respondents

Of the LGBT sample 47% (n=73) stated that they had some form of health care coverage and 11% (n=17) stated that they had no health care coverage at all.

Table 6 – Access to Routine Care

Time since last routine visit	Heterosexual Respondents	LGBT Respondents
Within the past year	29% (n=44)	36% (n=55)
Within the past 5 years	9% (n=14)	16% (n=24)
5 or more years ago	4% (n=6)	6% (n=9)

Missing data of 4 respondents

Of the 47% (n=73) with health care coverage only 36% (n=55) stated that they had gone for a routine check up in the past year. Sixteen percent (n=24) have gone within the past 5 years, six percent (n=9) went 5 or more years ago or weren’t sure when exactly the last time they went to the doctor. Respondents were also asked if, during the past year, cost was ever a factor in not going to the doctor. Seventy-five percent (n=66) said no, while 27% (n=25) said that yes.

Twenty-two percent of LGBT respondents and thirteen percent of heterosexual respondents have not gone to the doctor in the past year but they also stated that cost was not a factor in not going.

Primary Care Provider

Looking at cost as a factor, the question was also asked what kind of doctor provided the majority of their care.

Table 7 – Primary Care Provider; check all that apply

What type of doctor provides the majority of your health care?	Heterosexual	Other
Family Practitioner	72% (n=47)	70% (n=64)
Emergency Room/Urgent Care Physician	8% (n=5)	9% (n=8)
Nurse Practitioner	0% (n=0)	9% (n=8)
Internist	5% (n=3)	3% (n=3)
Other	11% (n=7)	7% (n=6)
Don't Know/Not Sure	5% (n=3)	2% (n=2)

Family practitioners had the highest percentage with 70% (n=64) saying they were seeing them for their primary care. Emergency rooms/urgent care at 9% (n=8), other 7% (n=6), other in this instance being an OB/GYN or Planned Parenthood, chiropractor, acupuncturist, physician assistant at the Urban Health and Wellness Center (a local health center that works with low-income people), cardiologist, or some form of walk-in clinic facility. Nine percent (n=8) of respondents go to a nurse practitioner, 3% (n=3) go to an internist, and finally 2% (n=2) aren't sure exactly who they go to. The majority of subjects stated that they have one person of whom they think as their personal doctor or health care provider 75% (n=68) while 25% (n=23) felt that they did not have one person they thought of as their primary care provider. The numbers don't look very different when the LGBT population is compared to the heterosexual population. Respondents for the majority have someone they receive routine care from.

Interaction with Health Care Provider

The LGBT respondents were asked to rate their experience seeing that doctor, as fair, good, or very good. The majority LGBT respondents stated their experience was good or very good data shows, Poor made up 3% (n=3), Neither Good nor Bad was 11% (n=10), Fair was 20% (n=19), Good was 39% (n=36), and finally Very Good at 28% (n=26). In the information provided in the literature review it was expected that more respondents would state that they had either a very bad, bad, or poor experience when they went to see a health care professional.

Most respondents, 62% (n=96), were not sure whether their doctor would be considered transgender friendly, yes was 21% (n=32), no was 4% (n=6) and the rest stated that they did not have a regular doctor. Respondents stated whether they considered their doctor to be knowledgeable about transgender people; yes 12% (n=19), no 12% (n=18), don't know/Unsure was the highest with 63% (n=98), and again some subjects stated that they did not have a regular physician they saw.

Recommendations

When looking at items that were important for subject's health care providers to have, the responses were pretty evenly divided between unisex bathrooms, already educated on transgender issues, willingness to prescribe hormone therapy, and has "transgender" listed on new patient intake forms. The highest percentage of responses was for willingness to work as part of a team to assist with health needs with 78% (n=95) and willingness to learn about trans-issues at 49% (n=60). Some other suggestions that subjects specified included: improvements in bedside manner, women's health, someone who doesn't judge health based on first appearances, knowledgeable in his/her field of medicine, friendly, professionalism and thoroughness, being called by the right name and pronouns, familiarity with LGBT issues and health concerns, competence and caring about people, LGBT friendly, and respect.

Chapter 5: Discussion of Results and Conclusions

Self Identification and Health Care

There is a difference in information illustrated on Figures 1 and 2 allowing respondents to have ability to select how they identify and having to pick between four different categories, a lot of nuance in the subjects is lost. This could be a loss of important information for doctors and health educators in the treatment setting and it would behoove those individuals to think of broadening these demographic categories.

The information provided in Figure 1 indicated the need for additional categories, because of the frequency of the use of the category of "other". "Other" most often meant either pansexual or asexual. This information makes it important to realize that two important groups need to be added to the next survey of this subject group; asexual and pansexual. Definitions of these identities should be discussed and provided to health care personnel in order to best serve their clients and understand their specific health requirements and needs.

The categories used in the question about having sexual intercourse with someone of the same or different gender did not take into account transgender people. There was difficulty arranging this question for transgender subjects because it depends on how they identify. For example they could have engaged in both depending on whether they identified as man or woman at the time of the sexual encounter. The identification issue was overlooked when putting together the survey and would need to be adjusted in the future use of this survey for data gathering.

The literature research illustrated that health is impacted by stigma, discrimination, and bias for LGBT persons. The data gathered with the survey does not illustrate this same impact. For some respondents their health was indeed impacted but the majority stated that they felt that

they were getting adequate care. They were not experiencing physical symptoms based on their experiences in everyday life. However they were experiencing stress as a result of the negative day-to-day interactions they experienced. They felt that their doctor's were knowledgeable. There did not seem to be a problem with the cost of care or of having insurance. Regardless, the health community can be more educated on their patients by asking more questions. They can have more information about sexual minorities as well as be aware of the mental impact of being LGBT. The surveyed said they wanted someone who has good bedside manner and is was willing to listen.

Comparing LGBT and Heterosexual Experiences

The majority stated that they did not feel that they were treated differently than other sexual orientations in health settings or in everyday life. Few stated that they experience physical symptoms based on how they were treated. They did not feel like they were having poor experiences when they received health care. This is not what the literature suggested. It could be possible that LGBT people in Michigan are being treated better than national data suggests or that the patients may not know that they are being treated differently or not receiving information. In fact Kathleen Sebelius from the Health and Human Services Department stated that national goals should to be to improve cultural competence among health care providers. Center for American Progress found that “due to factors like low rates of health insurance coverage, high rates of stress due to systematic harassment and discrimination, and a lack of cultural competency in the health care system, LGBT people are at a higher risk for cancer, mental illnesses, and other diseases, and are more likely to smoke, drink alcohol, use drugs, and engage in other risky behaviors” (Krehely 2009).

My study was not consistent with the literature in these areas. Information gathered from subjects which did not suggest that there was a higher incidence of lack of health insurance coverage. Many subjects felt they received good care and felt that they had a person who they thought of as their regular health practitioner. Respondents were asked whether they were treated better, the same, or worse than heterosexual patients. The results of this section stated that most respondents did not believe they were treated any differently than other sexual identities; they felt they were either treated the same, better, or were unsure/didn't know. Additionally respondents were asked whether they experienced physical symptoms (physical symptoms were defined as headache, upset stomach, tensing of muscles, or increased heart rate) based on their treatment because of their sexual identity; 56% (n=52) of LGBT respondents answered "never." The experiences between heterosexual and LGBT respondents were comparable excluding the stress of dealing with negative day-to-day experiences such as being threatened. The way to cure such issues is a change in the overall perception of LGBT people as a whole. Other than a change in the perception of LGBT the only other suggestion is to help LGBT people cope with this stress in a healthy way.

LGBT Respondents and Maladaptive Behaviors

Close to a quarter of LGBT respondents indicated that they currently smoke. Respondents were also asked about the last time they smoked regularly to see if they had recently quit smoking or if it had never been a maladaptive behavior they engaged in. Twenty percent (n=18) of the LGBT respondents had tried to quit in the last month.

The Genesee County rate of smoking is 39% according to the 2010 Speak to Your Health survey. This number is significantly more than the quarter LGBT respondents that reported smoking. Nationally the CDC states that 19.3% of people over 18 years of age are smokers, a

number less than the 20% of the LGBT community who stated they smoked regularly. This suggests that smoking is not just an LGBT issue but also an issue in the Genesee County area as a whole. Smoking cessation programs should be targeted at both heterosexual and LGBT populations. One positive is the law change in Michigan requiring smoking to stop. Bars are areas for LGBT people to meet and have peer support.

Alcohol is not the preferred way of dealing with stigma of choice to deal with discrimination and stigma. However looking further into drinking behaviors is important. The survey data on drinking is inconsistent with what the literature review suggested. The total number of respondents who engaged in drinking behavior was 85%. This is the same number that Speak to Your Health 2011 data had, that stated 85% of the population engaged in regular drinking behavior. The data between heterosexuals and LGBT people is comparable to each other. Despite the congregation of LGBT around bars they do not drink with more regularity than their heterosexual counterparts. Any sort of negative health impacts from drinking will be happening at the same rate for both populations. This is a high rate of drinking behavior for all populations so all health interventions should again address the whole population.

Health Outcomes of LGBT Respondents

Alcohol consumption is one of the ways people choose to self medicate as a response to stress; this was discussed early in the section dealing with discrimination and stigma. Drinking behavior however is comparable between the heterosexual and LGBT respondents. What is surprising is (the number who stated that they did not consume alcohol at all in the past 30 days. Of the subjects, 14% (n=22) stated not having a drink at all in the past 30 days.

Another maladaptive behavior explored was smoking cigarettes. The number of subjects that stated that they smoked was 19% (n=29) total respondents; those currently not smoking

cigarettes were 81% (n=127). Exploring the percentages more, those who were still smoking (20%, n=31) had tried to quit smoking or stopped smoking for a day or more in attempts to quit smoking and 9% (n=14) hadn't attempted to quit.

Taking this information into account, subjects stated that their health status in general was fair, good, or very good. This information is of importance because it indicates that respondents do not feel that they are unhealthy for the majority even if they are engaging in maladaptive behaviors. This is again is inconsistent with the literature which suggested that LGBT people would feel their health status as negative or poor. Respondents were asked about their mental health in the past 30 days and to state how many days they would say that their mental health was not good. Mental health compared to physical health was very different. Overall poor mental health experiences were the majority with over half having at least 2 days of poor mental health in the past 30. This is consistent with the literature review which stated that stress, stigma, and bias all negatively impacted mental health for the LGBT population. Taking all this information into account future health interventions should focus on mental health and coping with stress. The responses show this as the primary area of need for the population. Mental health is an area with stigma in and of itself so combating that stigma and having more health providers and mental health providers who are comfortable working with LGBT patients is a necessity.

Health Belief Model

The perceived barriers of accessing health care seemed not to be as present in the data gathered. Respondents stated that they were getting adequate care. The perceived benefits of getting health care seem not to be affected in this survey. Of respondents the majority of respondents went to the doctor within the last year and stated that they had someone they thought

of as their personal doctor or primary care provider. Over half rated their experience with their regular health care provider as good or very good.

Perceived susceptibility and perceived severity do not seem to be factors influencing access to health care with these subjects either. Their susceptibility to illness does not seem to be altered one way or another by their sexual orientation or gender identity. They receive care as needed as illustrated with the results of the question about how often they go to the doctor. The severity of treatment is also not something of consequence because again the majority of subjects stated that they had positive experiences with their primary care provider. As far as respondents are concerned, the data stated that doctors were available and that there was no bias or discrimination keeping LGBT people from accessing the care that they needed. Nor were they being treated in a way to prevent them from wanting to receive that care.

Limitations

1. Psychometrics weren't done, all analysis was conducted with descriptive analysis, this was because the majority of subjects were heterosexual and further analysis would be difficult with such a small sample size. It would be best in the future to have a screening question to identify as to whether they were a member of the LGBT community as the majority of respondents to this survey were heterosexual.
2. All analysis conducted utilized descriptive statistics so therefore you can see no correlations could be discovered.
3. Sample was not a diverse sample because there were not enough LGBT participants.
4. Small sample size which made it difficult to do within group comparisons.

5. Questions were not worded in a way to answer the overall questions. Only asked about two aspects of health so overall health outcomes were difficult to measure.

Made assumptions based on what data was collected.

6. The survey allowed people who identified as straight but engaged in same-sex behaviors to participate. This was to find any hidden populations for further analysis. It was asked whether they engaged in sex acts with only men, only women, or both men and women. It was believed that they would understand the gender identity of their partners. This does not take into account people who feel they do not fall into either category which was an error when creating the survey.

After completing the research and analyzing the data, the results illustrated where there needed to be some changes before using the survey again. The results illustrated most respondents were White/Caucasian. This showed a lack of diversity among subjects and was something that will need to be addressed in future research. This lack of diversity made it hard to apply this data to other areas and use as a guide to change practices across the country. The ideal would be to have a larger response pool in order to have the most complete analysis of information and be able to have a larger basis for suggestion for treatment of LGBT individuals within the health care area.

The issue of self identification was overlooked when putting together the survey and would need to be adjusted in the future use of this survey for data gathering. For example, perhaps a person would no longer identify as transgendered if they are finished with their transition. Or a person could identify as bisexual earlier in their life but have been in a monogamous homosexual relationship for the past 5 years. Those types of responses would also alter how to tailor health information and future questionnaires. Allowing people to self-identify

allows for more understanding of the risk factors with the assumption that the health practitioner understands the labels being used and that patients can identify in multiple ways.

There were a large number of heterosexual people who filled out the survey. This calls into question the results because the actual response pool of lesbian, gay, bisexual, and transgendered people is so small that the data gathered may not be representative of the whole state of Michigan.

Conclusions:

It is important to know that a lot about a person's health history can be missed when they are not given the ability to self-identify on intake paperwork. Also, inclusive paperwork sets the tone of a doctor's visit. If it allows for self-identification, the office portrays that it has had at least some cultural competency training and is prepared and welcoming to an individual who does not fall into a predefined category of gender. In the future it would be best to have a filter question asking about sexual orientation and also to have a much larger sample size in order to gain more substantial information about the LGBT population in Michigan and their experience.

What information that was gathered from this surveyed stated that access to care was not a problem, physical symptoms did not appear in the population based on treatment and respondents did engage in drinking alcohol at the same percentage as Genesee County rates. An area of need for the LGBT population is that of mental health. This is an area where a majority of respondents stated they had more poor health days than their heterosexual counterparts. It is important therefore to make sure to address LGBT mental health in the future. Giving mental health providers resources so they can work with LGBT people and making LGBT people aware of local supportive mental health providers is of the utmost importance.

References

- Anhalt, K., & Morris, T. L. (2003). Developmental and adjustment issues of gay, lesbian, and bisexual adolescents: A review of the empirical literature. In L. Garnets, & D. C. Kimmel (Eds.), *Psychological perspectives on lesbian, gay, and bisexual experiences* (pp. 587-617). New York, NY, USA: Columbia University Press.
- Anhalt, K., & Morris, T. L. (2003). Psychological perspectives on lesbian, gay, and bisexual experiences. In L. Garnets, & D. C. Kimmel (Eds.), (pp. 587-617). New York: Columbia University Press.
- Dean, L., Meyer, I.H., Robinson, K., Sell, R.L., Sember, R., Silenzio, V.M.B, ...Xavier, J. (2000). Lesbian, gay, bisexual, and transgender health: findings and concerns. *Journal of the Gay and Lesbian Medical Association*, 4(3), 102-151.
- Miller, F. H., Choi, M. J., Angeli, L. L., Harland, A. A., Stamos, J. A., Thomas, S. T., . . . Rubin, L. H. (2009). Web site usability for the blind and low-vision user. *Technical Communication*, 57, 323-335.
- Dhand, A., & Dhaliwal, G. (2009). Examining Patient Conceptions: A Case of Metastatic Breast Cancer in an African American Male to Female Transgender Patient. *Journal of General Internal Medicine*. 2010 Feb;25(2):158-61
- Equal Rights for LGBT Americans. Better Health and Wellbeing. (n.d.). Retrieved from http://www.hhs.gov/secretary/about/lgbthealth_update_2011.html
- Garnets, L. D., Herek, G. M., & Levy, B. (2003). Violence and victimization of lesbians and gay men: Mental health consequences. In L. Garnets, & D. C. Kimmel (Eds.), *Psychological*

perspectives on lesbian, gay, and bisexual experiences (pp. 204-222). New York, NY, USA: Columbia University Press.

Harcourt, J. (2006). Current issues in lesbian, gay, bisexual, and transgender (lgbt) health: Introduction. *Journal of Homosexuality*, 51(1), 1-11.

Hatzenbuehler, M. L., Keyes, K. M., & Hasin, D. S. (2009). State-level policies and psychiatric morbidity in lesbian, gay, and bisexual populations. *American Journal of Public Health*, 99(12), 2275-2281.

Herek GM, Garnets LD. Sexual orientation and mental health. *Annu Rev Clin Psychol*. 2007;3:353-75.

HIV Prevention and Health Service Needs of the Transgender Community in San Francisco:

Results From Eleven Focus Groups. San Francisco, Calif: San Francisco Dept of Public Health, AIDS Office; 1997.

Ibanez GE, Purcell DW, Stall R, et al. Sexual risk, substance use, and psychological distress in HIV-positive gay and bisexual men who also inject drugs. *AIDS*. 2005;19(suppl 1):49-55.

Kimmel, D. C. (2003). Identifying and addressing health issues of gay, lesbian, bisexual, and transgender (GLBT) populations in rural communities: Psychological perspectives. In L. Garnets, & D. C. Kimmel (Eds.), (pp. 451-through 456). New York, NY, USA: Columbia University Press.

Krehely, J. (2009). *How to close the LGBT health disparities gap* Center for American Progress.

Kuhr, F. (2005, Doctor of homophobia. *The Advocate*, 945, 52-55.

Lombardi, E., & Bettcher, T. (2005). Lesbian, gay, bisexual, and Transgender/Transsexual individuals. In B. S. Levy M.D., V. W. Sidel M.D. & M. W. Edelman (Eds.), *Social injustice and public health* (pp. 130-167). Cary, NC, USA: Oxford University Press.

Lombardi, E. (2001). Enhancing Transgender Health Care. *American Journal of Public Health*. 2001;91:869–872

McDonald, N. H. (2006). The hypocritical oath. *The Advocate*, (960), 42-43.

McLaughlin KA, Hatzenbuehler ML, Keyes KM. Responses to discrimination and psychiatric disorders among black, Hispanic, female, and lesbian, gay, and bisexual individuals. *American Journal of Public Health*. 2010;100(8):1477-84.

O'Hanlan M.D., K. A., Cabaj M.D., R. P., Schatz J.D., B., Lock M.D. Ph.D., J., & Nemrow M.D., P. (1997). A review of the medical consequences of homophobia with suggestions for resolution. *Journal of the Gay and Lesbian Medical Association*, (1), 25-39.

Remafedi G, French S, Story M, et al. The relationship between suicide risk and sexual orientation: Results of a population-based study. *American Journal of Public Health*. 1998;88(1):57-60.

Appendix A – Recruitment

Be part of an important lesbian, gay, bisexual, and transgender health research study

- Are you between 18 and 25 years of age?

If you answered YES to these questions, you may be eligible to participate in a LGBT health research study. The purpose of this research study is to gain knowledge about the experiences of lesbian, gay, bisexual, and transgender people receiving care from health professionals. Adults (18 – 25 years of age) are eligible to participate. This study is being conducted through an online survey at it (that) has been approved through the University of Michigan-Flint.

Please email Andrea Smith at smithan@umflint.edu for more information

Appendix B – Informed Consent**Consent to Participate in a Research Study****Welcome to the Lesbian, Gay, Bisexual, and Transgender Michigan Health Survey
(HUM00048255)**

Andrea Smith and Mary Black, students at the University of Michigan, Department of Public Health and Health Sciences invite you to be a part of a research study that explores the experience of LGBT individuals when they receive care from a health care professional. The purpose of the study is to better understand the health statuses and needs of lesbian, gay, bisexual, and transgender people in Michigan.

If you agree to be part of the research study, you will be asked to complete an online survey about your experiences in receiving health care. Your responses are completely confidential and anonymous. We expect this survey to take 30 to 45 minutes to complete. You may find some of the survey questions upsetting as you reflect upon your experiences. Please contact your local community mental health department for counseling, if necessary.

While you may not receive any direct benefit for participating, we hope that this study will contribute to the improvement of social support systems.

Participating in this study is completely voluntary. Even if you decide to participate now, you may change your mind and stop at any time. You may choose to not answer an individual question or you may skip any section of the survey. Simply click "Next" at the bottom of the survey page to move to the next question.

If you have questions about this research study, you can contact Andrea Smith and/or Mary Black, University of Michigan-Flint, Department of Public Health and Health Sciences, 2102 William S. White Building, 303 E. Kearsley St., Flint, MI 48502-1950, (810) 762-3172, smithan@umflint.edu.

If you have questions about your rights as a research participant, please contact the University of Michigan-Flint Institutional Review Board.

530 French Hall, Flint, MI 48503, 810-762-3384, irb-flint@umflint.edu

Appendix C – Survey Tool

Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Questionnaire. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, [2012]. Questions borrowed from BRFSS.

Section I: Demographic Information

1. What is your age in years?
2. Are you a resident in the State of Michigan?
3. What county do you live in?
4. What is your ZIP Code where you live?
5. What are your current living arrangements?
 - Homeless
 - Living in a shelter
 - Living in a group home facility or other foster care situation
 - Living in a nursing/adult care facility
 - Living in campus/university housing
 - Still living with parents or family you grew up with
 - Staying with friends or family temporarily
 - Living with a partner, spouse or other person who pays for the housing
 - Living in house/apartment/condo I RENT alone or with others
 - Living in house/apartment/condo I OWN alone or with others
6. What is the highest grade or year of school you completed?

- A. Never attended school or only attended kindergarten
 - B. Grades 1 through 8 (Elementary)
 - C. Grades 9 through 11 (Some high school)
 - D. Grade 12 or GED (High school graduate)
 - E. College 1 year to 3 years (Some college or technical school)
 - F. College 4 years or more (College graduate)
7. Is your annual household income from all sources:
- A. Less than \$25,000 (\$20,000 to less than \$25,000)
 - B. Less than \$20,000 (\$15,000 to less than \$20,000)
 - C. Less than \$15,000 (\$10,000 to less than \$15,000)
 - D. Less than \$10,000
 - E. Less than \$35,000 (\$25,000 to less than \$35,000)
 - F. Less than \$50,000 (\$35,000 to less than \$50,000)
 - G. Less than \$75,000 (\$50,000 to less than \$75,000)
 - H. \$75,000 or more
 - I. Don't know/Not sure
8. Which one or more of the following would you say is your race? (Check all that apply)
- A. White
 - B. Black or African American
 - C. Asian
 - D. Native Hawaiian or Other Pacific Islander
 - E. American Indian, Alaska Native

F. Other: [specify]_____

G. Don't Know/Not Sure

9. Which one of these groups would you say best represents your race (Check all that apply)? ARE QUESTION 8 AND 9 the same?

A. White

B. Black or African American

C. Asian

D. Native Hawaiian or Other Pacific Islander

E. American Indian, Alaska Native

F. Other: [specify]_____

G. Don't Know/Not Sure

10. What is your current sex?

A. Male

B. Female

C. Transsexual Male to Female

D. Transsexual Female to Male

11. Which one of these groups would you say best represents your sexual identity? (Choose all that apply.)

A. Gay

B. Straight/Heterosexual

C. Lesbian

- D. Queer
- E. Bisexual
- F. Other (please specify)_____

12. Which one of these groups would you say best represents your gender identity? (Choose all that apply.)

- A. Male
- B. Female
- C. Transgender

13. Who do you have sex with?

- A. Only Men
- B. Only Women
- C. Both Men and Women

14. Have you ever engaged in same-sex/same-gender sexual behaviors?

- A. Yes
- B. No

15. Do you currently engage in same-sex/same-gender sexual behaviors?

- A. Yes
- B. No

16. Have you engaged in sexual behaviors within the last year?

- A. Yes
- B. No

17. How often do you think about your race?

- A. Never

- B. Once a year
- C. Once a month
- D. Once a week
- E. Once and hour
- F. Constantly
- G. Don't Know/Not Sure

18. Within the past 30 days, how often have you felt emotionally upset, for example angry, sad, or frustrated, as a result of how you were treated based on your race?

- A. Always
- B. Usually
- C. Sometimes
- D. Rarely
- E. Never
- G. Don't Know/Not Sure

19. Within the past 12 months, when seeking health care, do you feel your experiences were worse than, the same as, or better than for people of other races?

- A. Worse than other races
- B. Same as other races
- C. Better than other races
- D. Don't Know/Not Sure

20. Within the past 30 days, how often have you experienced any physical symptoms, for example, a headache, an upset stomach, tensing of your muscles, or a pounding heart, as a result of how you were treated based on your race?

- A. Always
- B. Usually
- C. Sometimes
- D. Rarely
- E. Never
- G. Don't Know/Not Sure

21. Within the past 12 months at work, how do you feel you were treated compared to people of different sexual identities?

- A. Worse than other sexual identities
- B. The same as other sexual identities
- C. Better than other sexual identities
- D. Worse than some sexual identities, better than others
- E. Only encountered people of the same sexual identity
- F. Don't Know/Not Sure

22. How often do you think about your sexual identity?

- A. Never
- B. Once a year
- C. Once a month
- D. Once a week
- E. Once and hour
- F. Constantly
- G. Don't Know/Not Sure

23. Within the past 30 days, have you felt emotionally upset, for example angry, sad, or frustrated, as a result of how you were treated based on your sexual identity?

- A. Always
- B. Usually
- C. Sometimes
- D. Rarely
- E. Never
- G. Don't Know/Not Sure

24. Within the past 12 months, when seeking health care, do you feel your experiences were worse than, the same as, or better than for people of other sexual identities?

- A. Worse than other gender identities
- B. The same as other gender identities
- C. Better than other gender identities
- D. Worse than some gender identities, better than others
- E. Only encountered people of the same gender identity
- F. Don't Know/Not Sure

25. Within the past 30 days, have you experienced any physical symptoms, for example, a headache, an upset stomach, tensing of your muscles, or a pounding heart, as a result of how you were treated based on your sexual identity?

- A. Always
- B. Usually
- C. Sometimes

- D. Rarely
- E. Never
- F. Don't Know/Not Sure

26. Within the past 30 days, have you experienced any physical symptoms, for example, a headache, an upset stomach, tensing of your muscles, or a pounding heart, as a result of how you were treated based on your gender identity?

- A. Always
- B. Usually
- C. Sometimes
- D. Rarely
- E. Never
- G. Don't Know/Not Sure

27. Within the past 12 months, when seeking health care, do you feel your experiences were worse than, the same as, or better than for people of other gender identities

- A. Worse than other identities
- B. The same as other identities
- C. Better than other identities
- D. Worse than some identities, better than others
- E. Only encountered people of the same gender identity
- F. Don't Know/Not Sure

28. Within the past 30 days, have you felt emotionally upset, for example angry, sad, or frustrated, as a result of how you were treated based on your gender identity?

- A. Always
 - B. Usually
 - C. Sometimes
 - D. Rarely
 - E. Never
 - F. Don't Know/Not Sure
29. How often do you think about your gender identity?
- A. Never
 - B. Once a year
 - C. Once a month
 - D. Once a week
 - E. Once and hour
 - F. Constantly
 - G. Don't Know/Not Sure

Section II: Alcohol Consumption

One drink is equivalent to a 12-ounce beer, a 5-ounce glass of wine, or a drink with one shot of liquor. (Note: A 40 ounce beer would count as 3 drinks, or a cocktail drink with 2 shots would count as 2 drinks.)

30. During the past 30 days, on the days when you drank, about how many drinks did you drink on the average?
- A. 1-2
 - B. 3-4

- C. 5 or more
- D. I don't know
- E. I did not drink in the past 30 days

31. During the past 30 days, how many days per week did you have at least one drink of any alcoholic beverage?

- A. 1-2
- B. 3-4
- C. 5 or more
- D. I don't know
- E. I did not drink in the past 30 days

32. During the past 30 days, what is the largest number of drinks you had on any occasion?

- A. 1-2
- B. 3-4
- C. 5 or more
- D. I don't know
- E. I did not drink in the past 30 days

Section III: Health Status/Healthy Days

33. Would you say that in general your health is---

- A. Excellent
- B. Very good
- C. Good
- D. Fair

E. Poor

34. Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?

A. 1-2

B. 3-4

C. 5 or more

D. Don't Know/Not Sure

E. My mental health was good during the last 30 days

35. Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?

A. 1-2

B. 3-4

C. 5 or more

D. Don't Know/Not Sure

E. My physical health was good during the last 30 days

36. During the past 30 days, for about how many days did poor physical health keep you from doing your usual activities, such as self-care, work, or recreation?

A. 1-2

B. 3-4

C. 5 or more

D. Don't Know/Not Sure

E. My physical health was good during the last 30 days

37. During the past 30 days, for about how many days did poor mental health keep you from doing your usual activities, such as self-care, work, or recreation?
- A. 1-2
 - B. 3-4
 - C. 5 or more
 - D. Don't Know/Not Sure
 - E. My mental health was good during the last 30 days

Section IV: HIV/AIDS

The next few questions are about the national health problem of HIV, the virus that causes AIDS.

Please remember that your answers are strictly confidential and that you don't have to answer every question if you do not want to. Although we will ask you about testing, we will not ask you about the results of any test you may have had.

38. Have you ever been tested for HIV? Do not count tests you may have had as part of a blood donation. Include testing fluid from your mouth.
- A. Yes
 - B. No
 - C. Don't Know/Not Sure
39. Not including blood donations, in what month and year was your last HIV test?
- A. _____ Month/Year
 - B. I have never had an HIV test
 - C. Don't Know/Not Sure
40. Where did you have your last HIV test?

- A. A private doctor or HMO
- B. A counseling or testing site
- C. In a jail or prison
- D. At a drug treatment facility
- E. At home
- F. Other, please specify _____
- G. I have never had an HIV test
- H. Don't Know/Not Sure

Section V: Tobacco Use/Smoking Cessation/Secondhand Smoke

41. How long has it been since you last smoked cigarettes regularly?
- A. Within the past month (less than 1 month ago)
 - B. Within the past 3 months (1 month but less than 3 months ago)
 - C. Within the past 6 months (3 months but less than 6 months ago)
 - D. Within the past year (6 months but less than 1 year ago)
 - E. Within the past 5 years (1 year but less than 5 years ago)
 - F. Within the past 10 years (5 years but less than 10 years ago)
 - H. 10 years or more
 - I. Don't Know/Not Sure
 - K. I have never smoked cigarettes
42. Do you now smoke cigarettes every day, some days, or not at all?
- A. Every day
 - B. Some days

- C. Not at all
- D. Don't Know/Not Sure

43. Have you smoked at least 100 cigarettes in your entire life? [Note: 5 packs = 100 cigarettes]

- A. Yes
- B. No
- C. Don't Know/Not Sure

44. During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking?

- A. Yes
- B. No
- C. Don't Know/Not Sure

45. Do you currently use chewing tobacco, snuff, or snus?

Note: Snus (Swedish for snuff) is a moist smokeless tobacco, usually sold in small pouches that are placed under the lip against the gum.

- A. Every day
- B. Some days
- C. Not at all
- D. Don't Know/Not Sure

Section Via: Women's Health

The next questions are about breast and cervical cancer.

46. A mammogram is an x-ray of each breast to look for breast cancer. Have you ever had a mammogram?
- A. Yes
 - B. No
 - C. Don't Know/Not Sure
47. A Pap test is a test for cancer of the cervix. Have you ever had a Pap test?
- A. Yes
 - B. No
 - C. Don't Know/Not Sure
48. How long has it been since you had your last mammogram?
- A. Within the past year (anytime less than 12 months ago)
 - B. Within the past 2 years (1 year but less than 2 years ago)
 - C. Within the past 3 years (2 years but less than 3 years ago)
 - D. Within the past 5 years (3 years but less than 5 years ago)
 - E. 5 or more years ago
 - F. Don't Know/Not Sure
 - G. I have never had a mammogram
49. How long has it been since you had your last Pap test?
- A. Within the past year (anytime less than 12 months ago)
 - B. Within the past 2 years (1 year but less than 2 years ago)
 - C. Within the past 3 years (2 years but less than 3 years ago)
 - D. Within the past 5 years (3 years but less than 5 years ago)
 - E. 5 or more years ago

- F. Don't Know/Not Sure
- G. I have never had a Pap test

50. How long has it been since your last breast exam?

- A. Within the past year (anytime less than 12 months ago)
- B. Within the past 2 years (1 year but less than 2 years ago)
- C. Within the past 3 years (2 years but less than 3 years ago)
- D. Within the past 5 years (3 years but less than 5 years ago)
- E. 5 or more years ago
- F. Don't Know/Not Sure

51. A clinical breast exam is when a doctor, nurse, or other health professional feels the breasts for lumps. Have you ever had a clinical breast exam?

- A. Yes
- B. No
- C. Don't Know/Not Sure

52. A vaccine to prevent the human papilloma virus or HPV infection is available and is called cervical cancer vaccine, HPV shot, or GARDASIL®. Have you EVER had the HPV vaccination?

- A. Yes
- B. No
- C. Don't Know/Not Sure

Section VIb: Men's Health

Prostate Cancer Screening

A digital rectal exam is an exam in which a doctor, nurse, or other health professional places a gloved finger into the rectum to feel the size, shape, and hardness of the prostate gland.

53. Have you ever had a digital rectal exam?
- A. Yes
 - B. No
 - C. Don't Know/Not Sure
54. How long has it been since your last digital rectal exam?
- A. Within the past year (anytime less than 12 months ago)
 - B. Within the past 2 years (1 year but less than 2 years ago)
 - C. Within the past 3 years (2 years but less than 3 years ago)
 - D. Within the past 5 years (3 years but less than 5 years ago)
 - E. 5 or more years ago
 - F. Don't Know/Not Sure
 - G. I have never had a digital rectal exam

Section VII: Health Care Coverage/Access

55. What type of doctor provides the majority of your health care?
- A. Family Practitioner
 - B. General Surgeon
 - C. Internist
 - D. Urologist
 - E. Nurse Practitioner
 - F. Other (Please Specify) _____

G. Don't Know/Not Sure

56. About how long has it been since you last visited a doctor for a routine checkup? A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition.

- A. Within the past year (anytime less than 12 months ago)
- B. Within the past 2 years (1 year but less than 2 years ago)
- C. Within the past 3 years (2 years but less than 3 years ago)
- D. Within the past 5 years (3 years but less than 5 years ago)
- E. 5 or more years ago
- F. Don't Know/Not Sure

57. Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare?

- A. Yes
- B. No
- C. Don't Know/Not Sure

58. Was there a time in the past 12 months when you needed to see a doctor but could not because of the cost?

- A. Yes
- B. No
- C. Don't Know/Not Sure

59. Do you have one person you think of as your personal doctor or health care provider?
- A. Yes
 - B. No
 - C. Don't Know/Not Sure
60. When was the last time you saw your regular physician?
- A. In the past week
 - B. In the past month
 - C. In the past 6 months
 - D. In the past year
 - E. I haven't seen my regular physician in more than a year
61. On a scale of 1-5, how would you rate your experiences with your regular physician?
- 1 2 3 4 5
- Horrible Great
62. Would you consider your regular physician to be trans-friendly?
- A. Yes
 - B. No
 - C. I am not sure how I would answer that.
63. Would you consider your regular physician to be trans-knowledgeable?
- A. Yes
 - B. No
 - C. I am not sure how I would answer that.

64. Which items are important to you in a healthcare provider?

* Choose all that apply.

- Unisex bathrooms.
- Already educated on trans issues.
- Willingness to learn about trans issues.
- Willingness to work as part of a team to assist you in your needs.
- Willingness to prescribe hormone therapy or to refer you out for hormone therapy.
- Has transgender listed on their new patient forms.

Section VIII: Emotional Support and Life Satisfaction

The next two questions are about emotional support and your satisfaction with life.

65. How often do you get the social and emotional support you need?

- A. Always
- B. Usually
- C. Sometimes
- D. Rarely
- E. Never
- G. Don't Know/Not Sure

66. In general, how satisfied are you with your life?

- A. Very satisfied
- B. Satisfied

- C. Dissatisfied
- D. Very satisfied
- E. Don't Know/Not Sure

Section IX: Mental Illness and Stigma

67. Are you limited in any way in any activities because of physical, mental, or emotional problems?

- A. Yes
- B. No
- C. Don't Know/Not Sure

68. During the past 30 days, for about how many days have you felt sad, blue, or depressed?

- A. 1-2
- B. 3-4
- C. 5 or more
- D. Don't Know/Not Sure
- E. I did not feel sad, blue, or depressed during the past 30 days

69. During the past 30 days, for about how many days have you felt worried, tense, or anxious?

- A. 1-2
- B. 3-4

- C. 5 or more
- D. Don't Know/Not Sure
- E. I did not feel worried, tense, or anxious during the last 30 days

70. During the past 30 days, about how often did you feel so depressed that nothing could cheer you up?

- A. All of the time
- B. Most of the time
- C. Some of the time
- D. A little of the time
- E. None of the time
- F. Don't Know/Not Sure

71. During the past 30 days, about how often did you feel that everything was an effort?

- A. All of the time
- B. Most of the time
- C. Some of the time
- D. A little of the time
- E. None of the time
- F. Don't Know/Not Sure

72. During the past 30 days, about how often did you feel hopeless?

- A. All of the time

- B. Most of the time
- C. Some of the time
- D. A little of the time
- E. None of the time
- F. Don't Know/Not Sure

73. About how often during the past 30 days did you feel nervous?

- A. All of the time
- B. Most of the time
- C. Some of the time
- D. A little of the time
- E. None of the time
- F. Don't Know/Not Sure

74. During the past 30 days, about how often did a mental health condition or emotional problem keep you from doing your work or other usual activities?

"Usual activities" includes housework, self-care, caregiving, volunteer work, attending school, studies, or recreation.

- A. All of the time
- B. Most of the time
- C. Some of the time
- D. A little of the time
- E. None of the time

F. Don't Know/Not Sure

75. How much do you agree or disagree with the following statement about people and mental illness:

People are generally caring and sympathetic to people with mental illness.

- A. Agree strongly
- B. Agree slightly
- C. Neither agree nor disagree
- D. Disagree slightly
- E. Disagree strongly

76. During the past 30 days, about how often did you feel restless or fidgety?

- A. All of the time
- B. Most of the time
- C. Some of the time
- D. A little of the time
- E. None of the time
- F. Don't Know/Not Sure

77. Are you now taking medicine or receiving treatment from a doctor or other health professional for any type of mental health condition or emotional problem?

- A. Yes
- B. No

78. How much do you agree or disagree with the following statement about people with mental illness.

Treatment can help people with mental illness lead normal lives.

- A. Agree strongly
- B. Agree slightly
- C. Neither agree nor disagree
- D. Disagree slightly
- E. Disagree strongly
- F. Don't Know/Not Sure

79. During the past 30 days, about how often did you feel worthless?

- A. All of the time
- B. Most of the time
- C. Some of the time
- D. A little of the time
- E. None of the time
- F. Don't Know/Not Sure

Section X: Sleep

The next questions are about getting enough rest or sleep.

80. During the past 30 days, about how often have you felt you did not get enough rest or sleep?

- A. All of the time
- B. Most of the time
- C. Some of the time
- D. A little of the time
- E. None of the time
- F. Don't Know/Not Sure

81. On average, how many hours of sleep do you get in a 24-hour period? Think about the time you actually spend sleeping or napping, not just the amount of sleep you think you should get. (Note: Enter hours of sleep in whole numbers, rounding 30 minutes (1/2 hour) or more up to the next whole hour and dropping 29 or fewer minutes.)

- A. 4 or less
- B. 5 - 6 hours
- C. 7-8 hours
- D. 9 or more hours

Section XI: Life Events

The following are some questions about events that happened during your childhood. This information will allow us to better understand problems that may occur early in life, and may help others in the future. This is a sensitive topic and some people may feel uncomfortable with these questions. At the end of this section, you will find a phone number for an organization that can provide information and referral for these issues. Please keep in mind that you can skip any

question you do not want to answer. All questions refer to the time period before you were 18 years of age.

Now, looking back before you were 18 years of age:

Yes No Don't Know/Not Sure

82. Did you ever live with someone who was mentally ill, depressed, or suicidal?

83. Were you(r) parents separated or divorced?

84. Did you live with anyone who was a problem drinker or alcoholic?

85. Did you live with anyone who used illegal street drugs?

86. Did you live with anyone who abused prescription drugs?

Never Once More than once Don't know/Not sure

87. How often did a parent or adult ever hit, beat, kick, or physically hurt you in anyway? Do not include spanking.

88. How often did you(r) parents or adults in your home ever swear at you, insult you, or put you down?

89. How often did your parents or adults ever hit, beat, kick, or physically hurt each other?

90. Did anyone at least 5 years older than you or an adult (word missing)for you to have sex.

91. How often did anyone at least 5 years older than you or an adult touch you sexually?

92. How often did anyone at least 5 years older than you force you to touch him/her sexually?

Section XII: Sexual/Gender Discrimination

How often have you experienced any of the following due to your gender identity?

Never Once Twice Three or More Times

93. Verbal threats or intimidation
94. Physical violence
95. Verbal Abuse or name calling
96. Been followed or chased
97. Had personal property damaged
98. Turned down for a job you were qualified for
99. Denied a promotion
100. Harassed by employer or other employees
101. Forced to quit a job because of harassment
102. Fired from a job
103. Had to hide sexual identity
104. Denied a lease for a house/apartment you were qualified for
105. Harassed by landlord or other tenant
106. Forced to move or were evicted
107. Denied admission to school or academic program
108. Denied financial aid
109. Been bullied or harassed by other students
110. Been bullied by a teacher/teachers
111. Denied custody of your children
112. Had custody of your children restricted by courts
113. Had custody of your children restricted by former spouse/partner

114. Denied a loan or line of credit
115. Denied a ride or forcibly removed from public transportation
116. Denied a room in hotel/motel
117. Denied service in a restaurant
118. Denied membership/access to gym or fitness facility
119. Denied access to locker room/changing room at gym or fitness facility
120. Denied use of public restroom
121. Denied services of local government agency
122. Denied emergency medical attention
123. Denied non-emergency medical attention
124. Been harassed/verbally abused by emergency medical personnel
125. Harassed/verbally abused by the police

In this section, we want to know about any bias or discrimination you may have experienced because of your sexual orientation. Do not include your experiences of discrimination based on other grounds such as gender identity, race, religion, etc.

How often have you experienced any of the following due to your sexual identity?

Never Once Twice Three or More Times

126. Verbal threats or intimidation
127. Physical violence
128. Verbal Abuse or name calling
129. Been followed or chased

130. Had personal property damaged
131. Turned down for a job you were qualified for
132. Denied a promotion
133. Harassed by employer or other employees
134. Forced to quit a job because of harassment
135. Fired from a job
136. Had to hide sexual identity
137. Denied a lease for a house/apartment you were qualified for
138. Harassed by landlord or other tenant
139. Forced to move or were evicted
140. Denied admission to school or academic program
141. Denied financial aid
142. Been bullied or harassed by other students
143. Been bullied by a teacher/teachers
144. Denied custody of your children
145. Had custody of your children restricted by courts
146. Had custody of your children restricted by former spouse/partner
147. Denied a loan or line of credit
148. Denied a ride or forcibly removed from public transportation
149. Denied a room in hotel/motel
150. Denied service in a restaurant
151. Denied membership/access to gym or fitness facility
152. Denied access to locker room/changing room at gym or fitness facility

153. Denied use of public restroom
154. Denied services of local government agency
155. Denied emergency medical attention
156. Denied non-emergency medical attention
157. Been harassed/verbally abused by emergency medical personnel
158. Harassed/verbally abused by the police