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DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta, GA 30333

January 29, 1999

Dear Colleague:

I would like to call your attention to the two attached articles, which appeared in the January 25, 1999, issue of CDC's *Morbidity and Mortality Weekly Report (MMWR)*. The first article, "Increase in Unsafe Sex and Rectal Gonorrhea Among Men Who Have Sex with Men--San Francisco, California, 1994-1997," is authored by Dr. Rick Steketee from our Division of HIV/AIDS Prevention-Surveillance and Epidemiology. This article explores data from annual San Francisco behavioral surveys of men who have sex with men (MSM) and disease reports from STD clinics in the Bay area. The data show increases in self-reported unprotected anal intercourse and rates of rectal gonorrhea from 1994 to 1997. Researchers believe these increases may be related to perceptions surrounding highly effective antiretroviral therapy (HAART). There is growing concern, as some studies have documented, that advances in HIV therapy may be leading some to perceive HIV as a less serious, more manageable disease and to relax safe sex practices.

During the period studied, the proportion of MSM reporting unprotected anal intercourse increased significantly (from 30.4% to 39.2%), with the most dramatic increases among men 26 to 29 years old. The proportion of MSM having unprotected anal intercourse with multiple sex partners increased from 23.6% to 33.3%, with the youngest respondents reporting the largest increases. During the same time period, rates of male rectal gonorrhea in San Francisco STD clinics almost doubled (from 21 to 38 per 100,000 adult men), reversing a three-year decline.

After years of a stabilizing epidemic, because of the high HIV prevalence among MSM, even a small increase in risk behavior could lead to increases in HIV incidence. These findings should serve as a wake-up call to all populations at risk, especially the gay community and those who serve them. There is an urgent need for sustained prevention programs reinforcing the continued risk of unsafe sex and targeting MSM across all age and racial/ethnic groups. Such prevention efforts must take into account the impact of the changing HIV environment on attitudes and perceptions of MSM and others at risk.

In addition to Dr. Steketee's article, another article of interest in this week's *MMWR* is "HIV Testing – United States, 1996," by Karin Mack and Shayne Bland of CDC's Division of Adult and Community Health. This article describes variance in HIV testing rates by states based on data from CDC's Behavioral Risk Factor Surveillance System (BRFSS). The findings, as might be expected, document that the percentage of adults who reported ever having been tested for HIV is higher in states with higher rates of HIV infection.

Across the nation, nearly 42% of adults surveyed reported that they have had an HIV test. Other CDC research estimates that around two-thirds of those infected with HIV have been tested. HIV testing provides a critical avenue to reach individuals at risk with prevention counseling and services to link infected individuals with needed services and care.

We hope this information is useful to you. As always, if you have any questions, feel free to call our Office of Communications at (404) 639-8890.

Sincerely,

Helene D. Gayle

Helene D. Gayle, M.D., M.P.H.
Director
National Center for HIV, STD, and TB Prevention
Centers for Disease Control and Prevention

CDC

January 29, 1999 / Vol. 48 / No. 3

MMWR™
MORBIDITY AND MORTALITY
WEEKLY REPORT

Increases in Unsafe Sex and Rectal Gonorrhea Among Men Who Have Sex With Men — San Francisco, California, 1994–1997

Reductions in AIDS cases among men who have sex with men (MSM) have been attributed in part to widespread declines in unprotected anal sex since the mid-1980s (*1*) and use of increasingly effective antiretroviral therapy (ART) since the mid-1990s (*2*). Because data about HIV infection incidence are limited, other indicators of transmission risk have been used. In San Francisco, data from annual behavioral surveys among MSM (1994–1997) and from the sexually transmitted disease (STD) surveillance program (1990–1997) were analyzed to characterize changes in HIV risk behaviors of MSM and changes in incidence of male rectal gonorrhea. This report describes the findings of these analyses, which indicate increases in unsafe sexual behavior and increases in rates of rectal gonorrhea among MSM.

From 1994 through 1997, volunteers in The Stop AIDS Project, a San Francisco community-based organization, conducted standardized annual surveys in which MSM were approached in various settings (e.g., neighborhoods, clubs, bars, and outdoor events) and asked to respond to a peer-administered, one-page questionnaire. Persons were excluded if they had participated previously during the same year. Methods were identical across years. First-time interviews were completed among 21,857 MSM; 6223, 5989, 5472, and 4173 interviews were completed each respective year. Demographic and sexual behavior information was collected annually; in 1997, subjects were asked whether they knew the HIV serostatus of their sex partners. In the survey, unprotected anal intercourse (UAI) was defined as insertive or receptive anal sex during the previous 6 months without always using condoms. Multiple partners was defined as more than one sex partner during the previous 6 months. Male rectal gonorrhea data reported to the San Francisco Department of Public Health, Sexually Transmitted Disease Control Section, were reviewed. The annual incidence from 1994 through 1997 was calculated as cases per 100,000 adult men aged ≥15 years (1990 U.S. census data were used for the denominator). Changes in sexual behaviors and rectal gonorrhea incidence over time were assessed using the chi-square test for trend.

The proportion of surveyed MSM who reported having had anal sex increased from 57.6% (95% confidence interval [CI]=56.4%–58.9%) in 1994 to 61.2% (95% CI=60.1%–63.1%) in 1997 ($p<0.01$). Among MSM who had had anal sex, the proportion

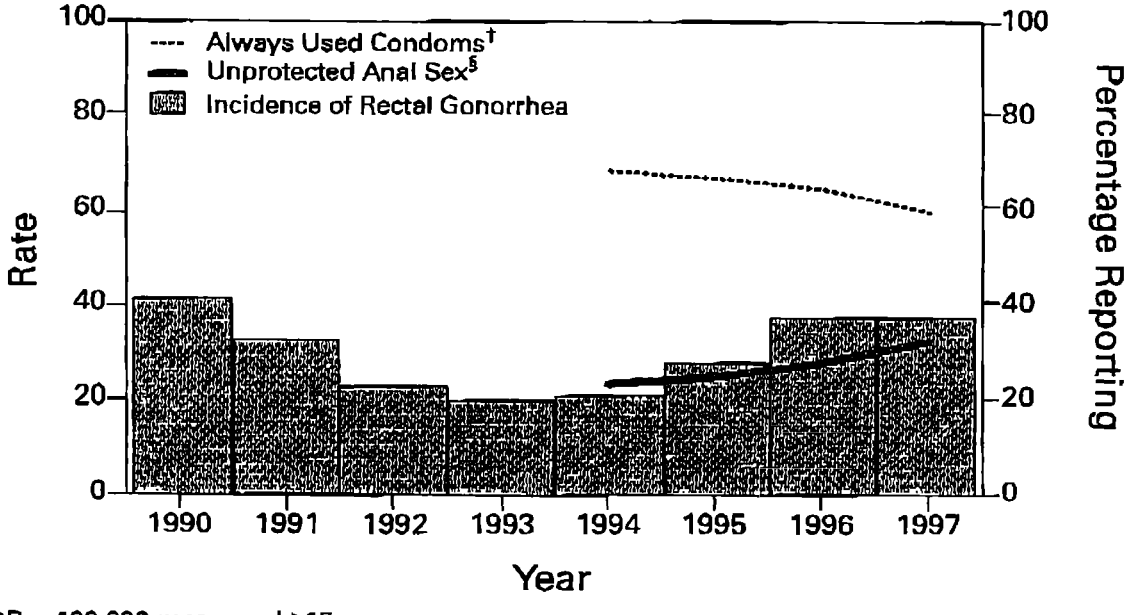
Unsafe Sex and Rectal Gonorrhea — Continued

reporting "always" using condoms declined from 69.6% (95% CI=68.1%–71.1%) in 1994 to 60.8% (95% CI=58.9%–62.7%) in 1997 (p<0.01) (Figure 1). The most pronounced decline in consistent condom use occurred among men aged 26–29 years (from 68.2% [95% CI=64.8%–71.5%] in 1994 to 58.0% [95% CI=53.7%–62.1%] in 1997). The proportion of men who reported having had multiple sex partners and UAI increased from 23.6% (95% CI=21.9%–25.4%) in 1994 to 33.3% (95% CI=31.1%–35.6%) in 1997 (p<0.01). The largest increase in this risk behavior was among respondents aged ≤25 years (from 22.0% [95% CI=18.4%–25.9%] in 1994 to 32.1% [95% CI=27.7%–36.7%] in 1997; p<0.01). Decreasing consistent condom use and increasing proportions of MSM reporting UAI with multiple partners occurred in all racial/ethnic groups. In 1997, 45% (95% CI=41.4%–48.8%) of 865 MSM who had had UAI during the previous 6 months also reported not knowing the HIV serostatus of all their sex partners. Among 525 MSM who had had UAI and multiple partners during the previous 6 months, 68.0% (95% CI=63.9%–72.7%) reported not knowing the HIV serostatus of all their sex partners.

Male rectal gonorrhea incidence declined from 1990 through 1993 (42, 33, 23, and 20 per 100,000 adult men, respectively). From 1994 through 1997, the incidence increased from 21 to 38 per 100,000 adult men (p<0.01) (Figure 1). This increase in incidence was observed in all racial/ethnic and age groups but was highest among men aged 25–34 years (from 41 to 83 cases per 100,000 men aged 25–34 years, p<0.01).

Reported by: KA Page-Shafer, PhD, W McFarland, MD, R Kohn, J Klausner, MD, MH Katz, MD, San Francisco Dept of Public Health, San Francisco; D Wohlfeiler, MPH, S Gibson, MSW, The Stop AIDS Project, San Francisco, California. Prevention Svcs Research Br, Program Evaluation Research Br, International Activities Br, Div of HIV/AIDS Prevention, and Epidemiology and Surveillance Br, Div of Sexually Transmitted Diseases Prevention, National Center for HIV, STD, and TB Prevention, CDC.

FIGURE 1. Percentage of men who have sex with men reporting selected sexual behaviors, and rate* of male rectal gonorrhea — San Francisco, 1990–1997



*Per 100,000 men aged ≥15 years.
†Condoms always used during anal sex during the previous 6 months.
§Unprotected anal sex with two or more partners during the previous 6 months.

Unsafe Sex and Rectal Gonorrhea — Continued

Editorial Note: The data described in this report suggest that increases in unsafe sexual behavior have occurred among MSM in San Francisco, resulting in increased risk for HIV infection and transmission. These data provide additional insight to a previous report of increasing gonorrhea among MSM in selected STD clinics (*3*) and document significant increases during 1994–1997 in rectal gonorrhea (a direct measure of UAI) and self-reported UAI among MSM.

The increases in reported risk behaviors and the increases in STDs in San Francisco coincide with the expanded availability of effective ART in San Francisco and the United States. Although ART can result in decreased viral load and decreased risk for HIV transmission, advances in HIV treatment and the resulting declines in AIDS deaths in San Francisco and nationally might lead to increased risk behavior by MSM who perceive that HIV infection can be managed effectively (*4*). Because the prevalence of HIV infection among MSM in San Francisco is high, small increases in unsafe behaviors in this population may result in increases in HIV infection incidence. Recent data do not show changes in HIV infection incidence among young MSM (aged 18–29 years) in San Francisco (*5*). However, HIV transmission may lag behind the transmission of other STDs, including gonorrhea, for several reasons (e.g., differences in infectivity and treatment) (*6*).

That increases in UAI may represent sex between mutually monogamous persons with concordant HIV serostatus (i.e., "negotiated safety") seems unlikely. One third of MSM reported UAI with multiple partners during the previous 6 months. Substantial numbers of men interviewed in 1997 reported not knowing the HIV infection status of all their partners. In addition, increases in rectal gonorrhea are inconsistent with increases in negotiated safe sex behaviors between MSM.

The findings in this study are subject to at least four limitations. First, the sample of MSM in The Stop AIDS Project surveys may not be representative of the general MSM community in San Francisco. Second, the questionnaire did not distinguish insertive versus receptive anal sex, and it did not inquire specifically about condom use with persons whose HIV serostatus was unknown. Third, survey respondents who reported UAI may not be similar to persons who acquired rectal gonorrhea. Fourth, the survey was not designed to assess the association between decreases in AIDS prevalence, AIDS deaths, or other factors and the described risk behaviors. However, the population surveyed was large, and increases in reported risk behaviors were consistent across all age and racial/ethnic groups. Other studies have described high and increasing rates of sexual risk behavior among MSM in San Francisco (*7*), elsewhere in the United States (*8*), and in Canada (*9*).

Male rectal gonorrhea is increasing among MSM amidst an overall decline in nationwide gonorrhea rates (*10*). During 1993–1997, national gonorrhea surveillance demonstrated an annual increase in the proportion of cases in males compared with cases in females in western states (CDC, unpublished data) consistent with an increase in gonorrhea infection among MSM.

The data presented in this report suggest that the substantial reduction in sexual risk behaviors among MSM and the decreases in rectal gonorrhea during the 1980s and early 1990s cannot be assumed to be maintained indefinitely. The availability of ART and the possible perception of lower risk for infection from persons receiving ART may lead to misunderstandings and complacency toward safe-sex messages. MSM of all ages and races/ethnicities in San Francisco continue to engage in behaviors that

Unsafe Sex and Rectal Gonorrhea — Continued

put them at high risk for HIV infection, and HIV prevalence is highest among the MSM populations compared with heterosexual populations. As the epidemic continues, it remains important to maintain resources for prevention activities targeted toward MSM across all racial/ethnic and age groups. Public health prevention and community-based outreach efforts to reduce risk behaviors and STDs remain crucial to reach these populations.

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HIV Testing — United States, 1996

Human immunodeficiency virus (HIV) infection is one of the leading causes of morbidity and mortality in the United States. HIV testing, in conjunction with counseling and other preventive services, can reduce the risk for HIV infection and appropriately link infected persons to treatment. To characterize HIV testing by region, state, and sex, CDC analyzed data from the 1996 Behavioral Risk Factor Surveillance System (BRFSS). This report summarizes the results of that analysis, which indicate a high degree of variability in HIV testing throughout the United States.

BRFSS is a state-specific, random-digit–dialed telephone survey of the U.S. population aged ≥18 years. In 1996, all 50 states and the District of Columbia (DC) participated in BRFSS. The 1996 survey included 14 questions about HIV/acquired immunodeficiency syndrome (AIDS)-related knowledge and attitudes and HIV-antibody testing history. The questions were restricted to persons aged <65 years, except in California, where the questions were asked of persons aged <45 years. In 1996, 97,006 persons responded to these questions (state-specific range: 899–3653). Data were weighted by demographic characteristics and by selection probabilities. Confidence intervals were calculated using SUDAAN to account for the complex survey design.

A mean of 42% of persons (range: 26% [South Dakota] to 60% [DC]) answered yes to the question "Have you ever had your blood tested for HIV?" Persons who answered "yes" were asked "What was the main reason you had your last blood test for HIV?" Responses were divided into two categories: those who chose to be tested for personal or health reasons (i.e., voluntarily tested) (responses included: "just to find out if infected," "for routine checkup," "doctor referral," "sex partner referral," "because of pregnancy," or "other"), and those who were tested for other reasons (e.g., military induction, insurance, and employment). A mean of 22% of persons (range: 10% [South Dakota] to 45% [DC]) reported obtaining HIV-antibody tests for voluntary reasons.

The rate of AIDS cases in 1996 was compared with HIV testing percentages in 1996. In general, in states where the AIDS rate was high, HIV testing also tended to be high (Figure 1). For example, DC had the highest AIDS rate and the highest testing percentage; Florida ranked third in both categories. In comparison, rates of overall testing and voluntary testing were lower in the Midwest, where the AIDS rate is low.

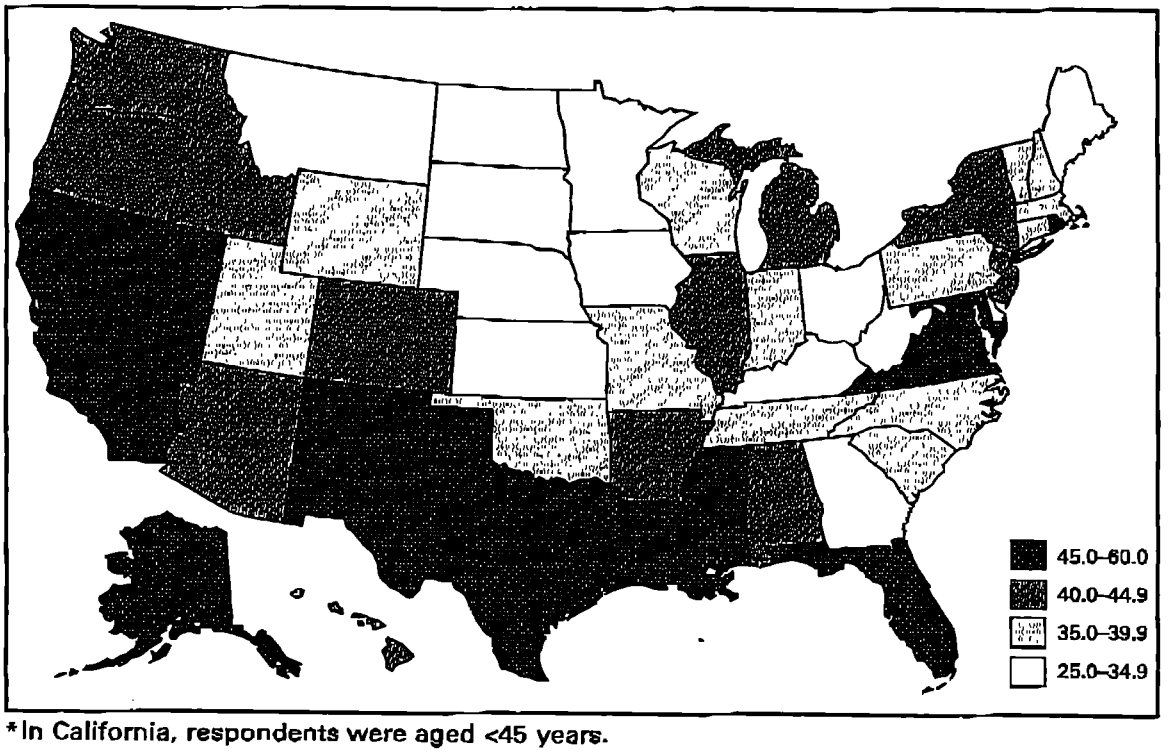
A mean of 44% of men reported having ever been tested for HIV (range: 28% [South Dakota] to 62% [DC]) (Table 1). A mean of 40% of women reported having ever been tested for HIV (range: 23% [North Dakota] to 57% [DC]). In 45 states and DC, a greater percentage of men reported ever being tested for HIV than women. The states with the greatest difference by sex of ever being tested for HIV were North Dakota (11%), Hawaii (10%), and New York (9%). The states with the smallest differences were Alaska, Delaware (both 0.5%), and Texas (0.6%).

A mean of 20% of men reported that their most recent HIV test was voluntary (range: 8% [South Dakota] to 46% [DC]) (Table 1). A mean of 25% of women reported that their most recent HIV test was voluntary (range: 12% [North Dakota] to 45% [DC]). In 49 states, a greater percentage of women reported being voluntarily tested than men. The sex-specific difference in reports of being voluntarily tested ranged from 0.1% in New York and Indiana to 13% in California.

Reported by the following BRFSS coordinators: J Cook, MBA, Alabama; P Owen, Alaska; B Bender, MBA, Arizona; J Senner, PhD, Arkansas; B Davis, PhD, California; M Leff, MSPH,

HIV Testing — Continued

FIGURE 1. Percentage of adults aged 18–64 years* reporting having ever been tested for HIV infection — United States, Behavioral Risk Factor Surveillance System, 1996



*In California, respondents were aged <45 years.

Colorado; M Adams, MPH, Connecticut; F Breukelman, Delaware; C Mitchell, District of Columbia; S Hoecherl, Florida; L Martin, MPH, Georgia; AT Onaka, PhD, Hawaii; J Aydelotte, Idaho; B Steiner, MS, Illinois; K Horvath, Indiana; A Wineski, Iowa; M Perry, Kansas; K Asher, Kentucky; R Jiles, PhD, Louisiana; D Maines, Maine; A Weinstein, MA, Maryland; D Brooks, MPH, Massachusetts; H McGee, MPH, Michigan; N Salem, PhD, Minnesota; D Johnson, Mississippi; T Murayi, PhD, Missouri; P Feigley, PhD, Montana; M Metroka, Nebraska; E DeJan, MPH, Nevada; L Powers, MA, New Hampshire; G Boeselager, MS, New Jersey; W Honey, MPH, New Mexico; TA Melnik, DrPH, New York; K Passaro, PhD, North Carolina; J Kaske, MPH, North Dakota; P Pullen, Ohio; N Hann, MPH, Oklahoma; J Grant-Worley, MS, Oregon; L Mann, Pennsylvania; J Hesser, PhD, Rhode Island; D Shepard, South Carolina; M Gildemaster, South Dakota; D Ridings, Tennessee; K Condon, Texas; R Giles, Utah; C Roe, MS, Vermont; L Redman, MPH, Virginia; K Wynkoop-Simmons, PhD, Washington; F King, West Virginia; P Imm, MS, Wisconsin; M Futa, MA, Wyoming. Behavioral Risk Factor Surveillance System, Behavioral Surveillance Br, Div of Adult and Community Health, National Center for Chronic Disease Prevention and Health Promotion, CDC.

Editorial Note: The findings in this report document a high degree of state-specific variability in self-reported HIV-antibody tests in the United States. Previous reports suggest this variability probably represents state-specific differences in such factors as prevalence of HIV infection and the activities of HIV-prevention and education programs (*1*).

The success of a health-promotion program depends on the level of participation of clients. Although HIV testing and counseling does not affect behavior change similarly across all population groups, in general, persons who voluntarily receive HIV testing are more likely to undergo counseling and modify their behaviors than those who

HIV Testing — Continued

TABLE 1. Percentage of persons aged 18–64 years who reported ever having had an HIV test and who reported that their last HIV test was voluntary*, by sex — United States, Behavioral Risk Factor Surveillance System, 1996

State	Sample size	Ever tested		Tested voluntarily		Ever tested			Tested voluntarily		
		%	(95% CI†)	%	(95% CI)	% Men	% Women	(95% CI§)	% Men	% Women	(95% CI§)
Alabama	1737	44.0	(±2.8)	23.3	(±2.4)	48.0	40.2	(1.1–1.8)	22.8	23.8	(0.7–1.3)
Alaska	1403	46.5	(±3.9)	29.0	(±3.6)	46.8	46.3	(0.7–1.5)	23.3	35.5	(0.4–0.8)
Arizona	1503	42.5	(±3.5)	20.6	(±3.0)	43.7	41.4	(0.8–1.5)	19.5	21.8	(0.6–1.4)
Arkansas	1391	42.7	(±3.2)	21.6	(±2.7)	44.0	41.4	(0.8–1.5)	17.9	25.1	(0.4–1.0)
California¶	2161	52.0	(±2.4)	31.6	(±2.2)	49.9	54.2	(0.7–1.1)	25.3	38.4	(0.4–0.7)
Colorado	1527	43.0	(±2.8)	25.3	(±2.4)	44.8	41.1	(0.9–1.5)	23.9	26.7	(0.6–1.2)
Connecticut	1507	38.7	(±2.8)	20.1	(±2.3)	42.2	35.3	(1.0–1.8)	19.8	20.4	(0.7–1.4)
Delaware	1707	45.2	(±2.7)	23.6	(±2.3)	45.4	44.9	(0.8–1.3)	19.6	27.4	(0.5–0.9)
District of Columbia	991	59.5	(±3.6)	45.2	(±3.6)	61.9	57.3	(0.8–1.7)	45.5	44.9	(0.7–1.5)
Florida	2634	52.2	(±2.1)	27.7	(±1.9)	54.6	49.8	(1.0–1.5)	24.4	30.8	(0.6–0.9)
Georgia	1908	33.1	(±2.4)	17.7	(±1.9)	33.8	32.4	(0.8–1.4)	14.7	20.6	(0.5–0.9)
Hawaii	1796	42.1	(±2.7)	21.8	(±2.2)	46.8	37.1	(1.1–2.0)	19.8	23.8	(0.6–1.1)
Idaho	2233	41.4	(±2.3)	21.1	(±1.8)	45.5	37.3	(1.1–1.8)	18.0	24.1	(0.5–0.9)
Illinois	2394	40.5	(±2.2)	20.3	(±1.8)	43.3	37.8	(1.0–1.6)	18.7	21.9	(0.6–1.1)
Indiana	1767	37.6	(±2.5)	19.5	(±2.1)	42.0	33.4	(1.1–1.9)	19.5	19.4	(0.7–1.4)
Iowa	2736	31.6	(±2.0)	12.8	(±1.4)	36.1	27.1	(1.2–1.9)	12.6	13.0	(0.7–1.3)
Kansas	1554	28.1	(±2.5)	15.3	(±2.0)	30.0	26.2	(0.9–1.6)	14.0	16.6	(0.6–1.2)
Kentucky	2705	32.3	(±2.0)	15.7	(±1.6)	35.5	29.1	(1.1–1.7)	13.3	18.1	(0.5–0.9)
Louisiana	1328	47.9	(±3.1)	24.5	(±2.7)	50.5	45.5	(0.9–1.6)	20.4	28.5	(0.5–0.9)
Maine	1332	33.6	(±2.8)	15.9	(±2.1)	38.1	29.1	(1.1–2.0)	15.4	16.4	(0.6–1.4)
Maryland	3653	48.1	(±2.1)	30.0	(±1.9)	49.8	46.4	(0.9–1.4)	28.4	31.4	(0.7–1.1)
Massachusetts	1479	36.8	(±2.8)	19.8	(±2.3)	40.5	33.3	(1.0–1.8)	18.7	20.9	(0.6–1.3)
Michigan	2115	41.8	(±2.3)	23.4	(±2.0)	44.4	39.2	(1.0–1.6)	20.6	26.2	(0.6–1.0)
Minnesota	3630	30.4	(±1.7)	15.2	(±1.3)	28.4	32.4	(0.7–1.0)	12.6	17.7	(0.5–0.9)
Mississippi	1260	46.0	(±3.2)	25.3	(±2.9)	45.8	46.2	(0.7–1.3)	20.7	29.6	(0.4–0.9)
Missouri	1208	38.0	(±3.2)	20.9	(±2.6)	40.7	35.5	(0.9–1.7)	19.6	22.2	(0.6–1.2)
Montana	1412	33.5	(±2.8)	15.0	(±2.1)	37.2	29.9	(1.1–1.8)	12.7	17.4	(0.5–1.0)
Nebraska	1596	33.2	(±3.0)	13.8	(±2.3)	37.0	29.5	(1.0–2.0)	11.9	15.3	(0.5–1.2)
Nevada	1506	53.8	(±3.6)	27.1	(±3.2)	53.7	53.9	(0.7–1.4)	23.7	30.8	(0.5–1.0)
New Hampshire	1237	35.0	(±3.1)	17.3	(±2.4)	36.1	33.9	(0.8–1.5)	14.6	20.1	(0.5–1.0)
New Jersey	2593	42.9	(±2.3)	22.2	(±2.0)	45.9	40.1	(1.0–1.6)	20.8	23.6	(0.6–1.1)
New Mexico	899	48.7	(±4.2)	21.9	(±3.3)	50.6	46.8	(0.8–1.7)	16.1	27.6	(0.3–0.8)
New York	3594	40.0	(±1.9)	23.0	(±1.6)	44.8	35.4	(1.2–1.8)	23.0	23.1	(0.8–1.2)
North Carolina	2115	37.8	(±2.4)	21.1	(±2.0)	38.3	37.3	(0.8–1.3)	19.1	23.0	(0.6–1.1)
North Dakota	1383	28.6	(±2.7)	10.2	(±1.7)	33.9	23.0	(1.3–2.3)	8.7	11.8	(0.4–1.2)
Ohio	1156	27.2	(±2.7)	14.3	(±2.2)	29.7	24.8	(0.9–1.8)	14.1	14.5	(0.6–1.5)
Oklahoma	1297	37.7	(±3.1)	17.1	(±2.4)	36.8	38.5	(0.7–1.3)	12.8	21.1	(0.4–0.8)
Oregon	2375	40.9	(±2.2)	21.3	(±1.8)	44.6	37.2	(1.1–1.7)	19.5	23.2	(0.6–1.1)
Pennsylvania	2824	39.1	(±2.1)	18.3	(±1.6)	42.3	36.0	(1.1–1.6)	17.0	19.6	(0.6–1.1)
Rhode Island	1470	45.9	(±2.9)	22.4	(±2.4)	49.6	42.4	(1.0–1.8)	19.9	24.8	(0.5–1.1)
South Carolina	1562	39.8	(±3.1)	20.9	(±2.5)	40.6	39.1	(0.8–1.5)	15.8	25.7	(0.4–0.8)
South Dakota	1575	26.1	(±2.4)	10.1	(±1.6)	28.0	24.3	(0.9–1.6)	7.5	12.7	(0.4–0.9)
Tennessee	2455	37.8	(±2.2)	19.5	(±1.8)	38.4	37.2	(0.9–1.3)	17.5	21.4	(0.6–1.0)
Texas	1441	49.4	(±2.9)	25.7	(±2.4)	49.7	49.1	(0.8–1.4)	21.5	29.8	(0.5–0.9)
Utah	2380	37.3	(±2.5)	17.9	(±2.1)	40.3	34.4	(1.0–1.7)	16.2	19.5	(0.6–1.1)
Vermont	2058	38.2	(±2.5)	19.2	(±2.0)	42.5	33.9	(1.1–1.9)	18.2	20.2	(0.6–1.2)
Virginia	1603	51.2	(±2.9)	27.5	(±2.5)	53.1	49.2	(0.9–1.6)	25.5	29.5	(0.6–1.1)
Washington	3011	41.5	(±2.0)	22.4	(±1.7)	41.9	41.0	(0.9–1.3)	18.1	26.8	(0.5–0.8)
West Virginia	1848	29.9	(±2.3)	13.1	(±1.7)	31.2	28.6	(0.9–1.5)	10.1	16.0	(0.4–0.9)
Wisconsin	1838	39.9	(±3.0)	16.7	(±2.1)	40.5	39.2	(0.8–1.4)	14.3	19.1	(0.5–1.0)
Wyoming	2119	38.3	(±2.3)	18.7	(±1.8)	39.4	37.2	(0.9–1.4)	15.3	22.2	(0.5–0.8)
Mean		*41.8*	*(±0.5)*	*22.3*	*(±0.4)*	*43.7*	*40.0*	*(0.7–0.8)*	*19.9*	*24.7*	*(1.1–1.2)*

* Reasons given for testing include "just to find out," for routine checkup, doctor referral, sex partner referral, because of pregnancy, or other.
† Confidence interval.
§ Confidence interval for the difference between men and women.
¶ Persons aged 18–44 years were surveyed.

HIV Testing — Continued

receive testing for other reasons (*2*). As a result, tracking overall testing rates and voluntary testing rates can help target health-promotion efforts.

The findings in this report are subject to at least two limitations. First, because BRFSS excluded persons without telephones, some persons at high risk for HIV infection probably were excluded. Second, because the BRFSS relies on self-reported data, some bias is expected.

HIV testing can help reach at-risk persons with counseling and other prevention services and link infected persons with needed health-care services. General population surveys, such as BRFSS, provide data to assess the use of HIV testing services across geographical areas. However, not all persons need to be tested for HIV. CDC recommends HIV counseling and testing services for persons with specific risk factors for HIV infection and in specific screening settings (e.g., tissue donation and pregnancy). Prevention programs should be structured to increase the proportion of at-risk persons who receive HIV-testing services.

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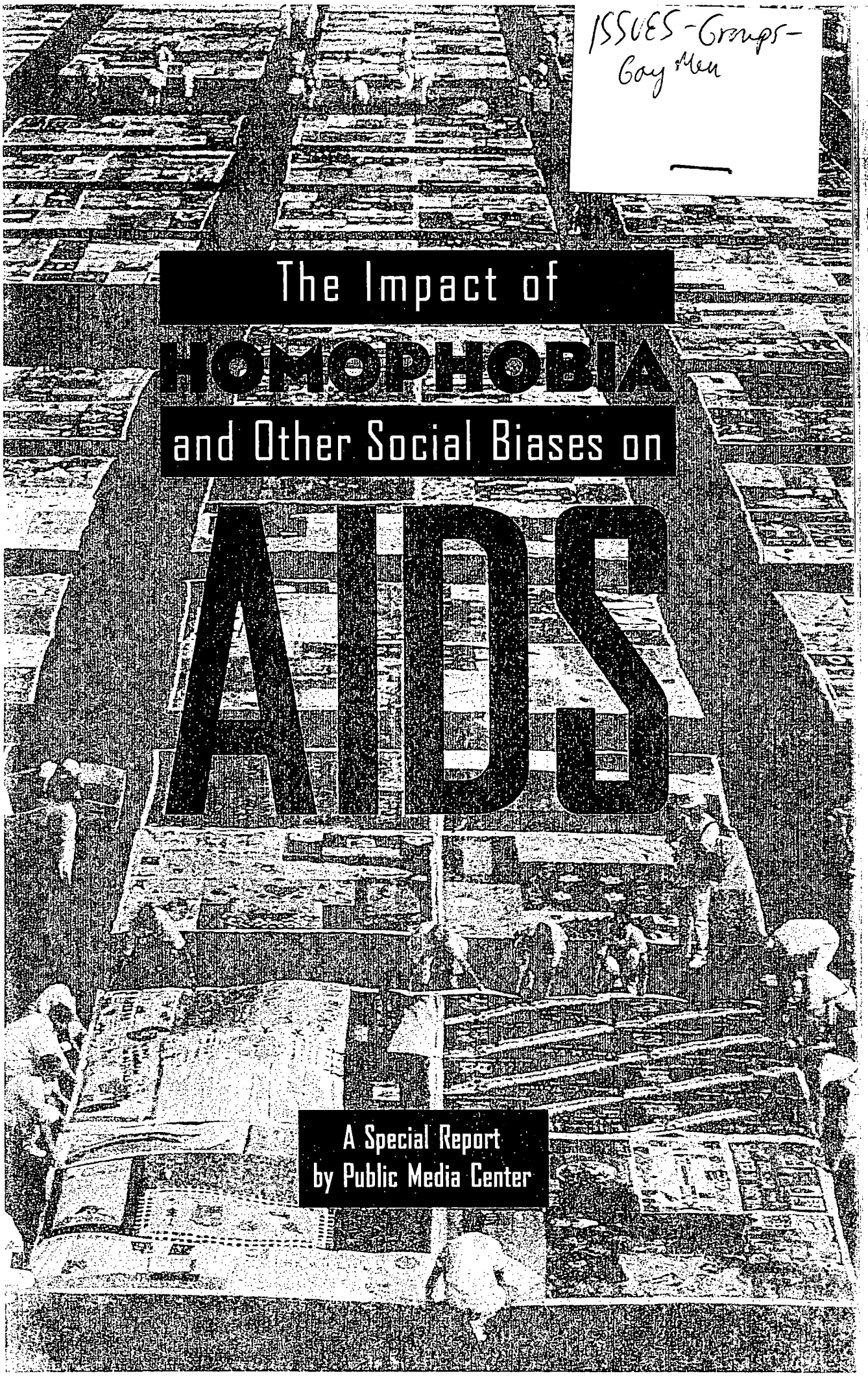
ISSUES - Groups - Gay Men

42

The Impact of Homophobia and Other Social Biases on AIDS - A Special Report by Public Media Center

ISSUES - Groups - Gay Men



The Impact of HOMOPHOBIA and Other Social Biases on AIDS

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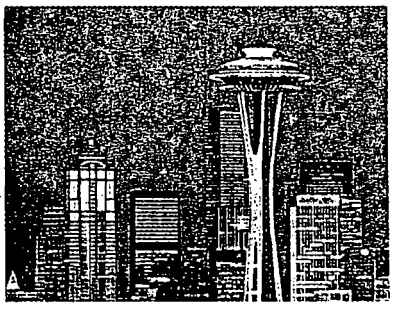

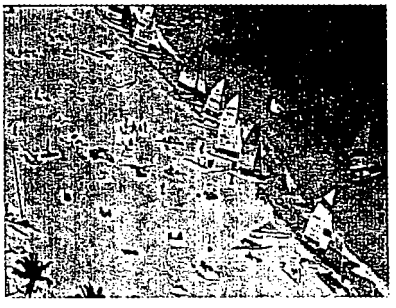

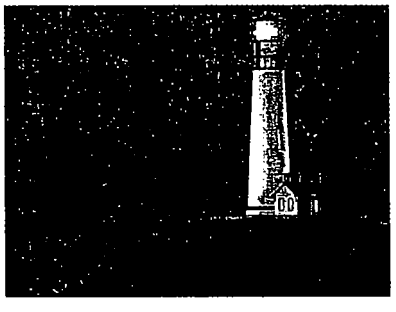

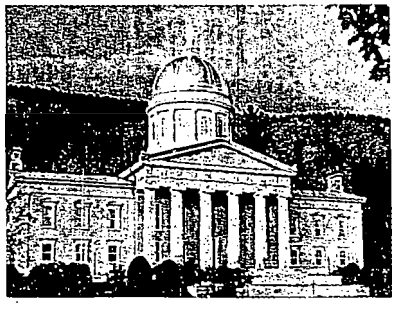

1998 Capital Gains and Losses

A State by State Review of Gay, Lesbian, Bisexual, Transgender, and HIV/AIDS-Related Legislation in 1998

A Publication of the National Gay and Lesbian Task Force Policy Institute

until it's over AIDS ACTION

PREVENTION NEWS

April 20, 1999...www.aidsaction.org... Contact: Francesca Fragomeni - 202-986-1300 x3071 - network@aidsaction.org

Prevention Leadership Forum: Gay Men and Community Planning

On April 12, 1999, AIDS Action, in collaboration with the Centers for Disease Control and Prevention (CDC), sponsored the first in a series of forums focusing on HIV prevention issues as they pertain to populations most at risk. By calling on community-based organizations (CBOs) and leaders in the AIDS community, the series aims to provide strategies for developing, and enhancing, HIV prevention leadership at the local level.

The first in the series – **Prevention Leadership Forum: Gay Men and Community Planning** – addressed the involvement of gay men, including gay men of color, in the CDC's prevention community planning process. Specifically, the forum examined to what extent the community planning process has been able to effectively incorporate the unique needs of gay men into prevention initiatives. The goal of the meeting was to craft recommendations on ways to make community planning more responsive to, and inclusive of, the prevention needs of gay men.

In attendance were representatives from community-based organizations around the country including Harlem Directors Group, Asian & Pacific Islander Wellness Center (San Francisco), Gay Men's Health Crisis (New York), and AIDS Project Los Angeles. Key recommendations formulated during the meeting include:

1) the need for the CDC to clearly articulate the goals of community planning and the roles and responsibilities of all participants;
2) the need for all organizations involved in community prevention planning (CDC, state health departments, and CBOs) to be invested in, and accountable, to the process;
3) in providing resources to local communities, the CDC should determine, and communicate, the consequences of not using such resources effectively;
4) the CDC should provide data and analysis on national HIV/AIDS trends to local communities involved in community planning, and should compare data on jurisdictions to identify areas that need improvement;
5) CBO's should provide support to health departments in developing partnerships with communities, understanding gay and lesbian health issues, and advocating for increased prevention funding at the local level;
6) health departments should build coalitions with local communities around prevention planning and seek support from the CDC to assist them with participating in community planning;
7) gay men should attempt to build capacity in their own communities by holding organizations accountable for participation in community planning and ensuring that planning groups are addressing local issues effectively;
8) the need to address issues of homophobia among all communities and entities participating in the community planning process.

Participants also discussed the need for development of an effective technical assistance strategy to assist local communities in prevention planning as well as what AIDS Action's role should be in prevention planning at the community level. Attendees recommended that AIDS Action continue to facilitate a national dialogue on prevention that communicates prevention standards and philosophy, build a constituency for prevention funding, and increase awareness of HIV prevention issues through the media and other public venues.

AIDS Action's next **Prevention Leadership Forum** coming up this May will focus on preventing HIV infection among youth in America and will identify successful youth prevention programs in community-based organizations. For more information on the Prevention Leadership Forum series, please contact Regina Tosca in AIDS Action's Government Affairs Department at 202/986-1300 ext. 3047.

Gay and alcoholic: epidemiologic and clinical issues.

Alcohol Health & Research World

March 22, 1991
SECTION: Vol. 15 ; No. 2 ; Pg. 151; ISSN: 0090-838X

BYLINE: Paul, Jay P. ; Stall, Ron ; Bloomfield, Kim A.

Although the rate of alcohol abuse in the gay community cannot be stated conclusively, it is clear that a substantial portion of gays, lesbians, and bisexuals drink problematically. The literature has demonstrated a need to address issues specific to the gay community in alcoholism treatment, and supports the notion of gay-specific treatment groups and programs.

Alcohol abuse among homosexual and bisexual men and women has become an area of growing scientific and public interest. In this article, we review the literature on the prevalence rates of alcoholism among gay men and lesbians, as well as the risk factors for alcohol abuse in the gay community.1 We also review recommendations from the treatment literature regarding clinical interventions for gay alcoholics.

This article is organized around a series of questions that we believe are crucial to understanding alcohol abuse and alcoholism within the gay community: (1) Do elevated rates of alcoholism exist in the gay community? (2) Are rates of alcohol abuse in the gay community changing? (3) What are the risk factors for alcohol abuse in the gay community? (4) Is there a need for gay-sensitive alcoholism treatment programs? (5) How can existing treatment programs respond to the needs of gay alcoholics? (6) How can gay alcoholics obtain the social support necessary to maintain sobriety? We have endeavored to present the evidence available to respond to these questions, but we do not imply that these questions have been answered conclusively. There are gaps in the research literature that we hope will be filled in the near future, particularly with regard to the drinking practices of lesbians.

Do Higher Rates of Alcoholism Exist in the Gay Community?

The presumption that rates of alcoholism2 and alcohol abuse within the gay community are higher than within the general population is based primarily upon a number of early studies. These studies reported high prevalence rates of heavy drinking or alcoholism among gay men and lesbians in several disparate communities (Fifield et al. 1977; Lohrenz et al. 1978; Morales and Graves 1983). One study comparing lesbians and heterosexual women (Saghir and Robins 1973) found that 35 percent of the lesbian sample experienced "excessive and/or problem drinking," as compared with 5 percent of the control sample of heterosexual women. Estimates of problematic alcohol use derived from this early literature for both gay men and lesbians have tended to cluster around a prevalence rate of 30 percent. Despite the use of divergent sampling and measurement

techniques, these studies as a whole indicated prevalence rates of problematic alcohol use to be far in excess of the figure of 10 percent usually ascribed to the general population.

Before accepting these high prevalence rates of alcohol and other drug abuse within the gay community, however, the methodological limitations of the supporting literature should be considered. Each of the studies cited above describes data derived using opportunistic sampling techniques; these data may or may not accurately represent the community from which they were drawn. Gay bars and their surrounding environs have traditionally been a significant source for recruitment of samples, as they are one of the few public settings in which gay Americans congregate freely. This sampling practice is especially problematic for alcohol or other drug studies, as it can lead to an oversampling of bar patrons. Bar patrons are more likely to be heavy drinkers than individuals in the general population (Clark 1981), and also may be more likely to use drugs other than alcohol. To the extent that research protocols rely on methods that overrepresent bar patrons, they risk overestimating the prevalence of alcohol and other drug abuse among homosexual and bisexual men and women. Furthermore, most of the samples obtained through opportunistic sampling techniques have been predominantly white and middle class, thereby limiting our knowledge of the drinking practices of ethnic minority gay men and women.

Since the start of the AIDS epidemic, however, studies have been designed that approximate representative samples of specific gay male communities. Data from these projects often can be used to generate estimates of gay male alcohol and other drug use more rigorous than those possible through opportunistic samples. Stall and Wiley (1988), for example, compared the alcohol and other drug consumption patterns of self-identified gay and heterosexual men who lived in the 19 census tracts of San Francisco with the highest cumulative incidence of AIDS. The rate of heavy drinking among gay men in this sample was 19 percent, as compared with 11 percent among heterosexual men in the sample, but few other differences were found between the drinking habits of the sample's gay men and heterosexual men. Although gay men did use a greater variety of drugs than their heterosexual male neighbors, differences in the frequency with which they used these drugs were comparatively minor.

To avoid the problem of oversampling bar patrons, McKirnan and Peterson (1988, 1989a,b) elicited their survey sample ($n = 3,400$) primarily from the readership of a Chicago gay newspaper. They compared their findings with those of a survey of alcohol use and problems within a national general population sample (Clark and Midanik 1982). They found rates of abstention from alcohol among gay men and lesbians in Chicago to be lower than those found in the national sample (14 percent versus 29 percent). Rates of heavy drinking among gay men and lesbians were comparable to those found in the general population (15 percent versus 14 percent), although rates of reported alcohol problems were higher in the gay sample (23 percent versus 12 percent, $p < 0.001$). Martin (1990) calculated alcohol consumption and alcoholism rates for a sample of self-identified gay men in New York City. He found considerable consistency in the typical alcohol consumption patterns of men in his study over a 4-year period (averaging about five drinks

per week, excluding abstainers). As of 1986, 12 percent of his sample met the Diagnostic Interview Schedule (DIS)/DSM-III diagnostic criteria for alcohol abuse or alcohol dependence, or both. This rate fell to 9 percent by 1987. In summarizing his own study and the Stall and Wiley study (1988), Martin concluded:

While this rate is certainly higher than the 4 percent rate suggested by Dohrenwend and colleagues... in their synthesis of true prevalence studies in the U.S., it clearly indicates that problem drinkers are not typical among gay men, and are unlikely to constitute as much as a third of the homosexual population (p. 32).

Population-based probability studies have yet to measure alcohol-related problems among lesbians. Thus, McKirnan and Peterson's (1989a) estimates of alcohol consumption and alcohol-related problems within the lesbian community (using samples elicited from the reader-ship of a Chicago gay newspaper) remain the most rigorous yet attempted.3 Rates of heavy drinking among Chicago lesbians were comparable with those of the general population (9 percent versus 7 percent). However, the rate of alcohol-related problems among these urban lesbians--23 percent--appears to be higher than the rate estimated for heterosexual women (8 percent) in a national sample of both urban and rural women (Clark and Midanik 1982).

Is Alcohol Abuse Declining In The Gay Community?

The most important issue faced by the gay male community during the past decade has been the AIDS epidemic. Repercussions from the epidemic have transformed gay life in most American cities. A number of reports have suggested declines in alcohol and other drug abuse patterns among gay men in the context of AIDS.

For example, Martin and his colleagues (1989) reported declines in alcohol abuse and other drug use in a cohort of gay men in New York City. Further, they found that approximately one-half of the men diagnosed as alcohol abusers in 1986 failed to meet the criteria for alcohol abuse upon followup in 1987. This change could be attributed to a very high rate of remission among the men in the sample, although the authors conservatively state that one cannot rule out the possibility of measurement bias. Statistically significant declines in the use of marijuana, inhaled nitrites, sedatives, amphetamines, and psychedelics also were observed. Use of inhaled nitrites, barbiturates, amphetamines, and hallucinogens declined 80 percent from the pre-AIDS baseline of 1981 to followup in 1987. The declines observed for use of cocaine and opiates did not achieve statistical significance. A study by Ostrow and his colleagues (1990) also reported substantial reductions in drug use within a cohort of gay men in Chicago, although the prevalence of heavy drinking within the cohort had remained constant over time.

Remien and his associates (1990) also found evidence for a pattern of remission from alcohol or other drug abuse among gay men in New York City. Data from an opportunistic sample of gay men being followed in a natural history study of human immunodeficiency

virus (HIV) infection showed high rates of lifetime alcohol (36 percent) or other drug (48 percent) abuse, but low rates of current abuse. These findings replicate those of the Martin group (Martin et al. 1989) and again suggest a phenomenon of remission from alcohol and other drug abuse among gay men.

The Remien group (1990) interviewed respondents who had stopped abusing alcohol or other drugs to determine their reasons for change. Among the men who had stopped after the onset of the AIDS epidemic, commonly given reasons included non-HIV-related health problems, changes in other risky behaviors that led to a reduction in alcohol or other drug use, and a general change in norms within the gay community regarding the use of the substances. Delaying onset of clinical AIDS symptoms was a reason commonly mentioned among HIV seropositive gay men. Only a small minority of the men in this sample attributed ending their alcohol and other drug abuse to treatment. The data from this study suggest patterns of ending alcohol and other drug abuse attributed to "maturation" or "spontaneous remission" (see Stall and Biernacki 1986), with the AIDS epidemic adding some urgency to the resolution of problem drinking.

During roughly the same period in which the AIDS crisis became a predominant concern in the gay male community, lesbians were reported to be experiencing shifts in their attitudes toward alcohol. As early as 1982, there emerged speculation that alcohol consumption in the lesbian community was beginning to decline. Hastings (1982), perhaps the first to discuss signs of this trend, suggested that the decrease was due in part to effects of the gay liberation and women's movements. Lesbian alcoholism was recognized during the 1970s in conjunction with a greater awareness of women's drinking problems in general. The feminist and gay rights movements of the 1970s helped to create alternative meeting places to the lesbian bar: women's restaurants, coffee houses, and bookstores first became fixtures on the American urban scene at that time.

Hastings (1982) also noted that the growing presence of recovering lesbian alcoholics may have influenced a shift of attitude and climate around alcohol use in the community toward one of temperance, if not abstinence. This growing mood was supported by a variety of developments within the lesbian community: the 1979 founding of a theater troupe composed of recovering lesbian alcoholics; the disclosure by several prominent lesbian musicians that they were recovering alcoholics; and the appearance of "alcohol- and chemical-free spaces" at women's concerts and other events, as well as cafes free of alcohol (Hastings 1982). In San Francisco, a well-known lesbian bar that had been in existence for more than 20 years closed in 1989, reflecting changes in lesbians' lifestyles (Rubin 1989).

What Are The Risk Factors For Alcohol Abuse In The Gay Community?

Although reseach to date does not provide a conclusive figure for the rate of alcohol abuse within the gay community, it appears that a substantial number of gays, lesbians, and bisexuals drink problematically. The question that remains, regardless of whether

these rates are closer to 10 percent or 30 percent, is how treatment efficacy for gay alcoholics can be improved. The balance of this article addresses this question.

In the 1970s, when findings of excessive alcohol use among homosexual samples were reported, a varied literature emerged to explain the etiology of alcohol abuse in the lesbian and gay communities. Fifield and her colleagues (1977) cited the work of Bales (1946), who identified three factors that contribute to the incidence of alcoholism in any culture: (1) the degree of stress and inner tension that a culture produces; (2) the culture's attitudes toward alcohol use; and (3) the degree to which the culture offers alternative means of satisfaction and coping with anxiety. This led to causal hypotheses emphasizing the stresses of gay life (the social stigmatization of homosexuality, the discrimination, and the internalized feelings of isolation, inadequacy, and alienation), and the special vulnerabilities created by the bar-oriented nature of much of gay social life. Ziebold and Mongeon (1982) noted the "seductive" nature of the gay bar, and its importance as the most available social milieu in which young people could explore their sexuality. Lesbian and gay bars have been among the most important institutions of the American gay community since World War II, offering a readily accessible, permissive, and safe meeting place (Achilles 1967; Berube 1990).

The risk of alcohol abuse in the setting of the gay bar was presumed to be heightened by the degree of tension, anxiety, depression, and guilt felt by many lesbians and gays in a society that has variously regarded homosexual behavior as immoral, pathological, deviant, and/or criminal (Bell and Weinberg 1978; Hammersmith and Weinberg 1973; Hawkins 1976; Saghir and Robins 1973; Weinberg and Williams 1974). A variety of clinical reports and published case study materials have discussed the issues related to being gay that may contribute to risk for alcohol and other drug abuse.

Coleman (1981/1982) noted that alcohol or other drugs may be used by lesbians, gay men, or bisexuals to manage discomfort and conflict around sexual orientation, thereby forestalling the process of coming to terms with their sexuality. Based upon his investigations (which were limited, however, by a small sample), Kus (1988) concluded that lack of acceptance of oneself as gay was "the prime etiological factor in alcoholism in gay American men" (p. 32). Jones and colleagues (1980) found that more than 65 percent of their sample of recovering gay alcoholics believed that being gay or dealing with their gay feelings contributed to their alcoholism. Similarly, difficulty in accepting a lesbian identity and struggles with internalized homophobia (negative attributions and feelings about homosexuality and homosexuals internalized from societal messages, which lead to low self- esteem, alienation, and depression) are suggested as contributing factors for lesbian alcoholism (Anderson and Henderson 1985; Diamond and Wilsnack 1978; Glaus 1988; Weathers 1980). Bisexuals may deal also with the pressure to conform to either an exclusively heterosexual or exclusively homosexual lifestyle (Paul 1988).

McKirnan and Peterson (1988, 1989b) provided the first survey data to test these suggested hypotheses concerning alcohol abuse in the gay community. They measured the importance of bars as a social resource, as well as two variables they related to the stress associated with being gay in our culture: "negative affectivity" (i.e., depression,

alienation, anxiety, and low self-esteem), and discrimination based on sexual orientation. Those subjects reporting more negative affectivity than others were more likely to see alcohol as a means of reducing tension and were more likely to use bars as a primary social setting. Those reporting more discrimination than other respondents also were more apt to use bars as a social resource. Tension- reduction expectancy is an important predictive factor in alcohol abuse among the general population (Brown et al. 1985; Christiansen et al. 1982; Rohsenow 1983), and it appeared to be an important predictor in this gay and lesbian sample. Stress-related use of alcohol was strongly correlated with alcohol problems; a substantial number of both gay males and lesbians (23 percent and 13 percent, respectively) reported using alcohol at least half of the time to cope with personal stress. McKirnan and Peterson concluded that the alcohol abuse among those who used bars as a social resource was significantly related to experienced discrimination and to the personal stress of low self-esteem, alienation, and depression.

A number of researchers have hypothesized that factors unique to lesbians contribute to their alcohol problems; these hypotheses have not yet been empirically tested. Some have argued that because lesbians may experience oppression both as homosexuals and as women, their risk for alcohol abuse is increased (J. Hall in review; Hastings 1982). Others have focused on gender-role conflict as a stress factor that could contribute to alcoholism among lesbians (Schaefer and Evans 1987), but gender-role conflict is not inherent in those who assume nontraditional gender roles. This line of inquiry is based upon early reports suggesting that alcoholic women demonstrated difficulties in their adjustment to adult female gender roles (Kinsey 1966) and that rejection of traditional female roles was associated with heavy drinking (Parker 1972, 1975).

Wilsnack and her colleagues (1986) also found a strong relationship between nontraditional gender role and higher rates of drinking and drinking problems in a national survey of women. It may be hypothesized that lesbians could be at higher risk for alcoholism if they as a group tend to demonstrate nontraditional female role attributes. However, little research has focused on this variable as a risk factor specifically within a lesbian sample. The available data do not confirm that the display of masculine-type traits among lesbians is in itself associated with alcohol problems or with undesired effects of alcohol (Diamond and Wilsnack 1978; Lewis et al. 1982).

Are Gay-Sensitive Alcoholism Treatment Programs Needed?

Reports that suggest gay-specific determinants of alcohol abuse imply a need for treatment programs that address special issues of gay, lesbian, and bisexual alcoholics (Diamond and Wilsnack 1978; Lewis et al. 1982; Zigrang 1982). As there is a growing understanding of variations in and multiple etiologies of alcoholism (Blane and Leonard 1987), treatment models may be more effective if they are oriented to specific categories of alcoholics. Research has yet to provide conclusive proof that gay-sensitive or gay-specific treatment agencies are more effective with gay alcoholics. However, the recognition that presumably "culture-free" models of psychotherapy are not equally effective across racial, gender, cultural, and socioeconomic lines has spurred the

development of culture-specific models that emphasize cultural influences and their interaction with individual variables. In these models, cultural variables are important in problem assessment, defining treatment goals, and the process of psychotherapy (Jackson 1990). Gay-specific or gay-sensitive mental health and substance abuse services can be seen as an extension of this trend.

There is evidence that gay, lesbian, and bisexual clients are more willing to attend treatment programs that address gay issues (Colcher 1982; Driscoll 1982; Jones et al. 1980) or to work with a counselor of the same sexual orientation. Morales and Graves (1983) found that approximately 60 percent of their opportunistic gay and lesbian San Francisco sample stated a preference for a gay or lesbian counselor. The importance of creating gay- sensitive or gay-specific treatment programs, as well as efforts to increase the number and visibility of gay staff members, stems from the need to encourage gay alcoholics to enter and stay in treatment. The client who identifies as a minority group member usually anticipates greater acceptance and understanding from a counselor who belongs to a similar minority (Agostini 1976; Brooks 1981; Goz 1973; Krupp 1983).

Morales and Graves (1983) used the Weinberg Homophobic Attitudes Scale on a sample of 98 alcohol and other drug abuse treatment providers, and found that 9 percent scored "homophobic" and 17 percent scored "marginally homophobic" in attitudes toward homosexuality. This is likely to be an underestimate of the rates of homophobic attitudes among providers, as some providers declined to participate in the survey and expressed the belief that their personal attitudes toward homosexuality were irrelevant to the quality of care they provided to homosexual clients. Homophobic attitudes among alcohol and other drug abuse counselors reflect a continued general tendency toward negative bias, lack of expertise, and inappropriate interventions with lesbians and gay men in psychotherapy (Garnets et al. 1991). If fear of negative reactions from either treatment staff or other recovering clients does not prevent gay alcoholics from entering treatment, it may pressure them to conceal their sexual orientation (Fifield et al. 1977; Freudenberger 1976; Rabin et al. 1986; Tapper and Sauber 1986). For example, many individuals entering Pride Institute--a gay-specific, inpatient alcohol and other drug abuse treatment center in Eden Prairie, Minnesota, with patients from across the United States--reported never having talked about issues related to their sexual orientation in prior inpatient treatment (Ratner 1988).

A study of alcoholism treatment providers at 36 New York City agencies (Hellman et al. 1989) found a lack of formal staff training in treatment issues of gay alcoholics, few or no gay staff members, and corresponding deficits in knowledge of gay community resources. The study also found that few efforts had been made to identify this treatment subpopulation and to create special interventions targeting this population. Overall, the evidence suggests that despite the perception that gay people have unique service needs, few treatment agencies have addressed such needs on a program level (Fifield et al. 1977; Morales and Graves 1983; Zigrang 1982).

Because sexual orientation generally is not apparent to the observer, nondisclosure can lead to underestimates of gay alcoholics in treatment, thereby minimizing the perceived

need within treatment agencies to address gay-specific issues. A survey of 46 Los Angeles alcoholism service agencies (Fifield et al. 1977) led to an estimate that only about 1 percent of their clients were lesbian or gay. As few clients were open about their sexual orientation, the numbers used to arrive at this estimation were based primarily on staff assumptions about their clients' personal appearance and mannerisms. Similar findings were noted by Smith and Schneider (1978) and Zigrang (1982). In stark contrast to the Fifield study, a 1987 San Francisco "sexual minority window survey" of 17 alcohol programs found that counselors reported 23 percent of their clients to be lesbian, gay, or bisexual (A.G. Abramowitz, personal communication, 1991). The reasons for the disparate estimates generated by the two studies may lie not only in the size of San Francisco's gay community, but also in the city's public health policies, which have identified sexual minorities as a special-risk population requiring targeting (Morales and Graves 1983; Vazquez et al. 1989).

A few reports suggest that gay-specific substance abuse programs may be more effective with gay, lesbian, and bisexual alcoholics and addicts; however, this work should be viewed as exploratory rather than as conclusive. Fifield and her colleagues (1977) reported that treatment success rates were markedly higher among a small sample of those who had received treatment at three gay-specific programs operating in Los Angeles. A majority of these clients were unable to attain sobriety in nongay programs. Preliminary reports from Pride Institute (Wert and Roiblatt 1990) suggest that treatment success (as measured in terms of maintaining sobriety) is unusually high among those who complete its program. The ability to generalize from these studies has been limited by their small sample sizes, limited treatment followup data, and the lack of standard operational definitions of treatment outcome (Heather and Tebbutt 1989; Hollister 1990; Peele 1990).

The growth of gay Alcoholics Anonymous (AA) groups has highlighted the need for programs tailored specifically for gay men, lesbians, and bisexuals. Begun in 1935, AA is the most widely utilized intervention for dealing with alcoholism in the United States today (Room 1989). As early as 1937, gay alcoholics presented a dilemma to AA's founders, and the question of their participation was answered by the creation of AA's Tradition Three ("The only requirement for membership is a desire to stop drinking"). When a furor arose over the inclusion of a gay, cross-dressing, African-American, one of AA's co-founders, Bill W., responded by saying, "Is he an alcoholic? I think that's the only question we have any right to ask" (Osborne 1990).

As early as 1945, Bill W. expressed some concern about the difficulties gay and lesbian alcoholics were having in maintaining sobriety and participating in AA (Kus 1987). Alcoholics Anonymous had formulated a policy of acceptance that went against mainstream cultural norms, and did not necessarily reflect the attitudes of all who came to AA meetings.(4) This problem no doubt was behind the formation in 1949 of the first "special interest" gay AA group in Boston; however, it foundered in the 1950s. It was not until about 1968 that another gay AA group was established on the West Coast. By 1974, 16 day groups were known to exist in the United States, and AA officially began to list gay meetings in its world directory. Gay AA has become the largest special-interest group

within the fellowship, with approximately 500 lesbian and gay groups in the United States today (Bloomfield 1990). In San Francisco alone, as of February 1990, 115 out of 560 AA groups meeting each week were oriented toward gays, lesbians, and bisexuals.(5) In several cities, gay and lesbian AA members hold annual conferences. San Francisco has had such a conference since 1976, with registered attendance of more than 4,000 participants for the past 3 years. Similar to general AA demographics, day and lesbian AA members are primarily white and middle class. However, Osborne (1990) notes that workshops to address racial and minority issues within the fellowship have been held at gatherings such as the annual New York gay and lesbian AA conference.

Observers have regarded the existence of gay and lesbian AA as a response to the special needs of gays and lesbians in recovery, such as the availability of a place where homophobia and discrimination do not interfere with recovery (Bloomfield 1990). In the case of women-only or lesbian meetings, there is also an opportunity to voice certain concerns more freely than at meetings in which males participate. In addition, AA has been said to appeal to lesbians and gay men because of its "decentralized democratic" organizational structure, which is familiar to gay people experienced in grassroots political movements. It is this organizational structure, which readily permits the establishment of new meetings, that has enabled lesbians and gay men to form their own AA meetings (Herman 1988).

How Can Treatment Programs Meet the Needs of Gay Alcoholics?

Much of the contemporary literature on alcoholism and treatment issues for gays, lesbians, and bisexuals is written by practitioners reporting the special clinical needs of this population. These papers--primarily reports based upon clinical observations--identify the need for special treatment services for gay alcoholics, and discuss the clinical issues specific to lesbian, gay male, and bisexual alcoholics that must be understood by alcoholism professionals working with this population.

Recognition of the need for specialized treatment services led to a number of policy recommendations by the San Francisco Department of Public Health's Office of Lesbian and Gay Health Services, and to their acceptance by the Department's Community Substance Abuse Services (Vazquez et al. 1989). On an administrative level, these recommendations included a commitment to financial support of treatment programs targeting sexual minorities, collaboration with mainstream treatment programs to increase numbers of gay- identified or gay-sensitive staff, and creation of a means of monitoring programs for discrimination based on sexual orientation. On a program level, these recommendations included developing specialized outreach strategies for the gay community, tracking the use of services by gay clients by collecting data on sexual orientation at intake, increasing specialized agency inservice presentations and training, and providing services for the partners of recovering gay alcohol and other drug users. Such programs also must address the needs of people of color who are gay, lesbian, or bisexual.

Separate mention is made in the report recommendations of the importance of addressing the special needs of lesbians in treatment. Despite the increasing number of women who hold managerial and professional jobs, women's wages continue to be lower than those of men (Bradford and Ryan 1988), imposing a gender-linked economic barrier to quality health care. Furthermore, models of psychotherapy traditionally have been male oriented (Miller 1976; Tennov 1976), and models of psychological health have been biased in favor of men (Broverman et al. 1970). Lesbians face barriers intrinsic to being women, and they also may face barriers intrinsic to their sexual orientation. A study by Modrcin and Myers (1990) found that two-thirds of the lesbians sampled would prefer counseling from a female professional.

Gay alcoholics are likely to seek treatment in settings that may not be specifically oriented to the gay community. If a broad array of treatment facilities are to improve their services for recovering gay alcoholics, they should consider a number of issues, which we will identify briefly below.

Changing Heterosexual Staff Bias

The sexual orientation of a client should not affect the quality of treatment services provided by alcoholism professionals. However, the issue of sexual orientation should not be ignored in treatment, and counselors should be aware of the role it can play in defining their attitudes and assumptions about clients. Inservice educational programs for staff can help to counter longstanding biases toward homosexuality and bisexuality in mental health settings (Coleman 1982; Morin and Rothblum 1991; Pillard 1982). Zigrang (1982) provides one such model for an inservice staff training program.

It was not until 1973 that the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders removed homosexuality as a disorder; revision of a later edition was necessary to remove "ego- dystonic homosexuality." Clients entering treatment are dealing with shame and fear of being rejected, not only for their alcoholism, but also for their homosexuality (Brown 1987). A therapist is an authority figure whose approval or disapproval typically carries a great deal of weight (Sophie 1987). Studies of gay men have indicated that many report a history of nonacceptance, prejudice, and a lack of understanding in their encounters with counselors and psychotherapists (Bell and Weinberg 1978; Saghir and Robins 1973). Lesbians face reactions to their homosexuality, as well as issues specific to women in treatment (Goz 1973; Tennov 1976). Staff should consider carefully their own attitudes and beliefs about gay people. The therapist's values and biases inevitably emerge and influence the process of treatment (Lopez 1989, and Murray and Abramson 1983, both cited in Garnets et al. 1991). If prejudicial attitudes prevent staff members from providing the best possible treatment, it would be wisest for them to work with a different population.

Understanding Gay Culture

Counselors should be aware of local community resources (including gay AA groups). Practitioners also should be aware of the ways in which factors associated with alcohol abuse--such as difficulties in feeling good about oneself or one's relationships with others, isolation, alienation, and low self-efficacy (Brown and Yalom 1977; Cox 1987; Van Hasselt et al. 1978)--are compounded by the issues of being homosexual or bisexual, of being a woman (Schaefer et al. 1987), or of being a member of an ethnic minority. Awareness of local gay groups and resources helps counselors to suggest networking alternatives to gay bars and to talk with clients about their experiences in exploring these alternatives. Further, because deficits in coping skills are viewed as a major cause of relapse (Donovan and Chaney 1985; Monti et al. 1989), counselors should address social issues specific to being gay and alcoholic (e.g., dealing with sex in recovery, codependency and same-sex couples issues, and issues related to AIDS and HIV infection).

The utility of a therapy regimen including modeling, behavioral rehearsal, assignments, and followup to develop competency in handling various issues relevant to "coming out" was demonstrated in early clinical reports (Duehn and Mayadas 1976). Because the desire for alcohol may be cued by both environmental triggers and psychological triggers, any relapse prevention and coping skills training programs should include gay-specific triggering situations in planning and in behavioral rehearsal.

Dealing with Internalized Homophobia or Biphobia

An important part of early recovery, in addition to focusing directly on stopping alcohol and other drug use and strengthening relapse prevention skills, is the important process of self-analysis and redefining oneself (Brown 1985). Because alcohol may have served as a crutch to deal with the intrapsychic conflicts created by same-sex desire and societal disapproval, clients in recovery may find themselves going through a process of redefining themselves sexually and coming to terms with their homosexuality or bisexuality (Colcher 1982; Sterne et al. 1983). Gay alcoholics may find themselves dealing with feelings of guilt, shame, alienation, and self- hatred.

To avoid further alcohol abuse triggered by these conflicts, clinical interventions should be aimed at helping clients to achieve a more functional resolution of sexual orientation concerns. The importance of dealing with internalized homophobia to maintain sobriety is supported by clinical reports (Kus 1988; Marschall 1980). Given the number of gay clients in mainstream alcoholism treatment programs who do not disclose their sexual orientation, it appears that many do not deal with the important issue of developing self-acceptance; this may then reinforce internalized homophobia and biphobia (Coleman 1981/1982; deMonteflores and Schultz 1978; Sophie 1987). Counselors may benefit from training to serve their clients with greater sensitivity and support on these issues.

Understanding How Sexual Behavior Affects Sobriety

Knowledge of lesbian, gay and bisexual lifestyles is important for any alcoholism professional working with this population. Understanding of and sensitivity to the dynamics of same-sex relationships allows counselors to identify and support their strengths, and not to assume that deficits exist when such relationships diverge from normative heterosexual models (Isensee 1990). Issues of sexuality and intimacy often are not addressed in chemical dependency treatment programs, although they may be crucial in dealing with the dynamics of alcohol and other drug abuse (Coleman 1987). For some men and women who are just coming out, drinking may be a prerequisite to approaching others of the same sex, as well as to any homosexual behavior (Chafetz et al. 1970). Some gay clients have never experienced "sober sex" and may be unused to the communication necessary for a satisfactory sexual experience (Smith 1982). Sex and alcohol and other drug use may be so strongly linked in gay clients' minds that sex becomes a situation that carries a high risk for relapse.

The knowledge and facility to work with clients on relationship and sexual issues may be as important to relapse prevention as working on situations in which the client is offered a drink. Because high rates of sexual practices that are high risk for HIV transmission have been found in gay and bisexual male abusers of alcohol and other drugs as a group, alcoholism treatment professionals also increasingly require training in sexual risk-reduction skills (Paul unpublished data 1990). Effective risk-reduction interventions require knowledge of male homosexual practices and nonjudgmental, "sex-positive" attitudes on the part of counselors (Quadland and Shattls 1987).

Providing Positive Gay Staff Models

A gay therapist one respects and admires can provide a positive model for gay clients' identification (Gottesfeld 1978; Krupp 1983; Schwartz 1989; Sophie 1987). The trend of counselors to be recovering alcohol and other drug abusers themselves indicates the therapeutic value many treatment programs see in providing staff as positive models. Furthermore, gay staff members can serve as an important resource for heterosexual staff working with gay clients. As in dealing with any prejudice (Allport 1954), institutional support for gay-identified counselors can help to increase awareness and to alleviate the misconceptions and the biases that are common in primarily heterosexual agencies (Finnegan and McNally 1980).

How Can Gay Alcoholics Obtain Support for Sobriety?

An important part of recovery is obtaining support for changing one's pattern of alcohol abuse, which is one reason why group treatment is favored by professionals over other clinical interventions. Whether based upon a cognitive-behavioral model or upon an interpersonal dynamic model, groups are an important means of helping recovering alcoholics to overcome feelings of self-contempt, isolation, depression, loneliness, and alienation (Brown and Yalom 1977). Group leaders should work to establish a rapport with group members by creating a climate conducive to self-disclosure, avoiding moralization

or judgement, and affirming the worth of group members (Khantzian et al. 1990). This work may be more difficult in a group in which there are only one or two gay members, as others in the group may regard them in negative, stereotypic terms, may be unsupportive, and may isolate them (Yalom 1975).

Developing social networks supportive of the sobriety of recovering alcoholics is a crucial part of relapse prevention after treatment. Many treatment programs work not only with individuals, but also with their families. However, gay alcoholics' sexual orientation may deprive them of this conventional primary source of social support (Nardi 1982). As gay men, lesbians, and bisexuals may be rejected by their families because of their sexuality, and because they are unlikely to have primary relationships conforming to the traditional nuclear family structure, alternative sources of social support are especially significant to the emotional well-being of recovering gay alcoholics (Nardi 1982). Programs should recognize the significant relationships that lesbians, gays, and bisexuals do have, and should help clients use the support these relationships can provide for their recovery. Friendship networks may play a more significant role in the life of many gay men, lesbians, and bisexuals than among heterosexual men and women. Self-help groups such as Alcoholics Anonymous can play a substantial role in developing supportive networks, and in this context, gay and lesbian special-interest AA groups and events take on added significance.

In a cross-sectional study, Bloomfield (1990) compared the social network structure of gay and lesbian members who had been in AA for varying lengths of time. Within their social networks, she found a significant increase over time in the number of other gay recovering alcoholics. Among those in AA less than 1 year, about one-half of their social network consisted of other lesbian or gay recovering alcoholics; this figure rose to three-quarters among those in AA for at least 6 years. Bloomfield also found that those members of the social network who were gay and recovering provided a high level of social support. Thus, membership in AA for gay alcoholics was associated with the apparent retention of gay friends supportive of their recovery.

Summary

Early studies of alcohol and other drug use among gay men and lesbians led to estimates that one out of every three was an abuser, but these studies used opportunistic samples that usually oversampled bar patrons. Later work (based on sampling techniques designed to approximate community-wide samples of gay men) found considerably lower rates of alcohol and other drug abuse among gay men.

Nonetheless, the early literature reflects an important social reality: gay culture has, until very recently, been heavily bar focused. It would be surprising if rates of alcohol abuse and alcoholism were not higher than those found in the general population, given that bars have been one of the few safe places for lesbians, gay men, and bisexuals to congregate in many American cities. The impact of encountering discrimination due to sexual orientation, combined with the availability of alcohol, may well contribute to drinking

problems within the gay community. Perhaps what is remarkable about the rates of problem drinking or alcoholism within the gay community is not that they are so high, but that they are as low as they are.

Some evidence has emerged that shows declining rates of problematic alcohol and other drug use in the gay male community. This resolution of problem drinking careers has been detected in cohorts of men followed over time, and so is strongly influenced by aging effects; but self-reported reasons for resloving alcohol and other drug abuse careers often include mention of the effects of the AIDS epidemic. In addition, the trend toward an increasingly alcohol- and recovery- conscious lesbian community suggests that rates of heavy drinking and alcohol problems may be decreasing among lesbians. However, there have been no attempts as yet to document empirically either the prevalence rates or any changes in rates over time for lesbians through the more valid population-based sampling methods. The sampling techniques developed to study gay men's health risks in the age of AIDS should be used to elucidate the health risks of lesbians, including alcohol and other drug abuse.

Several gaps exist in the epidemiologic literature concerning the alcohol and other drug use habits of gay men and lesbians. First, as already noted, the effort to approximate a community-based sample of lesbians has yet to be made. Second, most of the research on gay men and lesbians has relied on samples that are heavily white and middle class; the drinking and drug use practices of minority gay men and lesbians have yet to be studied in detail. Third, nearly all of the literature on gay drinking practices has come from the largest American urban centers. Data on drinking practices among those who live outside of these areas would add significantly to our understanding of gay men and women's drinking practices as a whole. Further research is necessary to improve understanding of the differences between those men and women in the gay community who manifest drinking problems and those who do not. This line of research is important for designers of primary prevention efforts in the gay community (Mongeon and Ziebold 1982). The findings from such research can help to direct the focus of studies comparing the experiences of lesbians, gay men, and bisexuals in conventional versus gay- specific treatment programs.

The existing literature demonstrates a need to address issues specific to the gay community in alcoholism treatment, and supports the notion of gay- specific treatment groups and programs. There is evidence of a need for formal training among alcoholism professionals in treatment issues specific to gay alcoholics, and a need for these professionals to know about the gay community, as well as a need to identify and provide special resources for this population. The available research indicates that gay alcoholics have difficulties in seeking treatment at many mainstream treatment settings, and may encounter prejudicial attitudes and nonacceptance from heterosexual staff.

The growth of gay and lesbian special-interest Alcoholics Anonymous groups over the past two decades reflects the need for gay-identified programs. This growth also reflects the demand within gay community for such groups. The merits of gay-specific alcohol and other drug abuse treatment programs can be seen in the context of other current public

problems within the gay community. Perhaps what is remarkable about the rates of problem drinking or alcoholism within the gay community is not that they are so high, but that they are as low as they are.

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The growth of gay and lesbian special-interest Alcoholics Anonymous groups over the past two decades reflects the need for gay-identified programs. This growth also reflects the demand within gay community for such groups. The merits of gay-specific alcohol and other drug abuse treatment programs can be seen in the context of other current public

health concerns. To date, the AIDS epidemic in the United States has exacted its greatest toll on gay and bisexual men, but in its wake we have seen the importance and efficacy of community-based programs to deal with major health issues. The gay community has significantly shaped and redefined its norms and values. It has mobilized in the last decade both to reduce rates of high-risk behaviors and to offer its HIV-infected members the choice of gay-specific services. Although we cannot quantify its impact, it appears that major changes have occurred over the last decade in how gay men and women approach the health care system and in their expectations that service providers be responsive to their needs. As part of the health care system, alcohol and other drug abuse treatment providers may face increasing pressure to become familiar with and to accomodate the specialized needs of their gay, lesbian, and bisexual clients.

(1) For brevity and clarity, we will use the term "gay" in referring to homosexual and bisexual men and women, rather than its more restrictive use, which refers to homosexual men (particularly homosexually active men who identify as "gay"). This usage is not meant to blur the distinctions between men and women, or homosexuals and bisexuals, and at times explicit reference will be made to one or more of fthese sub-groups.

(2) Throughout this article, we will use the terms "alcoholism," "alcohol abuse," "heavy drinking," and "problem drinking." There is no consensus in the alcoholism literature on the precise meanings for each of these terms; therefore, our wording at any given point must rely on the terms used by the authors in each report cited.

(3) Interpretations of data from a national study of lesbian health care (Bradford and Ryan 1988) are limited due both to opportunistic sampling procedures and to abbreviated measures of alcohol and other drug use. Two findings are suggestive, however. Only 14 percent of their sample (n = 1,925), recruited through women's centers, lesbian and gay organizations, personal networks, bookstores, and gay newspapers, reported being currently worried about their use of alcohol. Fewer than 12 percent reported having sought counseling for alcohol problems or other drug problems, or both.

(4) In 1980, Jones and colleagues surveyed gay alcoholics in recovery and found that 68 percent of the respondents felt that their recovery process would be easier if they could openly discuss their sexuality at general AA meetings.

(5) These figures are courtesy of 18th Street Services (a gay-identified alcohol and other drug abuse treatment agency) and Alcoholics Anonymous in San Francisco.

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