3.1.7 Eating Disorders

Survey Data

- Twelve per cent of respondents had, or had had, an eating disorder: 14 per cent of men and 13 per cent of women.
- Thirty-four per cent of respondents often or sometimes dieted: 35 per cent of men and 48 per cent of women.
- Fifty-three per cent of respondents often or sometimes skipped meals: 63 per cent of men and 64 per cent of women.
- Fifty-seven per cent of respondents often or sometimes worried about their weight: 59 per cent of men and 70 per cent of women.
- Forty-three per cent of respondents were not happy with their bodies: 48 per cent of men and 40 per cent of women. The reasons they were not happy with their bodies are shown in Table 16.

Table 16: Reasons why Respondents were Unhappy with their Bodies

Reasons	Men	Women
"Not thin enough"	1	
"Too big/fat"	13	9
"Not fit enough"	3	2
"Not enough muscles"	7	1
"Skin problems"	2	
"Hair colour"	1	
"I generally feel ugly"	2	1
"Don't like body shape/size"	11	8
"I'm self-conscious"	1	
"Low self-esteem"	1	
"Gender dysphoria"	2	

Note: n = 65

- Fourteen per cent of respondents (23 per cent of men and eight per cent of women) thought that their sexual identity was a factor in their unhappiness with their bodies. However, 51 per cent did not think it was related to their sexual identity.

Data from Interviews

Several young people raised the issues of body image and eating disorders during interviews:

"The stereotypes [about how gays and lesbians should look] can be very oppressive and they are perpetuated on the scene. I find it very depressing." (Young man.)

"Discussing body image [during a Youth Group issue session] was important. This was something that had worried me. A lot of people feel the same about image. People talked about appearance, first impressions, stereotypes, weight and other things." (Young man.)

"The gay media is full of pictures of muscle men. There is no-one ordinary." (Young man.)

Discussion

An international review by Hoek (1993) of epidemiological studies of eating disorders estimated the incidence of new cases of anorexia nervosa as 8.1 per 100,000 population per year and new cases of bulimia nervosa as 11.4 per 100,000 per year (cited in Eating Disorders Association, 1996d).

It has been estimated by the Royal College of Psychiatrists (1992) that about 60,000 people in Britain may have anorexia nervosa or bulimia nervosa at any one time (cited in Eating Disorders Association, 1996d).

Research has shown that women account for nine out of ten cases on anorexia nervosa, reflecting the intense social pressure upon women (Eating Disorders Association, 1996a).

It has been estimated that men account for between five and ten per cent of people with eating disorders, although a considerable number of men are thought to be not seeking help and are therefore not reflected in the statistics. This under-reporting seems to demonstrate a greater reluctance to seek help. Other factors may include denial that there is a problem and the fact that many health professionals do not consider anorexia nervosa as a possible diagnosis in males and are surprised or disbelieving about the existence of men with eating disorders (Eating Disorders Association, 1996b).

Research has shown an increased incidence of depression, obesity and substance abuse among people with eating disorders and a greater incidence of eating disorders in the families of sufferers (Eating Disorders Association, 1996a).

Other findings have shown that people with eating disorders – both female and male – had similar personalities and symptoms, except that men seemed more achievement-oriented and showed more sexual anxiety. In general, men also appeared to be excessively athletic and over-valued physical fitness, body appearance and muscular strength (Eating Disorders Association, 1996b).

There has been an ongoing debate about whether the causes of these disturbed eating patterns were genetic or social. Research has shown that some people are genetically susceptible to developing an eating disorder, although it may have been triggered by social factors. Others point to connections between society's ever-increasing emphasis on thinness over the last 20 or 30 years and the dramatic increase in the number of anorexics over the same period (Eating Disorders Association, 1996a).

A study by Duncan *et al* (1985) of nearly 6,000 adolescents between 12 and 17 years of age showed that 70 per cent of the young women wanted to be thinner (cited in Moore and Rosenthal, 1993).

Statistics revealed that anorexia nervosa was most commonly found among young women, adolescent or slightly older. Studies of young women at school have shown that between the ages of 16 and 18 about one in every 200 suffer from the condition. Bulimia however usually begins between the ages of 15 and 20 (Eating Disorders Association, 1996a).

A long-term survey of children's attitudes to health by the Schools health Education Unit (1998) questioned 30,000 young people aged 9 to 16. These were the main findings among young women:

- Young women were developing an unhealthy obsession with slimming in their mid-teens.
- Nearly half had the mistaken impression that they were overweight.
- At the ages of 14 and 15 one in five had had nothing for breakfast and one in seven did not each lunch (termed 'slimming by missing').
- Six out of ten thought they needed to lose weight.
- Sixty to 70 per cent had dieted.
- One to two per cent had developed severe eating disorders such as anorexia and bulimia.
- Only 15.5 per cent weighed too much for their age and height.

These were the main findings among young men:

- One quarter said they would like to lose weight.
- Young men felt increasingly uneasy about their weight as they grew older.
- Only one in five were actually overweight.

(Cited in Carvel, 1998).

The following five studies were conducted in the United States.

Striegel-Moore *et al* (1990) compared 30 lesbian students with 52 heterosexual students in terms of body esteem, self-esteem and disordered eating. Few group differences were found although lesbian students reported lower self-esteem and body esteem was found to be more closely related to self-esteem (cited in Lesbian Information Service, 1995b).

Siever's (1994) study investigated the hypothesis that gay men and heterosexual women were more likely to be dissatisfied with their bodies and vulnerable to eating disorders because of a shared emphasis on physical attractiveness and thinness based on a desire to attract and please men. Lesbians and heterosexual men are less likely to be dissatisfied with their bodies and less vulnerable to eating disorders. The sample of 53 lesbians, 59 gay men, 62 heterosexual women and 63 heterosexual men generally confirmed the research hypothesis.

Schneider *et al* (1995) compared the food-related attitudes and behaviours of heterosexual men and women with those of lesbians and gay men in an attempt to find out whether sexual identity contributed to differential risk. The study of 25 lesbians, 50 gay men, 75 heterosexual women and 75 heterosexual men found that heterosexual women were the most dissatisfied with their weight, although heterosexual men were more objectively overweight. Gay men and heterosexual women were similar in disordered eating patterns, contrasting with lesbians and heterosexual men.

Beren *et al* (1995) studied gay culture's emphasis on physical appearance and its effects on body dissatisfaction. Sixty-nine lesbians, 72 heterosexual women, 58 gay men and 58 heterosexual men took part in their study. The results found gay men reporting significantly more body dissatisfaction than heterosexual men. In contrast, lesbians and heterosexual women did not differ. Although affiliation with the gay community was associated with body dissatisfaction in gay men, affiliation with the lesbian community was unrelated to body dissatisfaction in lesbians.

French *et al* (1996) studied 788 heterosexual, gay, lesbian and bisexual men and women. Their hypothesis was that homosexual identity would be associated with higher rates of body dissatisfaction, dieting and eating disordered behaviours in males, with lower rates in females. The results found that gay men were more likely to report poor body image, frequent dieting, binge eating and purging behaviours than heterosexual men. Lesbians were more likely to report positive body image than heterosexual women were.

A health survey by North Hampshire Gay Men's Health Initiative of local gay and bisexual men revealed that 30 per cent of respondents considered themselves 'overweight' or 'very overweight'. Ninety-six per cent of those who considered themselves 'overweight' worried about their weight 'all the time' or 'sometimes'. One third of the respondents were aged between 16 and 25 (Rendell, 1994).

Swainson (1995) reported a common feeling of confusion among lesbians as a result of images of women in the heterosexual mainstream media and the images of women in the gay and lesbian media which also portray lesbians in the traditional male sex object image.

A survey conducted by Lesbewell (1998) in 1995 found that 15 per cent of respondents had, or had had, an eating disorder. Several people later contacted Lesbewell to discuss their experiences in more detail. The striking thread running through these women's experiences was the relationship between gaining control and coming out. Eating disorders were not, as they are so often perceived to be, a problem solely in isolation. It seemed that the development of anorexia and bulimia was a way of coping with other emotions, including those around sexual identity.

McColl's (1995) survey of youth workers asked them to cite the major sources of distress and their consequences for the young bisexual, gay and lesbian people they worked with. Eating disorders were cited as a major source of distress for young people by seven per cent of youth workers.

Williamson's (1997) study made a comparison between a sample of young gay men and young heterosexual men in terms of body image and eating patterns. The study revealed a number of significant differences between the samples:

- Young gay men on average scored much higher on measures of eating disturbance than the heterosexual participants, particularly with regard to measures of dieting, bulimia-like behaviour and food pre-occupation. One in five young gay men engaged in disordered eating behaviour, compared to one in twenty young heterosexual men.
- Young gay men were significantly more dissatisfied with their bodies.
- Young gay men chose ideal body images, which were significantly thinner than young heterosexual men, regardless of their current body size. A small but significant minority (19.6 per cent) chose very thin ideals.
- The degree of body dissatisfaction correlated strongly with the self-esteem of young gay men, but this was not true of heterosexual participants. This suggested that feeling attractive was more important for young gay men in developing positive self-image.
- Feelings of dissatisfaction with sexual identity were linked to eating disturbance, self-esteem and body dissatisfaction.
- Internalised homophobia and socio-cultural influences within the bisexual, gay and lesbian communities were also probably important.

ReachOUT's research project found that 12 per cent of respondents had had an eating disorder, 34 per cent had often or sometimes dieted, 53 per cent had skipped meals, 57 per cent had often or sometimes worried about their weight, 43 per cent were not happy with their body and 14 per cent considered there to be a link between this dissatisfaction and their sexual identity.

Several respondents were dissatisfied with their appearance, body shape and/or size. One young man and a young transsexual were suffering from gender dysphoria and three young men's dissatisfaction seemed specifically related to self-esteem.

Young bisexual, gay and lesbian people seem to be *more likely* to suffer from eating disorders compared to the general youth population, for example bisexual and gay men were *three times more likely*. See Figures 15 and 16.

Figure 15: Eating Disorders among Young Men

	Young Bisexual and Gay Men: ReachOUT's Findings	**Young Gay Men: Other Studies**	**Young Men: General Studies**
With Eating Disorders	14% (1)	11% (2)	5% (2)

Note: (1) n = 94; (2) McColl (1995), Williamson (1997); (3) Williamson (1997).

Figure 16: Eating Disorder among Young Women

	Young Bisexual and Lesbian Women: ReachOUT's Findings	Lesbian Women (All Ages): Other Studies	Young Women: General Studies
With Eating Disorders	13% (1)	15% (2)	No figures available.

Notes: (1) n = 64; (2) Lesbewell (1998).

The evidence demonstrates that eating disorders affect young people whatever their sexual identity. This is a reflection of peer and social pressures generally; to be 'attractive', 'fit' and 'healthy' according to socially prescribed norms.

However, there are two factors that are *pronounced* (as opposed to specific) for bisexual, gay and lesbian youth: the gay and lesbian media and the nature of the scene. The media and the scene both promote the body beautiful and being slim as 'normal' and to be aspired to. The two extremes for men seem to be very slim, or muscle-bound. The pressure on women is to be fit and slim. Needless the say, the vast majority young people do not fit these prescribed 'ideals'/stereotypes, hence the high levels of dieting, skipping meals, worrying about weight and body dissatisfaction.

3.1.8 Experience of Health Services

Survey Data

- Twenty-seven per cent of respondents were out as bisexual, gay or lesbian to their GPs (29 per cent of men and 32 per cent of women) while 63 per cent were not.
- Twenty-six per cent of respondents would like to be out to their GPs (41 per cent of men and 37 per cent of women) while 40 per cent would not.
- Eight per cent of those who had come out to their GPs stated that it had been a 'good experience', two per cent stated it had been a 'bad experience' and 18 per cent felt it had 'made no difference'.

Data from Interviews

Several young people raised the issue of their experiences of health services during interviews:

"An STD [sexually transmitted disease (genito-urinary medicine, GUM)] clinic that I went to was very cold and clinical. The staff were unfriendly and they didn't reassure me. They asked lots of what I thought were very irrelevant questions when I told them I was gay. They then sent me a letter asking me to contact them urgently. I had to wait the whole weekend before I could get in touch with them. I was panicking. It turned out to be nothing to do with STDs. They apologised but I was furious." (Young man).

"When I went to see my GP I ended up telling him that I was a lesbian. I was so angry at the way he approached my health asking if I was sexually active and whether I was using contraceptives. He just assumed my sexuality without asking. Once someone has made that assumption, it's much harder to come out." (Young woman.)

"I have a friend who gets really pissed off with doctors trying to make her have a smear test every time she sees them. Obviously lesbians do need to have smear tests but the risk of cervical cancer is much less. She finds it very difficult when GPs ask about what condoms or contraceptives she uses." (Young woman.)

"My experiences of GPs are more about how they treat women rather than how they treat gay people. I mean that's what I found more of a problem. The whole kind of not taking you seriously, not listening to what you are saying." (Young woman.)

"STD services need to be safe, confidential and anonymous. They also need to be well known and publicised." (Young man.)

Discussion

In the United States, Newton (1979), Degen and Waikevictz (1982) and Robertson (1992) all noted the invisibility of lesbians and lesbianism in health care settings and literature. Smith *et al* (1985) reported that one third of lesbians in their study in the United States had not disclosed their sexual identity to their GP despite wanting to (cited in Lesbian Information Service, 1995b).

Lesbewell (1995) conducted a questionnaire with 120 women (105 identified as lesbian, 11 as bisexual and 36 were under 25 years of age). The survey found only 28 per cent out to their GP and 44 per cent had experienced homophobia in the National Health Service.

Das' (1996) survey of 111 lesbians' experiences of health care revealed that only 36 per cent felt able to be open with their GP (compared to 57 per cent of heterosexual women), 62 per cent felt their lesbianism negatively affected their health care and only 41 per cent felt able to be open about their sexual identity. Furthermore, two lesbians had not been able to visit their partner in hospital, six were treated disrespectfully when they did and nine had partners ignored by health care workers. Heterosexual women experienced none of this.

Muir-Mackenzie's (1996) survey of 55 bisexuals, gay men and lesbians found that 53 per cent were not out to their GP.

ReachOUT's research project found that only 27 per cent of respondents were out to their GP and that 26 per cent would like to be, 8 per cent found coming out to have been a 'good experience', two per cent a 'bad experience' and 18 per cent found it 'made no difference'.

The evidence suggests that there are two main issues at two extremes: the invisibility of bisexuals, gays and lesbians within health care settings (and the consequences for their care, assumptions, etc.) and the real or perceived intrusiveness when health workers know about a service user's sexual identity. Take for example the experiences of lesbian women who are assumed by health care workers to be heterosexual and who are therefore encouraged to undergo smear tests. If lesbian women do not have sex with men there is no risk of contracting the virus which is understood to cause cervical cancer. Their health care is inappropriate because of their invisibility and the assumptions made about their sexual practice and history. This has obvious lessons for practitioners.

For agencies' perspectives see Section 4.1 and for health workers' perspectives see Section 4.3.

3.1.9 Mental Health

Survey Data

- Fifteen per cent of respondents had, or had had, a mental health problem: 29 per cent of men and 35 per cent of women.

The types of mental health problems experienced by respondents are shown in Table 17.

Table 17: Respondents' Mental Health Problems

Mental Health Problem (1)	Men	Women
"Agoraphobia"		1
"Anxiety"	1	1
"Bulimia"		1
"Depression"	10	6
"Epilepsy"	1	
"Gender dysphoria"	2	
"Manic depression"		1
"Panic attacks"	2	
"Paranoid schizophrenia"		1
"Pre-menstrual tension"		1
"Schizophrenia"		2
"Stress"		1

Note: n = 31; (1) Mental health problems were self-defined by young people.

- Four men and four women were currently receiving treatment for their mental health problem and seven men and seven women had received treatment in the past.

Table 18 shows the types of treatment experienced by respondents.

Table 18: Types of Treatment for Mental Health Problems

Treatment	Men	Women
Counselling	3	3
Medication	3	3
Counselling and medication	2	1
Specialist	1	
Psychotherapist		3

Note: n = 19

- Two people did not receive any treatment:

"I was told to go away." (Young man)

"[The psychotherapist] told me that being a lesbian was a phase and that I should wait until I was 21 to become heterosexual again." (Young woman)

- Seven men and four women felt that their treatment had helped their mental health problem, three men and eight women felt it had not and three people had no opinion.
- Three men thought that their sexual identity was a factor in their mental health problem, eight men and eight women did not think it was related and eight people were not sure.
- Those who did believe their sexual identity was a factor cited the following reasons, as shown in Table 19.

Table 19: Reasons why Respondents' Sexual Identity was a Factor in their Mental Health Problem

Factor	Men	Women
"Feelings of confusion"	3	2
"Not being able to cope"	1	
"Family and guilt"	1	
"Relationship problems"	2	
"Unstable lifestyle"	2	

Note: $n = 11$

- Five men and five women were out during their treatment while five men and seven women were not.
- One man and two women felt that coming out had affected the quality of the service the received, six men and five women said it had not affected the service quality and three had no opinion.
- Fifty-five per cent of respondents had thought about committing suicide: 57 per cent of men and 59 per cent of women.
- Twenty-two per cent of respondents had actually attempted to commit suicide: 24 per cent of men and 23 per cent of women.
- Thirty-three per cent of respondents had deliberately harmed themselves: 30 per cent of men and 42 per cent of women.

Data from Interviews

"I had low self-esteem for a long time." (Young woman.)

"My parents are really homophobic. They get it from what they read and watch. It really gets me depressed now and again and this affects my work. It's something I'd like to change but I don't think I'll be able to." (Young man).

"I'm often in situations where I feel I have to act [as if heterosexual]. I have to do it every day and it's stressful." (Young man).

"I've [acted] for so long that I don't really care." (Young man.)

"Some of my friends have [mental health] problems. I think that's because they haven't had the opportunity to talk about stuff. They get confused and worried. A friend of mine has tried to kill himself a few times. He lay down in front of a car and threw himself out of a window. He was going out with a girl at the time, in a long-term relationship. It was just assumed that he wasn't gay because he was going out with a girl. As he was a friend, I found it quite stressful to deal with this. He is better now he has come out." (Young man).

"I sometimes makes me angry and depressed that some people are so ignorant. Me being gay shouldn't affect them. I think some of them worry that I'll jump on them, it's the whole stigma thing. People think of gay men as being old and preying on people. They think we're paedophiles, going round raping young children. They see gay people as seedy, hanging around in dark alleys, having sex in public toilets." (Young man.)

Discussion

Trenchard and Warren's (1984) survey of 416 young gays and lesbians found that 15 per cent had been sent to a psychiatrist when they came out and ten per cent had been sent to a GP.

Bhugra's (1988) study found that ten per cent of GPs thought that gay and lesbians patients should be 'returned to normality' by therapy and two thirds felt uncomfortable having gay and lesbian patients (cited in McFarlane, 1998). Bhugra found that less than a half of patients would reveal their sexual identity to their GP and that these attitudes may actually discourage the seeking of medical care (cited in Golding, 1997).

Research indicates that many people were reluctant to reveal their sexual identity to staff in mental health services for fear of discrimination and abuse (Paroshi, 1987; Stevens and Hall, 1988; Getty and Stern, 1990) and for fear that their confidentiality would not be respected (Getty and Stern, 1990; Zeidenstein, 1990) (cited in Golding, 1997).

O'Connor and Ryan (1993) examined the ways in which psychoanalytic theory had portrayed homosexuality as various forms of pathology, perversity or immaturity (cited in Golding, 1997).

Ellis (1994) found some British therapy training institutions would not accept openly gay and lesbian students (cited in McFarlane, 1998).

Man's (1994) study reported that half of gay and lesbian people seeking counselling had encountered negative reactions and a lack of understanding about sexual identity (cited in McFarlane, 1998).

The Royal College of Nursing Lesbian and Gay Working Party's (1994) study of the experiences of bisexual, gay and lesbian mental health service users revealed several commonly recurring themes: fear and anxiety, lack of privacy, risks in disclosing sexual identity, fear of discrimination and physical abuse, feeling vulnerable, ignored or disbelieved, being pressurised into treatment, sexual identity being seen in purely sexual terms, inappropriate questioning, insensitive interviewing, inappropriate use of language, prejudiced staff attitudes, inappropriate psychiatric referrals and not allowing partners to visit (cited in Golding, 1997).

Taylor and Robertson (1994) studied American and British surveys of nurses' attitudes and found 40 per cent of nurses in one sample did not condone homosexuality, a minority claimed the right not to treat gay and lesbian patients and some saw AIDS as divine punishment (cited in Sayce, 1995).

Sayce (1995) described the ways in which the 1983 Mental Health Act was discriminatory towards bisexual gay and lesbian people. Sayce argued that the history of treating homosexuality as a mental illness was a long one and that the pathologisation of homosexuality continued (through aversion therapy, hormone treatment, etc).

Young (1995) reported difficulties in getting sexual identity onto the institutional agenda of organisations like the British Association for Counselling, the British Psychological Society, etc. (cited in McFarlane, 1998).

Davis and Neal (1996) lamented the paucity of research into the experiences of bisexual, gay and lesbian people in the mental health system. They identified psychotherapists who attempted to 'cure' homosexuality, using treatments akin to torture.

Roberts' (1996) study of 39 young bisexual and gay men under 25 found a half had been to a counsellor and a half had used helplines and support groups.

Golding's (1997) study of 55 bisexual, gay and lesbian mental health service users found:

- Fifty-five per cent did not feel safe disclosing their sexual identity and 40 per cent of these feared discrimination and prejudicial treatment.
- Forty-four per cent feared the pathologisation of their sexual identity.
- Seventy-eight per cent feared disclosing to other service users.
- Fourteen per cent feared physical and verbal abuse.
- Nineteen per cent feared rejection.

Having analysed their perceptions and fears, Golding then asked about their experiences and found:

- Seventy-three per cent had experienced discrimination and harassment in the mental health system and in some cases physical assault (68 per cent of these incidents occurred in hospital environments).
- Thirty-eight per cent had met negative responses when they came out.
- Twenty-six per cent had experienced physical and verbal abuse.
- Ten per cent had had their sexual identity pathologised.
- Only five per cent felt able to challenge the discrimination and homophobia.
- Twenty-two per cent experienced victimisation (including violence, rape and sexual assault).
- Half had been encouraged to hide their sexual identity.
- Two-thirds of those with partners said their partners were not treated on an equal basis with heterosexuals.
- Fifty-one per cent said their sexual identity had been inappropriately used to explain the causes of their mental distress.
- Seventy per cent of those who requested information about bisexual, gay and lesbian support services were not given any.
- Seven per cent had been forced to have a HIV test.
- There was no investigation, or an unsatisfactory one, in 82 per cent of cases where people complained about the service they received.

All of those who reported discrimination felt they had experienced negative emotional feelings as a direct result (in a supposed therapeutic environment).

Koffman's (1997) study of bisexual, gay and lesbian mental health service users found:

- The internalising of society's homophobia had an impact on mental health.
- Several people had attempted suicide because of confusion and conflict around their sexual identity.
- Several people had experienced homophobic abuse, assault and harassment (which contributed to anxiety, fear and stress and feeling unsafe in their homes).
- Several people felt isolated following negative reactions to coming out to their families.
- Negative reactions from other bisexuals, gays and lesbians because of their mental health problem.
- Institutionalised discrimination and homophobia within the mental health system.
- Fear of coming out to other service users and workers.
- Invisibility because they do not feel safe to come out.
- Homophobia from other service users.
- Pathologisation: their sexual identity was seen as a mental disorder.

Bisexuals, gays and lesbians with mental health problems experienced discrimination and prejudice because of their sexual identity and because of their mental health problem: a double stigma.

Mind (1997) reported estimates from the United States that between 200,000-500,000 people with serious mental health problems were bisexual, gay or lesbian. In Britain, the Leeds Crisis Centre reported that 16 per cent of users identified as gay or lesbian. Mind outlined the long history of homophobia and pathologisation in the mental health system.

The PACE (Project for Advice, Counselling and Education) study of 35 gay and lesbian mental health service users found that 35 per cent had experienced depression, 25 per cent had had suicidal thoughts and 29 per cent had alcohol problems. Several of the participants had experienced physical and verbal abuse, stereotyping, inappropriate questioning, being silenced, judgemental attitudes and the pathologisation of their sexual identity (McFarlane, 1998).

ReachOUT's research project found that 15 per cent of respondents had had a mental health problem. Eight respondents were currently receiving treatment and 14 had received treatment in the past, 11 respondents felt their treatment had helped while 11 did not. Three men thought their sexual identity was a factor in their mental health problem. Ten respondents had been out during treatment and three people felt that coming out had affected the quality of the service they received.

Mental health problems affect young people whatever their sexual identity, see Figure 17.

Figure 17: Mental Health Problems among Young People

	Young Bisexuals, Gays and Lesbians: ReachOUT's Findings	**Young Gays and Lesbians: Other Studies**	**Young People: General Studies**
With Mental Health Problem	15% (1)	16% (2)	15% (3)

Notes: (1) *n* = 82; (2) Mind (1997); (3) Melzer *et al*, cited in Coleman (1997).

However, the findings shown in Figures 18 and 19 suggest that some mental health problems are more *pronounced* for bisexual, gay and lesbian youth compared to the general youth population; more specifically, depression, self-harm and suicide.

Figure 18: Incidence of Depression among Young People

	Young Bisexuals, Gays and Lesbians: ReachOUT's Findings	**Young Gays and Lesbians: Other Studies**	**Young People: General Studies**
With Depression	9% (1)	No figures available.	2-3% (2)

Notes: (1) *n* = 16; (2) Melzer *et al*, cited in Coleman (1997).

Young bisexuals, gays and lesbians were *three times more likely* to suffer from depression than young people in general were.

The following sixteen studies of self-harm and suicide were conducted in the United States.

In terms of self-harm and suicide, Saghir and Robins (1973) and Bell and Weinberg (1978) studied the age at which young bisexuals, gays and lesbians attempted suicide. The average age was 20 or less. These studies found little differentiation in terms of ethnic identity and gender (cited in McColl, 1997).

The National Lesbian and Gay Health Foundation (1987) found that one quarter of lesbians (aged 17-24) in their study had attempted suicide (cited in McColl, 1997).

Martin and Hetrick's (1988) study found that 21 per cent of young bisexuals, gays and lesbians had attempted suicide (cited in McColl, 1997).

The Department of Health and Human Services (Task Force on Youth Suicide) report (1989) concluded that young lesbians were two to six times more likely to commit suicide than heterosexual women (cited in Bridget, 1990).

Gibson's (1989) study found that 20 to 40 per cent of young bisexuals, gays and lesbians had attempted suicide, and estimated that they comprised up to 30 per cent of completed suicides (cited in Bridget, 1990).

Schneider *et al* (1989) found that 20 per cent of young bisexuals, gays and lesbians had attempted suicide (cited in McColl, 1997).

Hunter (1990) surveyed 500 bisexual, gay and lesbian homeless young people. Forty-one per cent had experienced physical assault. Forty-six per cent of those who had been assaulted thought it was gay-related and of these, 44 per cent expressed suicidal feelings (cited in Governor's Commission on Gay and Lesbian Youth, 1993b).

Kruks' (1991) study found that 53 per cent of bisexual, gay and lesbian homeless young people had attempted suicide, compared to 32 per cent of the non-homeless (cited in McColl, 1997).

Remafedi's (1991) study found that 30 per cent of bisexual and gay young men (aged 14-21) had attempted suicide. The study also found that these suicide attempts were more determined and violent than attempts by young heterosexuals.

Hunter *et al* (1992) found high levels of suicide attempts among Black and Latino young bisexuals, gays and lesbians: 38 per cent of attempted and 12 per cent of completed suicides (cited in Governor's Commission on Gay and Lesbian Youth, 1994).

D'Augelli and Hershberger (1993) found that 42 per cent of their young bisexual, gay and lesbian sample had attempted suicide and concurred with Remefedi (1991) that attempts were more determined and violent (cited in McColl, 1997).

Between 1950-80, the suicide rate for those aged 15-24 increased 170 per cent (the suicide rate for the general population increased by 20 per cent). Bisexual, gay and lesbian suicides accounted for one third of this increase and they were two to three

times more likely to commit suicide than their heterosexual peers (Governor's Commission on Gay and Lesbian Youth, 1993b).

Hammelman's (1993) study found that 29 per cent of the young bisexuals, gays and lesbians had attempted suicide. Proctor and Groze (1994) found a rate of 40 per cent in their sample (cited in McColl, 1997).

Bridget (1994) collated and summarised the United States research findings and concluded that up to 30 per cent of completed suicides were young bisexuals, gays and lesbians, who were two to six times more likely to attempt suicide.

Twenty per cent of deaths of 15-24 year olds were the result of suicide according to the Samaritans North London Youth Group who surveyed 7,000 young people between 1991-97. They found suicide attempts by young women in their teens and early twenties at epidemic levels. One in five had attempted suicide before the age of 25 (compared to eight per cent of young men). Fifteen per cent of the young women felt they had no one to discuss problems with and bullying and drugs were found to be major factors (for example, one in three commit suicide after abusing alcohol or drugs) (cited in Nicoll, 1998).

Trenchard and Warren's (1984) study found that 19 per cent of young gays and lesbians had attempted suicide.

A Department of Health (1991) report acknowledged that young gays and lesbians were more at risk of suicide than other young people (cited in Sanderson, 1996).

Bridget's (1994) study of 20 young lesbians suffering from multiple oppression found that 14 had attempted suicide.

McColl (1995) asked youth workers to cite the major sources of distress and their consequences for the young bisexual, gay and lesbian people they worked with. Self-harm was cited as a major source of distress for young men by 18 per cent of youth workers, and for young women, by 24 per cent of youth workers. Suicidal thoughts were cited as a major source of distress for young men by 43 per cent of youth workers, and for young women, by 38 per cent of youth workers. Suicide attempts were cited as a major source of distress for young men by 17 per cent of youth workers, and for young women, by 18 per cent of youth workers.

Roberts' (1996) study included 39 young bisexual and gay men under 25. Over half had had suicidal feelings or had attempted suicide. One quarter self-harmed.

ReachOUT's research project found that 55 per cent of the respondents had thought about committing suicide and 22 per cent had attempted. Thirty-three per cent of respondents had deliberately harmed themselves.

Figure 19 shows the levels of suicidal thoughts, suicidal attempts, and self-harm, among young people.

Figure 19: Suicide and Self-harm among Young People

	Young Bisexuals, Gays and Lesbians: ReachOUT's Findings	**Young Gays and Lesbians: Other Studies**	**Young People: General Studies**
Thought about Suicide	55% (1)	45% (4)	No figures available.
Attempted Suicide	22% (2)	37% (5)	8% (Men) (7) 20% (Women)
Self-Harmed	33% (3)	23% (6)	No figures available.

Notes: (1) *n* = 162; (2) *n* = 160; (3) *n* =164; (4) McColl (1995), Roberts (1996); (5) Trenchard & Warren (1984), Bridget (1994), McColl (1995), Rivers (1998); (6) McColl (1995), Roberts (1996); (7) Nicoll (1998).

ReachOUT's research project found that its sample of bisexual, gay and lesbian young people were *no more likely* to suffer from mental health problems than the youth population in general (see Figure 16). The widespread pathologisation of sexual identity is clearly misplaced. However, the evidence suggests there are two main mental health issues relating to sexual identity: that depression, self-harm and suicide are pronounced among bisexual, gay and lesbian young people, and the incidence of discrimination within the mental health system.

ReachOUT's research project suggests that bisexual, gay and lesbian youth are three times more likely to suffer from depression and more likely to have attempted suicide than their heterosexual counterparts (young bisexual and gay men were almost *four times as likely*). ReachOUT's research project also found a high level of self-harm. It can be argued that depression, self-harm and suicide are often more *social* in nature – a reflection of society's homophobia and oppression and its impact on young bisexuals, gays and lesbians (for example, internalised homophobia, low self-esteem, stress, etc.) – compared to other mental health problems which tend to be more *clinical/neurological* in nature.

ReachOUT's findings, and the findings of other studies, also found evidence of discrimination within the mental health system. In ReachOUT's research project this took the form of a young person being refused services and having her mental health problems pathologised. In other studies, the discrimination was institutional as found by Golding's and Koffman's studies.

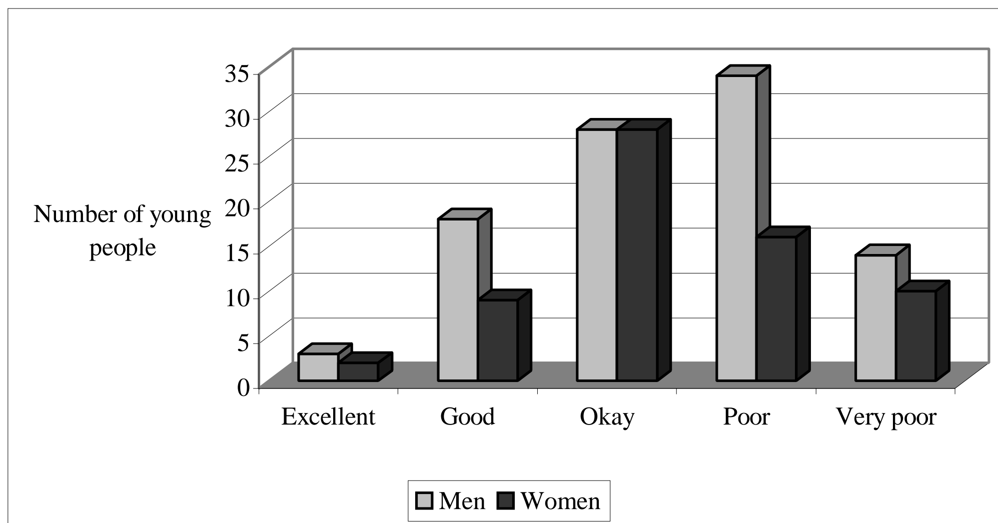
For local agencies' perspectives on mental health see Section 4.1 and for workers' perspectives see Section 4.3.

3.1.10 Sex Education

Survey Data

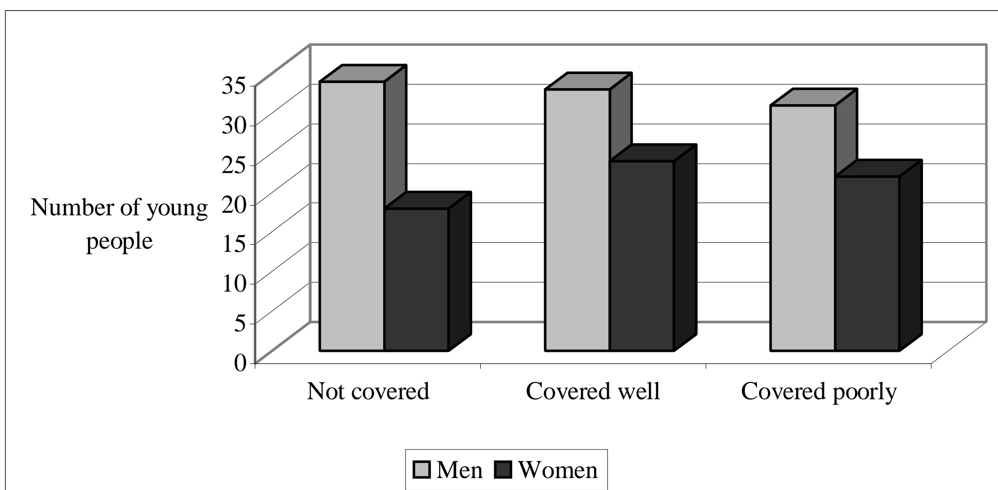
Chart 12 shows the quality of respondents' sex education, Chart 13 the coverage of respondents' sex education in terms of HIV and sexual health issues and Chart 14 the coverage in terms of gay and lesbians issues.

Chart 12: Quality of Respondents' Sex Education



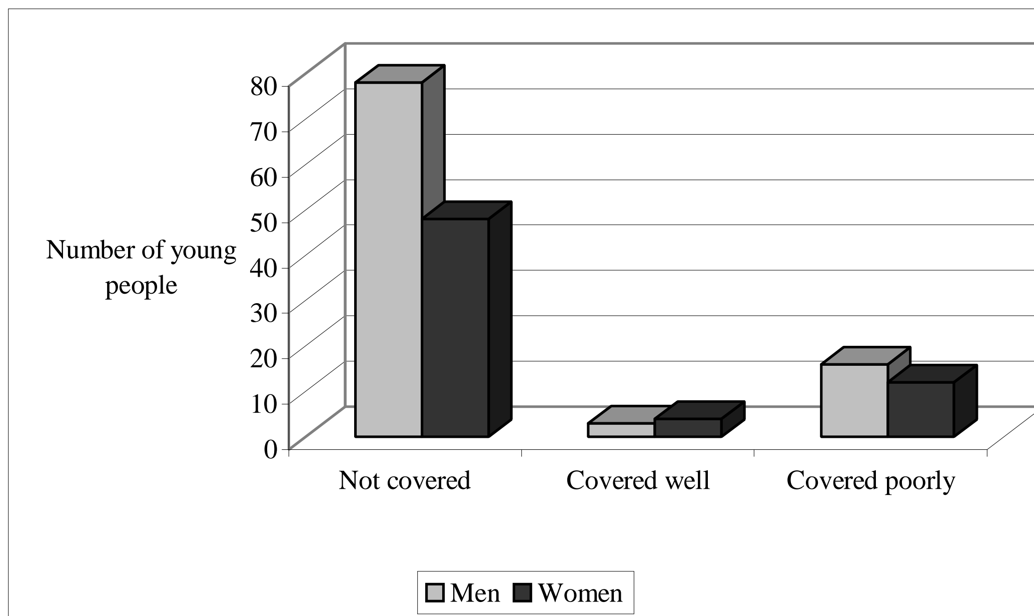
Note: n = 162

Chart 13: Coverage of Respondents' Sex Education in Terms of HIV and Sexual Health



Note: n = 162

Chart 14: Coverage of Respondents' Sex Education in Terms of Gay and Lesbian Issues



Note: n = 161

- Twenty per cent of respondents felt that the quality of their sex education had been 'excellent' or 'good'.
- Thirty-five per cent of respondents felt that it had been 'okay'.
- Forty-five per cent of respondents felt that it had been 'poor' or 'very poor'.
- Seventy per cent of respondents reported that their sex education had covered HIV and sexual health issues.
- Thirty-five per cent of respondents reported that HIV and sexual health had been covered 'well' and 33 per cent 'poorly'.
- Twenty-two per cent of respondents reported that their sex education had covered gay and lesbian issues.
- Four per cent of respondents reported that gay and lesbian issues had been covered 'well' and 17 per cent 'poorly'.

Data from Interviews

The issues of sex education was raised by several young people during interviews:

"Sex education was dealt with in RE [religious education]. Everyone sat and listened and then gave their views on it. But it was all about penis up the vagina and this didn't mean anything to me. They did deal with gay issues, but they dismissed it quickly and moved on to AIDS. It was all about the heterosexual side of things." (Young man.)
"They didn't mention sex education once at my school." (Young man.)

"Educating people about STDs is important because HIV is the one that most people know about." (Young man.)

"Sex education was just about HIV and AIDS. I think the other STDs should have been covered more at school. I got my information and messages from stuff at university and programmes on television. I got bits of information from different places but it was down to me to put the picture together. More should have been done at school, my sex education was mainly focused on heterosexuality. I did have some gay teachers though, so some issues were raised." (Young man.)

"Sex education wasn't particularly helpful. It was taught in science and didn't get anywhere near human sexuality." (Young man.)

"I reckon they should have compulsory sex education dealing with gay issues for everyone." (Young man.)

"Sex education generally should be dealt with far better in schools, it should cover everything." (Young woman.)

"There was very little sex education at my school. We had a very passionate religious education section. They just wouldn't let anything pass that was even remotely non-heterosexual. We did all the straight stuff and at the end they said, 'and then there's homosexuality' and then quickly turned the overhead projector off." (Young man.)

"We did gay issues in business studies. One of the tasks was to set up a gay youth club. So we had half a term of gay education and business studies." (Young man.)

"My sex education was shit. It was non-existent." (Young man.)

"Sex education in my school was like penis, vagina, go forth and multiply. And they did!" (Young man.)

"We need a safe confidential service, somewhere you know is going to be supportive. You need a resource centre where you can get sexual health stuff in a gay context so that you don't have to come out to get the right advice. So that you don't have to go to your GP or to the Florey Unit which is intimidating enough for adult gay men who are comfortable with themselves, never mind someone who is a teenager or whatever." (Young woman.)

Discussion

Trenchard and Warren's (1984) study of 416 young gay and lesbian people found that only 2.4 per cent reported homosexuality being discussed in their sex education.

Allen (1987) surveyed parents and young people about sex education. Eleven per cent of parents preferred their children to learn sex education at home, 27 per cent preferred their children to learn at school and 60 per cent preferred both the home and school as learning environments. Twenty per cent preferred the school to cover sexual health and homosexuality (cited in Douglas *et al*, 1997).

A Health Education Authority (1990) survey of 4,400 adolescents aged 16-19 found that only 18 per cent had received any information on gay male issues and only 14 per cent on lesbianism. The National Children's Bureau's (1992) report on sex education concluded that there was anxiety, confusion and inconsistency in schools about sex education and Section 28 (cited in Black, 1994).

A Health Education Authority (1994) study of 1,462 parents found that 94 per cent thought schools should play a role in teaching pupils about sexuality issues, 56 per cent sexual identity and 80 per cent HIV (cited in Douglas *et al*, 1997).

Stonewall (1994) surveyed 2,408 bisexuals, gay men and lesbians about their sex education. Forty-eight per cent of respondents stated that their sex education had been poor or very poor, 31 per cent had received no sex education and only 15 per cent had received a good or adequate sex education. Assessing the coverage of male homosexuality in sex education, only one per cent felt the coverage had been good, 13 per cent felt it had been very poor and 82 per cent said it had been non-existent. Assessing the coverage of lesbianism, six per cent felt it had been very poor and 89 per cent said it had been non-existent. Of the 390 young men who had received sex education since 1987 (the year of the government's first HIV awareness campaign) 41 per cent confirmed that safer sex had been discussed but only 2.5 per cent said safer sex for young gay men had been discussed.

Isay (1993) reported that research in Britain and the United States suggests that for young gay men homoerotic attraction starts somewhere between the ages of 8-14. Furthermore, in the playground and classroom conformity is prized and atypicality attracts verbal and physical abuse and harassment (cited in Kelly, 1996).

Rogers (1994) and Lynch (1995) found that the needs of lesbians in particular were being marginalised, both in discussions in schools and in HIV prevention initiatives. They concluded that lesbian sexual health was being ignored (cited in Douglas *et al*, 1997).

Jowett's (1995) study of sex education in Berkshire secondary schools found that about one-third of schools covered same-sex relationships, one-third did not and one-quarter stated they were discussed only in response to students' questions.

Biddulph (1996) argued that confusion among young gay men regarding their emerging masculinity was reflected in the anti-femininity norm through sexist, misogynist and homophobic behaviour (cited in Kelly, 1996).

Kelly (1996) commented on the invisibility of lesbians, arguing that it was a reflection of the dominant idea that women's sexuality was as a response to male sexuality. Studies have found that women are accessing youth groups and other services when they are much older when compared to men. Kelly also cited a study of 1,000 young people in Barnet (London) in which over half stated they wanted more information about homosexuality.

In Roberts' (1996) study of 39 young bisexual and gay men (under 25), four fifths stated that their sex education had been poor or very poor.

Sexual identity and HIV education was circumscribed and determined by the following legislation according to Douglas *et al* (1997):

- Education (No.2) Act 1996.
- Department of Education and Science Circular 11/87.
- Section 28 of Local Government Act 1988.
- Education Reform Act 1988.
- National Curriculum Council – Curriculum Guidance: Health Education 1990.
- Education Act 1993.
- Department for Education Circular 5/94.
- Education Act 1996.
- Health of the Nation White Paper 1992.
- HIV and AIDS Health Promotion – *An Evolving Strategy* 1995.
- Criminal Justice and Public Order Act 1994.

Douglas *et al* (1997) conducted a survey of 307 secondary schools in England and Wales. Although 98 per cent of these schools had sex education policies, only 51 per cent dealt with bisexual, gay and lesbian issues. Sixty-two per cent of teachers thought that schools were appropriate settings to deal with sexual identity. Sixty-one per cent felt that sexual identity should be part of the taught curriculum. Seventy-five per cent of teachers were aware of Section 28, eight per cent thought it made discussion of homosexuality illegal while 20 per cent did not know. Forty-eight per cent of teachers had experienced difficulties in addressing the needs of young bisexuals, gay and lesbians because of Section 28. Ninety-five per cent of the schools addressed HIV in the sex education and ten per cent had a policy of supporting pupils and families with or affected by HIV and AIDS. However, 72 per cent of teachers had not received any training around HIV-related issues.

ReachOUT's research project found that 20 per cent of respondents felt their sex education had been 'excellent' or 'good', 35 per cent 'okay' and 45 per cent 'poor' or 'very poor'. Seventy per cent reported that their sex education had covered HIV and sexual health, 35 per cent 'well' and 33 per cent 'poorly'. Twenty-two per cent reported that their sex education had covered gay and lesbian issues, four per cent 'well' and 17 per cent 'poorly'.

The findings of ReachOUT's research project and others suggest that young bisexual, gay and lesbian people do not receive an adequate sex education at school. The young people participating in the interviews stated that, where sex education was delivered, it tended to focus on heterosexuality and heterosexual issues, spending little time on issues of concern to them. Although most young people's sex education had

covered HIV and sexual health issues, one third reported that it had been ‘poor’. Similarly, even where young people’s sex education had covered gay and lesbian issues, it tended to be of poor quality.

The results of this poor education are that many young bisexual, gay and lesbian people begin their adult lives and sexual careers with inadequate, little or no information about HIV and sexual health issues, lifestyle issues, etc. This has obvious implications for their self-esteem (and mental) and sexual health. It is also incumbent on them to piece together any information they have obtained. This is difficult in a homophobic society that peddles a number of myths and stereotypes about sexual identity and alternatives to heterosexuality.

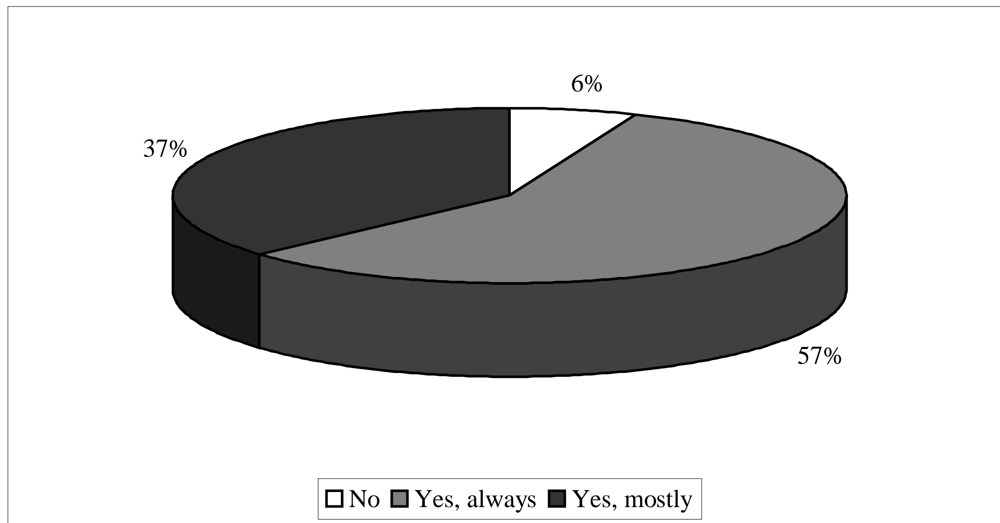
For schools’ perspectives on sex education see Section 4.2.

3.1.11 Sexual Health

Survey Data

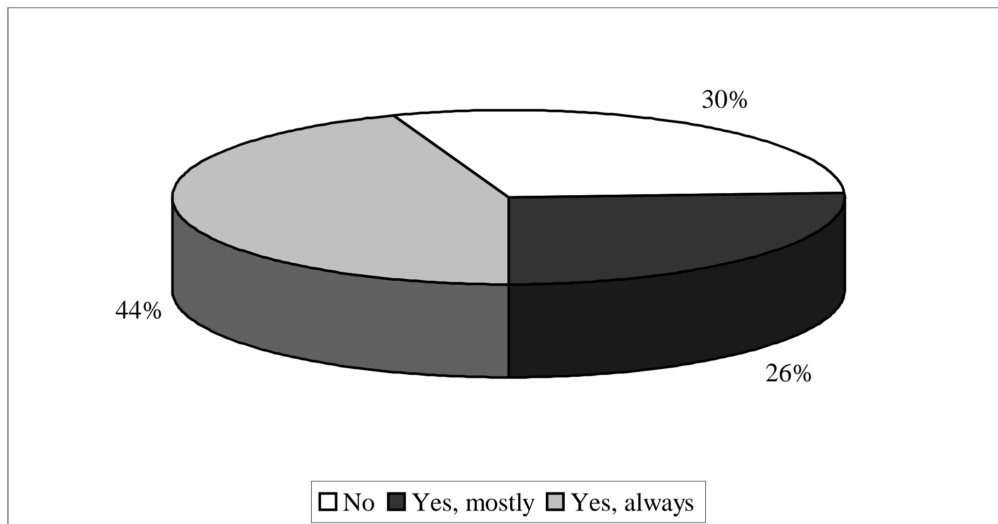
Chart 15 shows the proportion of men practising safer sex and Chart 16, the proportion of women.

Chart 15: Practice of Safer Sex by Young Men



Note: n = 98

Chart 16: Practice of Safer Sex by Young Women



Note: n = 54

- Fifty-seven per cent of men reported that they ‘always’ practised safer sex, 36 per cent ‘mostly’ did and six per cent did not.

- Twenty-six per cent of women reported that they ‘always’ practised safer sex, 44 per cent ‘mostly’ did and 30 per cent did not.

- Thirty per cent of respondents had had an HIV test: 41 per cent of men and 14 per cent of women.

- Two respondents stated that they were HIV-positive: one man and one woman.

- Fifty young people stated that they were HIV-negative: 93 per cent of men and 80 per cent of women.

- Three people did not want to declare their HIV status: two men and one woman.

- Forty-one men and 42 women believed their HIV status to be negative and 16 people (11 men and five women) did not know what their status was.

- Thirty-six per cent of respondents had been vaccinated against hepatitis B: 47 per cent of men and 27 per cent of women.

- Fifteen per cent of respondents had had a sexually transmitted infection (STI): 19 per cent of men and nine per cent of women. The types of sexually transmitted infections are shown in Table 20.

Table 20: Incidence of Sexually Transmitted Infections

Sexually Transmitted Infection	Men	Women
Anal warts	2	
Crabs	9	
Chlamydia	1	
Genital herpes		1
Gonorrhoea	2	1
Non-specific urethritis	2	
Scabies	1	
Thrush	1	3
Vaginal warts		1
Warts	1	

Note: $n = 25$

The treatment services for STIs used by respondents are shown in Table 21.

Table 21: STI Treatment Services Used by Respondents

Treatment service	Men	Women
Chemist	4	1
Family planning clinic		1
Florey Unit (local GUM clinic)	6	2
GP	3	3
Other GUM clinic	9	3

Note: n = 32

Data from Interviews

“I never forget to practice safer sex, even when I’m off my face.” (Young man.)

“Some people think it’s more fun to have unsafe sex.” (Young man.)

“I think people who have unsafe sex are a danger to society.” (Young man.)

“A lot of diseases can be passed without full sex.” (Young man.)

“I think this generation is going to be one of the safest, because we’ve had it drummed into us from a very early age.” (Young man.)

“I think condoms and stuff should be free everywhere.” (Young man.)

“Most people assume that lesbians don’t need protection or to practice safer sex. I don’t think that’s true.” (Young woman.)

“I found out about safer sex at university. There was a sex education week that had a specific gay session. It was really good.” (Young man.)

“There’s definitely a need for gay organisations to fill the gaps left from school.” (Young man.)

“Safer sex [Youth Group] sessions were useful, but it would be nice to have someone to talk to one-to-one, to avoid embarrassment.” (Young man.)

“I think whether people practice safer sex depends on the situation. People get drunk, and if they’re not completely with it, they’re not going to think of it. And some people don’t know where to get condoms and stuff from.” (Young man.)
“I think some people believe, ‘well it’s my body’.” (Young man.)

“The scare in the 1980s is where I got most of my information from.” (Young man.)

“I think it’s rammed down your throat on the gay scene and that’s good, but other STDs are being ignored.” (Young man.)

"Having a HIV test can affect things like insurance." (Young man.)

"I don't worry about HIV, but I would if I slept around a lot." (Young man.)

"I use condoms, but I still worry about lower risk things like pre-cum and saliva." (Young man.)

"There are a lot of conflicting messages about safer sex, what you should and shouldn't do." (Young man.)

"Women's and lesbians' issues around HIV and sexual health do tend to be forgotten or ignored." (Young woman.)

"I think people have not got much perception about the kinds of things lesbians do in bed." (Young woman.)

"So much sexual health advice for lesbians is about sex toys." (Young woman.)

Discussion

Fitzpatrick's (1989) survey of 356 gay men (aged 16-67) found that 21 per cent had engaged in unprotected anal sex. Thirty-seven per cent had had non-specific urithritis, 28 per cent gonorrhoea, 19 per cent genital warts, 13 per cent hepatitis B, 12 per cent syphilis, 12 per cent thrush and seven per cent herpes.

Project Sigma's survey of 1,633 men at the 1993 Pride Festival included almost 30 per cent who were under 26 years of age, 1.2 per cent were African-Caribbean, 1.3 per cent were Asian and 95 per cent were white. Five per cent identified as bisexual and 86 per cent gay. Forty-three per cent had attended GUM clinics in the year before and nine per cent had had unprotected anal intercourse (Hickson *et al*, 1994).

Hickson *et al* (1994) and the Health Education Authority (1997) reported that sex between men remained the most common way of acquiring HIV in Britain, accounting for 61 per cent of all reported infections. This was acknowledged in the government's HIV health promotion strategy: "vulnerable groups requiring targeted health promotion are gay men (in particular, young gay men)" (Department of Health, 1995).

Statistics from GUM clinics in London and Southeast England revealed that HIV prevalence among bisexual and gay men was 11.33 per cent and 3.83 per cent outside London. In London it was estimated that 29 per cent of men with HIV were not diagnosed compared to 35 per cent outside London (Health Education Authority, 1997).

The annual incidence of AIDS increased almost six-fold between 1984-94 while the prevalence of AIDS cases among bisexual and gay men rose twelve-fold (Health Education Authority, 1997).

The Health Education Authority (1997) reported a decline in the incidence of some STIs among bisexual and gay men during the 1980s, but increases in the incidence of others.

The Health Education Authority's (1997) survey of behaviourally bisexual men found 87 per cent had had both female and male partners in the year before, 67 per cent had engaged in unprotected vaginal intercourse and 22 per cent had engaged in unprotected anal intercourse with a female and 20 per cent with a male.

A notable lack of research into the sexual behaviour and HIV prevention needs of ethnic minority bisexual and gay men was identified (Hickson *et al*, 1993; Gorna, 1993; Aggleton, 1995; Bhatt, 1995; Prout and Deverell, 1995; Annetts *et al*, 1996; and Kelly *et al*, 1996) (cited in Hickson *et al*, 1997b).

According to the Public Health Laboratory Service's Communicable Diseases Surveillance Centre (PHLS-CDSC), 95 per cent of white men with AIDS had acquired it through homosexual sex compared to 2.6 per cent of Black men and 1.3 per cent of Asian men (Health Education Authority, 1997).

Robertson and Schachter (1981) reported there was little information or research into lesbians' sexual health. Analysis of data by Johnson *et al* (1987) and Edwards and Thin (1990) suggested that lesbians were at lower risk for most STIs, including HIV (cited in Lesbian Information Service, 1995b).

Haines and Lee (1995) noted the worldwide trend towards increased rates of HIV infection among women, particularly young women. They argued there was too little information and research into lesbians' sexual health. They acknowledged the low risk of HIV infection from lesbian sex, but pointed to other sources of risk for lesbians (artificial insemination, sex with men, sharing needle works, etc.).

Lesbewell's (1995) survey of 120 women (105 identified as lesbian, 11 as bisexual and 36 were under 25 years of age) found that 17 per cent had children, 77 per cent had had sex with men in the past, five per cent had sex with men regularly and seven per cent did occasionally, 15 per cent had used dental dams and latex gloves, 25 per cent had had thrush, eight per cent cystitis and six per cent genital herpes.

Shady's (1996) lesbian sexual health project noted the lack of research and evidence about women-to-women transmission of HIV. Several women in the project felt they had to rely on their common sense about risk. They cited a study of 27 lesbian clients at St Thomas' Hospital GUM Clinic. This study found a high prevalence of STIs and ten of these women had had abnormal smears. They also cited research by the Street Outreach Service Project in Brighton (1994) which found that 55 per cent of the 88 women in the study had had some STI and 85 per cent only had sex with women.

The Health Education Authority (1997) concurred that women-to-women transmission was rare and in the cases where it had occurred, other risk factors were nearly always present.

A study by Givertz *et al* of young bisexual and gay men (aged 16-22) in the United States found high rates of unprotected sex. The study also revealed significant ethnic differences: 56 per cent of African-American, 40 per cent of Latino and 27 per cent of Asian young men had engaged in unprotected sex compared to 22 per cent of young white men. The Massachusetts Department of Public Health found 50 per cent of STI cases related to young people under the age of 24. Another study reported that 16 per cent of young homeless men who had had sex with men were HIV-positive (70 per

cent of these young men identified as bisexual or gay) (cited in Governor's Commission of Lesbian and Gay Youth, 1994).

Davies *et al* (1992) concluded that young gay men remained an invisible group in terms of research and intervention strategies (cited in Douglas *et al*, 1997).

Evans *et al* (1993) in their study of reported HIV infections among men who had had sex with men, found a declining number of under 25s who tested positive: from 17.8 per cent before 1986 to 13.4 per cent in 1991 (cited in Hickson *et al*, 1994).

Hickson *et al* (1994) argued that the belief that younger gay men are at higher risk of HIV infection than older men had almost reached the status of accepted fact. Three sources of data were usually cited to support this belief: a series of papers from the United States reporting behavioural data, papers from GUM clinics in Britain and papers from the PHLS-CDSC. This belief was compounded by the fact that young gay men receive little or no relevant sex education in schools (an education failure underpinned by Section 28 of the 1988 Local Government Act). Consequently most young gay men embarked on their sexual careers with little knowledge of safer sex techniques and underdeveloped negotiation skills. Furthermore, this belief was fuelled by young people who saw themselves as invulnerable and who saw HIV as a problem for and of older men.

Project Sigma undertook a survey of 1,633 men at the 1993 Pride Festival. Thirty per cent of these men were under 26. Forty-three per cent of the sample had attended a GUM clinic in the year before and nine per cent had engaged in unprotected anal intercourse. No significant differences were found between the age groups. They found no evidence for the contention that younger bisexual and gay men were more at risk from HIV infection (Hickson *et al*, 1994).

Carey Parkes (1996) summarised results from four London GUM clinics. Men over 25 years of age accounted for only 1.9 per cent of reported HIV infections while men under 25 accounted for 8.9 per cent. A wider London sample found that men under 25 accounted for seven per cent of reported HIV infections.

Frankham's (1996) study of 54 young gay men and their HIV prevention needs revealed a number of key issues: coming out, accessing information and resources, bullying in schools and problems communicating with teachers (cited in Douglas *et al*, 1997).

Roberts' (1996) study of 39 young bisexual and gay men (under 25) found that one in five had had unprotected anal sex, three quarters had been vaccinated against hepatitis B, half had had sex with women, half had been to a GUM clinic, half had used public sex environments and of these, 16 per cent had engaged in unprotected anal sex, and one quarter had started using public sex environments between the ages of 11 and 15.

Warwick *et al* (1988) cited several studies that argued that young people's beliefs about HIV and AIDS were of a sophisticated nature. Furthermore, the studies suggested that young gay men and lesbians were more knowledgeable than their heterosexual peers were. However, young gay men were becoming infected. Figures collated by the PHLS-CDSC between 1985-87 show that 14.9 per cent of all notified HIV infections and 3.2 per cent of AIDS cases (acquired through sex between men) occurred in those

under 25 years of age (cited in Douglas *et al*, 1997). Douglas *et al* (1997) concluded that although a series of studies in the United States suggested a correlation between age and HIV-related sexual risk taking, studies in Britain and Europe did not.

Hickson *et al* (1998) in their national sample of 4,370 men found that six per cent had tested HIV-positive, 42 per cent had never tested, 28 per cent had had unprotected anal intercourse in the preceding year, young men were more likely to engage in 'unknown' unprotected anal intercourse, one in five indicated they found it hard to 'stick to safer sex' and two thirds of men expressed a need for more information about sexual health.

ReachOUT's research project found that 57 per cent of male respondents and 26 per cent of women 'always' practised safer sex, 36 per cent of men and 44 per cent of women 'mostly' did and six per cent of men and 30 per cent of women did not. Forty-one per cent of men and 14 per cent of women had been for an HIV test. Most respondents either knew or believed themselves to be HIV-negative. Two respondents reported that they were HIV-positive. Forty-seven per cent of men and 27 per cent of women had been vaccinated against hepatitis B. Fifteen per cent of respondents had had a sexually transmitted infection.

Nationally, the Health Education Authority (1997) stated that sex between men accounted for 61 per cent of HIV infections. Locally in 1996/97, the figure was 71 per cent of cases (Berkshire Health Authority, 1997). Both locally and nationally, there is a high incidence and prevalence of HIV among bisexual, gay and men who have sex with men hence the targeting of these groups in the Department of Health's HIV prevention strategy (1995).

There are several similarities between the findings of ReachOUT's research project and other studies: there are a number of men who do not, or who have difficulties in, practising safer sex, most men have not tested for HIV, sizeable numbers of men have been vaccinated against hepatitis B, lesbians' (and indeed women's) sexual health needs are marginalised and there is a general need for more information about HIV and sexual health and a role for gay and lesbian organisations in meeting these needs.

Nationally, other studies found that between ten per cent and one third of men have engaged in unprotected anal intercourse (the HIV transmission route carrying the most risk). Locally, Mitchell's (1999) survey of men in Berkshire (of all ages) found that 47 per cent of men had engaged in unprotected anal intercourse. ReachOUT's research project found that six per cent of men did not practice safer sex and 36 per cent 'mostly' did (it should be noted that the concept of unsafe sex as understood by survey respondents should not be automatically equated with unprotected anal intercourse). These high levels of risk behaviour prompted the national Terrence Higgins Trust 'Assume Nothing' campaign in 1998.

Nationally, Hickson *et al* (1999) found that 42 per cent of men had not had an HIV test. Locally, Mitchell (1999) found that 36 per cent had not and ReachOUT's research project found that 59 per cent had not. Campaigns in recent years have stressed the importance of individuals knowing about their HIV status, for example the national Terrence Higgins Trust 'Think, Talk, Time to Test' campaign in 1998.

Nationally, Hickson *et al* (1999) found that 47 per cent of men had completed the hepatitis B vaccination course. ReachOUT's research project also found that 47 per cent of men had been vaccinated. These figures represent a success in terms of recent health promotion campaigns promoting vaccination, and the fact that vaccinations are free to those 'at risk', a group taken to include gay men.

ReachOUT's research project identified a number of important gender differences: men were twice as likely to 'always' practice safer sex and women were five times as likely not to practice safer sex compared to men. Most of these women identified as lesbian. Twice as many men had been for an HIV test and had been vaccinated against hepatitis B compared to women and men were twice as likely to have had an STI. These gender differences may reflect two issues: the perceived or actual fact that sex between women is low risk in terms of HIV and that fact that lesbians' (and indeed women's) sexual health needs are marginalised.

Health promotion messages targeted at lesbian women have indeed pushed the 'low risk isn't no risk' line in terms of HIV. However, there are risks for bisexual women and it is also important to note that some lesbians have sex with men occasionally as found by Lesbewell (1995). In addition, there are other risks, as identified by Haines and Lee (1995). Several women during interviews discussed the mythology around lesbian sex and its implications in terms of health promotion. For example, lesbian women were perceived to be at low risk, except where sex toys were used. It is clear that there is a need to focus on behaviour rather than identity so as to avoid making assumptions and stereotyping with their obvious implications for HIV prevention and sexual health promotion.

Given that bisexual, gay and men who have sex with men are a key target group in the Department of Health's HIV prevention strategy, most effort and funds are directed at this group. This is justified given that this is a group that often engages in high-risk sexual behaviour. However, this has encouraged HIV prevention and sexual health promotion with lesbian women, and women generally, to be marginalised. For example in recent years, several lesbian sexual health projects have folded through lack of funds. This issue highlights the debate about targeted work. Should HIV prevention and sexual health promotion focus on specific groups (by virtue of the *assumptions* made about the sexual behaviours of members of that group), or should it focus on sexual behaviour irrespective of sexual identity?

Nationally Hickson *et al* (1999) found that two thirds of men expressed a need for more information about sexual health. Several young people in ReachOUT's research project expressed the need for more information about HIV and STIs, and highlighted the role of gay and lesbian organisations in 'filling the [knowledge] gaps'.

There is not enough evidence to suggest that young bisexuals, gays and lesbians are more likely to contract STIs. Contraction is more a reflection of behaviour than sexual identity. However, it is interesting to note that ReachOUT's research project revealed that young people do not always access GUM clinics for treatment for STIs. They also access treatment via chemists, family planning clinics and GPs. This has implications for service provision – HIV prevention/sexual health promotion in these settings – and highlights the need for an integrated service.

Locally and nationally, there has been a recent increase in the number of HIV infections transmitted through heterosexual sex. Nationally, the PHLS-CDSC reported

in June 1999 that "heterosexuals outnumbered gay men in terms of new cases of HIV for the first time" (*Pink Paper*, 1999). Locally, there have been 23 new cases of HIV in Berkshire in 1999. This is double the average of the past five years. The rate of transmission of HIV between men is around five per year, between men and women, nine per year. This trend is likely to have some bearing on the Government's task force that is currently reviewing the Department of Health's HIV prevention strategy. There is the risk that HIV prevention monies will no longer be 'ring-fenced' and that specific HIV prevention work may be subsumed and superseded by generic sexual health promotion. This would encourage the 'de-gaying of AIDS' for the second time.

Summary of Main Health Findings

Data obtained from the Young People's Health and Housing Survey and interviews:

Age of Consent for Gays and Lesbians

⇒ The age of consent for gay men at the time of writing was 18. In the absence of a legal age of consent for lesbian women, the practical age is 16.

⇒ Forty-five per cent of young people were aware of their sexual identity or 'sexual difference' before the age of 18.

⇒ Eighty-two per cent of young people had been sexually active by the age of 18.

⇒ Sixty-nine per cent of men's first sexual experiences were with other men.

⇒ Sixty-nine per cent of women's first sexual experiences were with men and only 31 per cent with other women.

⇒ Fifty-one per cent of young people had had their first gay or lesbian sexual experience before the age of 18.

⇒ Sixty-five per cent of young people had had their first gay or lesbian sexual experience with someone aged 25 or under who they met through school, college, university, on the scene (i.e. bisexual, gay and lesbian social space, for example bars, clubs and pubs) or it was a friend or through friends.

⇒ Bisexual and gay men seem to be sexually active at an earlier age compared to heterosexual men.

⇒ Heterosexual women seem to be more sexually active by the age of 18 compared to bisexual and lesbian women.

⇒ Of those young people who expressed an opinion, most were in favour of an age of consent at 16, and/or equal to the heterosexual age of consent.

Alcohol Use and Abuse

⇒ Eight per cent of young people did not consume alcohol.

⇒ The majority (59 per cent) of young people consumed at or below the recommended safe level.

⇒ Twenty-two per cent of young people consumed more than the recommended safe level.

⇒ Fifteen per cent of young people considered their alcohol consumption to be a problem.

⇒ Alcohol use among bisexual, gay and lesbian youth was comparable with use among the general youth population.

⇒ Three factors seem to be associated with alcohol use and abuse: a gay and lesbian scene based around alcohol-selling venues, the ‘Ab Fab’ lifestyle factor (i.e. the hedonistic lifestyle as featured on the BBC2 TV comedy series ‘Absolutely Fabulous’) and the coping factor. These factors are not *specific* to bisexual, gay and lesbian youth, but seem to be *pronounced.*

Bisexuality

⇒ Eight per cent of men and 12 per cent of women identified as bisexual.

⇒ The majority (63 per cent) of young people considered bisexuality to be a sexual identity in its own right.

⇒ Seven per cent of young people considered bisexuality to be a ‘phase’.

⇒ The findings of this study seem to contrast with those of others. Other studies found evidence of widespread biphobia and several common assumptions and myths about bisexuality.

Bullying at School

⇒ Eleven out of the 35 young people (31 per cent) who participated in the interviews had experienced bullying at school because of their sexual identity, real or perceived and several knew of others who had been bullied in this way. Some of this bullying was serious and systematic over a prolonged period of time.

⇒ Two young people used to bully others.

⇒ There was evidence that schools and teachers sometimes responded to this bullying in ways that were not appropriate or effective.

Commercial Sex Work

⇒ Sixteen per cent of young people had sold sex for money.

⇒ The central issues seem to be consent and power.

Domestic Violence against Young People

⇒ Nineteen per cent of men and 25 per cent of women had experienced domestic violence.

Drugs (Use and Abuse of Prescribed and Recreational Drugs)

⇒ Fifty per cent of young people had used drugs.

⇒ Thirty-eight per cent of young people had used amyl nitrate, 32 per cent amphetamines, 59 per cent cannabis, 20 per cent cocaine, 26 per cent ecstasy and 20 per cent LSD.

⇒ Men were three times as likely to have used amphetamines, amyl nitrate, cocaine, ecstasy and LSD compared to women.

⇒ Drug use is common among all young people, however, participants in this study were between two and five times more likely to have used amphetamines, amyl nitrate, cocaine, ecstasy, heroin and LSD compared to the general youth population.

⇒ Four factors seem to be associated with drug use and abuse: the high level of use by young people generally, the gay and lesbian club scene, the 'Ab Fab' lifestyle factor and the coping factor. These factors are not *specific* to bisexual, gay and lesbian youth, but seem to be *pronounced*.

Eating Disorders

⇒ Twelve per cent of young people had had an eating disorder.

⇒ Thirty-four per cent of young people had often or sometimes dieted, 53 per cent had skipped meals, 57 per cent had often or sometimes worried about their weight and 43 per cent were not happy with their body.

⇒ Several young people were dissatisfied with their appearance, body shape and/or size.

⇒ Fourteen per cent of young people considered there to be a link between this dissatisfaction and their sexual identity.

⇒ Young bisexual, gay and lesbian people seem *more likely* to suffer from eating disorders than the general youth population, for example young bisexual and gay men were *three times more likely*.

⇒ The gay and lesbian media and scene both promote 'ideal' body types at odds with reality for the majority of young people. These young people aspire/are pressured to achieve these 'ideal' types.

Experience of Health Services

⇒ Twenty-seven per cent of young people were out to their GP and 26 per cent would like to be.

⇒ Eight per cent of young people found coming out to have been a good thing, two per cent a bad thing and 18 per cent found it made no difference to the quality of service they received.

⇒ There seem to be two main issues at two extremes: the invisibility of bisexuals, gays and lesbians within health care settings (and the consequences for their care, assumptions, etc.) and the real or perceived intrusiveness when health workers know about a service user's sexual identity.

Homophobia and Homophobic Crime

⇒ Seventy per cent of young people had been verbally abuse (called named, shouted at and threatened), 63 per cent because of their sexual identity.

⇒ Thirty-nine per cent of young people had been physically abused (beaten up, hit, kicked, pushed and having things thrown at them), 26 per cent because of their sexual identity.

⇒ Twenty-four per cent of young people had been harassed (abusive calls and letters, blackmail, graffiti and vandalism), 16 per cent because of their sexual identity.

⇒ Thirty-two per cent of young people had been sexually abused (being flashed at, groped, raped and sexually assaulted). Eight per cent of men and 13 per cent of women had been raped.

⇒ Only 12 per cent of young people reported abuse, harassment and violence incidents to the police.

⇒ Gangs or strangers on the street perpetrated most incidents of homophobia and homophobic crime. However, a significant number occurred in local schools, colleges, in the workplace and on the bisexual, gay and lesbian scene.

⇒ The study found evidence of domestic violence within same-sex relationships. The study found evidence of abuse, harassment and violence because of disability, ethnic identity, gender and mental health problems. The study also found evidence of abuse, harassment and violence on the bisexual, gay and lesbian scene.

Mental Health

⇒ Fifteen per cent of young people had had a mental health problem.

⇒ Eight young people were currently receiving treatment while 14 had in the past.

⇒ Eleven young people felt that their treatment had helped while 11 did not.

⇒ Three young people thought their sexual identity was a factor in their mental health problem.

⇒ Ten young people had been out during treatment and three young people felt that coming out had affected the quality of the service they received.

⇒ Fifty-five per cent of young people had thought about committing suicide.

⇒ Twenty-two per cent of young people had attempted suicide.

⇒ Thirty-three per cent of young people had deliberately harmed themselves.

⇒ Bisexual, gay and lesbian youth were *no more* likely to suffer from a mental health problem than youth generally. However, they *were more* likely to suffer from depression, self-harm and suicide. For example, young bisexuals, gays and lesbians were *three times as likely* to suffer from depression and young gay men were almost *four times as likely* to have attempted suicide. Depression, self-harm and suicide are mental health problems that are more social in nature, as opposed to clinical/neurological disorders.

Sex Education

⇒ Twenty per cent of young people felt that their sex education had been 'excellent' or 'good'.

⇒ Forty-five per cent of young people felt it had been 'poor' or 'very poor'.

⇒ Seventy per cent of young people reported that their sex education had covered HIV and sexual health.

⇒ Twenty-two per cent of young people reported that their sex education had covered gay and lesbian issues.

Sexual Health

⇒ Fifty-seven per cent of men and 26 per cent of women 'always' practised safer sex.

⇒ Thirty-six per cent of men and 44 per cent of women 'mostly' practised safer sex.

⇒ Six per cent of men and 30 per cent of women did not practice safer sex.

⇒ Thirty per cent of men and 14 per cent of women had been for an HIV test.

⇒ Most young people either knew, or believed themselves to be, HIV-negative.

⇒ Two young people were HIV-positive.

⇒ Forty-seven per cent of men and 27 per cent of women had been vaccinated against hepatitis B.

⇒ Fifteen per cent of young people had had a sexually transmitted infection.