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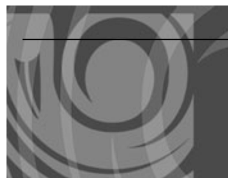

Assessment and Treatment of Depression in Gay and Bisexual Men in Emergency Settings

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Abstract

Gay and bisexual men are at higher risk for certain mental health disorders, including anxiety, depression, and suicide. These individuals often present to emergency settings in need of evaluation and treatment. Despite the utilization of emergency mental health services by this population, clinicians are often underprepared in responding to their unique needs. This article discusses depression in gay and bisexual men and provides an evidence-based approach in treating these men in emergency settings. Directives for future research and advanced practice nursing education are also presented. **Key words:** anxiety, bisexual, depression, emergency, gay men, homosexual, mental health, psychiatric, suicide

JACOB, A 25-YEAR-OLD gay man, presents to the emergency department with the chief complaint of chest pain. During his triage assessment, he informs the nurse, "I have horrible chest pain. It started this morning and it really hurts. It takes my breath away!" Although Jacob does not have any overt risk factors for cardiovascular disease, the nurse assumes the worse and immediately brings him back to the treatment area. The nurse practitioner (NP), currently managing several clients within the department and feeling very pressed for time, performs a quick assessment and chooses to focus primarily on Jacob's chest pain. The NP fails to ask him any information about his sexual orientation during health history taking but is concerned about a questionable family history of early cardiac disease. Subsequently, a 12-lead electrocardiogram and a chest radiograph are obtained and both are normal. Consequently, the NP discharges Jacob and informs him that his chest pain "is probably gas." If the NP had asked about Jacob's psychosocial well-being, sexual orientation, and current affect, he would have replied, "I just feel down so much lately. I just came out of the closet and told my family I was gay a few months ago. It's been so difficult ever since. I just feel like I am worthless and that no one wants anything to do with me."

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EMERGENCY MENTAL HEALTH SERVICE UTILIZATION BY GAY AND BISEXUAL MEN

The Gay & Lesbian Medical Association (GLMA) has identified mental health as a major area of health disparity among gay and bisexual (bi) men (GLMA, 2014). Specifically, GLMA lists substance abuse and alcoholism, depression and anxiety, and tobacco use as common mental health disorders that warrant further discussion among gay/bi men and their health care providers (GLMA,

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2012a, 2012b). In addition, gay/bi men are more likely to access emergency services due to acute distress related to mental illness (Sanchez, Hailpern, Lowe, & Calderon, 2007). Data suggest that higher utilization of the emergency department by gay, lesbian, bisexual, and transgender (GLBT) persons has been associated with recent psychological distress, recent mental health counseling, desired mental health treatment, and substance abuse (Sanchez et al., 2007).

Regardless of consideration of sexual orientation, appropriate evaluation, treatment, and referral for clients in need of mental health services in general remain an ongoing public health challenge. Treatment of clients with mental health needs has also been identified as a major issue for emergency nurses. These clinicians have indicated a need for more education on effective treatment and service referral for these clients (Innes, Morphet, O'Brien, & Munro, 2013). Mental health service provision with GLBT clients carries additional complexities. Cleary, Horsfall, Hunt, Escott, and Happell (2011) concluded that attitudes of mental health professionals could serve as a major impediment to providing public mental health services. Data indicate that gay clients in need of mental health care experience ongoing stigma and discrimination within the health care system; they experience treatment inequities compared with their heterosexual counterparts (Ash & Mackereth, 2013). Consequently, some gay men accessing the health care system for mental health-related treatment are reluctant to disclose their sexual orientation to providers (Robertson, 1998). Thus, it is essential to discuss heterosexism and homophobia in clinicians as obstacles to effective mental health treatment of gay/bi men.

LITERATURE REVIEW

Heterosexism and Homophobia: Obstacles to Effective Mental Health Services Provision

While the suffix "phobia" typically refers to "a fear or aversion to," the term "homophobia" has been expanded to also include "discrimination against homosexuals or homosexuality" (*Merriam-Webster*, 2014b). "Heterosexism" is a similar term that describes "discrimination or prejudice by heterosexuals against homosexuals" (*Merriam-Webster*, 2014a). Unfortunately, homophobia and heterosexist attitudes are common traits in health care professionals, and despite increasing social acceptance of GLBT persons in society over the last three decades, continued discrimination against GLBT patients in health care exists (Irwin, 2007).

Just as societal engrained homophobia and heterosexism affect the psychological well-being of gay/bi men (Aguinaldo, 2008; Blosnich & Bassarte, 2012; Choi, Paul, Ayala, Boylan, & Gregorich, 2013), discriminatory attitudes by providers can have profound negative effects on gay/bi male patients with mental health needs (Ash & Mackereth, 2013; Faria, 1997; Robertson, 1998). Perhaps, the existence of homophobia and heterosexism in the psychiatric/mental health field is rooted in its traditional views of homosexuality and bisexuality (Rutherford, McIntyre, Daley, & Ross, 2012). Homosexuality was classified as a psychiatric illness by the American Psychiatric Association (APA) until its decision to remove it as a diagnosis from the *Diagnostic and Statistical Manual* (*DSM*) on December 15, 1973 (Meyer, 2013). Psychoanalysis placed the cause of development of a homosexual orientation on dysfunctional family dynamics. More specifically, this theory proposed that male homosexuals develop their sexual orientation as a consequence of their perpetual search for a lost male identity (Nicolosi, 1997; Socarides, 1978); gay males form a female gender identity as a result of cold and distant relationships with their fathers (Nicolosi, 1997; Socarides, 1978). A study by Bieber in 1962 that compared 106 homosexuals with 100 heterosexuals concluded that male homosexuality was the result of growing up in an environment with overbearing mothers who encouraged alienation between boys and their fathers, resulting in interpersonal

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disturbances between sons and their fathers (Meyer, 2013). That study had major methodological issues and flaws (Besen, 2003). But it continued to shape the mind-set of mental health clinicians, particularly psychoanalysts, who continued to portray gay/bi men as predatory sexual deviants both in their clinical settings and in their interactions with the media (Meyer, 2013).

As psychological research regarding human sexuality began to proliferate in the late 1960s and early 1970s, the perceptions of homosexuality as a disease began to erode (APA, 2006). Emerging literature and experts on human sexuality began to support the notion that a homosexual orientation did not meet criteria to maintain its classification as a mental illness. The eradication of homosexuality as a mental illness in the *DSM-III* (1980) occurred as a result of emerging science that began to show variance in human sexuality as a common phenomenon and called into question the methodologies and ethics of prior work on gay samples (Meyer, 2013). And by 1975, other mental health organizations (e.g., National Association of Social Workers) stood behind the APA's decision (Meyer, 2013). However, shedding the homophobic and heterosexist underpinnings of the perception of gay/bi men by mental health professionals has been difficult, with many psychoanalysts clinging to outdated theories for decades (Meyer, 2013).

The nursing profession has also lagged behind in its professional stances on the treatment of gay/bi persons. The American Nurses Association's (ANA's; 2010) current *Code of Ethics* does not specifically mention sexual orientation at all. However, the statements within the *Code* related to care of patients are very broad and have been extrapolated in the nursing literature to include the treatment of gay persons. For example, Blackwell (2008) specifically indicated that the participation of nurses in sexual reorientation or conversion/reparative therapies was a direct violation of the ANA's *Code of Ethics*.

Although there are data to suggest the existence of discriminatory attitudes among health care professionals, there is far less assessment of these attitudes among those who work in mental health. In a somewhat smaller ($n = 37$) and dated study, Robertson (1998) assessed perceptions of mental health care services by gay men. Some of the men in the sample from that study cited prior poor reactions by mental health clinicians regarding sexual orientation as a driving force for nondisclosure to providers (Robertson, 1998). The researcher concluded that this resulted in a significant number of mental health needs going unmet. A more recent study by Ash and Mackereth (2013) found similar findings with discontent among gay persons receiving mental health services. Participants in their study reported that mental health professionals inadequately responded to their needs and failed to consider the unique differences that might make care needs of gay persons dissimilar to that of heterosexuals.

In conclusion, clinicians need to gain cultural competence in their treatment of gay/bi persons. Demonstrating empathy for gay/bi patients begins with the first interaction between the patient and the provider, when establishing trust between the clinician and the client is vital. Thus, advanced practice nurses, physicians, and physician assistants working in emergency departments must have the skill needed to provide a culturally appropriate health history to gay/bi men. These providers must also correctly assess and diagnose these clients' conditions and devise an appropriate and effectively tailored plan of care under often-stressful circumstances with limited resources.

DISCUSSION

Establishing Trust: Ascertaining Sexual Orientation

Establishing trust in the initiation of care is essential to any patient–provider encounter. However, this can be daunting when working with clients with mental illness, who often avoid care and can be distrustful of clinicians. Some provider qualities that have been

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identified as being vital to the process of developing empathy for these clients include altruism, compassion, loyalty, involvement, tenacity, and patience (Schout, de Jong, & Zeelen, 2010).

The subject of clients' sexuality is sensitive. Clinicians should not make any assumptions about any individual's sexual orientation. Language used during health history taking should be neutral and not reflect judgment. Instead of asking "Are you married?" or "Do you have a girlfriend?" the provider should be direct. For example, an assertive approach such as asking the client to "Tell me about your sexual practices" or asking "Do you have sexual relationships with men, women, or both?" are open-ended methods that do not imply judgment that can produce a great amount of detail about one's sexual history (Seidel, Ball, Dains, & Benedict, 2006). This will allow the clinician to begin constructing a culturally appropriate plan of care.

Cause of Depression in Gay/Bisexual Men

The precise causalities for the increased risk for anxiety disorders and depressive symptoms in gay/bi men are multifactorial. Studies suggest that these problems can result in this population from interpersonal conflicts related to masculine identification, internalized homophobia, discriminatory experiences, and expectations of rejection (Fischgrund, Halkitis, & Carroll, 2011; Hatzenbuehler, Hoeksema, & Erickson, 2008). In addition, research has shown that family acceptance can be a predictor of greater self-esteem, social support, and general health in gay individuals (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). It is also a protective factor in reducing depression, suicidal ideation, and substance abuse. Emergency health care providers must have the necessary skill to quickly assess and recognize symptoms of depression and anxiety in gay/bi men and be able to construct culturally appropriate plans of care with an interdisciplinary focus that ensure optimal care for the client.

Assessment of Anxiety and Depression in Gay/Bisexual Men in Emergency Settings

In emergency settings, gay/bi men may express self-injurious desires or may have even attempted suicide as a consequence of depression and/or anxiety. The clinician needs to be able to quickly assess the patient's psychological distress and make clinical decisions based on this assessment. There are a wide array of instruments used in the mental health field to assess depression and anxiety. Unfortunately, many of these tools are lengthy and require a time-intensive commitment on behalf of the provider, client, or both. Emergency professionals, who often practice within stressful environments that require rapid assessment and treatment of acute symptoms, do not possess the luxury of being able to spend large segments of time performing comprehensive evaluations on clients. Thus, more concise manners of assessment are paramount.

One assessment tool that is supported in the literature and can be used to rapidly screen for psychological distress in gay/bi men is the Brief Symptom Inventory–18 (BSI-18). This tool's use in gay/bi samples has primarily focused on GLBT youth, but it has demonstrated validity and reliability in studies using other groups as well (Mustanski, Garafalo, & Emerson, 2010). The BSI-18 has also been widely used in time-limited settings (Derogatis & Melisaratos, 1983), making it possibly ideal in emergency practice environments. In addition to depression, the BSI-18 has been used to measure both somatization and anxiety (Meijer, de Vries, & von Bruggen, 2011). The instrument consists of 18 questions that are designed to assess psychological distress within the past week. Respondents rate the degree to which they agree with each item (Meijer, de Vries, & von Bruggen, 2011), ranging from 0 (*not at all*) to 4 (*very much*).

Clinicians interpret the scores within each of the three individual dimensions on a range of 0–24, with increasing scores corresponding to increasing distress within that dimension. The global severity index of distress score comprises the sum of the three

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dimensions and ranges from 0 to 72. Although data are divergent as to how the scores should be interpreted and applied clinically with different client populations (Asner-Self, Schreiber, & Marotta, 2006), generally higher scores indicate higher levels of psychological distress (Asner-Self et al., 2006).

Evidence for the Treatment of Depression in Gay/Bisexual Men

Treatment of depression in the gay/bi male client within emergency settings should first focus on safety. If the client is a risk to himself or others, he will need to be admitted to an acute mental health facility or to the inpatient mental health department of a hospital, oftentimes involuntarily. The topic of involuntary commitment is both controversial and ethically perplexing (Caruso, 2014). And although a detailed discussion of involuntary commitment is beyond the scope of this article, it is essential to introduce. Regulatory policies that dictate the clinical indications for involuntary commitment vary from state to state (Caruso, 2014). However, in the United States, the maximum initial time for involuntary commitment is 3–5 days (Caruso, 2014). Clinicians can learn more about their state's specific regulations regarding involuntary commitment by visiting the *State-by-State Standards for Involuntary Commitment (Assisted Treatment)* page on the Mental Illness Policy Organization (2011) website at http://mentalillnesspolicy.org/studies/state-standards-involuntary-treatment.html.

Clients who are not suicidal or not in need of immediate acute care and/or stabilization need referral to the appropriate resources (see Table 1). Data suggest strong benefits in matching gay/bi clients with gay/bi mental health providers. These benefits include the clinicians' personal knowledge of the unique issues facing the GLBT community and greater ease in creating a safe environment for disclosure and discussion of sexual orientation for the client (Rutherford et al., 2012). Unfortunately, matching client and provider sexual orientation is difficult (Rutherford et al., 2012). This highlights the importance of referral to other culturally appropriate sources of care. Research strongly supports the use of mental health services that are specifically designed for gay/bi men (Blackwell, 2008).

Research assessing interventions to reduce depressive symptoms among a group of methamphetamine (meth)-dependent gay/bi men found that those men enrolled in a gay-tailored group had quicker rates of meth cessation and consequently had more rapid reductions in depressive symptoms than men in other treatment or placebo arms that did not receive gay-tailored interventions (Jaffe, Shoptaw, Stein, Reback, & Rotheram-Fuller, 2007). Gay-specific interventions were also found to be promising in a two-phase study conducted by Diamond, Levy, Closs, and Ladipo (2013) that focused on family-centered therapy in depressed and suicidal GLB adolescents. Results indicated higher rates of retention in treatment in addition to significant decreases in suicidal ideation, depressive symptoms, and anxiety (Diamond et al., 2013).

Although nurse practitioners and other clinicians working in emergency settings typically do not directly refer clients for mental health services themselves, as members of interdisciplinary teams integral to emergency mental health service delivery, it is important for them to consider evidence-based approaches in the treatment of depression in gay/bi men. Nurses, social workers, and other clinicians responsible for mental health service linkage need to ascertain what specific GLBT-oriented resources are available within the treatment facilities to which they refer clients. Finally, it is essential that providers include history items that assess interpersonal violence. Data indicate that interpersonal violence is associated with suicide attempts; clinicians need to ensure that depressed clients are not placed back into a dangerous situation, that the partner is not mistaken as a source of social support, and that additional services be offered as needed (Blosnich & Bassarte, 2012).

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Table 1. Top resources: GLBTQQI health[a]

Resource	Description	Website
Centers for Disease Control and Prevention: LGBT Health	U.S. organization; has thousands of materials and resources related to GLBTQQI health	http://www.cdc.gov/lgbthealth/links
Fenway Institute	Interdisciplinary center for research training, education, and policy development; major focus on improving health access for GLBTQQI persons	http://www.thefenwayinstitute.org
Gay & Lesbian Medical Association	Largest organization of GLBTQQI health care professionals; advocate for health care equality; resource linkage	http://www.glma.org
National Alliance on Mental Illness	Multicultural Action Center dedicated to addressing mental health disparities in GLBTQQI persons	http://www.nami.org
National Coalition for LGBT Health	Focus is on improving the health and well-being of GLBT persons	http://www.lgbthealth.webolutionary.com

Note. GLBT = gay, lesbian, bisexual, and transgender; GLBTQQI = gay, lesbian, bisexual, transgender, questioning, queer, in-between; LGBT = lesbian, gay, bisexual, and transgender.
[a]See reference list for additional resources.

CONCLUSION

Increasing GLBT Mental Health Competencies in Health Care Professionals

Data clearly indicate a lack of gay-specific cultural competence and bias in health care professionals (Irwin, 2007). This could be particularly detrimental to GLBT clients entering the health care setting for mental health services (Ash & Mackereth, 2013; Robertson, 1998). No specific studies have assessed homophobia among advanced practice nurses in emergency departments. Smith and Matthews (2007) assert that although overall homophobia has lessened, it still exists. Therefore, it is vital to include GLBT-specific content in the educational and clinical residency programs that prepare nurses and nurse practitioners, physicians and physician assistants, social workers, and other health care professionals. Unfortunately, research indicates that many health care professionals receive little to no GLBT-specific content within their curricula and/or clinical experiences (Lim, Brown, & Jones, 2013; Rutherford et al., 2012; Walsh, Barnsteiner, De Leon Siantz, Cotter, & Everett, 2012). Medical, nursing, and social work educators must make additional efforts to augment their curricula to incorporate GLBT health-related concepts, including a focus on GLBT mental health.

These professionals need to have greater exposure to GLBT communities within their programs of study, especially in clinical experiences. This might increase their comfort in working with GLBT men and women seeking care. In addition, homophobia and heterosexism among health care professionals need to be identified and aggressively discouraged. Continuing education that includes concepts related to GLBT mental health should be provided to clinicians currently practicing in emergency settings. Finally, future scholarship needs to focus on GLBT health disparities, including mental health, and ways in which these disparities can be reduced.

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Research identifying barriers to effective mental health service delivery for gay/bi men in emergency settings is nonexistent; this is an area in desperate need of study. Social workers are often relied upon to link mental health clients with community resources. Unfortunately, GLBT-dedicated social work scholarship has been found to be lacking (Scherrer & Woodford, 2013). Social work journals need to be more inclusive of GLBT-related research, and the profession needs to encourage social work scholars to conduct critical inquires on the subject.

CONCLUSION

Gay/bi men are at higher risk for certain mental health disorders, including anxiety, depression, and suicide. These individuals often present to emergency settings in need of evaluation and treatment. Despite the utilization of emergency mental health services by this population, clinicians are often underprepared in responding to their unique needs. This article specifically discussed depression in gay/bi men and provided a basic overview of an evidence-based approach in treating these men in emergency settings. Directives for future research and education were also suggested. Mental health service provision for gay/bi men in emergency settings is challenging. However, when emergency health care professionals, including advanced practice nurses, increase their competence and apply evidence-based strategies to assess, diagnose, plan, and treat gay/bi men with depression, they not only grow professionally but also contribute to much needed improvements in care for a very vulnerable human population.

REFERENCES

Aguinaldo, J. P. (2008). The social construction of gay oppression as a determinant of gay men's health: "Homophobia is killing us." *Critical Public Health*, *18*(1), 87–96. doi:10.1080/0958159080198255

American Nurses Association. (2010). *Code of ethics for nurses with interpretive statements*. Retrieved from http://www.nursingworld.org/MainMenuCategories/EthicsStandards/CodeofEthicsforNurses/Code-of-Ethics-For-Nurses.html

American Psychiatric Association. (2006). *Position statement: COPP position statement on therapies focused on attempts to change sexual orientation (reparative or conversion therapies)*. Retrieved from http://www.aglp.org/pages/position.html#Anchor-55000

American Psychiatric Association. (1980). *DSM-III: Diagnostic and Statistical Manual of Mental Disorders* (3rd Ed.). APA: Washington, DC.

Ash, M., & Mackereth, C. J. (2013). Assessing the mental health and wellbeing of the lesbian, gay, bisexual, and transgender population. *Community Practitioner*, *86*(3), 24–27. doi:A326505541

Asner-Self, K. K., Schreiber, J. B., & Marotta, S. A. (2006). A cross-cultural analysis of the Brief Symptom Inventory-18. *Cultural Diversity and Ethnic Minority Psychology*, *12*(2), 367–375. doi:10.1037/1099-9809.12.2.367

Besen, W. (2003). *Anything but straight: Unmasking the scandals and lies behind the ex-gay myth*. New York, NY: Harrington Park Press.

Bieber, I. (1962). Homosexuality: A psychoanalytic study. Jason Aronson, INC: Lanham, MD.

Blackwell, C. W. (2008). Nursing implications in the application of conversion therapies on gay, lesbian, bisexual, and transgender clients. *Issues in Mental Health Nursing*, *29*(6), 37–41. doi:10.1080/01612840802048915

Blosnich, J., & Bassarte, R. (2012). Drivers of disparity: Differences in socially based risk factors of self-injurious and suicidal behaviors among sexual minority college students. *Journal of American College Health*, *60*(2), 141–149. doi:10.1080/07448481.2011.623332

Caruso, K. (2014). *What is involuntary commitment?* Retrieved from http://www.suicide.org/involuntary-commitment.html

Choi, K. H., Paul, J., Ayala, G., Boylan, R., & Gregorich, S. E. (2013). Experiences of discrimination and their impact on the mental health among African American, Asian and Pacific Islander, and Latino men who have sex with men. *American Journal of Public Health*, *103*(5), 868–874. doi:10.2105/AJPH.2012.301052

Cleary, M., Horsfall, J., Hunt, G. E., Escott, P., & Happell, B. (2011). Continuing challenges for the mental health consumer workforce: A role for mental health nurses? *International Journal of Mental Health Nursing*, *20*(6), 438–444. doi:10.1111/j.1447-0349.2011.00757.x

Derogatis, L. R., & Melisaratos, N. (1983). The Brief Symptom Inventory: An introductory report. *Psychological Medicine*, *13*, 595–605. doi:10.1017/S0033291700048017

Diamond, G. M., Diamond, G. S., Levy, S., Closs, C., Ladipo, T., & Siqueland, L. (2013). Attachment-based family therapy for suicidal lesbian, gay, and bisexual

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adolescents: A treatment development study and open trial with preliminary findings. *Psychology of Sexual Orientation and Gender Diversity*, *1*(S), 91–100. doi:10.1037/2329-0382.1.S.91

Faria, G. (1997). The challenge of health care social work with gay men and lesbians. *Social Work in Health Care*, *25* (1/2), 65–72.

Fischgrund, B. N., Halkitis, P. N., & Carroll, R. A. (2011). Conceptions of hypermasculinity and mental health states in gay and bisexual men. *Psychology of Men & Masculinity*, *13*(2), 123–135. doi:10.1037/a0024836

Gay & Lesbian Medical Association. (2012a). *Then things bisexual men should discuss with their healthcare provider* [Brochure]. Washington, DC: Author.

Gay & Lesbian Medical Association. (2012b). *Then things gay men should discuss with their healthcare provider* [Brochure]. Washington, DC: Author.

Gay & Lesbian Medical Association. (2014). *Top ten issues to discuss with your healthcare provider*. Retrieved from http://glma.org/index.cfm?fuseaction=Page.viewPage&pageId=947&grandparentID=534&parentID=938&nodeID=1

Hatzenbuehler, M. L., Nolen-Hoeksma, S., & Erickson, S. J. (2008). Minority stress predictors of HIV risk behavior, substance use, and depressive symptoms: Results from a prospective study of bereaved gay men. *Health Psychology*, *27*(4), 455–462. doi:10.1037/0278-6133.27.4.455

Innes, K., Morphet, J., O'Brien, A. P., & Munro, I. (2013, December). Caring for the mental illness in patient in emergency departments—A exploration of the issues from a healthcare provider perspective. *Journal of Clinical Nursing*. Advance online publication. doi:10.1111/jocn.12437

Irwin, L. (2007). Homophobia and heterosexism: Implications for nursing and nursing practice. *Australian Journal of Advanced Nursing*, *25*(1), 70–76.

Jaffe, A., Shoptaw, S., Stein, J. A., Reback, C. J., & Rotheram-Fuller, E. (2007). Depression ratings, reported sexual risk behaviors, and methamphetamine use: Latent growth curve models of positive change among gay and bisexual men in an outpatient treatment program. *Experimental and Clinical Psychopharmcology*, *15*(3), 301–307. doi:10.1037/1064-1297.15.3.301

Lim, F. A., Brown, D. V., & Jones, B. A. (2013). Lesbian, gay, bisexual, and transgender health: Fundamentals for nursing education. *Journal of Nursing Education*, *52*(4), 198–203. doi:10.3928/01484834-20130311-02

Meijer, R. R., de Vries, R. M., & von Bruggen, V. (2011). An evaluation of the Brief Symptom Inventory-18 using item response theory: Which items are most strongly related to psychological distress? *Psychological Assessment*, *23*(1), 193–202. doi:10.1037/a002192

Mental Illness Policy Organization. (2011). *State-by-state standards for involuntary commitment (assisted treatment)*. Retrieved from http://mentalillnesspolicy.org/studies/state-standards-involuntary-treatment.html

Merriam-Webster. (2014a). Heterosexism. Retrieved from http://www.merriam-webster.com/dictionary/heterosexism

Merriam-Webster. (2014b). Homophobia. Retrieved from http://www.merriam-webster.com/dictionary/homophobia

Meyer, W. S. (2013). Part 1: The psychoanalyst and the "homosexual": A long, dark journey into light. *Smith College Studies in Social Work*, *83* (1), 18–35. doi:10.1080/00377317.2013.746920

Mustanski, B. S., Garofalo, R., & Emerson, E. E. (2010). Mental health disorders, psychological distress, and suicidality in a diverse sample of lesbian, gay, bisexual, and transgender youth. *American Journal of Public Health*, *100*(12), 2426–2432. doi:10.2105/AJPH.2009178319

Nicolosi, J. (1997). *Reparative therapy of male homosexuality: A new clinical approach*. Northvale, NJ: Jason Aronson Inc.

Robertson, A. E. (1998). The mental health experiences of gay men: A research study exploring gay men's health needs. *Journal of Psychiatric and Mental Health Nursing*, *5*, 33–40. doi:10.1046/j.1365-2850.1998.00097.x

Rutherford, K., McIntyre, J., Daley, A., & Ross, L. E. (2012). Development of expertise in mental health service provision for lesbian, gay, bisexual, and transgender communities. *Medical Education*, *46*, 903–913. doi:10.1111/j.1365-2923.2012.04272.x

Ryan, C., Russell, S. T., Huebner, D., Diaz, R., & Sanchez, J. (2010). Family acceptance in adolescence and the health of LGBT young adults. *Journal of Child and Adolescent Psychiatric Nursing*, *23*(4), 205–213. doi:10.1111/j.1744-6171.2010.00246.x

Sanchez, J. P., Hailpern, S., Lowe, C., & Calderon, Y. (2007). Factors associated with emergency department utilization by urban lesbian, gay, and bisexual individuals. *Journal of Community Health*, *32*(2), 149–156. doi:10.1007/s10900-006-9037-1

Scherrer, K., & Woodford, M. (2013). Incorporating content on gay, lesbian, bisexual, transgender, and queer issues in leading social work journals. *Social Work Research*, *37*(4), 423–431. doi:10.1093/swr/svt031

Schout, G., de Jong, G., & Zeelen, J. (2010). Establishing contact and gaining trust: An exploratory study of care avoidance. *Journal of Advanced Nursing*, *66*(2), 324-333. doi:10.1111/j.1365-2648.2009.05171.x

Seidel, H. M., Ball, J. W., Dains, J. E., & Benedict, G. W. (2006). *Mosby's guide to physical examination*. St. Louis, MO: Mosby.

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Smith, D. M., & Matthews, W. C. (2007). Physicians' attitudes toward homosexuality and HIV: Survey of a California Medical Society-revisited (PATHH-II). *Journal of Homosexuality*, *52*(3–4), 1–9. doi:10.1300/J082v52n03_01

Socarides, C. (1978). *Homosexuality*. New York, NY: Jason Aronson Inc.

Walsh, A. M., Barnsteiner, J., De Leon Siantz, M. L., Cotter, V. T., & Everett, J. (2012). Lesbian, gay, bisexual, transgendered, or intersexed content for nursing curricula. *Journal of Professional Nursing*, *28*(2), 96–104. doi:10.1016/j.profnurs.2011.11.004

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