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**Lesbian, Gay, and
Bisexual Identities
and Youth**

Psychological Perspectives

Edited by

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Avoiding HIV/AIDS and the Challenge of Growing Up Gay, Lesbian, and Bisexual

Arnold H. Grossman

The realities of HIV/AIDS can be approached from a variety of perspectives. For many gay, lesbian, and bisexual youths and adults, these realities are linked to moral differentiations that society has based on modes of HIV transmission. Those termed "medical victims" (i.e., blood transfusion recipients, men with hemophilia, and infants infected perinatally) are seen as deserving compassion, while those who acquire the disease through sexual transmission are stigmatized and are associated with homosexuality and other "condemned lifestyles" (Manning, 1997; Novick, 1997). For many gay, lesbian, and bisexual youths, these perspectives frequently connect HIV/AIDS to several disquieting concerns: being a member of the social group blamed for starting the "gay plague," seeing portraits of gay men and lesbians with physically frightening manifestations, observing death and dying, witnessing increased anti-gay violence, viewing prevention messages that do not affirm "immoral" (i.e., homosexual) behaviors, engaging in same-sex behaviors that are labeled "taboo," and experiencing homophobic behaviors that underlie social attitudes toward sexuality, including sexual pleasure outside of marriage (Public Media Center, 1995). Gay, lesbian, and bisexual youths have to face these HIV/AIDS-related stigmatized portrayals while developing their personal, social, and sexual identities. Gay, lesbian, and bisexual youths must also meet the special challenge of avoiding HIV infection.

Heterosexuality Needs No Explanation

The biological sex of people with whom one is sexually intimate determines whether one is labeled as heterosexual, homosexual, or bisexual. However,

sexual orientation encompasses more than the gender of the people with whom one engages in sexual activities; it includes sexual attractions, fantasies, feelings, and self-identification, as well as sexual behaviors. Adolescents who grow to realize that they have sexual attractions to and fantasies about people of the opposite gender and who engage in sexual behaviors with them are not required to give any explanations about those behaviors. In fact, heterosexually identified adolescents are provided with opportunities to pursue social activities, learn dating skills, and explore relationships. Many cultures strongly encourage males to engage in sexual activities, training them to be dominant and independent in relationships with women. On the other hand, the mores of most communities present a double message to their young female members: enjoy the pleasures of sexuality (as portrayed in the mass media and advertising) and abstain from sexual activities until marriage (as proselytized by the family and religious institutions). Heterosexually identified adolescents have the support of their families, schools, and churches in their attempts to learn about their gender identities, gender roles, and sexual behaviors. They are provided with after-school athletic activities, youth clubs, parks, and recreational centers. In these spaces, youths learn the expectations and norms of heterosocial society (Grossman, 1998). As part of these lessons, most adolescents are provided with heterosexually based HIV/AIDS prevention education programs. Concurrently, homosexual attractions are either ignored or portrayed as shameful and abnormal. In relation to the latter, myths and stereotypes about gay, lesbian, and bisexual people are taught. In a society that embraces heterosexuality as normative behavior (D'Augelli, 1998), these messages lead to a heterosexual orientation being accepted as the "default" category. If individuals do not label themselves otherwise, they are assumed to be heterosexual in their orientation and behaviors. Consequently, those youths who are gay, lesbian, or bisexual and who decide not to disclose their sexual orientations are assumed to be heterosexual and are provided with HIV/AIDS education programs designed for heterosexual youths. These programs are not developmentally appropriate for gay, lesbian, and bisexual youth, do not address their unique concerns, and are not effective in helping them to avoid HIV infection. For example, these curricula frequently lack opportunities for gay, lesbian, and bisexual youths to acquire social skills appropriate to their adolescent development or to create peer support systems that enhance their identity formation (Cranston, 1991). These youths are also not given chances to learn the implications of general adolescent risk-taking characteristics such as living in the present or seeing themselves as invulnerable (Grossman, 1995); and this includes their not feeling susceptible to HIV infection as a result of their unsafe sexual behaviors. For instance, although a substantial number of urban African-American and Hispanic youths (of various sexual orientations) in one study worried about contracting AIDS, the majority believed it would not happen to them (Ford & Norris, 1993).

Giving Up the Privileges of Heterosexuality

Gay, lesbian, and bisexual youths tend to become aware of their same-sex feelings at about the age of 10 years, and they label these feelings at about 14. On average, they first disclose their sexual orientation to another person at 16 years of age, which begins the "coming out" process (D'Augelli, Hershberger, & Pilkington, 1998). In disclosing their sexual orientation, these youth frequently give up many heterosexual privileges. They lose opportunities to date, to develop intimate relationships, to learn socialization skills, to share feelings with peers, to experiment sexually in physically safe environments, and to achieve a sense of independence and competence. They are deprived of support networks and a sense of community, often leading to feelings of isolation and loneliness, and to barriers that prevent the construction of personal and social identities. Those resilient gay, lesbian, and bisexual youths grow into adulthood relatively unscathed, while others become emotionally scarred (DeCrescenzo, 1994). The disclosure of their sexual orientation often transforms them from adolescents with difficult information to manage into individuals with difficult circumstances to get through (Grossman, 1998). They have to learn how to meet others with similar sexual orientations, to gauge who will and who will not respond favorably to knowing about their same-sex orientation, and to escape from becoming a victim of those who stigmatize homosexuals (Rotheram-Borus, Hunter, & Rosario, 1995). Society's homophobia not only marginalizes these gay, lesbian, and bisexual youths and creates impediments to their developing authentic identities, but it increases the probability that they will be at risk for HIV infection. For example, Rosario and Rotheram-Borus (1992) found that gay adolescents' inability to predict others' reactions to the disclosure of their sexual orientation was correlated with risky sexual behaviors, substance use, and stress in other areas of their lives.

Before continuing with the discussion of risks for HIV infection among gay, lesbian, and bisexual youths, it is important to recognize that there is much variability among them. The diversity among gay, lesbians, and bisexual youths reflects differences with respect to their sexual behaviors and relationships based on their feelings from childhood, personal histories of attachments, and opportunities to meet potential partners. Many of the youths are sexually experienced by the time they are in high school, some by choice and some not. Some are sexually active only with members of their own sex, but many experiment with friends of both sexes over time. Some practice celibacy or monogamy, but many are involved with multiple partners or experience serial monogamy (i.e., many short-lived relationships with one partner at a time). If gay, lesbian, and bisexuals youths are sexually active, their need for approval and acceptance (especially if they are being victimized at home or at school) may be driving their risk-taking behaviors, including sexual and drug-using activities. Limited also by their levels of cognitive and social development, these youths may not be able to make a

rational calculation about their HIV risk-taking behaviors. Though less often, other youths who engage in HIV-risky behaviors with same- and opposite-sex partners are facing hormonal challenges that are affecting their sexual behaviors or they are seeking to develop a personal identity as a transgender person.

Homophobia and HIV-Risk Behaviors

Having to cope with a disparaging and oppressive society creates unique stresses and developmental variations in identity development for gay, lesbian, and bisexual youths, especially in adolescence and young adulthood (Gonsiorek & Rudolph, 1991). As most gay, lesbian and bisexual youths do not want to be rejected by their families, friends, and teachers or experience verbal and physical abuse from their peers (D'Augelli et al., 1998), they hide their sexual orientation (Martin, 1982). Hiding often leads to feelings of marginality, deviance, and emotional and social isolation (Hetrick & Martin, 1987), and the youths' psychological energy becomes focused on avoiding situations in which their sexual orientation may be discovered. Additionally, it is important to note that the incidence of cancer and moderately serious infectious diseases has been found to increase in gay and bisexual men (over the age of 18) to the degree to which they conceal their homosexual identity (Cole, Kemeny, Taylor, & Visscher, 1996). According to Cole et al., these findings conceptually replicated the results of a previous study that documented accelerated HIV progression among gay men who concealed their homosexual identity. Similar studies need to be conducted among gay, lesbian, and bisexual youths to determine if the degree to which they conceal the expression of their homosexuality impacts their health, including the progression of HIV infection.

Those youths who do not totally conceal their homosexual or bisexual orientation either disclose their sexual identity or remain publicly hidden and find sexual activity as their primary source of social and emotional contact (Grossman, 1994). "Coming out of the closet" frequently leads to victimization (D'Augelli et al., 1998) and the use and abuse of alcohol and illicit drugs (Grossman & Kerner, 1998; Hunter, Rosario, & Rotheram-Borus, 1993; Rosario, Hunter & Gwadz, 1997). Gay, lesbian, and bisexual youths who self-identify during high school (grades 9–12) are more likely than their peers to report a variety of health risks and problem behaviors, including suicide, victimization, sexual risk behaviors, and multiple substance use (Garofalo, Wolf, Kessel, Palfrey, & DuRant, 1998).

Alcohol and drugs are frequently consumed as a way of coping with the stresses associated with prejudice and discrimination linked to homosexuality (Rosario & Rotheram-Borus, 1992). Becoming dependent on alcohol and drugs often leads to poor judgment and high-risk sexual behaviors for HIV infection (Remafedi, 1994b; Rotheram-Borus et al., 1995). For those who re-

main hidden, "the most troublesome conflict occurs at the intersection of HIV risk and the expression of homoeroticism through sexual behavior" (D'Augelli, 1998, p. 195). These conflicts may be more distressing for gay, lesbian, and bisexual youths who are also members of ethnic minority communities (Hunter & Haymes, 1997). Members of these communities frequently possess strong attachments to their ethnic cultures (Peterson, 1995), with some developing strong feelings of pride. They tend to define homosexuality in differing ways from the "white" majority because of their experiences with homophobia and racism (Kuszelewicz & Lloyd, 1995) and their devotions to three different communities: their family and ethnic/racial community, the lesbian and gay community, and society in general (Hunter & Schaefer, 1994). Additionally, HIV transmission through male-to-male sexual contact among adolescents has been found to vary by ethnicity, with transmission being much higher for African Americans than for Hispanics or Whites (Manloff, Gayle, Mays, & Rogers, 1989). As Diaz (1998) reminds us in his discussion of Latino gay men and HIV, it is important to acknowledge that many self-identified respondents in such studies do not publicly disclose their sexual orientation to family, co-workers, or even friends.

Gay and bisexual male youths who remain hidden often seek sexual contact with other males in places where prostitution occurs (e.g., selected streets and parks) and where they may be frequently exposed to HIV and other sexually transmitted infections. Often unable to feel worthy of romantic love, of being cherished, or of becoming a life companion, these gay and bisexual males view themselves as sexual commodities to be used by more "perfect" men (Novick, 1997). Lesbian and female bisexual youths who remain hidden may seek heterosexual relationships as protection against the discovery of their sexual orientation. Often occurring simultaneously with a lesbian relationship, females' heterosocial sexual activities place them at risk for HIV infection. This risk increases if the partner is a gay or bisexual male who engages in unprotected sex with other males (Hunter & Haymes, 1997; Rotheram-Borus et al., 1995). Findings of a study examining the sexual behaviors of 111 young (<21) gay and bisexual men in England and Wales indicated that 45% had had a female sexual partner, and 34% reported having had vaginal intercourse (Davies et al., 1992). Although the sexual orientation of the females was not reported, the investigators noted that youth is a time for sexual experimentation and that a proportion of young men (i.e., under 21 years) had sex with both a man and a woman in the month and year preceding the interview. The proportion was greater for the young men than it was for the older men in the larger cohort of the study.

Gay, lesbian, and bisexual youths have also been found to be at increased risk for suicidal ideation and attempts (Grossman & Kerner, 1998; Hershberger, Pilkington, & D'Augelli, 1997; Remafedi, Farrow, & Deisher, 1991; Remafedi, French, Story, Resnick, & Blum, 1998). In their study of 221 self-identified gay, lesbian, and bisexual youths (72% male and 28% female, with an aver-

age age of 18.5 years), Proctor and Groze (1994) found that 40% attempted suicide and 26% had a serious thought about it at least once. Hershberger et al. reported that 39% of their sample of 194 gay, lesbian, and bisexual youths engaged in suicidal thinking in the week prior to data collection, and that 42% reported at least one suicide attempt, with the number of past attempts ranging from 1 through 15. The investigators found that the strongest correlations with past suicide attempts were low self-esteem and the loss of friends owing to the disclosure of sexual orientation. In a sample of 36,254 public junior and senior high school enrollees in Minnesota, Remafedi and his colleagues (1998) found that suicide attempts were reported by 28% of the gay/bisexual males and 21% of the lesbian/bisexual females, 15% of the heterosexual females, and 4% of the heterosexual males. Sexual orientation was found to be associated with suicidal intent and attempts of only the gay/bisexual males. While drug overdose has been reported as the most common method of attempting suicide (used by 70% of the attempters in the Hershberger et al. [1997] study), no studies have investigated whether those gay, lesbian, and bisexual youths who consistently engage in high-risk sexual behaviors or other self-destructive behaviors are employing other methods of attempting suicide.

HIV/AIDS and Gay, Lesbian, and Bisexual Youths

Adolescent sexual orientation is conflated with teenage sexual behavior by most of American society. According to Ehrhardt (1996), social attitudes are polarized concerning the suppression of teenage sexual behavior and acceptance of the fact that youth will become sexually active during their teens. This frame of mind has led to ambivalent and insufficient approaches to sex education, focusing on biological reproduction versus healthy sexual relationships. As well as leaving adolescents uninformed and untaught about reaching responsible decisions regarding intimate relationships with same- or opposite-sex partners, the denial of teenage sexual activities has also led to a scarcity of studies that include adolescent sexual feelings or behaviors as normal aspects of human development. Those studies on adolescent sexuality that have been conducted tend to be "solely or predominantly conceptualized, assessed, and discussed within the context of risk behavior: risk for pregnancy, risk for STDs, and for HIV infection" (Ehrhardt, 1996, p. 11). This bias toward the negative consequences of teenage sexual behaviors has certainly been true of those studies examining HIV/AIDS among gay, lesbian, and bisexual youths.

Many adolescents in the United States are engaging in behaviors that increase their risks for HIV infection and AIDS (Centers for Disease Control and Prevention, 1995). While a small number of teenagers (ages 13–19 years) has been diagnosed with AIDS (i.e., 3,130 of 641,086 cumulative cases of AIDS through December 1997), 17% of all male and 22% of all female cases

of AIDS reported through December 1997 were among young adults between the ages of 20 and 29 years. With the long time between HIV infection and diagnosis of AIDS, it appears likely that many of these 111,368 people were infected during their adolescent years. Of the 30 states that reported HIV infection cases in 1997 (which does not include those who have developed AIDS), 4% of the cumulative total of 92,107 reported through December 1997 were between 13 and 19 years, while 14% were between 20 and 24, and 22% were between 25 and 29 (Centers for Disease Control and Prevention, 1997a). Among these are gay, lesbian, and bisexual youths.

Most of the studies concerning HIV/AIDs among sexual minority youths have focused on gay and bisexual male youths, their risks for HIV infection, and HIV seroprevalence rates among them. Kegeles, Hays, and Coates (1996) summarized the findings of some recent studies among gay and bisexual men. One study found that 18% of the young gay men (ages 18–29 years) in San Francisco were HIV positive, while a second study of gay and bisexual men (ages 17–22 years) in the San Francisco Bay Area reported a 9.4% seroprevalence rate. A surveillance study of 13 clinics for sexually transmitted diseases around the United States found the median rate of HIV infection among young homosexual/bisexual males (ages 20–24 years) to be 30%. Based on the findings of several studies, Kegeles and her colleagues calculated that 33% to 43% of young gay (and bisexual) men engaged in unprotected anal intercourse in the past two to six months. These findings are consistent with those revealed by Lemp et al. (1994) and the results reported by Dean and Meyer (1995). Lemp et al. found that one-third of youths in their study of 17- to 22-year-old homosexual and bisexual men in San Francisco had engaged in unprotected anal intercourse during the past six months. Unsafe sexual contact was associated with the lack of peer support for safe sex, as well as a history of forced sex. They also found that 4% of the 17- to 19-year-olds and 12% of the 20- to 22-year-olds were HIV positive. In their study, Dean and Meyer found that 37% of 18- to 24-year-old gay men had engaged in unprotected receptive anal intercourse over a two-year period. The findings of Lemp and his colleagues indicated that there were significant correlations between unprotected anal intercourse, the use of nitrites, a history of "forced sex" or sexual abuse, and perceived decreased peer support for safer-sex practices.

Summarizing findings of previous studies, Rotheram-Borus, Reid, and Rosario (1994) indicated that adolescent and young gay males (ages 14–22 years) have been found to have multiple sexual partners, use condoms infrequently, exchange sex for money or drugs, and engage in more sexual risk acts than older gay men. Additionally, they reported that many gay male adolescents have sexual relations with adult gay men and engage in noninjection drug use. In structured interviews with gay males aged 15 to 21 years, Gold and Skinner (1992) found that the two primary factors of self-justification related to "unsafe" sexual encounters were: (1) responding to a negative mood state, and (2) inferring that the partner was unlikely to

be HIV-infected based on perceptible characteristics. Another situational factor facilitating the occurrence of unsafe sex, reported by the young gay men in the Gold and Skinner study, was the failure to communicate their desires concerning safe sex. In a study of 239 gay and bisexual male adolescents between the ages of 13 and 21 years, Remafedi (1994b) found that 63% were at "extreme risk" for HIV exposure based on histories of unprotected anal intercourse and/or intravenous drug use. Risky sexual behavior was not associated with sociodemographic characteristics, reported psychosocial problems, or HIV antibody testing. The young men often engaged in high-risk sex even when they were knowledgeable about HIV, were acquainted with HIV-infected persons, and were aware of their susceptibility. Persons in steady relationships were more likely than others to have unprotected intercourse; and inconsistent use of condoms was associated with non-communication with partners about risk reduction, substance use in sexual situations, and frequent anal intercourse. Although Remafedi found no relationship between knowing people with HIV disease and adherence to safer sex practices, Morris, Zavisca, and Dean (1995) found weak support between this variable and adherence to safer-sex practices in a sample of 563 young gay men. However, Morris et al. found that younger gay men with older partners were on the leading edge of the epidemic in their cohort—that is, they were more likely to be HIV-infected. Contrary to the Remafedi findings, in a study about sexual behavior and AIDS knowledge in a sample of young male prostitutes in Manhattan, of which 50% were homosexual and 26% were bisexual, Pleak and Meyer-Bahlburg (1990) reported that AIDS knowledge was high and positively correlated with the sexual-risk avoidance. Additionally, they found that the prostitutes were safest in sex with their male customers, less safe with the male partners they selected for pleasure, and least safe with their female partners. Although drug and alcohol abuse and dependence were frequent, they were not significantly associated with the degree of safety in sex.

In the study of 111 young (<21) gay and bisexual men in England and Wales cited above, Davies et al. (1992) found that condom use varied with relationship status. "Of those in a monogamous relationship, 50% *always* used a condom for receptive anal intercourse, 30% of those in a non-monogamous regular relationship, and 63% of those not in a regular relationship. The corresponding figures for the insertive mode are 33%, 43%, and 60%" (p. 267, italics in original). They also found that a higher proportion of the younger than the older men (from a larger cohort) were in non-monogamous regular relationships, which the investigators concluded were a major predictor of unsafe sexual behavior. Davies et al. also pointed out, however, that these young men were making reasoned and rational decisions about risk reduction by choosing to have regular anal intercourse within their relationships rather than with casual partners. Rightly, they judged that the efficacy of this response in limiting the spread of HIV is questionable. While Davies et al. found that condom use was slightly more

consistent among the young gay men than older men, Ridge, Plummer, and Minichiello (1994) found that there was no difference in the level of recent unprotected anal intercourse among young gay men (<25 years) of different ages in Melbourne, Australia. They discovered, however, that those young men sampled from a gay commercial venue and those who reported no affiliation with a gay organization had a significantly higher level of recent unprotected anal sex than did other young gay men. According to the investigators, the results suggest that the commercial gay scene may not provide the same "safe-sex culture" for younger men as it may for older gay men (who usually have more power in such situations), while being part of a gay organization does seem to provide access to that culture for younger men. The findings also suggest that sexual HIV risk for young gay men is not socially uniform, and it may be more appropriate to define HIV risk within specific historical and culture cohorts than to work with the universally defined categories of "youth" and "adolescence." Studies are also needed to assess the efficacy of HIV risk-reduction intervention programs targeted to groups of young gay men in various communities of a geographical location and to those who use different "spaces" within those communities.

Cases of female-to-female transmission of HIV are extremely rare; however, research on adult lesbians have indicated that most have been sexually active with men. This sexual activity with men places them at risk for a range of sexually transmitted diseases (STDs), including HIV (Einhorn & Polgar, 1994; Ryan & Futterman, 1998). Two studies of women considered at high risk for HIV due to their sexual behavior, drug use, or place of residence found that 16% to 24% of these women self-identified as lesbian or bisexual. Additionally, the findings indicated that those women who reported at least one female sexual partner (regardless of self-identified sexual identity) were more likely to have engaged in anal sex with men, more likely to have injected drugs, and had higher HIV seroprevalence rates than do the exclusively heterosexual women (Gomez, 1995). Cochran and Mays (1996) found that over one-quarter of their sample of 18- to 24-year-old lesbian and bisexual women had heterosexual intercourse in the previous year. Of the bisexually identified women, 10% had sex with a gay male partner in the past year. Respondents who reported sex with a gay man were younger than other women, many in their adolescent years.

Consistent with adolescent sexual behaviors, lesbian teenagers often experiment sexually or have ongoing sexual contacts with friends in their social networks, including gay and bisexual male adolescents they meet at social and recreation programs or through same- and cross-gender friendships (Hunter & Schaecher, 1994). Consequently, their risk for HIV infection may be higher than expected as their male partners may be HIV-positive, or may be engaging in sex with other males who are. Additionally, both female and male youths tend not to employ safer-sex practices with friends, often falsely assuming that lesbians cannot contract HIV/AIDS. There are few HIV prevention messages addressed to lesbian and bisexual teenagers

and to those questioning their identity (Hunter, 1996). In addition, the meaning of "safer sex" has been found to be particularly confusing between women, and definitions of it have been found to be highly variable (Einhorn & Polgar, 1994).

Some lesbian adolescents may try to hide their homosexuality by having sex with males or by becoming pregnant, placing themselves at risk for HIV and other sexually transmitted infections (Nelson, 1997). In a qualitative study of 20 young lesbians (mean age of 19 years) conducted in New York City, Hunter et al. (1993) found that 75% of them engaged in heterosexual vaginal intercourse, which was initiated a year before oral sex with females (means of 14 and 15.4 years, respectively). These findings were confirmed in a larger study of lesbian and gay adolescents ($n = 164$, ages 14–21 years). Four out of five young lesbian and bisexual female youths ($n = 81$) reported being sexually active with male partners in one study, and they had initiated sexual contact with males at an earlier age than with females. Findings of this study also indicated that these lesbian and bisexual females engaged in manual sex more than in any other sexual practice. An additional finding indicated that more of them engaged in oral, penile-vaginal, and vaginal-digital sex than in anal-penile sex (Rosario et al., 1996). In another study, 26% of the young women (ages 13–21 years) reported engaging in anal intercourse; however, only 15% of the lesbian-identified youth reported having engaged in this sexual activity (Ryan & Futterman, 1998).

In a study of 136 self-identified gay and bisexual male adolescents (ages 14–19 years), Rotheram-Borus et al. (1994) found that significant reductions occurred in the number of unprotected same-sex anal and oral acts as a result of an HIV-preventive intervention over a one-year period. However, those youth who were most likely to attend the HIV-intervention sessions increased their risk acts the most over two years (Rotheram-Borus et al., 1995). For both anal and oral sex, the best predictors of unsafe acts were high levels of anxiety and depression, and frequent alcohol use.

In a recent study of lesbian, gay, and bisexual urban youths (ages 14–21) in New York City, Hunter (1996) discovered that those who self-identified as gay/lesbian, versus those who labeled themselves as bisexual, had higher numbers of same-sex and lower numbers of opposite-sex contacts. Males having same-sex contacts were not as likely as females to be in relationships. Regardless of sexual identity status, however, both the young males and females were found to be at high risk for HIV infection because of unsafe sexual behaviors; both males and females reported high levels of unprotected same- and opposite-sex activities. Hunter also found no significant relationship between coming out and unprotected same-sex acts for either males or females; and a negative attitude toward their own homosexuality or bisexuality was not significantly related to unprotected sexual behaviors. Therefore, while choice of the gender of their sexual partners and the number of same-sex contacts were related to identity status, condom use was not. Hunter speculated that other issues may have been operating with regard

to unprotected sexual acts, including a desire for exploration, substance use, and intimacy (e.g., wanting to be close, having sex without barriers), and that HIV-prevention approaches effective in reaching different communities of the gay, lesbian, and bisexual youths in the study may not have been employed.

HIV Prevention Education

Although the term "youth" does not have the associations normally attributed to the term "adolescents," it is important to acknowledge that for many people it carries implications regarding behavior and attitudes of individuals of certain ages, including the content thought to be appropriate for HIV prevention education programs. Additionally, differences of gender, ethnicity, and socioeconomic status have to be recognized. This chapter assumes a focus on young people who range in age from their mid-teens to their mid-twenties.

Novick (1997) described three layers of damage to be associated with HIV/AIDS stigma. First, individuals associated with AIDS are members of groups (including gay and bisexual men) whose fundamental human rights had been truncated before the appearance of HIV. Second, long-term stigmatization has profound effects on the lives of the disdained. With regard to gay and bisexual men, this branding and shame led to fostering short-term, and often anonymous, relationships that guaranteed HIV transmission. Finally, the stigmas intrude on creating or supporting HIV/AIDS prevention programs that are humane and sensitive to the needs of vulnerable people, including those specifically designed for gay, lesbian, and bisexual youths.

In discussing programs effective in reducing HIV risk behaviors for lesbian and gay youths, Rotheram-Borus and her colleagues (1995) concluded that it is important to help gay and bisexual youths feel positive about themselves and their life situations and to provide supportive programs to help youth confront coming-out issues. Other effective HIV intervention programs have recognized that behavior is not changed by knowledge alone. While knowledge about HIV/AIDS transmission is necessary, Bandura (1992) indicated that is not sufficient in changing behavioral practices. He pointed out that perceived self-efficacy is required for one to reduce the likelihood of engaging in risk behaviors. Studies focusing on the best ways to enhance perceived self-efficacy among various groups of gay, lesbian, and bisexual youths need to be conducted.

One important component for HIV-prevention education targeted to lesbian, gay, and bisexual youths is communicating an accepting environment to the youths and the significant adults in their lives. Homophobia drives many lesbian, gay, and bisexual youths away from needed information and care. A prevention program also has to be a reliable source of accurate in-

formation about lesbian, gay, and bisexual health issues, as well as HIV/AIDS. Research has indicated that the education provided must be developmentally, language, culturally, and social-class relevant (National Institute of Health, 1997), and it should not be moralistic, prohibitive, or sex negative in its messages. Additionally, HIV/AIDS education programs face added challenges when they target groups such as African Americans and people with lower socioeconomic status, as research findings suggest that distrust is more prevalent among these groups and other individuals from relatively powerless sectors of the population (Herek & Capitano, 1994).

According to the Centers for Disease Control and Prevention, approximately three-quarters of high school students have had sexual intercourse by the time they complete the 12th grade (Office of National AIDS Policy, 1996). Interventions should target the reduction of HIV-risk behaviors among these diverse groups of youth. Additionally, the results of studies should be used to dispel widely held myths that sex education programs result in the earlier onset of sexual behaviors or that condom availability fosters sexual and risky behaviors (NIH, 1997). In fact, Guttmacher et al. (1997) found the contrary among 7,119 students from 12 randomly selected New York City public schools. Other myths that have to be addressed are related to injection drug use. Results from studies do not support the assertions that needle-exchange programs lead to increased needle-injecting behavior among current users or that they increase the number of users (NIH, 1997).

Effective HIV prevention interventions are not single programs or single events; studies demonstrate that numerous intervention points over extended periods of time are more efficacious than once-only approaches (NIH, 1997). The interventions should be community based, sustained, and integrated with other prevention programs, such as programs on sexually transmitted diseases, unwanted pregnancies, and substance abuse. Prevention messages for lesbian, gay, and bisexual youths should facilitate their developing to their full potential and provide them with safe environments (e.g., schools, community centers, athletic leagues) in which to do so. Unfortunately, the policies of some school districts preclude the discussion of subjects such as sexual orientation, intercourse, and condom use (Office of National AIDS Policy, 1996).

Lesbian, gay, and bisexual youths should be involved in the design, development, and implementation of HIV prevention programs (NIH, 1997). Peer education has been demonstrated to be effective in helping youths to establish community norms regarding safer-sex and drug-using behaviors. Youths often find that peers make HIV/AIDS more relevant to their lives and that prevention messages are more realistic when delivered by their peers (DiClemente, 1993; Office of National AIDS Policy, 1996). Additionally, findings from research studies with gay men and heterosexual adolescents have indicated that perceptions of peer norms concerning sexual risk behavior are strongly associated with one's own sexual behavior (Kegeles et al., 1996). According to results of a study of 2,515 tenth-grade students in

Dade County (greater Miami, FL) public high schools, conducted by Langer, Zimmerman, Warheit, and Duncan (1993), peer interventions concerning AIDS-related knowledge, beliefs, attitudes, and skills are more effective with some groups than others. These researchers found that boys were significantly more likely to be peer-directed than girls, and girls were significantly more likely to be self-directed than boys. (Roughly, one-third of each gender group was defined as parent-directed.) Additionally, nearly half of the white, non-Hispanic students identified themselves as peer-directed, whereas only 19% of black, non-Hispanic students identified in the peer-directed group. Consequently, it is important that HIV prevention programs be designed to accommodate those who are peer-directed and those who are self-directed, and recognize that these characteristics may vary by gender and ethnicity. In a study of gay men, Kelly, St. Lawrence, Hood, and Brasfield (1989) found that perceived peer norms concerning the acceptability of safer-sex practices and AIDS health locus-of-control scores were associated with change in risk-reduction behaviors. Peer pressure is crucial among adolescents too, and it has been found to be the major reason for first sexual experiences among young people (Ingham, Woodcock, & Stenner, 1991).

HIV prevention interventions for lesbian, gay, and bisexual youths (as for other youths) should be embedded in a broad context of health, social, and recreational affairs. Experience and research have indicated that fears and cultural messages associated with AIDS do not make HIV education an appealing issue by itself, and social matters are highly important to young people (Kegeles et al., 1996). HIV interventions should be linked to other issues that gay, lesbian, and bisexual youths find important, such as coming out, finding and meeting potential partners, learning social skills, dating, relationships, intimacy, and sexual activities.

Providing HIV intervention to gay, lesbian, and bisexual youths requires addressing human sexuality, including the topic of sexual orientation. Talking about sexual matters is often difficult for professionals working with youths, as well as the youths' parents. Youths often find the lessons to be of little value, too biological, too vague, or conducted by teachers perceived to be embarrassed by the whole area (Woodcock, Stenner, & Ingham, 1992b). Researchers need to investigate the terminology and messages that effectively communicate HIV-prevention information to youths. For example, are messages that use such terms "know your partner" or "use protection to prohibit the transmission of bodily fluids" effective or do they contain words that are open to interpretation? Ingham et al. (1991) found that advice containing ambiguous terminology leads youths to believe that they are following the advice when they are not doing so; however, this research has not been replicated.

As with other young people, HIV prevention designed with lesbian, gay, and bisexual youths needs to address issues related to their feelings of perceived immortality and personal invulnerability. Youths, especially those in their early teens, tend to be short-term thinkers, with the present

being important and the future perceived in vague terms. Others feel invulnerable to harm and make decisions to meet their immediate desires rather than considering the long-term consequences. Woodcock, Stenner, and Ingham (1992a) asked young people to justify, where appropriate, their perceptions of invulnerability to HIV infection. The investigators were able to categorize the responses into three groupings: (1) those young people who did not take the threat of HIV infection more seriously than other risks in life; (2) those who had their own ways of assessing risks related to perceived (often irrelevant) properties of sexual partners, e.g., occupation, where they lived, parent's occupation; and (3) those who thought their personal identity was not similar to those in "risk groups," and therefore they were safe.

Stresses in the lives of many lesbian, gay, and bisexual youths that are not related to their sexual orientation must also be taken into consideration. Problems arising from chaotic family environments, parental addictions, and family violence, as well as from youths' ethnic, racial, gender, and economic status, may create challenges related to living and survival that relegate HIV prevention to a low status of relative importance. On the other hand, there are lesbian, gay, and bisexual youths who become vulnerable to HIV infection because of feelings of shame, isolation, and worthlessness that result from stigmatization and discrimination based on their sexual orientation. Responding to opportunities to explore sexual and personal identities, as well as meeting their needs for acceptance and intimacy, some lesbian, gay, and bisexual youths place themselves in circumstances beyond their control—for example, agreeing to be involved in sexual or romantic relationships in which they become powerless (Hunter, 1996; Miller, Hunter, & Rotheram-Borus, 1992). They become victims of sexual abuse and violence, and are susceptible to HIV infection from their sexual partners, as well as the negative consequences of victimization. These stressful experiences are cumulative and increase the risk for infection. Therefore, HIV prevention education interventions must be based on the premise that safer sex requires reducing gay-related stresses (Rosario & Rotheram-Borus, 1992) and attaining a high level of sexual self-confidence. To assist youths in achieving these goals, prevention education activities should focus on skill building (e.g., problem solving, decision making, and negotiation) and provide opportunities for youths to engage in role plays that allow them to practice those skills (Remafedi, 1994a). Additionally, the programs need to provide opportunities for youths to learn the importance of exerting responsibility for protecting themselves and others from HIV infection (Miller et al., 1992; Office of National AIDS Policy, 1996).

Effective HIV prevention education efforts have recognized the need to confront myths about sexuality and HIV/AIDS. Myths that only gay men engage in oral and anal sex, that homosexuality is a disturbed behavior or a transient phase, and that lesbians are not at risk for HIV infection must be explored. Other myths that need to be addressed are: that once people start using condoms or dental dams, they will use them forever; that women can

readily protect themselves with condoms, as many women may not have control over male partners' use of condoms; and that individuals do not engage in sexual activities with same-sex as well as opposite-sex partners over time. Interventions also need to differentiate between those who are HIV-infected and uninfected and to provide primary prevention for the uninfected, without implying that there is something "wrong" with the lives of those who are infected (Odets, 1997). Research on effective interventions to combat these myths among gay, lesbian, and bisexual youths needs to be conducted.

Although directing his thinking to HIV prevention among gay men, Odets (1997) pointed to other realities that need to be acknowledged in primary prevention among gay, lesbian and bisexual youths; however, studies related to the outcomes of these messages have still not been undertaken. The messages are: (1) safer sex does not mean using protection every time one engages in sexual activity, but is *any* sex that does not transmit HIV; (2) HIV cannot be transmitted between two uninfected youth, therefore knowing one's HIV status is important; (3) gay, lesbian, and bisexual youths cannot live their lives in fear of being infected by their partners—it is not conducive to healthy relationships; and (4) uninfected gay, lesbian, and bisexual youths (who are hoping to stay uninfected) *are* hoping for futures that most infected youth cannot have, and ways must be found to help them remain uninfected.

Voluntary HIV counseling and testing programs provide opportunities for risk assessment, prevention education, early intervention, and research about the effectiveness of each of these processes among various age and ethnic groups of gay, lesbian, and bisexual youths. The main objective of counseling and testing with adolescents is to identify HIV-positive youth and to initiate appropriate medical care and support services. HIV counseling and testing also provide opportunities to relieve the anxiety of youth who are HIV-negative, to talk about sexual orientation and same-sex activities, to identify high-risk behaviors that may not have been previously discussed, and to link lesbian, gay, and bisexual adolescents with other services (Ryan & Futterman, 1998). For runaway or homeless youth, housing, food, education, job-training, help in obtaining health insurance, and other support services also become critical (Office of National AIDS Policy, 1996). Evaluation research about the relationships of effectiveness of counseling services appropriate for the youths' sexual orientation, language, culture, and age and social and emotional development levels needs to be conducted. Additionally, studies related to the sensitivity of services to lesbian, gay, and bisexual youths' fears and anxiety about HIV testing need to be undertaken.

For those youth who receive negative test results, posttest counseling not only provides them with opportunities to examine their own behaviors and develop individual HIV risk-reduction plans but also creates teachable moments in which providers can counteract untruths about the

outcomes of HIV/AIDS treatments—for example, combination therapies are efficacious for everyone, and an undetectable viral load level means a person is noninfectious. For those youths who learn that they are HIV-positive, effective posttest counseling sessions become important first steps in understanding the meaning of their HIV status and in designing a plan of care. The plan should include a harm-reduction component, especially for those who engage in compulsive sexual activities, trade sex for food and shelter, or use injection drugs. Although access to a needle-exchange program among a group of youths (ages 16–24 years) who injected an illicit drug was found to be effective in reducing the sharing of needles, sharing other injection equipment, and use of unsterile needles (Kipke, Unger, Palmer, & Edgington, 1997), this research needs to be replicated with gay, lesbian, and bisexual youths. The efficacy of harm-reduction programs related to HIV-risk behaviors resulting from compulsive sexual activities, trading sex, and feelings of powerlessness in romantic relationships also need to be investigated.

Research on adolescent decision making has found that youth (particularly those aged 14 and over) have the capacity to make their own health-care decisions; however, because HIV testing is so anxiety provoking and a positive result has an enormous impact, Ryan and Futterman (1998) have recommended that youths identify a supportive adult who can be involved in the testing process. This person can also assist in explaining any limits relating to confidentiality and the potential negative impact of disclosing an HIV-positive status. Barriers to implementing effective counseling and testing services, and treatment programs for HIV-positive lesbian, gay, and bisexual adolescents include legal issues and parental rights. Most states in the United States consider youth aged 18 and over to be adults for legal purposes, which means that they can consent to treatment. Those under 18 years of age are minors, and parental consent is generally required for health care. Although all states have laws that allow minors to give consent with regard to the diagnosis and treatment of STDs, not every state classifies HIV as an STD. However, some states have laws that allow minors to consent to HIV testing and treatment, as well as treatment related to other health concerns—for example, alcohol and other substance abuse, rape, sexual assault and pregnancy (Ryan & Futterman, 1998). Researchers and providers need to investigate laws that authorize consent by minors and protect confidentiality in their respective localities.

HIV Prevention Intervention Studies with Gay/Bisexual Male Youths

Three significant research studies have tested the efficacy of HIV prevention education programs for gay and bisexual male youths. In an intervention conducted over a one-year period (1988–89), Rotheram-Borus et al. (1994) examined factors mediating changes in sexual behaviors that increased the risk of HIV infection among 136 gay and bisexual male adolescents ages 14

to 19. The youths were recruited from a gay-identified agency and were predominantly Hispanic (51%) and African American (31%). A 20-session intervention, with sessions rotated over a three-week sequence, allowed youths to join the intervention at various points. Small group sessions were held two or three days a week, with the content of the sessions varying by the day of the week. The intervention contained five components: (1) information about HIV communicated through video and art activities, (2) coping skills training to help youth manage risky situations, (3) access to health care and other resources, (4) addressing individual barriers to safer sex through private counseling, and (5) examining how prejudice against gays and positive feelings toward coming out might influence safer-sex attitudes. Sexual risk assessments were completed at 3, 6, and 12 months after the baseline interview. The researchers found that significant reductions occurred in the number of unprotected same-sex anal and oral acts among those youths who had less risk in their previous sexual history, who had been abstinent before enrollment, who did not engage in commercial sex, and who attended more sessions. The impact of the sessions varied significantly by race/ethnicity, with African-American youths most significantly reducing their risks over one year (e.g., the proportion of protected anal sex acts was 36% at baseline, 80% at 3 months, 67% at 6 months, and 84% at 12 months). Additionally, the youths in the study significantly reduced the number of sexual partners following the interventions, and this reduction was maintained through the 12-month follow-up. The cutback in the number of sexual partners was greatest among those youths who were not involved in commercial sexual activity. The investigators point to some limitations of the study: not having a control group and not randomly assigning participants to intervention and control conditions, not measuring the contributions of specific components of the intervention, and not basing the findings on a representative sample.

The second study involved 139 predominantly Caucasian (75%) gay and bisexual male youths, ages 13–22 (Remafedi, 1994a). Results demonstrated significant improvements in HIV-risk reduction over an average five-month period (with a range of three to six months). The program was part of an ongoing study of youth who were enrolled in 1989–1991, and it employed repeated contact with clients and diverse prevention strategies. The project included individualized HIV/AIDS risk assessments and risk-reduction counseling, peer education, and referrals to needed services. Compared to the initial HIV risk assessment, 60% fewer subjects reported unprotected anal intercourse with recent partners three to four months later. The participants also described less frequent anal intercourse and more consistent use of condoms during follow-up. Additionally, substance abuse severity scores and use of amphetamines and amyl nitrite declined. However, one-quarter of the subjects reported ongoing high-risk behaviors, which were associated with having more gay friends, multiple sexual partners, and frequent anal intercourse. Although he concluded that HIV-risk reduction improved over

time, Remafedi acknowledged that the study was not designed to test the effect of the intervention and that other sources of knowledge and experience could have contributed to the reduction in HIV-risk behaviors. Further research is needed to determine which of the interventions is most efficacious and whether ongoing risk-taking behavior may reflect underlying psychosocial problems. Remafedi states that bold initiatives are necessary to spare another generation of young gay and bisexual men from HIV disease: HIV prevention interventions coupled with opportunities for positive adult role models, and health socialization with peers in safe environments. These projects need to be implemented and their outcomes evaluated.

The research by Rotheram-Borus et al. (1994) and Remafedi (1994a) were based in cognitive-behavioral frameworks of prevention. The results of their studies indicated that while high-risk gay and bisexual male youths (who were African American, Caucasian, and Latino) were accessible and amenable to HIV prevention interventions, they were not a homogenous group in their exposure to risks related to HIV, nor were they uniform in their responses to prevention programs. Moreover, there are no research reports of specific interventions directed to either young lesbians or to Asian-Pacific Islander and Native American gay and bisexual males. The two research studies also reinforced the importance of recognizing the unique dilemmas that gay, bisexual (and lesbian) youth must confront in establishing long-term relationships with same-gender partners. The findings demonstrated that: (1) gay and bisexual male youths engage in sexual activities with many partners in order to assess and affirm their personal and sexual identities; and (2) that effective HIV prevention approaches determine the youths' safer-sex knowledge and behaviors in these sexual relationships, which makes the relationships an important basis for designing interventions. Using harm-reduction strategies to minimize risky behaviors in ongoing sexual activities appears to be effective, except for those involved in commercial sexual activities who may need to learn other skills for negotiating safer sex in circumstances where there is an imbalance of power. Rotheram-Borus et al. (1994) conveyed the importance of designing innovative HIV-prevention strategies for youths who are already practicing safer sex to ensure consistency of those behaviors. Based on his findings, Remafedi (1994a) noted that some young gay and bisexual youths may initiate, continue, or return to high-risk behaviors, despite education and assistance from health professionals; consequently, other approaches may be required. Remafedi states that the youth may "benefit from social skills training, general educational development, and recognition and treatment of underlying psychosocial problems" (pp. 147-148). It is important that other investigators confirm his findings and determine the effectiveness of various prevention strategies.

Kegeles et al. (1996), the investigators of a third research study, developed and evaluated a community-level HIV risk-reduction intervention program in the early 1990s. The program was peer-led and implemented in

a mid-size Oregon community for a period of eight months. It contained three components: peer outreach (used to disseminate safer-sex messages), small groups (focused on meeting men, clearing up misconceptions about safer sex, eroticizing safer sex, promoting condom use, and orchestrating safer sex strategies with partners), and a publicity campaign within the gay community (used articles and advertisements in the gay newspaper and word-of-mouth messages to spread awareness of the project, establish its legitimacy, invite young men to participate and provide a reminder of the norm of safer sex within the community). Longitudinal cohorts of young gay men (aged 18–29) were recruited in two communities, the second serving as a comparison community. The program was run by a “Core Group” of 12 to 15 young gay men and a community advisory board, with the Core Group choosing “The Mpowerment Project” as the intervention’s name. The mean age of the men in the cohorts was 23 years, with 86% identifying as gay and 14% as bisexual; and 81% white, 6% Latino, 4% African American, 7% Asian or Pacific Islander, and 2% “other.” In the intervention community, 65% ($n = 103$) of those who completed preintervention assessment answered postintervention surveys. Results of the study indicated that the proportion of men engaging in any unprotected anal intercourse decreased from 41% to 30%, decreasing from 20% to 11% with nonprimary partners and from 59% to 48% with boyfriends. No significant changes occurred in the comparison community over the same time period. The investigators concluded that the prevention approach effectively led to HIV-risk reduction and that HIV-prevention activities should be embedded in social and community programs.

It is important to note that the effective HIV prevention interventions, described in the Rotheram-Borus et al. (1994), Remafedi (1994a), and Kegeles et al. (1996) studies, were developed before the recent adoption of HIV-treatment guidelines endorsing antiviral drug treatments with “cocktail” therapies that include a protease inhibitor. Additional drugs that treat opportunistic infections have also been discovered. Both of these advances have contributed to a dramatic decrease in deaths associated with AIDS (Centers for Disease Control and Prevention, 1997b). Future studies of HIV prevention interventions among lesbian, gay, and bisexual (as well as heterosexual) youths need to assess whether the advances in drug treatments have any effect on maintaining or reducing risky behaviors. Misconceptions about the safety and efficacy of these therapies and treatments, as well as the consequences of resistance and nonadherence to drug regimens, need to be investigated in future research. Examining factors such as locus of control, self-esteem, social support, substance use and abuse (concurrent with therapies), internalized homophobia, current and cumulative stress factors in relation to HIV, and mental health problems is important in determining the effect of long-term antiviral drug therapy with lesbian, gay, and bisexual youths.

In conducting a recent study, Rotheram-Borus and her colleagues (1997) found that a low number of HIV+ youths were linked to medical care, de-

spite the availability of prophylactic treatment and an emphasis on early intervention among youths. Although this was not a study that focused on prevention interventions, its results provide information that is relevant to HIV prevention programs. Although the large majority of 102 youth were identified as HIV+ about 32 months prior to recruitment, significant percentages of them (75% identified as male, and 87% as "gay" or "bisexual") continued to engage in unprotected sexual activities and used considerable amounts of alcohol and other drugs. When their current risk behaviors were assessed over two consecutive 3-month periods, almost one-third had been sexually abstinent; however, among the youths who were sexually active, most had multiple sex partners, ($M = 6$, Time 1 and 5, Time 2) and used condoms (72–77% sexual acts protected). Most of them always used condoms (63–64%). The use of alcohol (63%), marijuana (41%), hard drugs (36%), and injection drugs (12%) was also substantial. The youths were found to be relatively healthy (i.e., not having disease symptoms), which may explain why they attended only about one-third of medical appointments related to their HIV infections. The investigators concluded that while all youths were linked to adolescent HIV programs, unhealthy behavior and risk acts remained common.

Conclusions

The challenges of HIV/AIDS prevention with gay, lesbian, and bisexual youths do not only involve protecting and advocating for them but also embrace processes that center on empowering them and their communities. Empowerment not only provides these youths with opportunities to become agents of their own desires but also develops into a decisive factor in helping gay, lesbian, and bisexual youths to confront homophobia, street violence, harassment, and the risks involved with sexual encounters. Youths who feel empowered are more secure in their identities, and they are less willing to take risks and engage in "reckless acts" that may lead to HIV infection. On the other hand, those who lack feelings of empowerment may face greater difficulties and are often unable to protect themselves (Herdt & Boxer, 1993).

Eradicating HIV and curing individuals with HIV disease are probably unattainable with the currently available classes of antivirals (Roland, 1998). HIV's ability to generate drug-resistant variants is a major factor that limits the effectiveness of antiretroviral therapies in reversing the natural history of AIDS (Centers for Disease Control and Prevention, 1998). Providing opportunities and training for lesbian, gay, and bisexual youths to develop self-esteem, interpersonal skills, supportive networks, and access to HIV risk-reduction materials and services is required (Cranston, 1991). Effective intervention programs are those that: (1) publicize occasions for meeting other young lesbian, gay, or bisexual people; (2) provide a variety of

approaches that engage youths in determining ways to protect themselves from HIV infection; (3) assist youths in creating safer-sex strategies and peer norms; (4) help youths in coping with psychosocial problems arising from victimization based on their sexual orientation; (5) target specific subgroups of the lesbian, gay, and bisexual youth community, taking their particular needs and experiences into consideration (e.g., being and not being HIV infected); and (6) integrate HIV/AIDS prevention and care programs with other community services.

A review of research on the behavioral impact of HIV/AIDS and sexual health education on young people, commissioned by the Joint United Nations Programme on HIV/AIDS (UNAIDS), reported findings that provide evidence of the viability and effectiveness of education programs. The results also provide the rationale for establishing programs that can be communicated to policy makers, program planners, and educators; and they give future directions of HIV/AIDS prevention activities, including those directed to gay, lesbian, and bisexual youths. The major conclusions of the review were as follows: (1) education about sexual health and/or HIV does not encourage increased sexual activity; (2) 22 studies indicated that HIV and/or sexual health education delayed the onset of sexual activity, reduced the number of sex partners, or curtailed unplanned pregnancy and sexually transmitted disease (STD) rates; (3) responsible and safe behavior can be learned; and (4) sexual health education is best started before the onset of sexual activity. Further results indicated that only high-quality educational activities had an impact on behavior. Effective programs included the following elements: (1) a focused curriculum with clear statements about behavioral aims, including the delineation of the risks of unprotected sex and methods to avoid it; (2) a focus on learning activities that addressed social and media influences; (3) teaching and providing for practice in communication and negotiation skills; (4) encouraging openness in talking about sex; and (5) education activities that were grounded in theories which stress the social nature of learning (Centers for Disease Control and Prevention, 1998). HIV/AIDS prevention education programs incorporating these elements should be designed and implemented for all gay, lesbian, and bisexual youths so as to prevent their devastation by this disease. In addition, these educational efforts can change the tragedy of AIDS into opportunities for gay, lesbian, and bisexual youths to learn about themselves, to develop support systems, to become empowered, and to enhance their physical and mental health.

Many of the studies of gay, lesbian, and bisexual youths cited in this chapter (particularly those focused on HIV prevention intervention) were conducted in urban settings. There is a need for research to be conducted among youths living in suburban and rural communities. Additionally, many of the findings were based on studies of young people from self-selected populations (e.g., persons presenting at community-based agencies for gay, lesbian, and bisexual youths; HIV/AIDS prevention programs; and sexually trans-

mitted disease clinics). Some of these community-based services tend to attract youths of particular socioeconomic statuses and racial/ethnic backgrounds, thereby limiting the generalizability of the research findings. Lacking representative samples from the population of gay, lesbian, and bisexual youths, and hampered by societal stigmas about homosexuality (e.g., students participating in anonymous studies in school settings may fear self-identifying as gay, lesbian, or bisexual), the studies may represent only HIV high-risk youths and may not provide an accurate portrayal of the population as a whole.

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