

Heightening Tobacco Prevention in Consideration of Sexual Minority and Gender Variant Youth

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It is vital for tobacco prevention programs to heighten their impact by being respectful of and responsive to the needs of sexual minority and gender variant youth. A critical need exists for more research describing smoking patterns of lesbian, gay, bisexual and transgender (LGBT) youth. There is a strong desire to bring research to practice that has been prohibited by a lack of research and barriers to research. Informed prevention in this population is difficult because it may never be determined why LGBT youth smoke earlier or why they smoke at higher levels. However, researchers have proposed arguments as to why LGBT youth might be more susceptible to smoking. There are many strategies and action items for tobacco prevention programs to address these possible influences. These include: policy level changes; awareness, sensitivity and creating safe spaces; messaging and media promotion strategies; and strategies for program implementation and sensitive providers.

Higher Rates of Smoking

A growing body of evidence sustains the assertion that sexual minority youth and gender variant youth are among the highest impacted by tobacco use. Lesbian, gay, bisexual and transgender (LGBT) people show significantly higher smoking rates than the general population, based both on data from samples of youth and of adults living in America (Aaron & Markovic, 2001; Austin, 2004; Bontempo & D'Augelli, 2002; Cochran S., 2001; Faulkner & Cranston, 1998; Greenwood, 2005; Gruskin, et. al. 2001 & 2007; Russel, 2002; Remafedi & Carol, 2005; Ryan, et. al, 2001; Stall, 1999; Tang, 2004; Xavier, Honnold & Bradford, 2007). The estimated smoking rates for lesbian, gay, and bisexual youth ranged from 38% to 59%. National youth smoking rates during the comparable periods ranged from 28% to 35% for adolescents (Ryan, et al. 2001). Variations in estimated rates may be due in part to a lack of research and the difficulties in conducting such research. There is a scarcity of data describing smoking patterns among gender variant and transgender youth. However, the Virginia Transgender Health Initiative Study found in its sample of participants aged 18 to 69 that 75% of Females To Males (FTMs) and 59% of Male To Females (MTFs) had used tobacco in their lifetimes (Xavier & Bradford, 2007). This data suggests that gender variant and transgender youth may demonstrate much greater rates of smoking.

Difficulties for LGBT Youth Research

So far no statewide data on smoking rates has been collected on gender variant and transgender youth. The limited surveillance data that has identified LGB

youth smoking rates is a decade old and based in either California, Vermont or Massachusetts (Faulkner & Cranston, 1998; Garofalo et al. 1998; Bontempo & D'Augelli 2002). Given that these states are among the lowest in cigarette smoking prevalence it may be difficult to generalize these findings to other states. The general lack of statewide surveillance data on LGBT Youth Smoking is rooted in political concerns that surface in government agencies, health departments, mainstream tobacco control efforts such as quitlines, community based tobacco control organizations, funders and institutional review boards (IRBs). These political issues range from myths about "The Gay Agenda" and "recruiting youth" to fears that inclusion would mean condoning "Alternative Lifestyles."

There are also methodological difficulties measuring sexual orientations through either identities or attractions. For example, youth can engage in sexual behaviors in same-sex couples but still self-identify as heterosexual. Researchers have found that more youth will respond positively when asked about their same-sexual "attractions, fantasies and behaviors" than about their sexual minority identity (Diamond, 2000; Golden, 1994; Laumann & Gagnon, 1994; Remafedi & Resnik 1992; Savin-Williams, 2001). Vivian Cass outlined sexual minority identity development as a process that extends across the lifespan and includes various stages: identity confusion; identity comparison; identity tolerance; identity acceptance; identity pride; and identity synthesis (Cass, 1979, 1984, 1990). Trying to measure sexuality with youth that may be transitioning through their identity development is difficult. More recent work by D'Augelli suggests yet another example of identity development: exiting heterosexual identity; developing a personal LGB identity; developing a social LGB identity; becoming a LGB offspring; developing a LGB intimacy status; and entering a LGB community (D'Augelli, 1994, 1991). Thus the "coming out" process seems to vary between individuals and there is no single perfect way or time frame or age for folks to become well-adjusted homosexuals. Additional research is needed on appropriate terminology and optimal ordering of questions to produce the most accurate picture of sexual orientation for youth (Friedman & Silvestre, 2004). There may also be important geographical differences when considering gender, race, socioeconomic status and ethnicity as well as data collection methods such as: in-person interviews, telephone interviews, self-administered surveys or computer assisted questionnaires (Friedman & Silvestre, 2004). Researchers have shown enough significant differences from these methods to warrant further investigation.

Continuum of Sexuality Higher Smoking Rates

Those who are questioning their sexual orientation or who are engaging in same-sex attractions and behaviors without identifying as gay, lesbian, bisexual or transgender may also smoke more. Males with romantic attractions to both males and females reported higher numbers of cigarettes smoked than their

peers and were also more likely to drink and use drugs than their peers (Russell, 2002). Females with romantic attractions to both males and females smoked more than their peers and more than those with same sex attractions. They were also more likely to increase their smoking (Russell, 2002). The study's authors also suggest that there may be differences in smoking behaviors between those youth who self identify as LGB and those who have same gender attractions without the identity (Russell, 2002). Austin (2004) examined the prevalence of tobacco use in a community-based sample of the children of nurses (n=10,685) living throughout the United States. The conclusion indicated that "mostly heterosexual" youth of both sexes and lesbian and bisexual girls were at heightened risk for tobacco use (Austin, 2004). Most troubling was the finding that lesbian and bisexual girls were 9.7 times more likely to smoke than their peers (Austin, 2004). This study focused on "attractions" and "self-identifications" and presents interesting evidence that differences emerge based upon the measures of sexuality used in research methodology. In a more recent article Gruskin found an alarming 44% of women who have sex with women (Age 18-Over 65) but who do not identify as lesbians or bisexuals smoked (Gruskin, 2007). The subgroup of younger women 18-24 years old showed the following percentage of current smokers: 73.5% lesbians; 29.3% bisexuals; 52.9% of women who have sex with women without the identity; and 13.2% of heterosexuals women (Gruskin, 2007). The percentage of smokers for the subgroup of younger men 18-24 years was as follows: 34.9% gay men; 41.8% bisexual men; 100% men who have sex with men without identity; 22.4% heterosexual men (Gruskin, 2007). An adult convenience sample from New Mexico's 2006 Lesbian, Gay, Bisexual, And Transgender (LGBT) Tobacco Survey LGBT Tobacco Survey found that bisexual people smoked at a much higher rate (58.1%) compared to lesbians (32.3%) and gay men (39.9%) (Padilla, Reid, & Peñaloza, 2006). A convenience sample from 2006 Oregon Pride survey (age 14-79) showed higher smoking rates for bisexuals at 35% compared to lesbian/gays (29%) and Queer identity (23%) (Kirk, Schubert & Szego 2006). If prevention programs are going to speak effectively to these youth, it is important for facilitators to learn to use gender-neutral pronouns in discussing attractions. Given the many social challenges faced by these youth in general, such an environment would also provide them with psychosocial support to reduce distress and possibly decrease other risk behaviors.

Multifaceted Gender Roles

There is also a lack of research on gender variance among youth who do not conform to a traditional binary conception of gender and how best to ascertain gender identity and its potential impact on smoking behaviors. However, a small study of college students (18-28-years-old) demonstrated that smoking attitudes, beliefs and behaviors have specific issues related to: gender roles; coping styles; depression, anxiety, self-esteem, stress levels; victimization; stigmatization and self-acceptance of sexuality; body image; family support; and

avoidance coping behaviors (Massey, 2004). Massey found that gay male smokers were more at risk for mental health issues and higher stress levels, than gay male nonsmokers and heterosexual peers (Massey, 2004). Gay male smokers also felt stigmatized for their sexual orientation. Massey found that lesbian smokers were at higher risk for lower family support and avoidance coping behaviors than lesbian nonsmokers or heterosexual peers. In addition, lesbian smokers reported a stronger identification as a lesbian than lesbian nonsmokers (Massey, 2004). These findings suggest that there are differences between gay men and lesbian smokers that are very important to investigate to tailor prevention programs to address. Remafedi's small qualitative study suggests that LGB smokers may smoke because they desire a more masculine persona (Remafedi, 2007). The industry attempts to attract teens and young adults by associating smoking with gender roles of "toughness," "butchness," power, independence, rebelliousness, glamour, being "femme," or finding your voice, by sponsoring music concerts, giving away free stuff, sponsoring promotional nights at bars, and supporting sports events (Sepe & Glantz, 2002). The tobacco industry has successfully promoted cigarette use as a way of reinforcing the dominant culture's socially constructed gender norms. It is important to closely examine how specific messages may impact smoking behaviors of gender variant and sexual minority youth because traditional gender roles do not seem to be accurate and applicable yet they still influence smoking behaviors and this is a potential barrier for success in prevention programs.

How Has Tobacco Been Marketed to Youth? Let's Look Directly At Industry Documents

As seen in Industry Documents (RJ Reynolds, 1973) here are marketing thoughts about cigarettes for youth:

- Self-image Enhancement--Sign of maturity and sophistication, identification with valued persons (actors, role models) who are daring, free to choose, adults
- Experimentation--Trying something new, experimenting, associated with rebelliousness or living on edge
- Group Identification—Participating, sharing, conforming, A trait of an "alternative crowd"
- Stress and Boredom relief—Buys time, valid interruption, bridges awkward times and situations, something to do as a sign of individuality, standing out from crowd, nicotine response
- Sensory Effects—Flavor, visual pack, cigarette and smoke attributes
- Manipulative Effects—Handling, lighting, puffing, holding, ashing, extinguishing (From 1973 R.J. Reynolds Document, research planning memorandum on some thoughts about new brands of cigarettes for the youth market R.J. Reynolds Tobacco Company. February 2, 1973. Bates No. 502987357-7368 Available at <http://www.rjrtdocs.com>, www.library.ucsf.edu/tobacco/mangini. Accessed December 1, 2000).

These are plainly images and behaviors that can be linked to identity, and are not merely about a tobacco product. The industry's understanding of youth behaviors helps to explain why marketing strategies highlight integration with activities and environments like work, military service, college, and especially bars and nightclubs and other leisure and social activities (Ling & Glantz, 2002). The industry is well aware of the struggles faced by youth transitioning from Middle School to High School, High School to College, or College to the Work Force and developed marketing strategies that encourage initial experimentation to becoming confirmed pack-a-day smokers. They placed tobacco as a means to connect to others during times of transition. Feeling different and social isolation can sometimes be a part of the "coming out" process so this appeal of connection to others is strong.

The tobacco companies also study the attitudes, social groups, values, aspirations, role models, and activities of youth so that they can infiltrate both their physical and social environments (Ling & Glantz, 2002). Better understanding of how this process affects LGBT youth is needed for prevention to be successful. This suggests that it is important to develop comprehensive counter marketing programs that reduce smoking initiation and also prevent increased smoking across all stages of youth development. So to be effective, prevention programs may need to infiltrate both their physical and social environments and to specifically target teens 13-16, and young adults aged 17-24 with differing messages and activities across each stage of development.

Elizabeth Smith, Naphtali Offen, Bob Gordon, Perry Stevens and others have documented the tobacco industry's overt advertising and marketing in the LGBT communities as well as their more subtle tactics (Offen, 2005; Smith, 2005; Harris Interactive, 2005; Offen, 2003; Smith, 2004; Smith, 2003; Stevens, 2004). By sponsoring HIV/AIDS charities, non-profit organizations, Pride festivals and advertising in the gay press tobacco companies have shown their acceptance and validation of LGBT communities (Stevens, 2004). Tobacco prevention organizations need to have visibility in LGBT space. There are many effective counter-marketing tactics such as: placing advertisements and/or prevention messages in gay press; training quitline staff to be sensitive to LGBT callers; advertising quitline telephone numbers and messages that welcome LGBT callers in the free classified section of Alternative Papers; distributing flyers or business cards about programs and services in community centers and book stores; having Internet links to LGBT organizations and resources and to LGBTIQ Anti-Tobacco Community Organizations on websites; doing outreach or having a table, float or booth at Pride Events or LGBT Local Theater/Concert events; having program information or flyers at concerts for known LGBT performers, such as: Melissa Ferrick, Tegan and Sarah, Googol Eordello, Ellen DeGenerus, Leisha Halley, Tattoo, Sierra, Alix Olson, k.d. lang, Melissa Etheridge, Rosie O'Donnell, Rufus Wrainwright, or R.E.M.; having information at homeless drop-

in centers and youth drop-in centers; scheduling a time to attend and talk to LGBT social support groups or school-based "gay-straight alliances" or national youth organizations like Advocates for Youth or the National Youth Advocacy Coalition or local P-FLAG (Parents and Friends of Lesbian and Gays) groups.

How might LGB youth (no T because of no research) be more susceptible to smoking? (Paul, 2002)

- "Coming out" and the issue of difference
- Managing stresses of difference/marginality
 - Anti-gay violence and discrimination
 - Higher stress levels in the face of oppression
 - Lack of support from peers and family
- Socialization into the LGBT community
 - Exploration of gay bars--access as minor
 - The role of smoky bars as a primary social outlet
- Finding a sense of belonging. Acceptance of smoking in the community
- Finding relationships
- Increased incidence of substance abuse
- Reduced access to health care, because of the lack of insurance or trauma from insensitive providers
- Targeted marketing efforts by the tobacco industry
- GLBT youth are two to three times more likely than their straight counterparts to begin smoking.
- Fear of weight gain, concern about "looks" and body image.

Paul found the above themes when he did qualitative interviews of 100 LGB Youth from the African American, Latino, Asian Pacific Islanders and White communities and presented these findings at the National Conference on Tobacco or Health, November, 2002. Remafedi's smaller qualitative study discovered the following reasons for smoking such as: hunger; rebelliousness; drive for sensory stimuli; desire to appear more masculine; attractive or glamorous; poor self-esteem; predisposition to nicotine addiction; poverty; homophobia; and lack of health care and lack of positive role models (Remafedi, 2007). There is very little research on why LGBT youth smoke more than their peers. Prevention programs that provide psychosocial support and alternative leisure activities may help address the above themes.

Violence and Bullying

Those who had experienced multiple episodes of victimization are far more likely to smoke than their peers (Bontempo & D'Augelli, 2002; Cochran, B., et. al., 2002). Most LGBT youth face negative stigma, rejection, discrimination and harassment from teachers, peers, parents and family members (Austin, 2004; Constantino, 2002). Social isolation and emotional and physical abuse may

result so that neither school nor home feels safe (Constantino, 2002). Little is known about gender variant youth and transgender youth and smoking. However, studies of mostly adult transgender people have found extremely high levels of violence (Xavier & Bradford, 2007; Xavier, et al 2005, Xavier, 2000). Youth need support and tips for surviving oppression and dealing with bullying especially if prevention messages are only given in schools. Also, facilitators need to be coached on how to handle bullying or homophobic comments made by youth during potential prevention sessions, because if they are not addressed, LGBT youth will be unlikely to return or hear the prevention messages. Sensitivity trainings for prevention facilitators and having brochures that identify resources within the local LGBT communities or from other local supportive organizations can provide support for survivors of violence and bullying.

Homelessness

Homelessness may be another factor that influences youth smoking behaviors especially if longer than one year (Cochran, B., et. al., 2002). Researchers found information in the industry documents about "Project Scum" (Sub-culture Urban Marketing) a marketing initiative that targeted homeless people and gay men (Stevens, 2004). Homeless LGBT youth may face more pressures to smoke because they represent a disproportionate amount of homeless youth (Unger, et. al., 1997). Due to difficulties, little data has been collected to estimate the percentages of GLBT youth that live on the streets (Sell, 1997; Rotheram-Borus, 1991; Diamond, 2002). In 1985, the National Network of Runaway and Youth Services estimated that about 6% of homeless adolescents were gay or lesbian. However, more recent studies discovered rates ranging from 11% to 35% (Kruks, 1991; Tenner, 1998). Tobacco prevention programs should target homeless support programs and include psychosocial support or cessation groups for vulnerable LGBT homeless youth.

LGBT of Color

A lot of people of color do not identify as LGBT but engage in same-sexual behaviors and smoke more than their heterosexual peers (Gruskin, et. al., 2007). Of women who have sex with women without identity, Gruskin found the following percentage of smokers: 37.4% Latinos; 40.78% African Americans; 65.8% Asian Pacific Islander; and 67.1% other race/ethnicity. Of men who have sex with men, Gruskin found the following percentage of current smokers: 53.4% Latinos; 21.7% African Americans; and 43.8% other race/ethnicity. Messages from LGBT identified tobacco prevention programs may not reach this population. Mainstream programs within communities of color are perfectly placed to provide prevention and should consider making messages that address the continuum of sexuality.

Welcoming and Inclusive Programs

The language that we use and our efforts towards inclusion are vital because the data thus far shows vast disparities between LGBT Youth and their peers. Thus it is important to address the urgent needs of the LGBT and gender variant youth in light of their unique situations and barriers. Youth tend to feel a need to mask sexual orientation, and tobacco use may serve as an instant gratification break from the oppression and stressors of hiding their feelings from their family and friends. Creating a welcoming environment for LGBT people can include posters or pictures depicting LGBT in hallways, or having LGBT leaders on boards or advisory groups (Stevens, 2004). It is especially important to have LGBT youth--preferably former smokers or current smokers--included in the revision process of prevention programs because their input and experience can inform local needs and trends. When no messages are heard that specifically address LGBT youth, most will feel their identity is invalidated or nonexistent. Prevention programs may want to develop "ground rules" for trainings to welcome and be respectful of all youth and to avoid homophobic statements or statements around religion and spirituality when fielding questions about sexuality that could deter LGBT youth and LGBT volunteer facilitators from participating. It is essential that prevention programs advocate for nondiscrimination policies that include sexual orientation and gender identity and gender expression to welcome and include youth.

Successful Tobacco Prevention Programs

The Cochrane Collaboration is a global non-profit organization that performs independent high-quality research using scientific evidence-based methods, to evaluate health care programs. Its study of the effectiveness of current school-based prevention programs found that even though there is a short term benefit there is little evidence that school based prevention programs are effective in long term prevention of smoking uptake (Thomas & Perera, 2006). It also found that giving information alone is not effective (Thomas & Perera, 2006). The outcomes that showed limited effectiveness were achieved with combination of social interventions and multi-modal approaches (Thomas & Perera, 2006). This lack of effectiveness is indicative of the need to put effort into reforming and improving our school based prevention programs. In a previous review, the Cochrane Collaboration found that community based interventions did provide some limited evidence that a coordinated, multi-component community program can help to reduce smoking initiation (Sowden & Stead, 2003). It will be important to include LGBT initiatives in community based prevention programs. For example, if youth community prevention groups are working to pass Clean Indoor Air Laws they could partner with local gay bars and/or LGBT community organizations to advocate for one smoke-free night per week, or for them to host a one-time smoke-free event where they provide prevention messages and information. Or prevention organizations advocating for outdoor smoking laws for parks or playgrounds could partner with local outdoor Pride events to

encourage them to be a smoke-free environment. Policy prevention groups that advocate for increases in cigarette taxes to reduce smoking and to use the new funds for providing more health care for children could include requests for part of those funds to go to HIV/AIDS or Cancer health care organizations. Prevention groups could encourage LGBT community groups to adopt a policy of not taking tobacco sponsorship money for their events. Any creative way to partner with local LGBT leaders or LGBT organizations that brings visibility for tobacco prevention program to the LGBT communities will lead to more successful efforts.

Remafedi identified several important topics to consider when creating LGBT specific interventions: LGBT youth should be involved in the design and implementation of interventions; prevention programs should support positive identity formation, as well as focusing on the positive aspects of nonsmoking and not the negative aspects of smoking (Remafedi, 2007). The general approach to prevention should be entertaining, supportive, and interactive; and the public might not distinguish primary prevention from cessation activities (Remafedi, 2007). Most importantly prevention messages should highlight the positive qualities of nonsmoking (Remafedi, 2007). The success of the TRUTH campaign also suggests these messages should be nondirective and not anti-smoking messages but, anti-industry. There are some great examples of strong messages such as: Fierce Pride New Mexico's message, "We Are A Community, Not a Target Market" (with images of LGBTQ community members); or California's message with a Rainbow Flag with a cigarette embedded for one of the colors of the flag and the caption, "When Did Smoking Become Part of Us?" It is important to give clear messages that incorporate references to sexuality and LGBT images and culture. Messages that are about protecting the community or about standing up to the industry also show promise. The research implies that LGBT youth smoke earlier than their peers so cessation messages should be included with prevention. Including information about second hand smoking risk for pets, especially dogs and cats, have also been a wonderful starting point for cessation programs.

Action Items: Recommended Strategies For Prevention

Policy Level Strategies:

- ◆ **Tobacco prevention programs should advocate for nondiscrimination policies that include sexual orientation and gender identity and gender expression.**
- ◆ Be sure to include and ask LGBT Youth for suggestions and guidance in any efforts to revise or alter the current prevention curricula. Preference should be given to former smokers and current smokers and non-smoking LGBT youth should also be included.
- ◆ Organizations may want to develop "ground rules" for the facilitators and their workshops to welcome and be respectful of all youth and to avoid

homophobic statements or statements around religion and spirituality when fielding questions about sexuality that could deter LGBT youth and LGBT volunteer facilitators from participating.

Awareness, Sensitivity and Creating Safe Spaces

- ◆ Traditional gender roles do not seem to be accurate and applicable to sexual minority youth and gender variant youth. Prevention messages that specifically promote traditional conceptions of binary gender should be avoided.
- ◆ Facilitators need to be coached on how to stop bullying or homophobic comments made by youth during sessions, because if they are not addressed, LGBT youth will be unlikely to return.
- ◆ Facilitators will need education on the proper use of pronouns and using preferred names for gender variant youth who may not fit into a binary system of gender.
- ◆ Prevention organizations may also want to develop a “LGBT Youth and Smoking Brochure” to welcome LGBT youth because without overt welcoming many assume they are not included. Resources for facilitators could be offered for referring LGBTIQ youth, which would serve to reinforce that it is not okay to exclude LGBT Youth from programs.
- ◆ Create welcoming and inclusive spaces that include images of LGBT people.

Messaging and Media Promotion Strategies:

- ◆ Clear messages that incorporate references to sexuality and LGBT culture or that are about protecting the community or standing up to the industry show promise.
- ◆ Include culturally specific messages to target LGBT youth across differing developmental stages i.e. one for teens 13-16 that focus on prevention and 17-24 that include prevention and cessation messages.
- ◆ It is important to closely examine how specific messages may impact smoking behaviors of gender variant and sexual minority youth. Policies should be made explicit that youth disclosure of information about sexuality it will be accepted and validated, without fear of judgment or fear of violation of confidentiality. If youth are not asked, they will not disclose and the unique stressors they face that contribute to higher risk for tobacco use will not be addressed (D’Augelli, 2004).
- ◆ Non-directive messages that highlight the positive attributes of nonsmokers and nonsmoking might prove useful in prevention campaigns. Negative messages that focus on health effect of have images like non-smoking signs are not successful.

- ◆ Messages to the LGBT communities that include information about second hand smoking risk for pets (especially dogs and cats) have also been a wonderful starting point for cessation programs.

Strategies for Program Implementation and Sensitive Providers:

- ◆ Youth need psychosocial support and tips for surviving oppression and dealing with bullying in order to make prevention efforts more successful.
- ◆ Those who are questioning their sexual orientation or who are experiencing same-sex attractions and/or same-sex behaviors and not identifying as gay, lesbian, bisexual or transgender may smoke more. It may be important for facilitators to learn to use gender neutral pronouns in discussing attractions and to use open questions such as: "Are you attracted to boys, girls, both or neither at this point in your life?" These questions send a very different message to youth than those that only ask about opposite sex attraction (D'Augelli, 2004).
- ◆ Have Unisex bathrooms or stated policies about not "policing" bathrooms
- ◆ Visibility and outreach to community organizations is important. Having links on websites to other LGBTIQ Anti-Tobacco Groups or resources will provide more visibility and promote feelings of tolerance.
- ◆ Facilitators may also need LGBTIQ sensitivity training that explains the differences between gender identification and sexual orientation and to be aware that youth may have experienced past judgments and hostility about sexuality. Some have negative feelings about religious programs that have attempted to change their sexuality.
- ◆ Listen carefully and be aware of non-verbal clues.
- ◆ Adjust intake forms to reflect the continuum of gender expression and sexual orientations. Include options for chosen name and not only legal name.
- ◆ Resist making assumptions about gender and ask politely and privately about preferred pronouns if uncertain.

References

Aaron, D.J. & Markovic, N., et al., (2001). Behavior Risk factors for Disease and Preventive health practices Among Lesbians Am J of Public Health, 91(6): 972-975.

Austin, S.B., Ziyadeh, N.; Fisher, L., et al., (2004). Sexual Orientation and Tobacco Use in a cohort Study of US Adolescent Girls and Boys. Arch Pediatric Adolesc Med, Vol 158:317-322.

Bontempo & D'Augelli (2002). Effects of at-school victimization and sexual orientation on lesbian, gay, or bisexual youths' health risk behavior. J Adolescent Health, 30(5): 364-374.

Cass, V. C. (1979). Homosexual identity formation: A theoretical model. Journal

of Homosexuality, 4(3), 219-235.

Cass, V. C. (1983/1984). Homosexual identity: A concept in need of definition. *Journal of Homosexuality*, 9(1-2), 105-126.

Cass, V. C. (1984). Homosexual identity formation: Testing a theoretical model. *Journal of Sex Research*, 20(2), 143-167.

Cass, V.C. (1979, 1984, 1990). In Ritter and Terndrup (2002) *Handbook of Affirmative Psychotherapy with Lesbians and Gay Men*.

Cochran, B., Stewart, A., Ginzler, J, and Cauce, A., (2002). Challenges Faced by Homeless Sexual Minorities: Comparison of Gay, Lesbian, Bisexual, and Transgender Homeless Adolescents With Their Heterosexual Counterparts. *Am J Public Health*, 92(5): 773–777.

Cochran, S. et al. (2001). Cancer-related risk indicators and preventive screening behaviors among lesbians and bisexual women. *AM J Public Health*, 91(4): 591-597. Here are the Seven Lesbian survey that were used in this study: 1993 National Lesbian and Bisexual Women's Health Survey [Gage]; 1987 Boston Lesbian Health Project [Roberts, Sorenson]; 1989 Michigan Lesbian Health Survey [Bybee, Roeder]; 1995-96 Massachusetts Lesbian Health Needs Assessment [Goldstein]; 1994 Houston Lesbian Health Initiative [Robison, Becker]; 1996 North Carolina Women's Health Access Survey [Rankow, Rimer, Tessaro]; 1993-1994 Oregon Lesbian Health Survey [White, Dull]; total n=11,876.

Constantino, J. (2002). *Gay Teens and Smoking: At Least the Carmel Doesn't Call Them names Or Kick Them Out of the House*, (I Need to find citation)

D'Augelli, A. R. (2004). Editorial, high Tobacco Use Among Lesbian, gay and Bisexual Youth: Mounting Evidence About a hidden Population's health Risk Behavior. *Arch Pediatric Adolescence Med*/Vol 158:309-310.

D'Augelli, A. R. (1994). Lesbian and gay male development: Steps toward an analysis of lesbians' and gay men's lives. In B. Greene & G. M. Herek (Eds.), *Lesbian and gay psychology: Theory, research, and clinical implications (Psychological Perspectives on Lesbian and Gay Issues, Vol. 1, pp. 118-132)*. Thousand Oaks, CA: Sage.

D'Augelli, A. R. (1994). Identity development and sexual orientation: Toward a model of lesbian, gay, and bisexual development. In E. J. Trickett, R. J. Watts, & D. Birman (Eds.), *Human diversity: Perspectives on people in context* (pp. 312-333). San Francisco: Jossey-Bass.

D'Augelli, A. R. (1991). Gay men in college: Identity processes and adaptations. *Journal of College Student Development*, 32(2), 140-146.

Diamond, L.M. (2000). Sexual identity, attractions and behavior among young sexual-minority women over a two-year period. *Developmental Psychology*, 36:241-250.

DuRant, R.H., Krowchuk, D.P., Sinal, S.H. (1998). Victimization, use of violence, and drug use as school among male adolescents who engage in same-sex sexual behavior. *Journal of Pediatrics*, 133:113-118.

Eisenberg, M., & Wechsler, H. (2003). Substance use behaviors among college students with same-sex and opposite-sex experience: Results from a national study. *Addictive Behaviors*, 28, 899-913.

Faulkner & Cranston (1998). Correlates of same-sex sexual behavior in a random sample of Massachusetts's high school students. *AM J Public Health*, 88:262-266.

Friedman, M.S., Silvestre, A.J., Gold, M.A., Markovic, N., et al.,(2004). Adolescents define sexual orientation and suggest ways to measure it. *Journal of Adolescence* Vol 27 Issue 3:303-317.

Garofalo et al. (1998). The association between health risk behaviors and sexual orientation among a school-based sample of adolescents. *Pediatrics*, 101:895-902.

Gillium, Jessie, (2001). "Issues at a Glance," *Young Women Who Have Sex with Women: Falling Through the Cracks for Sexual Health Care.* Advocates for Youth, 2001.

Golden, C. (1994). Our politics and choices: The feminist movement and sexual orientation. *Suicide and Life-Threatening Behavior*, 25 (supplement):40-51.

Greenwood, et. al. (2005). Tobacco use and cessation among a household based sample of US urban men who have sex with men. *AM J Public Health*, 95(1):45-151.

Gruskin, E., Greenwood, G.L., Matevia, M., Pollack, L., and Bye, L., (2007). Disparities in Smoking Between the Lesbian, Gay, and Bisexual Population and the General Population in California, *Am J Public Health*, 97 (8) 1496-1502.

Gruskin, E., Hart S, Gordon N, Ackerson L. (2001). Patterns of cigarette smoking and alcohol use among lesbians and bisexual women enrolled in a large health maintenance organization, *Am J Public Health*, 91 (6):976-979.

Harris Interactive. Gay and lesbian brand loyalty linked to advertising. <http://www.harrisinteractive.com/news/allnewsbydate.asp?NewsID=478>. Accessed May 23, 2005.

Kirk, D., Schubert, S., Szego, R., (2006). Smoking in the Oregon LGBTQ Communities, *Pride Survey, 2006*, Available from Oregon Department of Human

Services Tobacco Prevention and Education Program (TPEP) e-mail:
stacey.s.schubert@state.or.us or reszege@cascadiabhc.org .

Kruks G. Gay and lesbian homeless/street youth: special issues and concerns. *J Adolesc Health*. 1991;12:515–518.

Laumann. E.O., Gagnon. J.H., Michael, R.T. & Michaels, S. (1994). *The social organization of sexuality: Sexual practice in the United States*. Chicago: University Press.

Ling, P. & Glantz, S. (2002), Why and How the Tobacco industry Sells Cigarettes to Young Adults: Evidence From Industry Documents, *Am J of Public Health* 6/02 VOL 92, No 6:908-916

Massey, C.J. (2004). *Psychosocial Correlates of Smoking In College Students*, NIDA Funding, Pending Publication.

National Network of Runaway and Youth Services, (1985). *To whom do they belong? A profile of America's Runaway and Homeless Youth and the programs that help them*. Washington, DC: 1985.

Offen N, Smith EA, Malone RE. (2003). From adversary to target market: the ACT-UP boycott of Philip Morris. *Tob Control*. Jun 2003;12(2):203-207.

Offen, N. (2005). Is tobacco a queer issue? Perceptions of LGBT community leaders. Paper presented at: National Conference on Tobacco or Health; May 4, 2005; Chicago.

Paul, J. (2002). Qualitative Interviews of 100 LGB Youth from the African American, Latino, Asian Pacific Islander and White Communities presented at the National Conference on Tobacco or Health, November, 2002.

Padilla, J., Reid, C., Peñaloza, L., (2006) New Mexico's 2006 Lesbian, Gay, Bisexual, And Transgender (LGBT) Tobacco Survey LGBT Tobacco Survey; This report is available online at <http://hsc.unm.edu/programs/tupac/>.

Remafedi. G., (2007) Lesbian, gay, bisexual and transgender youths: Who smokes and why?, *Nicotine & Tobacco Research*, 9:1,S65-71

Remafedi. G. & Carol, H. (2005) Preventing tobacco use among lesbian, gay, bisexual, and transgender youths. *Nicotine and Tobacco Research*, 7:249-256.

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

Remafedi, G., Resnick., M, Blum, R. & Harris,.L. (1992). Demography of sexual orientation in adolescents. *Journal of Pediatrics*, 89(4):714-721.

Rotheram-Borus, M., Koopman, C. & Ehrhardt A. (1991). Homeless youths and

HIV infection. *Am Psychology*, 46:1188–1197.

Russell et al. (2002). Adolescent same-sex romantic attractions and relationships: implications for substance use and abuse. *American Journal of Public Health*, 92 (2):198-202.

Ryan, et al. (2001). Smoking among lesbians, gays, and bisexuals: A review of the literature. *Am J Prev Med*, 21(2):142-149.

Savin-Williams, R. C. (2001). Suicide attempts among sexual-minority youths: Population and measurement issues. *Journal of Counseling and Clinical Psychology*, 69 (6):876-882.

Sell RL., (1997). Defining and measuring sexual orientation: a review. *Arch Sex Behavior*, 26:643–658.

Sepe, E., & Glantz, S.(2002), "Bar and Club Tobacco Promotions in the Alternative Press: Targeting Young Adults" *Am J Public Health*, 2002; VOL 92, NO 1 pgs: 75-78

Skinner & Otis (1996). drug and alcohol use among lesbian and gay people in a Southern U.S. sample: epidemiological, comparative, and methodological findings from the Trilogy Project. *J Homosexuality*, 30 (3):59-92.

Smith, E.A., Offen, N & Malone, R. E. (2006). Pictures Worth a thousand Words: Noncommercial Tobacco Content in the Lesbian, gay, and Bisexual Press, *journal of Health Communication*, 11:635-649.

Smith, E.A., Offen, N & Malone, R. E. (2005). What makes an ad a cigarette ad? Commercial tobacco imagery in the lesbian, gay and bisexual press. *Journal of Epidemiology and Community Health*, December 2005;59:1086-1091.

Smith, E. A. & Malone, R. E. (2004) 'Creative Solutions': Selling cigarettes in a smoke-free world, *Tob Control*, 13:57-63.

Smith, E.A. & Malone, R. E. (2003). The outing of Philip Morris: Advertising tobacco to gay men, *Am J Public Health*, 93(6):988-993.

Stall, et al. (1999). Cigarette smoking among gay and bisexual men. *AM J Public Health*, 89 (12):875-878.

Sowden, A. & Stead, L., (2003). Community interventions for preventing smoking in young people. *Cochrane Database of Systematic Reviews* 2003, Issue 1 Art. No.: CD001291. DOI: 10.1002/14651858.CD001291.

Stevens P, Carlson LM, Hinman JM. (2004). An analysis of tobacco industry marketing to lesbian, gay, bisexual, and transgender (LGBT) populations: strategies for mainstream tobacco control and prevention. *Health Promotion Practice* July 2004;5(3 Suppl):129S-134S.

Tang, et al, (2004). Cigarette smoking among lesbians, gays, and bisexuals: How serious a problem? *Cancer Causes Control*, 15(8):797-803.

Tenner AD, Trevithick LA, Wagner V, Burch R. Seattle Youth: Care's prevention, intervention and education program: a model of care for HIV-positive, homeless, and at-risk youth. *J Adolesc Health*. 1998;23:96–106.

Thomas R. & Perera, R. (2006). School-based programmes for preventing smoking. *Cochrane Database of Systematic Reviews* 2006, Issue 3. Art. No.:CD0001293. DOI: 10.1002/14651858.CD001293.pub2.

Unger, J. B., Kipke, M. D., Simon, T. R., Montgomery, S. B., & Johnson, C. J. (1997). Homeless youths and young adults in Los Angeles: Prevalence of mental health problems and the relationship between mental health and substance abuse disorders. *American Journal of Community Psychology*, 25, 371-394.

Xavier, J., Honnold, J., and Bradford, J. (2007) The Health, Health-related Needs, and Lifecourse Experiences of Transgender Virginians. Virginia HIV Community Planning Committee and Virginia Department of Health. Available online at: <http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/documents/pdf/THISFINALREPORTVol1.pdf>

Xavier, J., Bobbin, M., Singer, T.B. and Budd, E. (2005). A Needs Assessment of Transgendered People of Color Living in Washington, DC. *International Journal of Transgenderism*, 8 (2/3):31-47.

Xavier, J. (2000) Final Report of the Washington DC Transgender Needs Assessment Survey. HIV and AIDS Administration, Government of the District of Columbia. Available online at: <http://www.gender.org/resources/dge/gea01011.pdf>