Published in final edited form as:
J Gay Lesbian Soc Serv. 2012 ; 24(2): 119–139. doi:10.1080/10538720.2012.669696.

The Relationship between Sexual Minority Verbal Harassment And Utilization of Health Services: Results from Countywide Risk Assessment Survey (CRAS) 2004

Laura Hoyt D'Anna, Dr.P.H.[1], **Hannah-Hanh D. Nguyen, Ph.D.**[1], **Grace L. Reynolds, D.P.A.**[1], **Dennis G. Fisher, Ph.D.**[1], **Michael Janson, M.P.H.**[2], **Cristy Chen, M.P.H.**[1], and **C. Kevin Malotte, Dr.P.H.**[1]

[1]California State University, Long Beach

[2]Los Angeles County Department of Health Services, Office of AIDS Programs and Policy

Abstract

We examined the prevalence of and associations between sexual orientation-based verbal harassment and reported utilization of health services across levels of sexual orientation in a diverse sample of adult recipients of Los Angeles County-funded HIV-related health and social services. Thirty-two percent reported they had experienced verbal harassment, the majority (80.3%) of whom identified as lesbian, gay, orbisexual. Those who reported being verbally harassed received significantly more services overall than those who were not verbally harassed, and service utilization varied by sexual orientation. These findings inform future efforts to identify and assess social discrimination in health and social service settings.

Introduction

Social Discrimination and its Health Consequences

Social discrimination is consistently shown to be associated with poor physical and mental health and health-seeking behaviors and outcomes (Banton, 1998; Byrd & Clayton, 2000; D'Anna, Ponce, & Siegel, 2010; Krieger, 2000; Krieger, Smith, Naishadham, Hartman, & Barbeau, 2005; Krieger & Sydney, 1996; Schulz et al., 2006; Williams, Yan, Jackson, & Anderson, 1997; Willie, Kramer, & Brown, 1973). Although the majority of research on social discrimination has been conducted among African Americans (Cain & Kington, 2003), there is evidence suggesting that being a member of a stigmatized social group defined by one's age, gender, social position and, most relevant to the present study, sexual minority identity (Ayala, Beck, Lauer, Reynolds, & Sundararaj, 2010; Mays & Cochran, 2001; McCabe, Bostwick, Hughes, West, & Boyd, 2010; Mills et al., 2004), can be associated with negative health outcomes and utilization of health services (Karlsen & Nazroo, 2002; Trivedi & Ayanian, 2006).

Social Discrimination in the Form of Verbal Harassment

Social discrimination has been classified into two types: (a) *structural discrimination*, which refers to social structures and policies that determine access to goods and services for certain groups, and (b) *interpersonal discrimination* that is directed toward and perceived by individuals (Jones, 2000). Interpersonal discrimination is manifest through behaviors such as mean, unfair, or unequal treatment which may include verbal or physical abuse that is

Corresponding author: Laura Hoyt D'Anna, Dr.P.H., Center for Health Care Innovation, California State University, Long Beach, 5500 Atherton St., Suite 400, Long Beach, CA90815, ldanna@csulb.edu (562) 985-2178, (562) 985-2180 fax.

intended to marginalize individuals or communities based on their affiliation with stigmatized opinions, behaviors, or individuals (Ayala, et al., 2010). Interpersonal social discrimination based on sexual orientation or "sexual prejudice" is defined as negative attitudes, or feelings of hostility or dislike directed at individuals because of their sexual "orientation" or identity (Herek, 2000). Individuals who identify as lesbian, gay, or bisexual (LGB) bear the overwhelming burden of this type of discrimination (Ahmed & Hammarstedt, 2009).

The Relevance of Social Discrimination to LGB Individuals' Health

Uncovering the prevalence of social discrimination targeted at LGB individuals is an important endeavor for several reasons. First, perceived discrimination has been found to be negatively associated with the use of preventive health services among LGB populations (Ayala, et al., 2010; Bakker, Sandfort, Vanwesenbeeck, van Lindert, & Westert, 2006; O'Hanlan, Dibble, Hagan, & Davids, 2004). LGB individuals may be less likely to obtain preventive health care due to: (1) high rates of being uninsured, particularly among lesbians and bisexual women, and transgender people (Johnson, Mimiaga, & Bradford, 2008; Valanis et al., 2000); (2) feelings that their health provider is not "LGB-friendly" (Beckerman & Fontana, 2009; Bjorkman & Malterud, 2009); (3) lack of trust that their provider is competent or knowledgeable about LGB health-related practices, needs or issues (Ayala, et al., 2010; N. F. Sanchez, Rabatin, Sanchez, Hubbard, & Kalet, 2006); and (4) victimization or negative experiences with health care providers resulting from homophobia, heterosexism, or ignorance (Willging, Salvador, & Kano, 2006). Second, among those who seek health care, an antagonistic environment may cause individuals to hide their sexual orientation, making it extremely difficult to obtain the necessary health services and information specific to their needs (Ayala, et al., 2010; Dean et al., 2000; Meyer & Northridge, 2007; J. P. Sanchez, Hailpern, Lowe, & Calderon, 2007; Willging, et al., 2006). Third, discrimination, prejudice, and verbal harassment are associated with scores of negative health outcomes, including risk of HIV infection among young gay men, other sexually transmitted infections (STIs) in gay, lesbian, and bisexual individuals of both genders (Diaz, Ayala, & Bein, 2004; Krieger, 1999), eating disorders (Coker, Austin, & Schuster, 2010), low self-esteem, depression, suicide and self-harm (Coia et al., 2002; Meyer & Northridge, 2007), alcohol and drug dependence (Cochran & Mays, 2000; Meyer & Northridge, 2007), and homelessness and prostitution among LGB youth (Coker, et al., 2010). Discrimination and prejudice are also related to psychiatric disorders, including major depression, simple phobia, and posttraumatic stress disorder, among lesbians and bisexual women (Cochran & Mays, 2000; Grella, Greenwell, Mays, & Cochran, 2009), and among other LGB populations (Cochran, Mays, Alegria, Ortega, & Takeuchi, 2007; Cochran, Mays, & Sullivan, 2003; Mills, et al., 2004). Discrimination and verbal harassment are also associated with trauma and violence against gay men and lesbians (Herek, 2009; Meyer & Northridge, 2007). Finally, harassment, ridicule, rejection and violence are associated with other health-eroding behaviors among men who have sex with men (MSM), such as concealing relationships, identities, behaviors, and feelings, and detaching from social support or other important resources that may have the potential to improve their general health, opportunities and quality of life (Ayala, et al., 2010; Cole, Kemeny, Taylor, & Visscher, 1996; Diaz, et al., 2004; Koblin et al., 2006).

Prevalence of Discrimination in Health Care and Associations with Service Utilization

Over the past two decades, initiatives to increase health equity across all groups have been launched nation wide, and attention has turned to uncovering the prevalence of, and factors associated with, discrimination in United States health care settings (Epstein, Taylor, & Seage, 1985; Hooper, Comstock, Goodwin, & Goodwin, 1982; Roter, Hall, & Katz, 1988; Smedley, Stith, & Nelson, 2003; van Ryn, 2002; Waitzkin, 1985). The bulk of the research

examining discrimination in health care settings has focused on medical provider perceptions and behaviors including racially and ethnically inequitable medical testing, referrals, treatment, medical procedures and pain management (Smedley, et al., 2003). As such, little is understood about patient perceptions of discriminatory events or interactions that may lead to psychological or physical stress responses including heath care avoidance or other poor health-related behaviors (Klonoff, 2009).

Historically, LGB persons have been underrepresented in the public health literature (Boehmer, 2002; Lee, 2000; Sell & Becker, 2001). In the 1980s and 1990s, the majority of articles published including LGB persons examined STDs, and specifically HIV/AIDS, with an overwhelming focus on gay and bisexual men (Boehmer, 2002). Some attribute the neglect of LGB individuals in research to the estimation that LBG-identified individuals comprise a relatively small proportion of the overall U.S. population and that it is difficult to fund and conduct population-based studies that are large enough to incorporate a representative sample (Hughes & Eliason, 2002). However, others have noted that the fear of stigmatization is a barrier to LGB individuals seeking health care services and participating in health-related research (Lee, 2000), and that the lack of available scientific data on the health of LGB contributes to the lack of prioritization of LGB health issues (Sell & Becker, 2001).

Previous investigations that have included LGB individuals have noted higher utilization of certain types of health services (mental health, substance abuse treatment, and emergency department services) (Grella, et al., 2009; J. P. Sanchez, et al., 2007), but lower use of other services (routine primary healthcare, mammograms, Pap tests) by various groups who identify as LGB (Buchmueller & Carpenter, 2010) (O'Hanlan, et al., 2004), lesbians who identify as "butch" as opposed to "femme" (Hiestand, Horne, & Levitt, 2007), and MSM who identify as heterosexual (Merighi, Chassler, Lundgren, & Inniss, 2010). However, little research has been conducted on the relationships between social discrimination and health, and health care-seeking behaviors within sexual minority groups in the United States (Hughes & Eliason, 2002). Previously published findings based on the Los Angeles Countywide Risk Assessment Survey (CRAS) demonstrated that those who used more health care services were more likely to be HIV positive, to have had a recent HIV test, and to have been the victim of physical partner abuse (Fisher et al., 2010).

In the present study, our research aims were as follows: (a) we examined the prevalence of sexual orientation-based discrimination (in the form of verbal harassment) in a racially and ethnically diverse sample of adult recipients of Los Angeles County Department of Health Services, Office of AIDS Programs and Policy (OAPP)-sponsored health and social services; and (b) we explored possible associations between reported lifetime experiences of sexual orientation-based discrimination (i.e., verbal harassment) and reported utilization of health services across levels of sexual orientation.

Methods

The present study used data from the Los Angeles County Department of Health Services, OAPP Countywide Risk Assessment Survey (CRAS) designed to prioritize funding for HIV prevention in Los Angeles County.

Procedures

Data were collected in May and June of 2004 by 220 HIV prevention service provider staff from fifty-one OAPP-funded agencies located throughout greater Los Angeles County, a 4,000 square mile area composed of urban, suburban and rural areas. This survey utilized a two-tiered sampling method, which consisted of a combination of stratified and systematic

sampling. Stratified sampling was employed because it was believed that there were differences in client characteristics among the different agencies. Systematic sampling was used to facilitate a representative sample of participants (Fisher, et al., 2010). Each interviewer was given a number (n) after he/she completed six hours of training on the CRAS and was told to interview each *nth* client.

The CRAS consisted of four main sections with multiple questions about (a) clients' demographic information, (b) their alcohol/drug risks (e.g., type of drugs used and needle use/sharing), (c) their sexual history (e.g., both primary and casual partners, methods of HIV protection [condoms], and sexual incentives), and (d) their use of HIV- and STD-prevention services as well as other services made available by a participating OAPP agency and/or within other L.A. County agencies (all within the past 6 months at the time of survey). Client perceptions concerning HIV and AIDS were also assessed. The survey required between 15 and 30 minutes to administer in a face-to-face interview. Participants were offered one of three incentives for completing the CRAS: 1) a non cash food voucher worth $10; 2) two movie tickets with an approximate value of $20; or a non cash gift card in the amount of $15. The data collection methods used for the CRAS have been previously described in detail (Edwards, Fisher, & Reynolds, 2007; Fisher, et al., 2010).

Measures

Several items from the 2004 CRAS were used to address the research questions in the present study. The two outcome variables included perceived verbal harassment because of sexual orientation and use of health services. For the first outcome variable, demographic variables (i.e., sex, sexual orientation, race/ethnicity, and education) served as the predicting variables.

Perceived Verbal Harassment—This dimension of interpersonal discrimination served as either an outcome variable or a predicting variable in the present study. Perceived verbal harassment was assessed with one question in the CRAS 2004 which was treated as a reasonable proxy for the construct of sexual orientation-based discrimination because the respondent was asked whether or not they would attribute the verbal harassment experienced to their sexual orientation as follows, "*Did anyone ever make offensive, insulting, hateful, or hurtful sexual comments because of your sexual orientation?*" (yes/no) Note that, although sexual identity is a more widely accepted term, "sexual orientation" is used in this paper to be consistent with the language used in the CRAS 2004 survey. This variable was one of four questions concerned with negative issues associated with sexuality. The other questions covered sex trading, intimate partner violence (being slapped or hit) and unwanted sexual touching.

Health Service Utilization—Reported use of various types of health care services was treated as another outcome variable in the present study. Participants were asked, "*Did you in the past six months receive from my agency*….?" and they could endorse any of the following 18 health services they had received: "(a) HIV information where you came to an office or clinic; (b) HIV information where someone came to you, such as a discussion leader or street outreach worker; (c) HIV education to promote behavior change; (d) HIV social support, like, in a group meeting; (e) HIV testing/counseling; (f) STD testing; (g) STD treatment; (h) Drug/alcohol treatment; (i) Case management; (j) Mental health or psychosocial support; (k) Transportation; (l) Housing/shelter information; (m) Housing/ shelter; (n) Treatment adherence counseling; (o) Medical services; (p) Dental services; (q) Child welfare services, and (r) Needle exchange." Additionally, participants were asked, "*Did you in the past six months receive from any other agency in L. A. County besides this one*…." and they could endorse any service from the aforementioned list of health services.

Two composite overall scale scores ("overall health services at this agency" and "overall services at other L.A. County agencies") were computed by taking the sum of the responses to the eighteen health service options. Also, based on the content of the health services, we further classified the services into four subscales (separately for "services provided by this agency" and for "by other agencies"): The four subscales included: (1) sexual health treatment at this/other L.A. County agency; (2) social support at this/other L.A. County agency; (3) social services at this/other L.A. County agency; and (4) medical services at this/other L.A. County agency (see Table 1). We then computed a composite score for each subscale (for a total of eight subscale scores). Note that we excluded four types of services from these subscales (i.e., drug/alcohol treatment; treatment adherence counseling; child welfare services, and needle exchange) because the content of these items did not fit into any of the four subscales (dimensions) noted previously. Additionally, there were no participants who ONLY endorsed one or more of these four items. Table 1 provides a summary of health and social service groupings for the interviewing agency and other L.A. County agencies.

Gender—Participants self-reported whether they were male, female, transgender male to female, transgender female to male, transsexual male to female, and transsexual female to male. This variable was subsequently recoded into (a) male, and (b) female only. We excluded transgender and transsexual individuals because there were comparatively fewer transgender and transsexual respondents in the sample ($n = 107$) compared to other sexual orientation groups (though comparable to or larger than those in other published studies that have included transgendered persons), and because the data from the same subsample of transgender respondents have been analyzed and the results were reported elsewhere (Edwards, et al., 2007).

Sexual Orientation—Sexual orientation was assessed with the question, "*Do you consider yourself to be….heterosexual/straight, gay, lesbian, bisexual or other?*" Participants could endorse any of these categories.

Race/ethnicity—CRAS participants were asked, "*How do you describe your racial or ethnic background?*" and they could choose one from the following list: African American/Black; American Indian/Native American; Asian/Asian American; Native Hawaiian or Other Pacific Islander; Caucasian/White/Anglo; Hispanic/Latino/Latina; and Other. Because there were very few participants in these categories compared with the other groups, the category of American Indian/Native American was subsequently merged into "Other," and the category of Native Hawaiian or Other Pacific Islander was recoded as "Asian American." The final racial/ethnic categories were: African American, Asian American, Caucasian, Hispanic American, and Other.

Education—Participants reported their highest grade completed (six responses), which was recoded into five categories (by combining the GED and high school categories together): (1) did not complete high school/GED; (2) GED/high school diploma; (3) between 1-3 years of college; (4) four year college degree, and (5) graduate or professional school. Increasing values indicated higher education.

Age—Age was included in our analysis given that age can affect utilization of health services. Respondents reported their age at the time of the survey and age was retained as a continuous variable.

HIV/AIDS-related Risk—Predictors related to *HIV/AIDS* that were associated with health service utilization were examined to assess their relationships with verbal harassment.

Several variables with multiple values were recoded into dichotomous variables such as, "*As far as you know, does this main sex partner have HIV or AIDS?*" (yes/no), "*As far as you know, did (does) any of your other partners have HIV or AIDS?*" (yes/no), and "*Please tell me the result of the most recent test you have had*" (HIV positive/negative).

Substance Use—Predictors related to alcohol, tobacco, steroid and hormone and illicit drug use in the past six months that were associated with health service utilization were examined to assess their relationships with verbal harassment.

Data Analyses

Analyses were conducted using SAS version 9.2. Sample characteristics using proportions and standard errors are presented first. Second, bivariate analyses were conducted using point-biserial correlation analyses and Pearson chi-square tests of association to determine which predictors and covariates were significantly associated (separately) with being verbally harassed due to one's sexual orientation.

To assess the relationships between being verbally harassed due to one's sexual orientation and utilization of health services, mean differences in the utilization of overall health services provided by the OAPP-funded and other L.A. County agencies were examined between those who reported being verbally harassed and those who did not, using a series of independent, two-sided, Satterthwaite *t*-tests for unequal variances. The mean differences in usage for each of the four sub-dimensions of health services (sexual health treatment, social support, social services, and medical services) were also compared. These analyses were stratified by sexual orientation.

Results

Participants

A total of 2,126 individuals with a mean age of 32.7 years participated in the CRAS survey (*SD*=11.02; range 12-69 years). The survey completion rate was 84.6%. Among those reporting their sex, 66.2% were men (*n*=1334), and 33.8% were women (*n*=682). The final analytic sample was 1,995 participants who had responded to the question about being harassed because of their sexual orientation; we excluded those who declared themselves as transgender or transsexual, and 21 additional participants because of missing data on some key measures. Table 2 summarizes the frequency of participants belonging to various sub-groups who experienced verbal harassment versus those who did not. Participants identified themselves as heterosexual (*n*=1091, 54.7%), gay (*n*=548, 27.5%), lesbian (*n*=36, 1.8%), bisexual (n=289, 14.5%) and other (*n*=31, 1.6%). The majority of participants had less than or equivalent to a high school education (65.8%) (Table 2). Hispanic Americans were the largest ethnic group (44.1%), followed by African Americans (27.0%), Caucasians (17.3%), American Indian/Native Hawaiian and mixed race/ethnicity (7.6%), and Asian Americans (4.0%). Finally, the majority of the participants (*n*=1553, 77.9%) was born in the United States.

Relationships between Predictors and the Experience of Verbal Harassment

Almost one-third (32.0%) of all participants (n=639) reported that they had experienced verbal harassment attributed to their sexual orientation; the majority of those who experienced this type of discrimination (80.3%) identified as LGB or other sexual orientation, although LGB comprised only 45.3% of the total sample. Additionally, the percentage of participants reporting verbal harassment increased at each level of education, with the exception of those who had achieved a college education or greater (Table 2).

Individuals who reported that their main partner, or any sex partner within the past 6 months, had HIV or AIDS were also more likely to report perceived verbal harassment compared to those who reported that their main partner did not have HIV or AIDS. A total of 324 respondents indicated that they had received a positive result on their last HIV test (16.2% of the total sample); 12.7% of all heterosexuals (n=94), 38.2% of gays (n=169), 14.8% of lesbians (n=4), 22.8% of bisexuals (n=51), and 28.6% of those who identified as being of other sexual orientation (n=6). HIV-positive respondents were more likely to report perceived verbal harassment than those who were HIV-negative. Additionally, having a sexual partner who had injected drugs since 1980 was associated with the experience of verbal harassment (Table 2).

The relationships between licit and illicit substance use and experiences of harassment were also explored (Table 2). Tobacco use in the past six months was associated with the experience of verbal harassment, as was the use of crack, crystal meth, and inhalants, poppers, nitrous oxide, whippets, glues, paint thinners, and aerosol propellants, and steroid use. However, heroin use in the past six months was not significantly associated with the experience of verbal harassment due to one's sexual orientation.

The Experience of Verbal Harassment and Utilization of Health Services

The examination of the relationships between verbal harassment experience and the utilization of the overall health services at the interviewing agency, as well as the four aforementioned categories of health services, revealed that among all participants those who reported being verbally harassed due to their sexual orientation received significantly more health services overall, more social support, and more social services than those who were not verbally harassed. Table 3 provides details of these analyses.

A similar pattern of findings was found regarding health services received from other L.A. County agencies among all participants. In addition, the significant relationships of interest were also found for the category of medical services received outside of the interviewing agency (Table 4).

Verbal Harassment-Service Use Relationships across Sexual Orientation

As evidenced above, the utilization of health and social services was associated with perceived verbal harassment. Further, t-test results showed that this relationship was modified by levels of sexual orientation. Specifically, among heterosexuals, those who experienced verbal harassment because of their sexual orientation used more overall health services from the OAPP-funded interviewing agency than heterosexuals who did not experience verbal harassment. The same was true for heterosexuals using OAPP-funded social support, social services and medical treatment (Table 3). Among gay men, those experiencing verbal harassment used social support and social services more often, where as participants who identified as bisexual and had experienced verbal harassment used social support more often (Table 3). Heterosexuals, gay men, and bisexuals who experienced verbal harassment used most services available through other L.A. County agencies more often than individuals who did not experience the same type of discrimination (Table 4). Due to small sample size, none of the relationships assessed were significant among lesbians, however, a greater number of all OAPP-funded interviewing agency services, sexual health treatment, social support and medical services, and a greater number of all services and sexual health treatment services within other L.A. County agencies were utilized by lesbians who experienced verbal harassment compared to those who did not.

Discussion

Our findings support the vast body of work suggesting that LGB individuals are the victims of social discrimination more often than those who identify as heterosexual or straight (Ahmed & Hammarstedt, 2009). A sizable proportion of the L.A. County OAPP-funded health and social service recipients who participated in this survey had experienced offensive, insulting, hateful, or hurtful sexual comments (verbal harassment) because of sexual orientation. Notably, although lesbians comprised less than two percent of the sample, an overwhelming proportion (greater than that of any other group) reported the experience of verbal harassment due to their sexual orientation. Individuals who were living with HIV/AIDS, or who had partners with HIV/AIDS, were significantly more likely to have experienced this type of discrimination. Further, the use of certain substances was associated with the experience of discrimination. Although substance use may be one coping strategy to buffer the effects of social discrimination, we were unable to estimate whether or not substance use occurred before or after the experience of verbal harassment examined in the present study, and what other events, stressors and factors may have also been associated with the substance use reported by CRAS participants.

Among this sample of Los Angelinos who were seeking HIV-related health and social services, at least one experience of perceived verbal harassment due to one's sexual orientation was related to a greater utilization of a number of OAPP-funded services for heterosexuals, gays, and bisexuals, but not lesbians. The experience of discrimination related to sexual orientation was common among the small group of lesbian women accessing services within the agencies participating in the CRAS; we attribute the lack of association between verbal harassment and utilization of the particular services analyzed in this study to the small sample size of lesbian women included in the CRAS. The small number of lesbian respondents is a reflection of the fact that HIV/AIDS in Los Angeles County is concentrated within other population groups (primarily men who have sex with men, injection drug users, and those participating in high-risk heterosexual sex behaviors).

This finding is also consistent with other research documenting higher utilization of certain types of health services (mental health, substance abuse treatment, and emergency department services) (Grella, et al., 2009; J. P. Sanchez, et al., 2007), but lower use of other routine, preventive services by various groups who identify as LGB (Buchmueller & Carpenter, 2010; O'Hanlan, et al., 2004). The fact that there was higher utilization of services by those who were victimized by verbal harassment suggests that the experience of social discrimination is associated with other health and social support service needs among this population who are at high risk for or living with HIV/AIDS and in need of other support services. Although the data available do not allow us to assess causality for this relationship, future research may offer additional insight to other factors that may be causally associated with, or mediators for, the observed relationship that were not measured in the present study.

A number of limitations to our study are noted. First, the sample is cross-sectional and thus causality cannot be demonstrated. Second, the CRAS measure of social discrimination was finite and limited to verbal harassment; for those reporting harassment, follow-up questions were not employed to assess whether the discriminatory event(s) actually occurred in a health care setting (i.e., this information cannot be estimated from the CRAS data). Thus, in the present study, we are unable to link the global, lifetime reports of verbal harassment due to sexual orientation to any particular service provider or type. Consequently, our findings merely suggest an association between the experience of verbal harassment at some point in the participant's lifetime and certain characteristics and health utilization behaviors. Additionally, the services provided by OAPP-funded agencies are specific to individuals

living with or at high risk for HIV/AIDS who also have associated health and social service needs. As such, these findings cannot be generalized to other sexual minority individuals with different health needs who are not seeking services in similar settings. Finally, there are some differences between county-funded providers. For example, at the time of the CRAS data collection, only three agencies provided needle exchange services. Not all agencies provide services in both English and Spanish and, while all agencies provided HIV counseling and testing services, not all agencies provided medical services for HIV/AIDS, such as highly active antiretroviral medications, on site. These provider differences may have influenced the CRAS data collection.

Finally, it is difficult to measure discrimination because people are more apt to recognize discrimination against groups as a whole than to recognize discrimination against themselves as individuals (Karlsen & Nazroo, 2002). Thus, discrimination is typically measured by asking what people think about their own (or another) group experiences. Further, discrimination may be underreported due to the issue of "internalized oppression" wherein unfair treatment is perceived by members of stigmatized groups as "deserved" and nondiscriminatory (Krieger & Sydney, 1996). It is impossible to know whether verbal harassment was underreported in this sample in that only a single question related to verbal harassment was asked of all participants.

The CRAS study achieved a sample that was representative of individuals being served by HIV service providers in Los Angeles County, a large, urban population center, which is an important strength of this study. Care was taken to include clients of all County-funded providers and training of provider staff ensured that data collection was as uniform as possible when conducting the community-based interviews.

The finding that this type of social discrimination (verbal harassment) is common among those seeking HIV-related health and social services from county providers can be used to inform future efforts to assess when, where, and how often this type of social discrimination occurs. For example, it would be useful to know what types of comments were defined as verbal harassment by CRAS participants, how often these experiences occurred within health care settings, and whether an experience of verbal harassment within one L.A. County agency resulted in seeking services from another L.A. County agency. Los Angeles County has a non-discrimination policy to which all county-funded service providers must adhere. Information about the reporting of verbal harassment was not obtained for clients for whom the experience of verbal harassment occurred at a county-funded provider. Information on the reporting of verbal harassment could be elicited in future versions of the CRAS and potentially correlated with actual reports made under the non-discrimination policy. This information could be used to improve efforts within county-funded health care settings to gain additional information about the linkages between verbal harassment, health service utilization, and deleterious health outcomes such as STI and HIV/AIDS, and how these relationships, and perhaps bias within these relationships, serve to worsen health outcomes for sexual minority individuals.

Although LGB individuals were significantly more likely to experience verbal harassment due to their sexual identify, it is noteworthy that those who identified as heterosexual/ straight also experienced verbal harassment, and, among those who did, increased utilization of a number of services was observed. As would be expected, a disproportionate number of HIV-positive CRAS participants identified as gay. However, a significant number of those who identified as heterosexual were also HIV positive (n=94; 12.7%). This suggests that individuals who are likely to seek HIV-related services from the county such as those that were assessed in the CRAS survey, may encounter environments that promote LGB identities, cultures and lifestyles. Attempting to better understand how the experiences,

coping strategies and health effects resulting from verbal harassment may be different for heterosexuals when compared to LGB individuals would be a useful research endeavor, as would investigating the prevalence of similar discriminatory experiences among LGB populations seeking services in other health care settings.

Acknowledgments

The Countywide Risk Assessment Survey (CRAS) was funded by the Los Angeles County Department of Health Services, Office of AIDS Programs and Policy, contract # PH000028. The preparation of this manuscript was supported in part by Award Number P20MD003942 from the National Institute for Minority Health and Health Disparities. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institute for Minority Health and Health Disparities or the National Institutes of Health."

References

Ahmed AL, Hammarstedt M. Detecting discrimination against homosexuals: Evidence from a field experiment on the internet. Economica. 2009; 76:588–597.

Ayala G, Beck J, Lauer K, Reynolds R, Sundararaj M. Social discrimination against men who have sex with men (MSM): The Global Forum on MSM and HIV (MSMGF). 2010

Bakker FC, Sandfort TG, Vanwesenbeeck I, van Lindert H, Westert GP. Do homosexual persons use health care services more frequently than heterosexual persons: findings from a Dutch population survey. Social Science & Medicine. 2006; 63(8):2022–2030.S0277-9536(06)00288-710.1016/j.socscimed.2006.05.024 [PubMed: 16820254]

Banton, M. Racial Theories. 2. Cambridge: Cambridge University Press; 1998.

Beckerman A, Fontana L. Medical treatment for men who have sex with men and are living with HIV/AIDS. American Journal of Men's Health. 2009; 3(4):319–329.10.1177/1557988308323902

Bjorkman M, Malterud K. Lesbian women's experiences with health care: A qualitative study. Scandinavian Journal of Primary Health Care. 2009; 27(4):238–243.10.3109/02813430903226548 [PubMed: 19958064]

Boehmer U. Twenty years of public health research: inclusion of lesbian, gay, bisexual, and transgender populations. American Journal of Public Health. 2002; 92(7):1125–1130. [PubMed: 12084696]

Buchmueller T, Carpenter CS. Disparities in health insurance coverage, access, and outcomes for individuals in same-sex versus different-sex relationships, 2000-2007. American Journal of Public Health. 2010; 100(3):489–495.10.2105/AJPH.2009.160804 [PubMed: 20075319]

Byrd, WM.; Clayton, L. An American Health Dilemma: The Medical History of African Americans and the Problem of Race. Vol. 1. New York: Routledge; 2000.

Cain VS, Kington RS. Investigating the role of racial/ethnic bias in health outcomes. American Journal of Public Health. 2003; 93(2):191–192. [PubMed: 12554567]

Cochran SD, Mays VM. Relation between psychiatric syndromes and behaviorally defined sexual orientation in a sample of the US population. American Journal of Epidemiology. 2000; 151(5):516–523. [PubMed: 10707921]

Cochran SD, Mays VM, Alegria M, Ortega AN, Takeuchi D. Mental health and substance use disorders among Latino and Asian American lesbian, gay, and bisexual adults. Journal of Consulting and Clinical Psychology. 2007; 75(5):785–794.2007-13640-01110.1037/0022-006X.75.5.785 [PubMed: 17907860]

Cochran SD, Mays VM, Sullivan JG. Prevalence of mental disorders, psychological distress, and mental health services use among lesbian, gay, and bisexual adults in the United States. Journal of Consulting and Clinical Psychology. 2003; 71(1):53–61. [PubMed: 12602425]

Coia, N.; John, S.; Dobbie, F.; Bruce, S.; McGranachan, M.; Simons, L. "Something to Tell You": A Health Needs Assesment of Young Gay, Lesbian and Bisexual People in Glasgow. Glasgow, UK: 2002.

Coker TR, Austin SB, Schuster MA. The health and health care of lesbian, gay, and bisexual adolescents. Annual Review of Public Health. 2010; 31:457–477.10.1146/annurev.publhealth.012809.103636

Cole SW, Kemeny ME, Taylor SE, Visscher BR. Elevated physical health risk among gay men who conceal their homosexual identity. Health Psychology. 1996; 15(4):243–251. [PubMed: 8818670]

D'Anna LH, Ponce NA, Siegel JM. Racial and ethnic health disparities: Evidence of discrimination's effects across the SEP spectrum. Ethnicity & Health. 2010; 15(2):121–143. [PubMed: 20131130]

Dean L, Meyer IH, Robinson K, Sell RL, Sember R, Silenzio VMB, Dunn P, et al. Lesbian, gay, bisexual, and transgender health: Findings and concerns. Journal of the Gay and Lesbian Medical Association. 2000; 4(3):102–151.

Diaz RM, Ayala G, Bein E. Sexual risk as an outcome of social oppression: data from a probability sample of Latino gay men in three U.S. cities. Cultural Diversity and Ethnic Minor Psychology. 2004; 10(3):255–267.10.1037/1099-9809.10.3.2552004-17288-006

Edwards JW, Fisher DG, Reynolds GL. Male-to-female transgender and transsexual clients of HIV service programs in Los Angeles County, California. American Journal of Public Health. 2007; 97(6):1030–1033.AJPH.2006.09771710.2105/AJPH.2006.097717 [PubMed: 17463365]

Epstein AM, Taylor WC, Seage GR. Effects of patient's socioeconomic status and physician's training and practice on doctor-patient communication. American Journal of Medicine. 1985; 78:101–106. [PubMed: 3966475]

Fisher DG, Wishart D, Reynolds GL, Edwards JW, Kochems LM, Janson MA. HIV services utilization in Los Angeles County, California. AIDS Behavior. 2010; 14(2):440–447.10.1007/s10461-008-9500-3

Grella CE, Greenwell L, Mays VM, Cochran SD. Influence of gender, sexual orientation, and need on treatment utilization for substance use and mental disorders: Findings from the California Quality of Life Survey. BMC Psychiatry. 2009; 9(52)1471-244X-9-5210.1186/1471-244X-9-52

Herek GM. The psychology of sexual prejudice. Current Directions in Psychological Science. 2000; 9(1):19–22.

Herek GM. Hate crimes and stigma-related experiences among sexual minority adults in the United States: prevalence estimates from a national probability sample. Journal of Interpersonal Violence. 2009; 24(1):54–74.088626050831647710.1177/0886260508316477 [PubMed: 18391058]

Hiestand KR, Horne SG, Levitt HM. Effects of gender identity on experiences of healthcare for sexual minority women. Journal of Lesbian, Gay, Bisexual, Transgendered Health Research. 2007; 3(4):15–27.

Hooper EM, Comstock LM, Goodwin JM, Goodwin JS. Patient characteristics that influence physician behavior. Medical Care. 1982; 20:630–638. [PubMed: 7109746]

Hughes TL, Eliason M. Substance use and abuse in lesbian, gay, bisexual, and transgender populations. The Journal of Primary Prevention. 2002; 22(3):263–298.

Johnson CV, Mimiaga MJ, Bradford J. Health care issues among lesbian, gay, bisexual, transgender and intersex (LGBTI) populations in the United States: Introduction. Journal of Homosexuality. 2008; 54(3):213–224. [PubMed: 18825859]

Jones CP. Levels of racism: A theoretic framework and a gardener's tale. American Journal of Public Health. 2000; 90:1212–1215. [PubMed: 10936998]

Karlsen S, Nazroo JY. Relation between racial discrimination, social class, and health among ethnic minority groups. American Journal of Public Health. 2002; 92(4):624–631. [PubMed: 11919063]

Klonoff EA. Disparities in the provision of medical care: An outcome in search of an explanation. Journal of Behavioral Medicine. 2009; 32(1):48–63.10.1007/s10865-008-9192-1 [PubMed: 19127421]

Koblin BA, Torian L, Xu G, Guilin V, Makki H, Mackellar D, Valleroy L. Violence and HIV-related risk among young men who have sex with men. AIDS Care. 2006; 18(8):961–967.L06714L5106L28L610.1080/09540120500467182 [PubMed: 17012086]

Krieger N. Embodying inequality: a review of concepts, measures, and methods for studying health consequences of discrimination. International Journal of Health Services. 1999; 29(2):295–352. [PubMed: 10379455]

Krieger, N. Discrimination and Health. In: Berkman, L.; Kawachi, I., editors. Social Epidemiology. New York: Oxford University Press; 2000. p. 36-75.

Krieger N, Smith K, Naishadham D, Hartman C, Barbeau EM. Experiences of discrimination: Validity and reliability of a self-report measure for population health research on racism and health. Social Science & Medicine. 2005; 61(7):1576–1596. [PubMed: 16005789]

Krieger N, Sydney S. Racial discrimination and blood pressure: The CARDIA study of young Black and White adults. American Journal of Public Health. 1996; 86(10):1370–1378. [PubMed: 8876504]

Lee R. Health care problems of lesbian, gay, bisexual, and transgender patients. Western Journal of Medicine. 2000; 172(6):403–408. [PubMed: 10854396]

Mays VM, Cochran SD. Mental health correlates of perceived discrimination among lesbian, gay, and bisexual adults in the United States. American Journal of Public Health. 2001; 91(11):1869–1876. [PubMed: 11684618]

McCabe SE, Bostwick WB, Hughes TL, West BT, Boyd CJ. The relationship between discrimination and substance use disorders among lesbian, gay, and bisexual adults in the United States. Am J Public Health. 2010; 100(10):1946–1952.AJPH.2009.16314710.2105/AJPH.2009.163147 [PubMed: 20075317]

Merighi JR, Chassler D, Lundgren L, Inniss HW. Substance use, sexual identity, and health care provider use in men who have sex with men. Substance Use & Misuse. 201010.3109/10826084.2010.502208

Meyer, IH.; Northridge, ME. The Health of Sexual Minorities. New York, NY: Springer; 2007.

Mills TC, Paul J, Stall R, Pollack L, Canchola J, Chang YJ, Catania JA, et al. Distress and depression in men who have sex with men: the Urban Men's Health Study. American Journal of Psychiatry. 2004; 161(2):278–285. [PubMed: 14754777]

O'Hanlan KA, Dibble SL, Hagan HJ, Davids R. Advocacy for women's health should include lesbian health. Journal of Womens Health (Larchmt). 2004; 13(2):227–234.10.1089/154099904322966218

Roter DL, Hall JA, Katz NR. Doctor-patient communication: A descriptive summary of the literature. Patient Education and Counseling. 1988; 12:99–119.

Sanchez JP, Hailpern S, Lowe C, Calderon Y. Factors associated with emergency department utilization by urban lesbian, gay, and bisexual individuals. Journal of Community Health. 2007; 32(2):149–156. [PubMed: 17571527]

Sanchez NF, Rabatin J, Sanchez JP, Hubbard S, Kalet A. Medical students' ability to care for lesbian, gay, bisexual, and transgendered patients. Family Medicine. 2006; 38(1):21–27. [PubMed: 16378255]

Schulz A, Gravlee CC, Williams DR, Israel BA, Mentz G, Rowe Z. Discrimination, symptoms of depression, and self-rated health among African American women in Detroit: Results from a longitudinal analysis. American Journal of Public Health. 2006; 96(7):1265–1270. [PubMed: 16735638]

Sell RL, Becker JB. Sexual orientation data collection and progress toward Healthy People 2010. American Journal of Public Health. 2001; 91(6):876–882. [PubMed: 11392926]

Smedley, B.; Stith, A.; Nelson, AL. Unequal Treatment: Confronting Racial and Ethinic Disparities in Health Care. Washington, DC: Committee on Understanding and Eliminating Racial Disparities in Health Care, Institute of Medicine, National Academies Press; 2003.

Trivedi AN, Ayanian JZ. Perceived discrimination and use of preventive health services. Journal of General Internal Medicine. 2006; 21(6):553–558.JGI41310.1111/j.1525-1497.2006.00413.x [PubMed: 16808735]

Valanis BG, Bowen DJ, Bassford T, Whitlock E, Charney P, Carter RA. Sexual orientation and health: Comparisons in the Women's Health Initiative sample. Archives of Family Medicine. 2000; 9(9): 843–853.foc9069 [PubMed: 11031391]

van Ryn M. Research on the provider contribution to race/ethnicity disparities in medical care. Medical Care. 2002; 40(1 Suppl):I140–151. [PubMed: 11789627]

Waitzkin H. Information giving in medical care. Journal of Health and Social Behavior. 1985; 26:81–101. [PubMed: 4031436]

Willging CE, Salvador M, Kano M. Brief reports: Unequal treatment: mental health care for sexual and gender minority groups in a rural state. Psychiatric Services. 2006; 57(6):867–870.57/6/86710.1176/appi.ps.57.6.867 [PubMed: 16754766]

Williams DR, Yan Y, Jackson JS, Anderson NB. Racial differences in physical and mental health: Socio-economic status, stress and discrimination. Journal of Health Psychology. 1997; 2(3):335–351. [PubMed: 22013026]

Willie, CV.; Kramer, BM.; Brown, BS., editors. Racism and Mental Health. University of Pittsburgh Press; 1973.

Table 1

Summary of Health and Social Service Groupings for Interviewing Agency and Other L.A. County Agencies

CRAS Item No.[a]	Service[b]
	Sexual Health Treatment (6 items)
D5a	HIV information in an office or clinic
D5b	HIV information delivered by a discussion leader or street outreach worker
D5c	HIV education to promote behavior change
D5e	HIV testing/counseling
D5f	STD testing
D5g	STD treatment
	Social Support (3 items)
D5d	HIV social support-group meeting
D5i	Case management
D5j	Mental health or psychosocial support
	Social Services (3 items)
D5k	Transportation
D5l	Housing/shelter information
D5m	Housing/shelter
	Medical services (2 items)
D5o	Medical Services
D5p	Dental Services

Note.

[a]The same services were repeated for those "receive from any other agency in L.A. County" (between D6a-D6r).

[b]Four additional types of services (D5h-drug/alcohol treatment; D5n-treatment adherence counseling; D5q-child welfare services, and D5r-needle exchange) were included in the overall service composite score (i.e., sum of a total of 18 services), but the content of these items did not fit into any of the four dimensions.

Table 2

CRAS Sample Description and Characteristics Associated with Experiences of Verbal Harassment Due to Sexual Orientation **(*n*=1,995)**

Characteristic	*All Participants n* (%)	Yes Harassment *n*(%)	No Harassment *n*(%)	X^2
Gender				
Women	674 (33.78)	159 (23.59)	515 (76.41)	
Men	1,321 (66.21)	480 (36.34)	841 (63.66)	33.30***
Sexual Orientation				
Heterosexual/straight	1091 (54.69)	126 (11.55)	965 (88.45)	
Gay	548 (27.47)	335 (61.13)	213 (38.87)	
Lesbian	36 (1.80)	30 (83.33)	6 (16.67)	
Bisexual	289 (14.49)	129 (44.64)	160 (55.36)	
Other	31 (1.55)	19 (61.29)	12 (38.71)	500.19***
Education				
<High School/GED	545 (27.35)	136 (24.95)	409 (75.05)	
GED/high school diploma	766 (38.43)	228 (29.77)	538 (70.23)	
Some college	481 (24.13)	190 (39.50)	291 (60.50)	
Four-year college degree	147 (7.38)	66 (44.90)	81 (55.10)	
>Four-year college degree	54 (2.71)	19 (35.19)	35 (64.81)	38.08***
Main Partner HIV+				
No	828 (90.49)	234 (28.26)	594 (71.74)	
Yes	87 (9.51)	36 (41.38)	51 (58.62)	6.51**
Any Partner HIV+				
No	426 (86.06)	151 (35.45)	275 (64.55)	
Yes	69 (13.94)	39 (56.52)	30 (43.48)	11.15**
Respondent HIV +				
No	1133 (77.76)	353 (31.16)	780 (68.84)	
Yes	324 (22.24)	159 (49.07)	165 (50.93)	35.49***
Other Partners IDU				
No	363 (75.63)	117 (32.23)	246 (67.77)	
Yes	117 (24.38)	59 (50.43)	58 (49.57)	12.62**
Tobacco Use				
No	792 (39.74)	193 (24.37)	599 (75.63)	
Yes	1201 (60.26)	446 (37.14)	755 (62.86)	35.71***
Crack				
No	1621 (81.38)	496 (30.60)	1125 (69.40)	

Characteristic	*All Participants n* (%)	Yes Harassment *n*(%)	No Harassment *n*(%)	X^2
Yes	371 (18.62)	142 (38.27)	229 (61.73)	8.17*
Crystal Meth				
No	1630 (81.75)	494 (30.31)	1136 (69.69)	
Yes	364 (18.25)	145 (39.84)	219 (60.16)	12.41**
Inhalants, Poppers, Nitrous				
No	1869 (93.73)	574 (30.71)	1295 (69.29)	
Yes	125 (6.27)	65 (52.00)	60 (48)	24.38***
Steroids, Hormones				
No	1950 (97.89)	615 (31.54)	1335 (68.46)	
Yes	42 (2.11)	24 (57.14)	18 (42.86)	12.37**

Note: The variable PCQ23 in the survey reads, "Did anyone ever make offensive, insulting, hateful, or hurtful sexual comments because of your sexual orientation?" The *Yes/No* columns in this table pertain to the frequency of participants reporting the experience of being verbally harassed (or not).

* $p<.05$;

** $p<.01$;

*** $p<.001$. No other associations were statistically significant. Cells in the "All Participants" column do not total to 1,995 in all cases due to a small number of missing responses on the demographic and drug use variables and the larger number of participants who did not report of their partner(s) HIV status or drug use.

Table 3

Average Number of Health Services Used from the Interviewing Agency by Sexual Orientation in the Past 6 Months

Sexual Identity	Description of Health Services	Verbally Harassed Mean	Not Verbally Harassed Mean	t
All Participants	All Services	4.46	3.95	-2.80**
	Social Support	.92	.63	-5.88***
	Social Services	.50	.38	-2.69**
Heterosexual	All Services	5.82	3.97	-4.36***
	Social Support	1.21	.62	-5.36***
	Social Services	.88	.42	-4.26***
	Medical Services	.41	.26	-2.33*
Gay	Social Support	.85	.65	-2.22*
	Social Services	.39	.26	-1.93*
Bisexual	Social Support	.88	.61	-2.33*

Note:

* p<.05;

** p<.01;

*** p<.001. **Lesbians** were analyzed separately. Due to small sample size, none of the relationships assessed were significant among lesbians, but a greater mean number of all services, sexual health treatment, social support and medical services were noted for lesbians who experienced sexual identity-related verbal harassment compared to those who did not. No other associations were statistically significant using the two-sided Satterthwaite t-test for unequal variances.

Table 4

Average Number of Health Services Received from other Los Angeles County Agencies across Levels of Sexual Orientation in the Past 6 Months

Sexual Identity	Description of Health Services	Verbally Harassed Mean	Not Verbally Harassed Mean	t
All Participants	All Services	4.19	2.88	-6.89***
	Sexual Health	2.10	1.37	-7.71***
	Social Support	.80	.46	-7.00***
	Social Services	.61	.38	-4.74***
	Medical Services	.55	.46	-2.65**
Heterosexual	All Services	4.36	2.91	-3.60**
	Sexual Health	1.72	1.32	-2.26*
	Social Support	.77	.45	-3.38**
	Social Services	.83	.40	-3.95**
	Medical Services	.64	.46	-2.36**
Gay	All Services	3.95	2.38	-4.94***
	Sexual Health	2.12	1.40	-4.47***
	Social Support	.81	.40	-5.02***
	Social Services	.52	.26	-3.44**
	Medical Services	.52	.36	-2.61**
Bisexual	All Services	5.00	3.30	-3.34**
	Sexual Health	2.54	1.67	-3.50**
	Social Support	.91	.57	-2.74**
	Social Services	.67	.41	-2.19*

Note:

* p<.05;

** p<.01;

*** p<.001. **Lesbians** were analyzed separately. Due to small sample size, none of the relationships assessed were significant among lesbians, but a greater mean number of all services and sexual health treatment were noted for lesbians who experienced sexual identity-related verbal harassment compared to those who did not. No other associations were statistically significant using the two-sided Satterthwaite t-test for unequal variances.