

Preventing tobacco use among lesbian, gay, bisexual, and transgender youths

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A paucity of information regarding tobacco use among lesbian, gay, bisexual, and transgender (LGBT) youths impedes prevention programs. The aim of the present study was to conduct formative qualitative research regarding subpopulations at risk for tobacco use, protective factors, patterns of use, and approaches to prevention. This report focuses on participants' recommendations for the development of preventive intervention. Purposive sampling and maximum variation sampling were used to select 30 LGBT youths and 30 interactors for face-to-face interviews. NUD*IST6 text software was used for the indexing and thematic analysis of qualitative data, based on a grounded theory approach. All participants offered suggestions for tobacco prevention pertaining to the optimal process of prevention and cessation programs, specific strategies to promote tobacco prevention and cessation, and general strategies to foster nonsmoking. Several key themes regarding prevention emerged: LGBT youth should be involved in the design and implementation of interventions; prevention programs should support positive identity formation as well as nonsmoking; the general approach to prevention should be entertaining, supportive, and interactive; and the public might not distinguish primary prevention from cessation activities. All but one young smoker had attempted to quit at least once; but only one individual had succeeded. By way of implications, prevention programs should involve young people in enjoyable and engaging activities, address the psychosocial and cultural underpinnings of tobacco use, support healthy psychosocial development, and consider offering pharmacological smoking cessation aids.

Introduction

Tobacco use is a common and life-threatening problem in the lives of lesbian, gay, bisexual, and transgender (LGBT) youths. A rapidly expanding body of scientific knowledge, based on the experience of LGBT youths and adults, chronicles the magnitude of harm and health risk across the lifespan. Since the 1980s, four studies have examined tobacco use by LGBT teens and young adults (aged 13–21 years), finding consistently higher rates of smoking among LGBT youths than among heterosexual comparison groups or the general population. Two of these studies involved convenience samples of youths (Remafedi, 1987; Rosario, Hunter, & Gwadz, 1997). The first study reported current daily smoking

among gay and bisexual male Minnesotans younger than 18 years of age. Daily smoking was more prevalent than in the general population during the same time frame. The second study described lifetime cigarette use by young men and women in a New York City alternative school for LGBT youths. The lifetime prevalence of tobacco use among lesbians, but not gay and bisexual males, was higher than national norms for same-gender students (Ryan, Wortley, Easton, Pederson, & Greenwood, 2001).

Subsequent school-based surveys in Massachusetts and Vermont found that LGBT students were more likely than their heterosexual peers to use tobacco. Approximately 4% of students were identified as LGB or “unsure” in the 1995 Massachusetts Youth Risk Behavior Survey; 70% of them had smoked cigarettes, and 33% had used smokeless tobacco (Garofalo, Wolf, Wissow, Woods, & Goodman, 1999). LGB students were significantly more likely than non-LGB peers to initiate cigarette use before age 13 years (48% vs. 23%), smoke cigarettes daily in the past month (59% vs. 35%), and smoke at school

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(37% vs. 18%; Garofalo, Wolf, Kessel, Palfrey, & DuRant, 1998).

In addition to the aforementioned studies of youths, Ryan et al. (2001) identified eight studies of smoking among LGBT adults that were published from 1987 to 2000, two among gay men, five among lesbians, and one in both groups. The prevalence of smoking ranged from 25% to 50% in gay men and from 11% to 50% in lesbian and bisexual women. In all but one study, involving lesbians at a health conference, smoking rates were higher than those seen in the general adult population during the same period.

Several other reports of smoking among lesbian and bisexual women, not included in the Ryan et al. (2001) review, have uncovered similar results. The Pittsburgh Epidemiological Study of Health Risks in Lesbians (Aaron et al., 2001) found that 35.5% of 1,010 bisexual and lesbian women currently smoked, well above national prevalence estimates for women in general. The second report, a meta-analysis of seven health surveys including almost 12,000 lesbian volunteers (Cochran et al., 2001), similarly concluded that the current incidence and lifetime prevalence of smoking among lesbians greatly exceeded national norms for women. Finally, Gruskin, Hart, Gordon, and Ackerson (2001) found that 20–34-year-old lesbian and bisexual members of Kaiser Permanente Medical Care Program, Northern California, were more likely to be current smokers and heavy drinkers than heterosexual women. However, no significant differences were found between the lesbians and bisexual women and heterosexual women in the older age groups, suggesting that younger women were especially at risk.

Awareness of tobacco-related problems and resources for smoking prevention and cessation are inadequate within LGBT communities. A recent online survey of U.S. adults found that LGBT respondents were more likely than heterosexuals to smoke cigarettes (34% vs. 24%) and to smoke more than one pack per day (47% vs. 36%). However, fewer LGBT persons (4% vs. 7%) considered smoking to be a personal health risk (Harris Interactive, 2003a), and 89% said they had not seen an anti-smoking education or awareness campaign targeted toward them (Harris Interactive, 2003b).

Moreover, a paucity of information regarding risk factors, mediators, and moderators of tobacco use among LGBT youths is an impediment to culturally specific approaches to prevention. For this reason, we initiated formative qualitative research that focused on the practical development of preventive interventions. Higgins and colleagues (1996, p. 38) defined *formative research* as “the process by which research or public health practitioners define the community of interest, ways to access that

community, and attributes of the community relevant to the specific public health issue” (e.g., tobacco prevention).

The research involved face-to-face semistructured interviews with youths and interactors to identify (a) Who are priority LGBT youth subpopulations for tobacco prevention programs? (b) Why do LGBT youths initiate, sustain, or—conversely—reject tobacco use? (c) When and where can LGBT youths be reached for intervention? and (d) How shall we intervene? This report, part of the larger study, focuses on participants’ recommendations for the development of preventive interventions. To enhance the relevancy and applicability of findings to tobacco prevention in our locality, the present study was conducted in partnership with academic and community agencies.

Method

Participants

In the following text, the terms *youths* and *interactors* refer to two different categories of participants. The term *participants* encompasses both groups collectively. *LGBT youths* were broadly defined as male, female, and transgender persons (<25 years of age) who had adopted a LGBT identity or who have sex with the same sex, regardless of perceived sexual identity. *Youths* refers to teens (aged 13–19 years) and young adults (aged 20–24 years). The research team intended to interview youths who were current and former smokers; nonsmokers; urban and suburban residents; persons in stable and unstable living situations; and a mix of persons of different gender identities, ages, and races/ethnicities.

Interactors were defined broadly as persons with in-depth knowledge or experience with LGBT youths but who were not part of their immediate social networks. With the exception of homelessness, the research team intended to select interactors with the diverse demographic characteristics mentioned above. In addition, we aimed to involve different occupations, including bartenders and restaurant servers, community advocates, health care professionals, law enforcement agents, LGBT business owners, parents of LGBT children, and other types of interactors who might be nominated by prior participants.

Sampling methods

The aim of the sampling procedures was to obtain the broadest possible range of respondents and answers to the research questions. The selection of both youths and interactors was an iterative process that tapped the knowledge of youths and interactors

to build and continuously expand the database of key informants until a point of saturation had been reached.

Purposive sampling (i.e., selecting cases to represent different groups of persons) and maximum variation sampling (i.e., selecting persons from as wide and complete a range of situations as possible) were used to select LGBT youths and interactors for the qualitative interviews. The research team initially identified different types of youths and interactors to be interviewed, based on their knowledge of the scientific literature and their practical experience working within the LGBT community. The initial participants informed the subsequent selection of interviewees by nominating other types of key informants, based on their own “insider” knowledge and experience. The main factor influencing the numbers of people interviewed was how quickly the information obtained became redundant.

Interview methods

The numbers and types of participants interviewed were reviewed at regular research team meetings. Based on the progress reports, the team members recommended additional types of interviewees and how, when, and where to reach them. Pursuant to recommendations from the research team and prior participants, the interviewer identified, approached, and screened potential candidates for the desired personal and behavioral characteristics; introduced herself and the study purpose; invited eligible candidates to participate; and obtained written, informed consent. Youths and interactors completed face-to-face interviews of 1–2 hr duration in a private location of their choice. With participants’ permission, the interviewer took notes and digitally recorded the interviews. Youths were offered a US\$20 incentive and referrals to smoking cessation programs on completion of the interview. The university institutional review board reviewed and approved all procedures and waived the requirement of parental consent for minors.

Instruments

The interviews with youths included 34 items (and additional probes) pertaining to leisure activities, relationships, knowledge and perceptions of tobacco use, factors that influence smoking, normative pressures from significant others, factors that would facilitate or hinder cessation, suggestions for preventive interventions, and incentives to participate in tobacco prevention interventions. Smoking status was determined with the following items (and additional probes): “Have you ever used tobacco?” “Have you ever been a regular smoker?” “How

much do you smoke now or much did you smoke before you quit?” and “Have you ever tried to quit smoking?” Interviews with interactors included 25 items regarding segments of the LGBT youth community at risk for tobacco use, ways to find them, the perceived risk and circumstances of tobacco use, and community resources for tobacco prevention and cessation. The research team selected and adapted the questions from prior research (Centers for Disease Control and Prevention, 2001).

One experienced staff member conducted all of the interviews. The principal investigator and research fellow provided additional training regarding subject recruitment, consent procedures, interview administration, other study procedures, and preparation of written synopses. The interviewer pilot tested each survey with three youths and three interactors. The purpose was to refine the instruments and to practice the procedures. The collaborative research team refined and finalized the questions prior to implementation in the field.

This report focuses on several items relevant to the development of preventive interventions. The youths were asked the following questions:

1. What kinds of services or activities would be appealing to LGBT youth to help prevent tobacco use?
2. What would turn them off?
3. What about young people who are very private about their sexuality and don’t want parents, coworkers, or others to know about that? How could we involve these people in activities or services that would help prevent tobacco use?

Two similar questions were asked of the interactors:

1. What are some of the services, programs, and activities that try to prevent LGBT youth from using tobacco products?
2. Are there special issues, values, or concerns that should be paid attention to in designing tobacco prevention programs and activities?

Additional data relevant to preventive interventions were reviewed when they appeared elsewhere in the context of the interviews.

Analyses

Interviews were digitally recorded and transcribed. The authors ensured consistency and quality of data collection methods by answering the interviewer’s questions regarding procedures, comparing audiotapes with field notes and transcripts, and providing feedback. In consultation with each other, the investigators independently coded the transcripts at unique nodes using NUD*IST6 text software for

indexing and analysis and reviewed each other's results. We used the grounded theory approach (Glaser & Strauss, 1967) to analyze the data. We used coding both to categorize qualitative data and to describe their details and implications. Participants were classified as current smokers if they reported smoking at least one cigarette in the past month.

Results

A total of 30 LGBT youths and 30 interactors completed interviews. Participants' characteristics are listed in Table 1. The interactors' areas of employment included social services ($n=7$), tobacco cessation or prevention programs ($n=5$), law enforcement ($n=3$), secondary education ($n=2$), LGBT-owned businesses ($n=2$), journalism ($n=2$), religious ministry ($n=2$), health care ($n=2$), research ($n=2$), public health ($n=1$), parks and recreation ($n=1$), and home ($n=1$).

Youths were sampled at a variety of venues, including cafes, drop-in centers, LGBT community events, social support groups, and "gay-straight alliances." Special efforts were made to include nonsmokers. However, more than two-thirds of the

final sample of youths reported being former ($n=1$) or current ($n=20$) smokers.

Youth responses

All of the youth participants offered suggestions, directly or indirectly related to tobacco prevention and cessation. Regarding recommendations for smoking prevention and control, no notable differences were found in responses related to age, race/ethnicity, gender, sexual identity, or housing status. Suggestions fell into three categories: (a) Optimal process of prevention and cessation programs, (b) specific strategies to promote tobacco prevention and cessation, and (c) general strategies to foster nonsmoking.

By way of process, three individuals recommended adopting culturally specific approaches for LGBT youths or directly involving LGBT youths in prevention planning. A 16-year-old White gay male observed:

I think commercials would work if they changed them and just zoomed in on GLBT youth. I think that would actually work if they had messages of older GLBT people saying—they smoked when they were younger and these are the effects and tell them how serious smoking is. It would be good to put things in people's minds that smoking is a waste of money and not worth it. The key element is that the commercial would be all GLBT people. This would get the attention of GLBT youth because anything gay on TV gets their attention right away.

As for specific strategies of tobacco prevention, 11 respondents recommended hosting recreational activities in smoke-free settings or physical activities that might distract people from smoking. The most popular idea, mentioned by six individuals, was smoke-free dances. Three persons recommended discussions of tobacco effects and cessation. Several others noted the need for education about tobacco effects and cessation strategies, as well as for ongoing support of tobacco avoidance and cessation. Six persons mentioned the importance of food and entertainment at gatherings. Finally, many of the respondents discussed the general importance of building social support for nonsmoking and bolstering individuals' self-esteem and positive identification within the LGBT community in the interest of smoking prevention.

Reflecting the difficulty of serving hidden populations, seven individuals said they had no idea how to reach them. Four respondents emphasized helping young people "come out," and others recommended creating advertisements, E-mail communications,

Table 1. Characteristics of 30 youth and interactor interviewees

Participant characteristic	Youth	Interactors
Gender		
Male	12	11
Female	14	18
Transgender	4	1
Age (years)		
<16	1	0
16–17	10	0
18–20	15	0
21–24	4	1
25–29	0	6
30–39	0	10
40–49	0	9
50–59	0	4
Ethnicity		
White	16	23
Black	4	3
Native American	2	2
Asian/Pacific	1	0
Latino/Hispanic	1	0
Mixed ethnicity	6	2
Residence		
Urban	22	0
Suburban	8	0
Sexual orientation		
Homosexual	19	21
Bisexual	9	2
Heterosexual	1	7
Other	1	0
Smoking status		
Current smoker	20	2
Former smoker	1	15
Never smoked	9	13

commercials, posters, fliers, and general smoking cessation programs for those who remain hidden. A 20-year-old White lesbian commented, “When I was worried about my sexuality, smoking was not my worry. It was not what I wanted to hear from anybody I loved. I would have had to come out and find a community or someone I trusted before I was ever going to try and quit smoking.”

Nine individuals mentioned that passive educational strategies such as lectures, seminars, and educational video formats would disinterest them. Five people, all of whom were smokers, emphasized that pressure to quit smoking and antismoking activism would discourage participation in prevention and cessation programs: “Telling youth what to do is a REALLY BIG TURN OFF. They have to be able to make their own decisions and they are not going to quit unless they want to. The youth population is rebellious. You rebel, regardless of whether you are gay or straight; it’s just natural” (20-year-old White lesbian).

Among the 21 youths who described themselves as regular smokers, all but one had attempted to quit at least once, and only one individual had succeeded for more than a short while. The main reasons for quitting were health effects ($n=11$), being unable to smoke (e.g., in prison, while hospitalized, or while traveling in a small van [$n=3$]), and the price of cigarettes ($n=2$). The most common method, used by 16 individuals, was gradually weaning from cigarettes or quitting abruptly. Few people had tried smoking cessation aids such as nicotine gum ($n=4$), inhaler ($n=2$), and patches ($n=2$), and bupropion hydrochloride ($n=1$).

Interactor responses

A total of 25 interactors identified special issues, values, or concerns that should be reflected in prevention programs and activities. As with the youths’ responses, their responses can be categorized in terms of process-oriented suggestions and suggestions for general and specific tobacco prevention strategies. A total of 15 interactors made process-oriented suggestions in five different areas: Role of youth, cultural specificity, holistic approach, changing norms, and role models.

Role of youth

A total of 11 interactors suggested that the success of tobacco prevention programs for LGBT youths requires their active participation in program planning, development, and implementation. Empowering youths to adopt leadership roles and fostering youths’ sense of ownership of programs were emphasized. One interactor summarized: “The youth

will plan it, market it, and sell it. They will do what it takes to get a good turnout or outcome. The adults need to move over sometime and give the youth power” (22-year-old Black, heterosexual, youth worker).

Cultural specificity

Of the 25 interactors, six (24%) identified culturally specific programming as a process goal, but the meaning of culture differed among respondents. Three people emphasized reaching communities of color, three mentioned age-specific approaches, and one highlighted the importance of sensitivity to issues unique to LGBT youth in tobacco prevention planning.

Holistic approach

Six interactors suggested that tobacco prevention should be designed with the whole person in mind. They listed a compendium of other issues facing LGBT youths, including substance use, school, home, and identity. Fostering general health and well-being was emphasized, with one interactor role-playing this hypothetical script: “Let’s talk about your health. Your health includes the mental, spiritual, physical, and sexual aspects of your life. Your health can be a component of how you see your life and the decisions you make” (32-year-old White lesbian psychotherapist).

Changing norms

Six interactors mentioned that tobacco should be addressed from a new perspective, to change youths’ relationship with it. Social marketing tools were recommended. Specific suggestions included emphasizing body image to counteract the idea that smoking is cool, sexy, or desirable; changing smoking to a negative norm; and helping youths to say no to the popular cultural norm. One respondent pointed out the role of tobacco in Native American ceremonies and how the sacred status represents a very different relationship with tobacco than is found in the dominant culture.

Role models

Five interactors indicated that role models could be used effectively in tobacco prevention programs to provide examples of behavior to emulate and to stimulate participation. Specific examples were suggested: (a) Youth workers modeling behavior on a daily basis, (b) testimonials by people who have quit smoking or otherwise changed their lives, (c) LGBT lawyers, nurses, and journalists as mentors, and

(d) holding events that feature LGBT celebrities or people with “clout.”

The majority of interactors (19 of 27) also suggested specific strategies for tobacco prevention. As with the youth interviews, entertainment and recreational activities predominated. Two interactors specifically noted that such activities could replace tobacco use. Other incentives such as food, money, and brand-name products were mentioned with lower frequency.

As for general strategies, seven interactors emphasized that prevention programs and staff should encourage youths, helping them (a) feel good about themselves and bolster self-esteem, (b) celebrate and embrace their identity as LGBT, (c) counteract negative and apathetic attitudes about health and smoking cessation, and (d) feel connected to the community. Three interactors described the need for caring adults to provide the environment and structure in which youths would develop stronger self-esteem. One interactor expressed it this way: “They have to feel people are personally invested in them, not as a group, not as a bi-section of our society, but really interested in them as a person. It’s feeling that somebody actually really cares about them and the smoking is just part of it” (39-year-old White heterosexual male journalist).

The interactors were not asked about hidden populations, but the general suggestions for tobacco prevention strategies from seven respondents included the need to address the stress of coming out or being LGBT in a non-LGBT dominant culture. Several interactors suggested that with these kinds of stressors, tobacco use prevention or cessation might be among the least of young people’s concerns. One interactor noted the “double-whammy” experience by LGBT youth of color coming out in the larger society and within their own cultural/ethnic communities, which may be even less tolerant of homosexuality. Four respondents described concerns of their own or expressed by youths regarding the identification of programs as “LGBT.” They suggested that it might be “tricky” because some young people are not personally or developmentally ready to identify as LGBT. One respondent suggested that youths need control in revealing their identity. Others knew of individual “closeted” youths who objected to advertising the LGBT makeup of gatherings or meetings they might attend.

In the course of answering this question, some respondents mentioned other conditions that could negatively affect youth participation in tobacco prevention programs. They were expressed as directives, such as, “don’t preach,” “don’t alienate,” “be nonjudgmental,” “don’t blame the smoker, blame the industry,” and “you can’t tell youth they

shouldn’t do something.” Lecture formats were thought to have limited potential, and a 28-year-old, White, lesbian high school teacher also discouraged use of 12-step models:

There might be some problems if it was like a 12 step program due to the issue of God. There may be a conflict of interest with being gay and where kids are in terms of God.... That is tough for kids. Can you imagine wrangling with, “I think I am gay. I have a smoking problem and where is my God? That is too much. Nobody loves me except the cigarettes.”

Conclusion

Beyond the epidemiological evidence of disparities in smoking rates related to sexual orientation, little information exists about the smoking prevention and cessation needs of LGBT communities and how to increase awareness and response to the problem. To our knowledge, this is one of the first qualitative studies of tobacco prevention and cessation in LGBT populations. Previously, collaborating community agencies in San Francisco conducted a needs assessment survey at four LGBT youth events and one educational/social event for transgender individuals (Center for AIDS Prevention Studies, 2002). Similar to the high interest in cessation among our participants, approximately two-thirds of smokers said they were interested in quitting at some time. Youths responded that they would like LGBT-specific services (90%) and recommended that LGBT ex-smokers (56%) and physicians (55%) teach classes. Based on their responses and best-practice models, the collaborators developed a smoking cessation manual tailored for LGBT persons and pilot-tested the curriculum in class with 18 persons. Satisfaction reportedly was high, but mostly older (35+years) Anglo-American LGB persons attended the class.

Responding to the paucity of data, we took a grounded theory approach to enlist a wide range of perspectives on previously unanswered questions regarding LGBT youth smoking. By doing so, we were able to identify and interview a diverse sample of youths and a wide range of interactors from different professions. Considerable agreement was found among youth subpopulations and interactors on several key themes. Youth should be involved in the planning and implementation of interventions. Young people can contribute ideas to the design and content of programs, build community, and model healthy behavioral norms.

Because gay-related stress is central to the tobacco problem, prevention programs for LGBT youths must support positive identity formation as well as

nonsmoking. In this regard, reaching younger LGBT youths and those whose sexual orientation is hidden pose special challenges to early preventive intervention.

The vehicle of prevention is as important as the message. Prevention programs should offer clients food, entertainment, and recreational opportunities in smoke-free settings. Smokers cannot be pressured to quit. Rather, prevention programs should create opportunities to discuss, model, and create norms of nonsmoking.

The distinction between cessation and primary prevention is blurred. All the questions asked referred to “prevention,” but participants frequently responded in relation to cessation. The public may not distinguish smoking cessation from primary prevention.

Almost all of the regular smokers had made failed attempts to quit, reflecting their interest in cessation. Most attempts to quit were motivated by health effects, and surprisingly few respondents mentioned the price of cigarettes. Many individuals had tried to quit abruptly without pharmacological aids.

Fostering youth involvement, enjoyment, healthy behavioral norms, and positive identity formation are reminiscent of similar themes that emerged from interviews and focus groups that led to a successful community-based HIV prevention program for young gay men (Kegeles & Hays, 1996). As other investigators have speculated, community-level social-network approaches to health promotion and disease prevention can be particularly useful within LGBT populations, whose behavioral norms might differ from those of the general population (Kelly et al., 1997).

Some of the themes we uncovered also echo lessons learned from smoking prevention and control programs for the general population of youth. For example, in a review of existing and promising interventions for youths, Lantz et al. (2000) embraced peer-led programs to role-model smoking prevention as a “major trend in school-based interventions.” Moreover, our findings are consistent with their recommendations to change the overall environment that induces adolescents to initiate tobacco use and to accelerate the development and implementation of tobacco cessation programs, including use of nicotine replacement therapies in adolescent smokers. Interestingly, our participants did not recommend other familiar strategies of tobacco control such as school-based education, tobacco advertising control, youth access restrictions, and raising excise taxes and cigarette prices.

The main limitations of the present study were the use of volunteers, the inaccessibility of hidden populations of LGBT youths (such as non-LGBT-identified persons who have sex with the same sex),

and the difficulty of finding former young smokers who had succeeded in quitting. These hard-to-reach groups might provide a unique perspective on successful prevention and cessation programs. Despite the limitations, we identified an overall sample that was diverse in age, gender, ethnicity, residence, sexual identity, and general smoking status.

The findings highlight the need for future research to quantify tobacco use and predisposing factors in representative, community-based samples of LGBT youths that include early and middle adolescents, out-of-school or homeless youth, and those who are early in the process of discovering their sexual orientation. Further study of LGBT youths who have not smoked cigarettes regularly and of those who successfully quit is needed in order to better understand protective factors.

Although we did not specifically study the smoking behaviors of the interactors, most of whom were themselves lesbians or gay, half identified themselves as former smokers. This observation raises intriguing questions about the trajectory of smoking behaviors and cessation across the lifespan of LGBT persons. Ultimately our findings—along with prior epidemiological research—reflect the need to develop and test appropriate prevention and cessation programs. Such programs should involve young people in enjoyable and engaging activities, address the psychosocial and cultural underpinnings of tobacco use, provide support for positive identity formation, and possibly offer pharmacological smoking cessation tools.

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