LGBT Disease Prevention and Health Promotion: Wellness for Gay, Lesbian, Bisexual, and Transgender Individuals and Communities

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INTRODUCTION

Although the federal government’s prevention agenda for the Nation, Healthy People 2010 (1), lays out an action plan for improving the health of all people in the United States, it neglects specific mention of the Nation’s gay, lesbian, bisexual, and transgender people (GLBT) (2). To fill this gap, the Gay and Lesbian Medical Association, developed a companion document to Healthy People 2010 (3) that gathered together existing quantitative and qualitative research and information specific to GLBT health in the areas defined in Healthy People 2010. This document discusses the health status of GLBT people in so far as data was available. Healthy People 2010 focuses, for the most part, on those health conditions (i.e., Cancer, HIV/AIDS, Infectious Diseases, Mental Disorders, and Sexually Transmitted Diseases), and

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health behaviors that are detrimental to human health (i.e., Substance Abuse, Tobacco Use, and Violence) that burden individuals and communities (4).

Missing from these discussions was any consideration of healthy GLBT people. Thus, this article focuses on wellness and health maintenance for the GLBT population. The authors recognize that individual health is closely linked to overall community health (including environments in which individuals live, work, worship, and play), but acknowledge that the “gay community” is a fluid, more conceptual community than an actual place in many communities. Granted, most large urban centers have a neighborhood or enclave that is largely identified as “that gay neighborhood,” such as the Castro in San Francisco, Capitol Hill in Seattle, or Dupont Circle in Washington, DC. However, these aggregations of restaurants, stores, and residences are transient, because the locus of GLBT social intercourse can change with changing urban conditions. Indeed, GLBT people are distributed throughout all socioeconomic levels, and may be found in worksites, places of worship, recreational sites, as well as in rural and urban communities.

Some GLBT individuals become targets of harassment and discrimination, while others “pass” because of their professional position in the community, or they may actively work at hiding within the larger society for fear of prejudice and discrimination. There are also individuals who truly do not initially recognize their sexual orientation, or accept it until they are adults. It is a fairly safe assumption that there are many more GLBT individuals than there are currently believed to be living in our communities. The hope of those who acknowledge their orientation is that, someday, the civil and human rights accorded to all other individuals within the United States will be extended to GLBT people. It is also hoped that the insidious and hate-filled misinformation promulgated by certain affinity groups and fringe faith traditions would become a thing of the past. But GLBT people acknowledge that, even with legal protection, minorities, women and variously abled persons will suffer from prejudice and discrimination. Equal and civil rights will take time, understanding, and mutual communication. However, disease prevention and health promotion can be attained now, based on choices about positive and negative health behaviors. This is the focus of this article.

The Fundamentals of Wellness

It is important that all people, including GLBT individuals, work on maintaining their own health and well being. Despite the miracles of contemporary western allopathic medicine, along with increasing respect for alternative (non-allopathic) medical practices, the ultimate responsibility for human health is one’s own. Ideally, when an individual has access to the medical care system, this encounter is advised and assisted by a primary care physician or nurse practitioner. Most clinicians assume that individuals will accept responsibility for their own behavior, including following therapeutic drug regimes and other prescribed activities. One of the earliest of the various influences on health promotion and disease prevention was described as the “health field concept.” The framework, initially discussed by Lafromboise in 1973 (5) was then expanded by Marc Lalonde, Canadian Minister of National Health (6,7), and put forward as the 1974 national plan for population
wellness among Canadians. Lalonde maintained that health was determined by a variety of factors that he distributed across four main divisions: human biology or genetics, health care organization, environment, and what Lalonde identified as “life style” (8,9).

Of these four major influences on human health, some are far more amenable to direct control by the individual than others. In reality, the individual has virtually no control over his or her biological inheritance determined by the genetic contribution of parents and ancestors. Thus, heredity may be viewed as the internal or host variable of health status (10). Genetic inheritance may help determine such autonomic functions as metabolism as well as patterns of behavior and susceptibility to chronic medical conditions such as cancers, coronary and/or vascular disease, and high cholesterol. Genes also encode conditions from color blindness to Huntington’s Disease. Some scholars and researchers have postulated that same sex orientation may also have genetic origins (11–15).

The environment is a second factor influencing human health. Unlike genetics, this is an external factor affecting people. The environment includes physical elements such as air and water, as well as chemical and biological pollutants, quality of housing and disease-bearing animal vectors (16). A different sort of environment might include those factors that enhance or diminish individual dignity and the maintenance of self-respect: the socio-cultural environment (17). The sociocultural environment may include the ways in which we work, the people with whom we interact, the faith community that we participate in, and those other environmental factors that enhance or deter the gratification received from this socialization or lack thereof (18). Thus, the social environment is perceived as a major determinant of an individual’s psychological health (19).

The third influential factor over health is also external, being the availability, quantity, quality, and utilization of health services. Some individuals equate this factor with that of the medical care system, a system that is undergoing rapid and dramatic changes as the processes of managed care saturate the private system and move rapidly into the public arena (20). The health care system is, however, much broader than the medical care system (see volume 19(2&3) issue of Clinical Research and Regulatory Affairs in this series on GLBT health). Whatever services are available to the individual, inappropriate utilization of the health care system occurs when either an individual or a provider “medicalizes” an individual’s life, reducing all problems to medical terms (21) or failing to perceive the presenting problems in the context of a whole person (i.e., one who has a life outside of the physician’s office).

The final factor said to influence health is what Lalonde originally termed “life style.” This factor includes behaviors that fall within the individual’s decision-making, including choices of positive or negative actions that would have direct consequences on his or her health. Included in life style behaviors are such behaviors as the amount and quality of diet, exercise, sexual activity, work, reaction to stress, and use of such drugs as alcohol, tobacco and the illicit drugs (e.g., heroine, cocaine, etc.), designer drugs (crystal methamphetamine, ecstasy, and ketamine among others) (22), and street-obtained pharmaceuticals such as oxycodon and valium. An individual can be made ill by the way he or she lives; and both behavioral excesses and deficiencies are factors determining health, wellness, disorder, or disease (23).
The term “life style” has been expanded by some to include sexual orientation. In the context of Lalonde’s “life style” concept, this is inappropriate. Life style does not bear any relationship to the genetic make-up of the individual. There is no “gay life style” unique to GLBT communities, but GLBT individuals can certainly choose to behave in ways that endanger their personal health just as do non-GLBT individuals. In addition, although there is not a “gay life style” as such, there may be GLBT subcultures with their own dress, language, customs, and social behaviors. These might include the female impressionists (often referred to as doing “drag”) (24–26), and those individuals who engage in sado-masochistic practices (sometimes referred to as the leather set). There are many other loose affiliations, as well as structured social groupings of gay individuals who come together for professional or recreational socialization in order to be with others who identify as gay and lesbian. These groups and organizations include an international association for individuals who love choral music, the GALA Choruses, discussed below, along with an increasing GLBT presence within professional associations. The growing number of within-organization groups found in most professional associations are the result of a need for GLBT members to focus on issues that affect GLBT members and/or professional practice as it deals with GLBT individuals. Thus, it is important to make a distinction between genetic contributions governing orientation and behavioral choices made by GLBT individuals about things that can be harmful or healthful. Most GLBT individuals would suggest that their orientation is not a choice they made, but an awareness that they try to accommodate and live with.

But there is concern among GLBT healthcare providers that, in part as a reaction to prejudice, discrimination, and violence, GLBT individuals may have a higher prevalence of alcohol, tobacco, drug misuse, and depression than members of the majority population may (27). However, there is data to suggest that other minority populations have increased substance misuse due to actual and perceived oppression and discrimination (28–31). But using “life style” to suggest that being homosexual is a choice, like selecting one’s electronic mail provider, is an incorrect application of this factor.

Overall, Lalonde’s four field concept for explaining and maintaining health was intended to focus policy and program on that area in which the greatest progress could be achieved most easily: health behavior choices (32). He did not rule out trying to make changes in the environment and the health care system, but he did recognize that these areas would be harder to change, and would require massive resources to bring about changes. The most immediate and positive changes are those that constitute individual health behaviors. Since Lalonde’s original discourse, there have been a plethora of published research seeking to explain and intervene in risk-taking behavior and directed at helping individuals make appropriate decisions for positive health behaviors (33). Changing negative to positive health behaviors is a plan that any individual can adopt, GLBT or not. In fact, a recent edition of the Guide to Clinical Preventive Services has added an entire section on health behavior counseling, including chapters on counseling to prevent tobacco use, motor vehicle injuries, youth violence, HIV infection, other sexually transmitted diseases, and unintended pregnancies (34). In addition, this volume also has chapters on the promotion of physical activity and a healthy diet.
Wellness Across the Life Span

One’s health status changes over time. What are optimal dietary and physical guidelines for a child and an adolescent are different for a mid-life or elderly individual. The basic recommendations for staying healthy essentially are the same for all people. Moderate intake of alcohol, a balanced diet low in fats and sugars, a regular exercise regimen that contributes to cardiovascular health, adequate sleep, reduction of stress, and cessation of tobacco use are generally recommended (35,36). In addition, there are standard recommendations for sexual and reproductive health (37). These guidelines include having regular check-ups for sexually transmitted diseases, an annual Pap smear regardless of sexual activity, regular testicular examination for adolescent and adult men, and familiarizing oneself with what is “normal” for each individual (i.e., some individuals have a lower or higher normal blood pressure than the average recommended in books. Know what is normal for you before jumping to conclusions that a lower blood pressure is a symptom of ill health). For sexually active adolescents and adults, regular use of a condom during intercourse (unless a child is wanted/planned) is recommended. Seeing a physician or nurse practitioner and dentist at regular intervals, commensurate with one’s age and health status, is a good practice for preventing disease and maintaining wellness for all people.

General health is also maintained if an individual receives required immunizations throughout the life span (38). Most local health departments can provide the latest guidelines on recommended intervals for such immunizations. Routine dental care is also recommended, beginning in childhood (39). Recommendations for mental health are more difficult to find, as the focus of research and treatment has been on mental illness and psychological disorder. Yet the majority of GLBT people are healthy, both physically and mentally. Adequate rest assists maintenance of mental health, stress reduction, adequate coping skills, high self-efficacy, and strong social support (including both secular groups and spiritual observances) (40,41). In addition, healthy social outlets and strong social support networks are needed, beyond the ubiquitous bar culture. This is especially true for GLBT individuals over the age of 60 (42,43) and for youth that are just becoming aware of their differences. These young people need parental figures among other GLBT individuals. As many families reject their GLBT children, often non-family members are found to be more supportive than family when it comes to getting information about living as a GLBT person (44).

GLBT individuals also have the same need for some spiritual outlet and support as other people do. Yet many established religious institutions hold that GLBT orientation is prohibited by their sacred texts, and thus GLBT individuals and families are denied access to many of the faith traditions (45,46). To counteract this exclusion, in 1968 a gay evangelical minister founded a Christian church, the United Fellowship of Metropolitan Community Churches (UFMCC), to minister particularly to GLBT’s who have been caste out of their childhood churches (47).

Achieving the Wholeness That Leads to Wellness

“We must move beyond pathology to recognize that health also includes pleasure and wellness.” Daniel Wolfe.
While the steps to attaining and maintaining GLBT wellness are basically no different from the non-GLBT population, there are areas within the physical, mental, social, and spiritual environments (taken from Four Worlds medicine wheel concept (48)) that do require special attention. The concept of wholeness is a major frame of reference for an individual seeking to define him- or herself. Wholeness implies a balance between physical, mental, spiritual, and emotional well being. Studies have documented the relationship between stress and physical health and how being out of “balance” can increase certain health risks. For the GLBT population, the stress associated with coming out to family friends, and employers, and stress sensitive disorders associated with homophobia and bias increases physical and mental health problems (49).

General wellness is critical for each stage of life for all individuals. Healthy behaviors are learned just as high-risk behaviors are learned. Chronic illness can be avoided in later years of life if healthier behaviors are adopted in adolescence. For example, learning and using safer sex practices as teens and young adults can protect individual from HIV infection, hepatitis and other sexually transmitted diseases. Therefore, focusing on youth and teaching them healthier behaviors is critical to public health. When examining GLBT youth, one finds a multitude of risk factors that contribute to high-risk behavior. Hart and Heimberg found that gay, lesbian and bisexual youth are at risk for various mental health problems stemming from homophobia among family, peers, and authority figures in both their home and school environments (50). Other problems included depression, suicidality, social anxiety, body image disturbance (51), increased substance abuse, school dropout, and homelessness (52). Risk factors put GLBT youth at greater risk for mental health problems, sexual risk taking and poorer general health maintenance (53). For example, suicide prevalence among GLBT youth ranges from 11–42% (54). Homelessness is also a major health risk affecting GLBT youth wellness. Homeless GLBT youth are found to leave home more frequently, have higher rates of psychopathology, and more sexual partners (55).

As GLBT individuals continue through the life cycle, they must also address issues affecting general wellness including substance misuse, homophobia, and domestic violence. For example, Merrill and Wolfe found that experiences of battered gay and bisexual men were similar to battered lesbians in that they infrequently sought assistance from battered women’s services and instead found individual counselors and agencies with individual counselors to be more helpful (56). Different from heterosexuals, battered gay men stayed not for financial reasons, but for hope of change, love for a partner, and HIV-status (57).

It is critical that providers are aware of the unique social development and psycho-educational needs of GLBT people in all stages of life. As an example, older male GLBT individuals (ages 60–91) report significantly more internalized homophobia, alcohol abuse and suicidality related to their sexual orientation than did women in one survey (58). Health provider’s awareness of these risk factors can better assist the individual in identifying social support systems and/or addressing depression later in life. Cochran stated that lesbians and gay men who seek mental health services must find culturally competent health providers in a system that does not address the unique features of the gay and lesbian community (59). Lehmann, Lehmann and Kelly attempted to identify psychosocial and health care needs of
Lesbians and their relationships with their primary care providers (60) and they found that of the 53 women who completed the questionnaire, 60% disclosed their sexual orientation to their parents, but only 31% had come out to their health care provider. Of those who came out, 27% reported negative effect on their health care (61). Lesbian risk factors identified by Lehmann and colleagues included childhood abuse, drug (including alcohol) problems, suicide attempts, and physical and verbal abuse at school (62). Negative health care experiences reduce the opportunities to address risk factors associated with poor health and lead to miss opportunities for increased psycho-educational dialogue that could promote healthier behaviors.

In an effort to increase wellness in the GLBT communities, community organizations, community clinics, and advocates have worked to incorporate cultural competency training in their health provider training. These groups have also worked hard to provide education to the general community to increase awareness and understanding about the GLBT individuals living within the community. For example, the Gay, Lesbian, Bisexual and Transgender Health Access Project in Massachusetts developed community standards of practice for provision of quality health care within the community (63). The Fenway Community Clinic is another example of a grassroots neighborhood clinic that expanded to provide GLBT clinical programs, community education, research, administration, planning, and development. Fenway established standards to improve the delivery of culturally competent care by focusing on GLBT health issues for other healthcare providers and presented programs to educate the broader community as well (64). In addition, internet websites like GayHealth.com promote healthy living by answering readers and questions and posting up-to-date information on sex, drugs, emotions, general health, image, food and fitness, and society for GLBT communities. GayHealth.com also has a provider-only section and a care network section. Daniel Wolfe’s “Men Like Us: The Gay Men’s Health Crisis Complete Guide to Gay Men’s Sexual, Physical, and Emotional Well Being” (65) and McClure and Vespry’s “Lesbian Health Guide” (66) are also major tools in empowering the GLB community in positive health. With growing awareness and education, the health care team can provide the support and understanding needed to address the unique issues GLBT individuals face in their journey to health and wholeness.

**Mental and Emotional Health**

GLBT individuals must deal with various factors affecting mental and emotional imbalance. These factors include everything from childhood abuse, homophobia, emotional and/or physical abuse as well as substance abuse. For example, sexual abuse was found to be significantly associated with mental health counseling and hospitalization, along with substance abuse, depression, suicidal thoughts or actions, lack of social support, sexual identity development, and HIV risk behaviors (67). In the 1994 National Lesbian Health Care Survey, over half the 1925 individuals in the sample stated that they had thoughts about suicide at some time and 18% had attempted suicide. Approximately 37% had been physically abused as a child or adult, 32% had been raped or sexually attacked, and 19% had been involved in incestuous relationships while growing up. Substance abuse included use of tobacco...
on a daily basis (33%), while 30% reported drinking alcohol more than once a week (68). More recent research has suggested that lesbians and gay men were at higher risk for stress-sensitive psychiatric disorders than heterosexuals were (69). These researchers found that perceived discrimination was positively associated with both harmful effects on quality of life and indicators of psychiatric morbidity.

Additional research has reported that significant mental and physical morbidity occurs among gay and bisexual men because health care providers are unaware of actual or potential health concerns (70). Specific mental health concerns include anxiety, depression, suicide, and alcohol and other substance abuse. Another study examined health indicators among self-identified lesbians, bisexual women and heterosexual women in Los Angeles County. Although prevalence rates of chronic health conditions were similar among women in Hispanic, African American and Asian American women, lesbians and bisexual women had higher behavioral risks and lower rates of preventive care than heterosexual women (71).

Other studies corroborate these findings. For example, a community survey of 4824 young and middle-aged adults in Australia recorded measures of anxiety, depression, suicidality, alcohol misuse, positive and negative affect and a range of risk factors associated with poor mental health (72). Through participant self-identification, the researchers identified homosexual, bisexual and heterosexual individuals and were able to compare emotional well being using the Positive and Negative Affect Scales (PANAS). The sample consisted of 2331 persons between the ages of 20 to 24 and 2493 between the ages of 40 and 44. Seventy-eight reported to be homosexual and 71 reported being bisexual. Incidence of bisexuality was greater among 20–24 year olds (1.8% in men and 2.7% in women compared to 0.8% in men and 0.8% in women). Homosexuality was reported more often in the 40–44 year old age group (73). The Jorm et al. study was able to examine poor mental health among heterosexual, homosexual and bisexual groups individually, something not done or weak in other studies on GLBT mental health (74).

Overall, the bisexual group had significantly poorer mental health than the homosexual group and the heterosexual group (75). This critical finding suggests that bisexuals have poorer mental health because of increased childhood adversity, more current adverse life events, less positive support from family and friends, more years of education and more financial difficulties than the homosexual group. Risk factors associated with findings include the possibility of not having a clear heterosexual or homosexual orientation and social pressures associated with having a different sexual orientation (76) (not fitting totally in the heterosexual community and not totally fitting in to the homosexuality community). The study had several limitations including a single question determining sexual orientation, whether or not the terms “homosexual,” “heterosexual,” and “bisexual” were clear and consistent, a low participation rate, low numbers of homosexual and bisexual participants, and the lack of measuring feelings of stigma and experiences of discrimination (77).

Little information is available about the specific factors affecting transgendered individuals’ mental and emotional well being. One researcher, in developing a review of clinical provider knowledge about GLBT patients, found that health care risks for these populations were elevated because providers lack the knowledge of the
patient’s sexual or gender orientation, and are ignorant of specific health care issues with these patients.

The patients, in turn, feel that the providers are homo- or transphobic, and thus not to be trusted (78). Health risks for the GLBT population are ones already cited (i.e., depression, suicide, and substance misuse), along with violence directed at individuals perceived to be GLBT (79). Among GLBT youth, the risks for emotional and psychosocial problems increase due to feelings of emotional isolation from peers, verbal and physical violence directed at them in school, and rejection by peers, family, and faith traditions. This may result in homelessness and prostitution, adding to GLBT risks of contracting HIV and other sexually transmitted diseases, as well as increased opportunities for drug misuse and violence (80).

For those individuals who identify as transgendered (81), there are even greater risks for depression, suicide, substance misuse, and anti-gay violence (even though transgender is not synonymous with same-gender orientation). In addition to risks for increased psychological pathology, transgendered individuals are still defined by the American Psychiatric Association as people having a gender identity disorder (82,83). They make up a minority within a minority, and there is very little research available to inform or enlighten interested clinicians. Among the GLBT community, these individuals are as deserving of clinical compassion and competence as any other sexual minority.

Overall, emotional health is a composite of a sense of self-worth, combined with strong social and/or spiritual support, and access to expressive or creative outlets. The arts have always provided positive emotional outlet for participating individuals. Common outlets for creative expression as well as social support are found in the arts, be this writing, painting, fashion design, theater performance, or music. One of the better known examples allowing wide involvement of GLBT people is the international gay and lesbian chorus movement: the GALA Choruses. This association serves 185 choruses representing 10,000 singers in 11 countries. It was founded in 1982 by 14 choruses and has grown with new choruses joining at the rate of one per month (84). There are also gay bands, symphonies, theaters, and the individual plastic arts: painting, sculpture, etc. Being ostracized from their communities and churches, GLBT people have sought to create their own recreational and cultural outlets. These efforts have been very successful and have attracted major corporate sponsors. Several of the larger choruses have a substantial non-GLBT following in their communities, and use music as a way to communicate and help overcome prejudice and misunderstanding.

Spiritual

The relationship between mental health, emotional health and spirituality is a critical one. The spiritual domain is often not discussed with mental and emotional health, perhaps because of its perceived subjectivity or the strong feelings around the issues that any discussion of faith traditions raise in “bible abused” (85–88) individuals. Spirituality provides us with a way in which we find meaning, explain our life and how we think about ourselves. This may include participation in established faith traditions or participating in alternative spiritual observances, such as Wicca.
Not only do GLBT people face homophobia within the general society, but also have additional negative stress associated between religion, heterosexism, and sexual orientation. Such a disruption adds to the emotional and mental stress of being an GLBT person.

Sources of conflict include denominational teachings, scriptural passages, shame, depression, and suicidal ideation (89). As a response, GLBT people have either made a clear distinction between spirituality and religion, changed their religious affiliations, ceased attending religious services or abandoned religion all together (90). GLBT people are then faced with not only dealing with social homophobia, but also church-based homophobia occurring within an institution whose main purpose is to provide spiritual comfort and emotional health. Toby Johnson (2000) stated: “Managing to reject social norms and prejudices and then to recreate a whole new interpretation of the world based on personal experience is an enormous task. The function of spiritual wisdom is to assist with such a task” (91 p.7).

Nothing has defined the role and importance of spirituality in GLBT life more than the impact of AIDS. Matthew Fox shared a story in de la Huerta’s book “Coming Out Spiritually,” about a good friend in his creation spirituality master’s program spirituality who also had AIDS. At the end of his life, he told Fox: “Tell the people that AIDS is a blessing. It is a blessing because the journey is so deep, and it is a blessing because it will help us to be more honest about sexuality” (92 p.xi). The AIDS crisis has given opportunity to people with AIDS, their caregivers and their family and friends to explore all aspects of living and to gain deeper understanding of compassion, grief, joy, and gratitude. A study by Hall (1998) looked at the role of spirituality in dealing with HIV. The qualitative interview identified three major themes (93):

1. The purpose of life emerges from stigmatization.
2. Meanings that arise from a disease without a cure; and
3. Spirituality as it frames one’s life (94).

From a caregivers’ perspective, spirituality provides personal growth, value and direction which in turn, relates to healthier emotional well being. Richards (1999) found that although there was no significant relationship between spirituality, mood, coping and physical health, there were some observed relationships needing further research to verify (95). Another study that included 125 bereaved partners (both HIV negative and positive) found that measured spiritual schemas based on beliefs, experiences, rituals, social support, and roles. The effects of spirituality connect the role it plays in mental and physical health. In looking at the relationship between spirituality, mood, and physical health of the 68 interviews, those reporting spiritual phenomena showed higher levels of depression and anxiety and lower positive states. They also used more coping strategies and reported more physical health symptoms. Health care providers and spiritual leaders need to be aware of the dynamic effects, both positive and negative, that spirituality has on the patient and the caregiver (96).

Where does a GLBT person find a positive environment to explore what it means to be gay and to foster spiritual growth? Johnson advises that the point of gay spirituality is to find and then proclaim the meaning of being homosexual, to answer the question; ‘What is the message from the Universe, from God, conveyed
by my queer nature?’ (97). One of the major sources of positive activity for emotional and spiritual health is church attendance and fellowship. There has been a great rise of affinity groups among the various faith traditions in the United States. These include the specific ministry founded to serve GLBT people, and now one of the fastest growing denominations in the world, the United Fellowship of Metropolitan Community Churches (Headquartered in LA), as well as support groups for members of most all faith traditions which are more or less in affiliation with their denominations. A church that mindfully and consciously decided to accept and affirm GLBT parishioners is variously referred to as “reconciling” (Methodists) or “Open and Affirming” (American Baptist, United Church of Christ. UCC is also the only denomination that has, as a denomination, declared itself to be open and affirming).

Virtually every major denomination has these gay support groups. These include Dignity for Gay Catholics and Integrity for Gay Episcopalians, as well as spiritual support groups for GLBT members of Jewish, Muslim, Lutheran, Baptist, Presbyterian, Methodist, the Church of Latter Day Saints of Jesus Christ (more commonly known as “Mormons”) and most all other faith traditions. There is hope that those GLBT individuals seeking support from the spiritual and faith communities will increasingly find welcome as more and more individual churches become reconciling or open and affirming. The issue of seeing Biblical passages as condemning homosexuality while ignoring those Biblical stories that support homosexuals (98) is increasingly being brought to denominational convocations by GLBT people in the faith traditions and their allies. There is also a national non-violent movement to stop church and biblical violence against GLBT people, headed up by the Rev. Jerry Falwell’s former ghostwriter, the Rev. Dr. Mel White. This movement based on the principles of Ghandi and Martin Luther King is called Soul Force (99).

Physical

Physical activities provide important social outlets as well as providing exercise. While there are various regimens and workout recommendations for maintaining physical health, there is general consensus that moderate physical activity on a regular basis is best for everyone. Walking is often cited as the easiest exercise. There are even charts of how many calories housework burns. Gay men tend to work out to emphasize their musculature, but require cautions about overworking muscles, overdeveloping the body, and use of drugs to enhance physique. Increasingly, women are also working out, and need guidance on setting healthy levels of exercise and use of weights.

Many GLBT individuals love recreational and competitive sports, both individual and team sports. One of the largest gatherings for GLBT sports aficionados is the rapidly growing international sports and cultural festival known as the Gay Games. These take place every 4 years, and are hosted by different nations. For example, the 2002 Gay Games VI, will be held in Sydney, Australia, with over 11,500 athletes expected, along with 3000 volunteers, and 2000 cultural festival participants. About 800 accredited media representatives are expected to cover the 45 sport venues, 31 sports, and 9 days of accompanying conferences and workshops. The games...
accommodate teams and individuals from every skill level, from previous Olympic athletes to community softball teams (100).

Need for Safe Schools and Accepting Communities

Growing up emotionally healthy implies a safe and nurturing environment, not only at home but also in one’s educational environment. In the last two decades of the 20th Century and the beginning of the 21st Century, there emerged increasing reports of school children being harassed, verbally and physically attacked, perhaps murdered, or driven to suicide because these children were perceived or known to be homosexual. Baker observes that children growing up gay are harmed by homophobia before anyone, including themselves, even knows they are gay (101). Young people are learning from rap music and their school peers that it is acceptable to hate GLBT people (102). Information provided by Parents and Friends of Lesbians and Gays (PFLAG) reports that an average high school student hears 25 anti-gay slurs daily, while 97% of high school students are regularly exposed to homophobic remarks (103). This constant barrage of negative information causes GLBT students to skip classes, drop out of school, and/or commit suicide (104).

Reviewing recent studies makes it clear that GLBT students are not safe in schools. In 1997, 31.2% of Massachusetts high school students identified as GLBT were threatened or injured with a weapon at school (105), while a 14-city study of GLBT youth found that 80% reported verbal abuse, 44% reported threats of attack, 33% reported having objects thrown at them, and 30 percent reported being followed or chased outside of school (106). In Michigan, 28% of school personnel surveyed determined that their school environments were emotionally unsafe for sexual minority youth (107), while in Seattle, 34% of students identifying as GLBT reported being the target of any-gay harassment compared to 6 percent of heterosexuals in a survey of over 8400 high school students (108). GLBT-identified youth are 2–6 times more likely to commit suicide than other youth, and account for 30% of all completed suicides among teens (109). Finally, service providers estimate that GLBT youth make up 20–40% of homeless youth in urban areas (110).

What can be done to make our schools safer? PFLAG suggests several ways in which school emotional and physical environments can be changed or improved to make schools a safer place for GLBT youth. Among their suggestions are: (1) Meeting with school administrators, school nurses, counselors and other health workers; (2) Organizing and participating in sensitivity training sessions for school personnel and students; (3) Supporting Gay/Straight Alliances, working with PFTAs and the other groups, and forming and supporting community groups for sexual minority youth; (4) Donating books on sexual orientation and gender identity to school libraries, with a school commitment to keep the books shelved and accessible; (5) Participating in community Safe Schools Coalitions; (6) Providing college scholarships to GLBT students; (7) Advocating for state legislation that protects GLBT students; (8) Writing letters to the editors of our local papers about Safe Schools issues; (9) Helping diversify schools’ curricula to include mention of GLBT
contributions to history, science, English and the arts, among other things; (10) Sponsoring proms for GLBT youth; (11) Speaking in colleges and universities to future teachers and school personnel; (12) Lobbying school boards for nondiscrimination policies that include sexual orientation; (13) Speaking out about Safe Schools issues in the broader community; (14) Filing lawsuits to ensure that our loved ones are safe in school; (15) Focusing our Safe Schools efforts on GLBT youth, as well as others perceived as “different” (e.g., variously abled individuals and immigrant students, among others); (16) Supporting families whose GLBT loved ones committed suicide or ran away due to unsafe schools; (17) Participating in educators’ conferences and distributing research and publications on GLBT youth issues; (18) Monitoring schools’ compliance with nondiscrimination policies; (19) Supporting GLBT teachers and staff, and advocating for fair personnel policies; and (20) Running for school board seats or other elected office to make a difference from within the educational and institutional culture and bureaucracy (111).

Safe schools are vital to the wellbeing of GLBT youth. They are possible, attainable, and crucial—but will require a concerted effort on the part of all individuals, who have gay children or who, in general, see diversity in our communities and schools as a positive and worthwhile contribution to the learning experience of all youth. Until we can accept the differences in one another, there will never be peace.

Living Well as Self

The key to staying well and preventing disease as individuals move through the life cycle is following those well-established practices that are recommended for everyone. This would include getting immunizations as recommended, seeing a primary care provider for routine screening recommended for your age cohort, engaging in regular exercise, eating a proper diet—or at least being moderate in your intake of higher risk foods (fats, sugars, alcohol). Knowledgeable caution should also be exercised in acquiring and using over-the-counter and alternative medications. While many of these nutriceuticals may have efficacious effects, it is important to check with a primary care provider or pharmacist to see that ingredients in the over-the-counter medications are not contraindicated for any prescription medication ordered. Positive health behaviors involve taking steps to reduce stress, get adequate exercise, avoiding or stopping use of harmful substances like tobacco and avoid use of all recreational drugs.

For foods, not only do people need to eat balanced meals (grains, fruits and vegetables, protein and sugars) but try a variety of foods, not only for the gustatory pleasures therein but because different foods have different vitamins and minerals. Vitamin and mineral supplements are recommended, because most 21st Century individuals are not engaged in the heavy physical labor of their great and great, great grandparents. Our workstyles have outstripped our evolutionary development. The result is greater food intake for the caloric output we experience, resulting in overweight. And overweight can become a risk-factor for heart disease, high cholesterol, and stroke, as well as kidney disease, diabetes, and other life threatening conditions.
Living Well as Transgendered Self

Transgendered individuals struggle with bringing their perceived selves into balance with their assigned bodies. The process of gender reassignment is a very long one (112). It involves psychiatric, endocrinologic, and surgical evaluation. Transgender people begin hormone therapy before any surgical procedure is undertaken. The hormone treatment itself carries risks of thromboembolism and liver abnormalities with estrogen use (113), and the rare possibility of developing a pituitary prolactinoma (114). For female-to-male transgender persons, androgen therapy carries an increased risk for heart disease, endometrial hyperplasia, and endometrial carcinoma (115). However, there is little long-term research to really assess long term outcomes of transgender medication regimes across the life span (Botzer, personal communication, June 17, 2002).

Gender reassignment surgery may also cause sexual dysfunction, especially with sexually responsivity (116,117). Despite the fact that the neovagina created for male-to-female transgendered individuals is relatively resistant to infection, cases of gonococcal urethritis and vaginitis have been reported (118,119). And for those individuals who use hormone therapy but decide not to undergo surgery, there are continued risks for endometrial cancer in female-to-male transgendered and for prostate cancer in male-to-female persons (120–122). Transgendered individuals are also at risk for HIV infection resulting from engagement in high-risk sex due to the belief that they are not susceptible to infection (123,124). The implications of this research suggest that regular appointments with one’s primary care provider are in order. Given the increasing knowledge of risks that transgender individuals face in their transitions, monitoring and accurate reporting to their providers is important. Transgender appropriate health education would also be beneficial. Greater sensitivity among providers of care is required to both counsel and care for transgendered individuals. Most of all, transgendered individuals should have their identities recognized as authentic (125). The implications for improved provider-patient communication include improved training of clinicians to increase their awareness and sensitivity to their transgendered patients (Botzer, personal communication, June 17, 2002).

Transgendered individuals also have to be prepared to deal with micro-aggression, or daily discriminatory or prejudicial insults that comprise stress sources in their lives. One young transgendered male-to-female college student was denied use of a women’s rest room by a faculty member on the grounds that the individual had not been “surgically corrected.” This same faculty member also denied the individual the opportunity to sing with the women’s choir (126). Such prejudice reflects a major lack of both social support and understanding about transgendered individuals and the process of their transition.

Living Well with Chronic Conditions

Despite our best efforts at health maintenance, there are still the bad things that happen to good people that we learn to accommodate and make a part of our lives. Gay men have learned to live well with Human Immunodeficiency Virus (HIV)
infection. This “living with HIV/AIDS” has become a major focus of AIDS support groups, counseling (personal and financial) and clinical care. Lesbians have learned to live well with breast cancer. Objectives to be met to improve GLBT health include reducing obesity, increasing self-esteem, pursuing smoking cessation, improving communication within and external to the GLBT community, and addressing substance misuse (i.e., alcohol, licit and illicit drugs, tobacco ingested by other means, and caution in the use of neutraceuticals).

HIV sets a stage for all the chronic illnesses affecting the GLBT community. HIV opened up the door to defining what community and social support really means and the critical role of the health care provider as gatekeeper. The more aware and understanding a provider is to the sexual and social identity of an individual, the greater the trust between patient and provider and the more enhanced care and greater therapeutic adherence is apt to be (127). HIV is not only similar to other chronic diseases as it transitions through various stages throughout life, but also attaches with it a stigmatized status. Some individuals have found that they needed to reconstruct their identity and seek out others similar to themselves for information, support, and affiliation (128).

Whether chronic illness is HIV, cancer, or hepatitis, positive emotional support is needed to maintain good physical health. Comprehensive health plans not only work to keep an individual healthy, but also enhance quality of life in GLBT individuals with chronic illnesses. The mind, the body, the spirit all need to be tended to for well being. Getting enough sleep, reducing stress, eating well, exercising, and positive social supports are fundamental in achieving wellness, especially when living with a chronic illness. Community health centers have developed various support networks for people with HIV/AIDS and their caretakers, and lesbian health centers are following suit. For example, the Lesbian Breast Cancer Outreach Project in Florida, The Lesbian Community Cancer Project in Chicago, the Seattle Lesbian Cancer Project, and the prototype lesbian cancer support program, the Mautner Project for Lesbians with Cancer all work to provide education, support and care for lesbians living with cancer.

Community health organizations and the world wide web are also outlets for the promotion of alternative therapies. Alternative therapies include acupuncture, meditation, herbal therapies, therapeutic massage, and homeopathy. Used in conjunction with conventional treatments, these complementary medicines enhance the wellness of the whole person. Alternative therapies are used to help alleviate the side effects of HIV/AIDS treatments or reduce the side effects of chemotherapy in cancer patients. The important element here is to let your primary care provider know that you are using alternative medicine so he or she can make certain there are no contraindicated pharmaceutical interactions with neutraceuticals.

**SUMMARY**

The authors suggest that it is up to the GLBT communities and individuals within them to assess their behaviors, change those that are negative, and work both individually and in groups to reinforce and maintain positive health behaviors: mentally, physically, socially, and spiritually. It is not necessary to seek out
GLBT-specific literature and guides because the basic wellness guidelines apply to all of us. However, be mindful that there are critical differences that may apply in certain communities or among specific groups. Wellness should be an individual and community goal for every GLBT citizen. By attaining and maintaining wellness, GLBT people present a very different picture to the larger community about who they are. GLBT youth need these role models and mentors so they will grow whole and well in the next generations.

In addition, the paucity of research suggests that GLBT health is a rich area for exploration. There is little information on the health needs of aging GLBT people or health promotion and maintenance for transgendered individuals. Increasingly, gays and lesbians are adopting or having children, and the needs and experiences of these new families need to be documented. The reintegration of GLBT people into mainstream faith traditions may hold valuable lessons about acceptance and healing. And there is a major need to continue research into the genetic contributions to homosexuality, so that once and for all, the idea of “choosing to be GLBT” can be set aside and no longer available as a weapon of discrimination. To support this work, funding needs to be available, which suggests that federal review panels must themselves work at overcoming prejudice and discomfort and expand their support for objective research into the human condition.

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