Lesbian Health and Homophobia: Perspectives for the treating Obstetrician/Gynecologist

Katherine A. O'Hanlan, M. D.

Assistant Professor, Associate Director, Gynecologic Cancer Section, H-302

Stanford University School of Medicine

Stanford, CA 94305-5317

Telephone (415) 723-8585

Facsimile (415) 723-7737

Accepted for publication in Current Problems in Obstetrics and Gynecology

Biographical Sketch

As Associate Director of Gynecologic Cancer Surgery at Stanford University, Dr. Kate O'Hanlan's research focus has been on pathobiology and surgical therapy for endometrial and ovarian cancer. In October 1992, Dr. O'Hanlan safely removed the world's largest ovarian mass, weighing 303.4 pounds. O'Hanlan co-authored the book Natural Menopause: Guide to a Woman's Most Misunderstood Passage.

Dr. O'Hanlan was also author of the Benefit Parity Bill at Albert Einstein College of Medicine in New York in 1988 and at Stanford University in December 1992. She is immediate past-president of the Gay and Lesbian Medical Association, the United States and Canadian association of gay and lesbian physicians and physicians-in-training. Dr. O'Hanlan founded and remains honorary chair of the Lesbian Health Fund. This fund has made ten grants for research on lesbian health, psychology, and access to care issues. Dr. O'Hanlan presented "Recruitment and Retention of Lesbians in Health Research" at the National Institutes for Health and addressed the President's Cancer Panel asking that prevention, research and treatment outreach efforts be focused on the gay and lesbian community as they are on other minority communities.

Lesbian Health and Homophobia: Perspectives for the Treating Obstetrician/Gynecologist

TABLE OF CONTENTS

LESBIAN HEALTH AND HOMOPHOBIA:
PERSPECTIVES FOR THE TREATING OBSTETRICIAN/GYNECOLOGIST

ABSTRACT--Surveys of the lesbian community assessing health risk profiles suggest the need for further scientific inquiry. A tentative health profile of lesbians suggests they are more likely to be nulliparous or oligoparous, possibly having a higher body mass index, using more tobacco and alcohol, and are less likely to contract gynecologic infections and sexually transmitted diseases. If this profile is correct, then lesbians would be at higher risk for breast, uterine, ovarian and colon cancers as well as heart disease and stroke.

Homophobia, the antipathy or disdain for gay men and lesbians, is a widespread response to this unfamiliar and previously hidden segment of society. Medical practitioners are not immune to having learned this pervasive societal prejudice and may unintentionally reflect disdain for lesbians when they present as patients. Survey evidence suggests that lesbian patients do perceive this disdain and have been alienated from the medical system, reducing their utilization of standard screening modalities, potentially resulting in higher morbidity and mortality from cancers and heart disease.

Abundant research suggests that diversity of sexual orientation appears to result variably from genetic influences, embryologic hormones, and personal experiences without any associated sociopathology. Thus, being lesbian is not genetically or biologically hazardous, but risk factors are conferred through "homophobic fallout." The medical and psychological effects of such disdain are profound on the developing self-concept of the youth as well as the adults who recognize within themselves a same-sex orientation. Therefore, the process of homophobia– the socialization of heterosexuals against homosexuals and concomitant conditioning of gays and lesbians against themselves–must be recognized by physicians as a legitimate health hazard. Solutions to homophobia as a health hazard are discussed which would improve the quality of medical care provided to gay men and lesbians and favorably impact the health and quality of life of this population.

IN BRIEF

Newspaper, television and theatre have over represented the sensational fringes of homosexual culture and portrayed gay men and lesbians as social deviates, while the vast majority of homosexuals have been blending into every segment of American society. The effect has perpetuated negative and inaccurate stereotypes and fostered continued disdain for homosexuals by well-meaning and reasonable heterosexuals. Perceiving this disdain, gay men and lesbians maintained a hidden subculture. In the absence of real experience of who lesbians and gay men really are, these stereotypes and misinformation have persisted.

For 40 years, the psychiatric literature has been providing consistent, abundant peer-reviewed evidence that gay and lesbian individuals are part of the normal expression of the natural diversity of human sexuality. The Diagnostic and Statistical Manual III, a handbook of psychiatric disorders which included homosexuality, was revised in 1981, excluding homosexuality as a disorder. The book's inclusion of homosexuality was found to be reflective more of societal prejudice than of any psychopathology observed in homosexuals. As a result, homosexuals have become empowered to personally and overtly reject these uninformed biases and stereotypes still held by the uninformed or unfamiliar, requesting recognition and what it perceives to be equal rights.

The distinguishing characteristics of the lesbian and gay communities are not only based on sexual behavior, but on the psychosocial impact of living in the focus of ubiquitous misunderstanding and hatred. Medicine has not immunized itself from the misunderstanding and hatred. What is now lacking is reliable information about the health habits of members of the gay and lesbian communities beyond the issue of their sexual behavior. Perceiving this lack, multiple lesbian health activists have undertaken health surveys to document and profile the health and demographic factors of their communities. While these informal surveys, distributed at lesbian social events are not the standard of statistical inference, they can provide valuable information with which to focus future research endeavors.

The major effects of discrimination against minority individuals include higher morbidity and mortality from cancers and heart attacks. This is because minority individuals possess more risk factors, and present later in the course of diseases. Minority individuals also encounter prejudice from medical providers which may further alienate them from obtaining health care.

The survey data from the lesbian community suggest that similar minority issues in medical care are present in the health care of the gay and lesbian community. It is perceived that providers lack knowledge of the issues salient in the lives of lesbians, and that healthcare providers have inadvertently or purposely alienated their patients. The gay and lesbian community needs medical care, based on quality research, which recognizes its unique medical demographic profile, and provides with sensitivity and respect.

A demographic profile of lesbian health will be described by reviewing the lesbian health literature. Medical and psychological effects of prejudice from health care providers, family, and educational, religious and governmental organizations will also be discussed because they exacerbate the problem, followed by suggestions for improvement. Greater understanding and knowledge of who lesbians are and the psychological effects of societal disdain for them will enable obstetricians and gynecologists to maintain the highest standard of medical care for all of their patients, including the lesbian patient.

LESBIAN HEALTH AND HOMOPHOBIA: PERSPECTIVES FOR THE TREATING OBSTETRICIAN/GYNECOLOGIST

INTRODUCTION

In the last 30 years American society has seen a subset of individuals coalesce and form a distinct culture which is now requesting both recognition and what it perceives to be equal rights.[1] Capitalizing on Americans' lack of familiarity with gay men and lesbians, newspaper, television and theatre have over represented the sensational fringes of homosexual culture and portrayed gay men and lesbians as social deviates. The effect has perpetuated negative but inaccurate stereotypes and has fostered continued disdain for homosexuals by well-meaning and reasonable heterosexuals. Gay men and lesbians remain the brunt of multiple levels of legal prejudice, with negative assumptions about their morality, sexuality, employability, and integrity. These categories of accusations are very similar to those made against African Americans, Jews, and other minority groups when prejudice against these groups was legal and widely practiced.

Perceiving this disdain, gay men and lesbians maintained a hidden subculture.[2] But this has resulted in perpetuation of misinformation and bias because most heterosexuals have subsequently been denied knowledge of the homosexuals in their own social circles, work places, and even families. It has been shown that when heterosexuals know increasing numbers of gay men and lesbians, their degree of prejudice and disdain drops significantly.[3]

Over the last 40 years the psychiatric literature has provided abundant peer-reviewed evidence that the stereotypes are incorrect and unrepresentative of gay and lesbian individuals. The Diagnostic and Statistical Manual III, a handbook of psychiatric disorders which included homosexuality, was reviewed in 1981 and revised, finding that it reflected the popular social intolerance of the time in categorizing homosexuality and even ego-dystonic homosexuality as psychiatric disorders.[4] As a result, homosexuals have become empowered to personally and

overtly reject the public's uninformed biases and stereotypes. Gay men and lesbians claimed a new sense of legitimacy in who they were (e.g., gay pride) as a backlash against long held internalized hatred, reminiscent of the civil rights battles for African Americans in the early 1960's (e.g., black pride). The gay and lesbian subculture has since become more open, with homosexuals now weaving openly through all segments of society.

It has been commonly thought that the distinguishing characteristics of the lesbian and gay communities were not culturally salient but based only on sexual behavior.[5] Medical researchers have not profiled the gay or lesbian communities as well as they have profiled other minority communities such as Native Americans, Latin Americans, or African Americans.[6, 7] There is scant statistically valid information about the health habits of members of the gay and lesbian communities beyond the issue of their sexual behavior.[8] Perceiving this lack, multiple lesbian health activists have undertaken surveys of local or national lesbian communities to document various health and demographic factors.[9-12] These "snowball" surveys, handed out and passed around at lesbian socials, and events are not the standard of statistical inference, but they provide valuable information with which to focus future research endeavors.(Table 1)

Funded research projects have failed to recognize not only the usual health demographic issues in the lesbian community by not stratifying by orientation or sexual behavior, but these projects have also failed to investigate the issues of membership in a distinct minority community that is still legally discriminated against.[13] It is widely recognized that the major effects of discrimination against minority individuals include higher morbidity and mortality from cancers and heart attacks.[14] Analysis of existing data suggest this is because minority individuals possess more risk factors and present later in the course of their diseases.[15] Minority individuals also encounter prejudice from medical providers which may further reduce their utilization of the health care systems.[16]

Survey data of the lesbian community suggest that similar minority issues in medical care are present in the health care of the gay and lesbian community.[9, 10, 17] It is perceived that providers lack knowledge of the issues salient in the lives of lesbians and that health care

providers have inadvertently or purposely alienated their patients.[18] The gay and lesbian community needs medical care, based on quality research, which recognizes its unique medical demographic profile and provides with sensitivity and respect.

In this review of lesbian health literature, the demographic profile of lesbian health will be described. The medical and psychological effects of prejudice from health care providers, family, and educational, religious, and governmental organizations will also be discussed, followed by suggestions for improvement. With greater understanding and knowledge of who lesbians are and the psychological effects of societal disdain for them, obstetricians and gynecologists can maintain the highest standard of medical care giving to all of their patients, including the lesbian patient.

DEFINING LESBIAN WOMEN

What is a lesbian? The definition can be based on either a specific sexual behavior or by an identity construct.[5, 19] In the health care context, both behavior and identity are important variables.[13] A lesbian defined by behavior is a woman whose sexual practices include homosexual sex. Behavioral investigation will only reveal variables associated with sexual activity, such as sexually transmitted diseases, sexual experimentation, and functional sexuality issues. "Are you sexual with men, women, both or neither?" is a question in the research setting or medical interview which will elucidate a woman's sexual behavior. She may be living ostensibly identified as a heterosexual in her social circle and may not ever call herself a lesbian but engage in sex only with women. On the other hand she may be living in a lesbian community but engaging in sexual relations with men during times of limited available relations in her social milieu. The importance of the strict behavioral definition is that it avoids requiring potentially uncomfortable self-labeling, but it misses the sociocultural identity and support systems which also impact health and behavior over time.

A lesbian defined by identity is a women who participates in the lesbian sociocultural network and may or may not engage in any sexual activity with other women. The lesbian identity appears to be present even before a young girl recognizes the incongruency between a her own feelings and those she perceives of other girls, although she may not self-label until much later.[20] A lesbian identifies with the specific social group's values and perceives herself connected to a larger social structure which provides her with a sense of community.[21] The stigmatization of the identity is the preponderant cause of ego-dystonic homosexuality and confers a majority of the psychosocial effects of homophobia: isolation, shame, diminished self-concept, self-destructive behaviors and unsupportive health habits.[13]

Identity can be investigated in both research and medical care giving situations with the question "Do you identify as heterosexual or straight, bisexual, gay or lesbian or homosexual, or none of these." The identity definition of lesbianism allows an individual to categorize herself based on her sociocultural self-concept and transcends the issue of sexual behavior. The identity based research question is complicated by the fact that the various terms for female homosexuality may not be used by all lesbians and may vary over time. Typically women who "came out," or began to self-identify as homosexual in the 1960's, will call themselves "gay women." The women who came out in the 1970's and early 1980's will most often self-label as "lesbians," while women who came out in the late 1980's and more recently may use the term "queer" or "dyke" for themselves. These latter two terms are actually used by some members of the lesbian community who have reclaimed their use from the strictly derogatory, denaturing the previous sting of disdain. These terms are not used in the clinical setting. The term "homosexual" is generally a clinical term which neither gay men nor lesbians use socially. In this discourse, and in the preponderance of literature about lesbians, any woman who self-identifies herself by her response to either an identity or behavioral question is included in the survey; however, she may actually engage in heterosexual activity or bisexual activity. Because the effects of both lesbian behavior and lesbian self-identity are important and require investigation, survey self

identification by identity and/or behavior will suffice and be used to generate the following profile of lesbian health.

Thus, adapting the definition of women's health issues as employed by the Office of Research on Women's Health, lesbian health issues are those issues to which lesbians are "more susceptible, may have greater prevalence, or may be unique in developing, or be affected by differently" than heterosexual women.[22]

THE INCIDENCE OF LESBIANISM

A review of surveys from such countries as Japan, Thailand, Denmark, France, The Republic of Palau, Great Britain and Australia reveal that .2 to 6.9% of women variably describe themselves as lesbians.[23] The surveys reviewed in the Unites States suggest that as much as 3.6% of the 65 million American women are lesbians. This means that our country is home to some 2.3 million lesbian citizens. Over 69,000 lesbian couples identified themselves in the 1990 census count, which is an unknown fraction of the lesbian population.[24] No study of lesbians has ever validated the popularly quoted 10% incidence of female homosexuality.

THE CAUSES OF ORIENTATION DIVERSITY

How can sexual orientation diversity be accounted for? Is it genetic or environmental? Current scientific literature supports a multifactorial determination of orientation with the following contributions.

Biologic Theories

Homosexuality has features of a purely biologic phenomenon, similar to handedness or hair-color, because of the patterns indicative of genetic inheritance are observed.[25] Anecdotally, many lesbians describe clear recall of same-sex attractions long before kindergarten.

There is molecular and anatomic evidence of biologic properties which impact on sexual orientation. One hypothesis considers the role of prenatal hormonal influences on brain sexual differentiation and subsequent orientation.[26] This theory is supported by recent evidence that females with prenatal exposure to diethylstilbesterol, or the salt-wasting variant of congenital adrenal hyperplasia, have a much higher probability of being lesbians than the study controls.[27] Also, genes such as the HY-antigen complex and the X chromosome have been shown to elicit secretion of various intrauterine hormones including testosterone within the fetal brain mediated by neurotransmitters. Gonadotrophin feedback does not appear to affect brain feminization in Homo sapiens. However, the balance of prenatal hormonally mediated masculinization and defeminization of the brain can provide a basic model for understanding some of sexual behavior.[28]

Studies of the midsagittal plane of the anterior commissure in autopsy specimens revealed that gay men had a 18% larger anterior commissure than heterosexual women and a 34% larger anterior commissure than heterosexual men.[Allen, 1992 #1125;Allen, 1992 #1125] The observed anatomical differences in commissural size observed in these autopsies may explain some differences in cognitive function and cerebral lateralization between homosexuals and heterosexual men.[Levay, 1991 #67] In another study, the volume of and cell number of the suprachiasmatic nucleus of homosexual men was observed to be twice as large as heterosexual male controls. During development, the volume and cell counts in this nucleus reach peak values around 13-16 months after birth, after which heterosexual males' and females', but not homosexual males', cell size and counts decline to about 35% of the peak value.[Swaab, 1992 #1127]

Clinical genetic studies also suggest modes of inheritance. When a large cohort of homosexual and heterosexual females and males were questioned about their siblings' sexual orientations, it was most clearly seen that both male and female homosexuality is, at least in part, familial.[32] Lesbians had a higher than expected number of homosexual brothers compared to heterosexual females. Furthermore, lesbians did not differ significantly from each other with

regard to proportions of either lesbian sisters or gay brothers. This suggests that similar familial factors influence both male and female sexual orientation.

In another study of twins, recruited by an ad in a lesbian newspaper, 48% of monozygotic co-twins, 16% of dizygotic co-twins, and 6% of adoptive sisters were homosexual, suggesting heritability.[33] More work is needed employing large samples and careful methods before the degree of co-familiality of male and female homosexuality can be resolved definitively.[32] Monozygotic-twin studies suggest that genetics accounts for about 70% of the determinants influencing the development of male homosexuality.[34, 35] Whether this is also true for lesbians has not been investigated.

Hormonal differences were investigated in the adult lesbian, stratifying between lesbians who were aware of their homosexuality since an early age, so called "primary lesbians," and lesbians who became aware of their true orientation later in life, or "secondary lesbians," in comparison to heterosexual women. Each of these groups were measured at the same point in the menstrual cycle for levels of testosterone, androstenedione, estradiol and progesterone, and all were tested on instrumentality and expressivity, two traits measured by the Personal Attributes Questionnaire (PAQ), related to sex roles. Apart from the defining criteria, no significant differences were found between any of the groups on any measures.[36]

Psychologic Theories

Sexual orientation does not appear to be a distinct trait with a strictly genetic basis but appears to also be a sociocultural expression of universal sexual and emotional drives. Many lesbians describe living satisfactory heterosexual early lives, even having marriages with children and "coming out" at midlife or in later life. This occurs typically at some later time of greater empowerment or after heightened self-examination, after which the woman begins to express herself more fully and accurately.

Parental and social enforcement of majority expectations teaches many young lesbians to repress their feelings and participate in majority culture.[2, 37] An individual chooses behaviors in response to environmental conditions, which results in a basic but evolving personal

psychosexual strategy. By this process, various expressions of the male and female genders, from military leaders to ballet dancers to celibates are explained, and a normative contemporary society is elucidated whose spectrum of sexualexpression ranges from purely homosexual to bisexual to purely heterosexual to celibate. This is reminiscent of ancient Athens and modern Mediterranean/Latin cultures.[38] In a study investigating the parent-child relationships of lesbians and heterosexual women, there was no significant family background variable or parental sex-role adherence variable that correlated with sexual orientation using a standardized questionnaire with interviews about family background relationships, sexual experiences, and attitudes.[39] Lesbians are not more likely than heterosexual women to have had poor or failed relationships with men or to have been mistreated, molested or raped by men.[9,40,41] Studies of lesbians confirm that they did not have more negative childhood sexual experiences with males, more positive childhood sexual experiences with females, more accepting parental attitudes toward sexuality and sexual experimentation or more distant relationships with their parents than heterosexual women. [42] There are no apparent family pathologic variables which have been associated with lesbianism,[39] although one study found that lesbians' parents differed from heterosexual women's parents with respect to having relatively more intellectual, independent, dominant mothers.[43]

Most theories of sexual development describe adolescence as a critical time in personal development because of changes in anatomy and physiology from puberty, psychologic awakening of sexual drives and increased importance of social messages about appropriate and inappropriate sexual behaviors and relationships. Human sexuality can not be rigidly compartmentalized into either homo- or heterosexuality but varies along a continuous spectrum.[44] It is clearly affected by psychodynamic influences. A small degree of orientation flexibility may result from the evolution of our capacity to learn, the complexity of the human central nervous system, and behavioral plasticity in general.[19] Some believe that before "coming out," young people should have the opportunity to explore their sexual identity with a psychotherapist.[45] Others have interpreted this as an ability to "change orientation" once one has

been established; however, this concept has been reviewed by the American Psychiatric Association and determined implausible.[46]

Social Theories

Homosexuality in modern industrial nations has risen as a result, in part, of the demographic transition to a culture with low mortality, lower fertility, and relaxed reproductive demands, which is a more permissive environment for individual expression of diversity of sexual decisions and partner gender choices.[38] Market pressures on the family have shifted to the more financially independent individual over the last century allowing greater differentiation of the individual from the family culture. With greater independence from the family unit, individuals have begun to pursue fulfillment of their social needs consistent with their orientation.[D'Emilio, 1992 #1156]

Character Preference Theories

For some individuals, the genital organs are not the prime focus of sexual attraction, with their sexual arousal based on criteria that transcend genital categories.[47] It should not be assumed that partner choice is based on biological sex, but rather a number of physical and psychological characteristics.[48] Investigation of an amalgam of characteristics, both related and unrelated to the partners' physical sex may best determine the basis of sexual attraction. In many studies androgynous individuals were more attractive than the very masculine or feminine stereotypes.[47] Many lesbians recognize their orientation later in life after very successful relations with men, and some feel this to be their choice.[van Gelder, 1993 #1159]

It may be most accurate to employ an ethologic perspective which synthesizes the various theories as they relate to homosexuality.[49] Temperament and personality are seen as interacting with heritable traits, family influences and social milieu during the time of emergence of the individual's sexuality. These traits are also heritable or developmentally influenced by hormones, making it is reasonable to assume a degree of indirect heritability for homosexuality without requiring that either genes or hormones directly influence sexual orientation per se.[50] Most investigators view sexual orientation as a multifactorial derivation of both heredity and

environment that is complexly determined and diversely experienced. Thus, only a biopsychosocial model currently fits our state of knowledge in this field.[21]

Psychologic Correlates of Lesbianism

Who are lesbians and what are they like? Diversity within the lesbian community parallels the diversity of the larger community defying conceptualization of the "average lesbian." There are, however, many widely held negative stereotypes about lesbians. Some of these negative perceptions include inappropriate seduction attempts on heterosexual women, sexual bravado, and a masculine aura, all correlating with intensity of social rejection of women, but not men, in our culture.[51] In a study of these stereotypes, it was shown that heterosexual women perceive lesbians significantly differently than lesbians actually see themselves.[52] These differences in perception persisted even when the heterosexual women knew a lesbian socially, suggesting these stereotypes are resistant to change. Another interpretation is that lesbians may, in fact, dress more casually and appear more androgynous because thay do not subscribe to restrictive popular standards of what is considered attractive in women's behavior and appearrance. In the absence of an internal drive to be attractive to and please men, lesbians culture has created its own standards of functional comfortable dress and independent behavior which they may not individually perceive as very different from the dominant cultural standard. Supporting this view, one study revealed that lesbians demonstrated significant differences concerning sex-role adherence as measured by the Bem Sex Role Inventory, with lesbians more masculinely sex-role typed than heterosexual women.[39] No differences were observed in the clinical scales of the Minnesota Multiphasic Personality Inventory (MMPI), however a difference in the degree of social alienation was observed.[53]

Concern has been voiced that lesbians may hate men.[54] What may have been misperceived as hatred toward men are, for some, an expression of resentment of the benefits conferred to men by discriminatory societal sexism and heterosexism. While heterosexual women may be willing to tolerate some degree of sexist bias in social settings in order to maintain attractiveness and connection to men, the lesbian derives no such benefit from

tolerating bias based solely on gender. Many lesbians perceive themselves as needing to overcome multiple obstacles to achieve what some men are naturally conferred by their in-group status in American social order.[2] Discriminatory treatment in job hiring and social interactions ultimately lead to a frustrating loss of opportunities and a subsequent economic deprivation with no avenue of recourse because such discrimination is legal and socially accepted. Reasonably, lesbians may also tire of dealing with the stigma of being considered unattractive social outcasts and having their relationships denied family support or legal recognition.[55]

Not surprisingly, some studies have revealed slightly higher lifetime rates of depression, attempted suicide, psychological help-seeking and substance abuse.[56-60] Many authors attribute this to the chronic stress from the enduring societal hatred[61] or the societal ascription of inferior status.[62, 63] Stress from homophobia may have worse mental health implications than other stresses because lesbians have lost their familial support systems[9, 62, 63] and may have a need to hide or suppress their feelings and thoughts from heterosexual friends or family.[64]

Most lesbians, however, are content with their orientation and function well in society.[65] In an Iowa survey of 117 lesbians and bisexual women in 1981, 92% of lesbians were extremely happy with their orientation and pleased most of the time.[66] When Ann Landers asked her readership if they were glad to be gay, 75,875 gay men and lesbians responded. Three percent of respondents wrote that they were not glad, citing victimization by violence, and family, governmental , job, or social discrimination.[67]

WHAT IS HOMOPHOBIA?

Homophobia, the "unreasoning fear of or antipathy toward homosexuals and homosexuality,"[Random House Dictionary of the English Language, 1987 #130] operates both internally and externally.[68, 69] Internal homophobia represents learned biases that all individuals incorporate (internalize) into their belief systems as they mature in a society biased against homosexuals. External homophobia is the overtly observed or experienced expression of those

biases. Such acts range from social avoidance to verbal abuse to civil, military, and religious discrimination to physical battery.[70] Homophobia persists when families, friends, teachers, colleagues, religious institutions, government, and the popular media perpetuate the inaccurate perception of gay men and lesbians as child molesters, immoral individuals or threats to traditional family values and the "natural" order.[71, 72] In one religious monthly booklet, youth can read that "God disapproves of all homosexual acts. He condemned homosexual practices as unnatural and 'obscene.'"[73]

Theories about the cause of this prejudice include a perception that heterosexuals may need to reassure themselves that they are "normal" or "moral"[74] or need to reject perceived feminine attributes in men and masculine attributes in women.[70] The mere development of disgust for homosexuals implies a preoccupation with the issue which may derive from difficulty coping with one's own attraction to the same sex, however small.[74] While most individuals do not perceive themselves as homophobic, unfamiliarity with members of the gay and lesbian community can inadvertently result in acceptance of misinformation or biased attitudes toward gay men and lesbians. It has been demonstrated that knowing one or more homosexuals personally is associated with less hostility toward all homosexuals.[3, 75]

Extensive psychiatric literature reveals no scientific basis for homophobic prejudice. No differences have been found in levels of maturity, neuroticism, psychological adjustment, goal orientation, or self actualization between heterosexuals and homosexual people.[1, 36, 42, 56, 74, 76-85] The inclusion of homosexuality as a mental disorder in the Diagnostic and Statistical Manual(DSM-III) has been reviewed and subsequently rejected. The original rationale for pathologizing homosexuality was more reflective of the social mores at the time it was inserted and is not supported by later literature.[4, 86] The category of ego-dystonic homosexuality similarly appears more reflective of the individuals' internalized homophobia or difficulty dealing with societal homophobia than of any intrinsic abnormality.[4]

LESBIANS AND THE DOCTOR-PATIENT RELATIONSHIP

Homophobia can lead to misdiagnosis and mistreatment by physicians and alienation and misunderstanding by patients.[17, 87-89]. Many studies have revealed significant prevalence of homophobic attitudes among every type of health care practitioner.

A 1987 questionnaire revealed that many faculty members at a Midwest bachelor-degree nursing school believed lesbianism was a disease (17%), immoral (23%), disgusting (34%), and unnatural (52%).[90] Some (17%) thought lesbians molest children, and a few (8%) thought lesbians were unfit to be registered nurses. In a survey of nursing students, respondents rated lesbians who preferred non-feminine garb as less intelligent, less achievement oriented, less socially desirable, and having fewer friends than the lesbians who wore more feminine garb.[91] Many respondents believed that lesbians "seduced 'straights'" and were a high risk group for AIDS.

Physicians hold similar biases. In a 1986 survey returned by 930 physician members of the San Diego County Medical Society, a higher percentage of Ob/Gyn physicians than the entire physician sample average scored in the "severely homophobic," range (31.4% versus 23%). Additionally, 31% of Ob/Gyns reporting that they would also refuse admission to a highly qualified lesbian or gay applicants to medical school or residency.[Matthews, 1986 #84] Overall 40% said they would stop referring to a colleague if they found out their colleague were gay or lesbian. Among OB/GYN respondents, half would not refer to a gay or lesbian pediatrician or psychiatrist, and one quarter would stop using a gay or lesbian surgeon or radiation oncologist. Thirty-one percent of the Obstetrician/Gynecologists and Family Practice/Internists, the primary care providers and gate-keepers for most comprehensive health plans, reported significantly hostile attitudes toward gay and lesbian patients. Forty percent reported that they felt somewhat uncomfortable providing care to gay or lesbian patients. [Matthews, 1986 #84]

This bias is observed by gay and lesbian physician colleagues. In the 1994 survey of the membership of the American Association of Physicians for Human Rights(now called The Gay and Lesbian Medical Association), a United States and Canadian medical association, 52% of the

711 respondents had observed denial of care or provision of reduced or suboptimal care to gay or lesbian patients.[92] (Table 2) Eighty-eight percent heard physician colleagues disparage gay or lesbian patients because of their sexual orientation. Although 98% of respondents believed it was critical that patients inform their physicians about their orientation, 64% believed that patients who did so risked receiving substandard care. Additionally, 17% reported being refused medical privileges, employment, educational opportunities, and referrals from other physicians because of their orientation. Verbal harassment, social ostracism or insults from their medical colleagues were reported by one third of physicians and by one half of medical student respondents.

Lesbian and gay obstetrician/gynecologists perceived themselves experiencing job-related discrimination and economic discrimination and being denied referrals more than the group averages for either category, second only to psychiatrists in both categories. Summarizing the survey results, only 12% of respondents felt that "gay, lesbian or bisexual physicians are accepted as equals in the medical profession."[92]

Gay and lesbian medical students have also complained of hearing frequent, overtly hostile comments about lesbians and gays by their attending physicians during clinical teaching rounds.[93] They have requested reliable information in their curricula about homosexuality, asking that medical school educators present updated, inclusive lectures that deal directly and honestly with gay-related health issues.

Most worrisome is the fact that patients perceive the negative attitudes of their care givers. In one study, 72% of lesbians surveyed about their experience as patients reported experiencing ostracism and rough treatment, overhearing derogatory comments, and having their life-partners excluded from discussions by their medical practitioners[94](Table 3). Many studies document that these negative reactions from health care practitioners began immediately after patients revealed their lesbian orientation.[Bybee, 1990 #28; Glascock, 1981 #90; Stevens, 1988 #255; Deevy, 1990 #93; Kass, 1992 #94; Dardick, 1980 #92; Smith, 1985 #447] Sensing this hostility toward them, between 67-72% of lesbians in various studies elected not to reveal their sexual orientation or same sex behavior to health providers citing fear of repercussions if they

did self-disclose.[17, 66, 95] One respondent summarized, "It's like putting your health in the hands of someone who really hates you."[18]

The observed alienation from health care providers caused 84% of surveyed lesbians to report that they were hesitant to return to their physicians' offices for new ailments.[94] Between 14 and 70% of bisexual women's and lesbians' physicians are unaware of their orientation. While one third to one half of lesbians w3ould like to share this information with their physician, over one third of those who did so reported a negative consequence to their care. Approximately half of lesbian survey respondents believe their care providers are good or very good. Six per cent of lesbians' providers tried to "cure" them of their homosexuality.

Many lesbians have subsequently turned to complementary health care providers who offer more nurturing care in more natural contexts.[9, 66] These lesbians are then unlikely to receive any of the standard medical screening tests, including pap smears, blood pressure assessment, serum cholesterol level, stool blood assays, etc. which are offered to patients at routine check-ups. The effects of this alienation from medical care have never been quantified but may result in significant increase in morbidity and mortality. This degree of institutionalized discrimination would not be tolerated by other minority groups.

When medical research is performed on lesbians or when homosexuality is discussed in textbooks, the social stigma persists. Scientific authors rarely involved research participants beyond the role of providing data, rarely reported feedback to subjects, and almost never indicated using their data to promote supportive social or health care action for homosexuals.[96] The photographs employed to portray lesbian individuals were observed to present an unfavorably inaccurate and unrepresentative view of lesbians.[97] Sometimes even educators who have supportive attitudes have held themselves back from providing lesbian-inclusive and gay-friendly information because they perceive that they will also be held in disdain or criticized for their support of immorality.[98]

None of the patient educational brochures created and distributed by the American College of Obstetricians and Gynecologists (ACOG) currently include any information about

sexual orientation in their brochures dealing with teenage sexuality, teaching children about sexuality, sexual dysfunction, painful "intercourse" (sic), and sexually transmitted diseases despite numerous requests to the ACOG Patient Education Committee.[99] After 3 years of written requests, the Committee has decided to revise these brochures and create one entitled "Lesbian Health."[100]

LESBIAN HEALTH: A COMPILATION OF THE SURVEY DATA

Until homosexuality was no longer categorized as a mental illness, the majority of research on lesbianism in many journals typically reflected the heterosexual, male, anglocentric bias of the authors which was not only prevalent but acceptable.[12, 101, 102] There are four articles based on a 1980 survey and in-depth practice observations of lesbians in Obstetric and Gynecologic specialty journals since the year 1966.[66, 103-105] These scholarly reports of survey data analyze results of detailed questionnaires of gynecologic issues distributed at women's music festivals and cultural events.

It is admittedly difficult to do research on a population whose "lifestyles" are unrecognized in 50 states and frankly illegal in 22 states. No federally funded population study has ever been stratified by orientation. In 1984, the next large-scale survey effort had as its purpose to "think through what lesbian health might mean."[9](Table 1) This detailed survey of 104 questions was distributed to lesbians across the United States and mailed back to the investigators. It was not immediately published because many statistical groups refused to analyze data about homosexuals. However, it has subsequently been analyzed and published and now it serves as the template for many of the surveys that followed. Also in 1984, among the most academically conceived survey instrument was being piloted among black lesbians. It focused on how multiple levels of discrimination influence their relationships and community interactions.[12] This culturally relevant and statistically valid 28-page questionnaire included a standardized depression scale with norms established for the black population. The next survey

was distributed by the Michigan Department of Public Health and focused on women's knowledge of and the impact of the AIDS epidemic as well as on a broad range of lesbians' health concerns and experiences.[10] Another survey done in Los Angeles was sponsored by the Los Angeles Gay and Lesbian Community Services Center. It included empirical questions about health care experiences and about attitudes toward future types of health clinic environments for lesbians.[11] The San Francisco survey was conducted by the Department of Public Health as one of a series of assessments of knowledge, attitudes, and behaviors of various San Francisco populations regarding sexual behaviors, drug practices and risk for AIDS.[106] It was expanded to include demographic and background information, health and disease histories, and mental health , as well as substance use, sexual attitudes, and behavior. Focusing on concerns about the risk of breast cancer in the lesbian community, members of the Lesbian Health Project of Los Angeles conceived their survey for distribution among the crowds at the National March on Washington in 1993.[107]

The information from these surveys cannot be generalized to represent all lesbian populations in the United States, as they are not all balanced with the census data of the lesbian community or the general population for race, age, income, urban location or education. The survey data represents lesbians who are accessible to surveys, are connected to the lesbian community, participate in such surveys, speak English, and who can confidently self-identify despite pervasive hostility toward lesbians. However, these surveys are very useful in pointing out areas which deserve more focused research. While it is not statistically reliable to compare results of one survey with results of another, such a comparison may be somewhat informative and may point out the directions for further structured study. In this light the surveys will be reviewed and discussed.

Demographic Profile

The mean age of lesbians in all of the surveys is in the early- to mid-thirties (Table 4). A disproportionate number of survey respondents were caucasion or white, despite the fact that many studies actively sought members of the lesbian of color communities.

Education and earnings. A high proportion of surveyed lesbians have college or graduate degrees with 28-32% of lesbians completing graduate work and 20-61% of lesbians completing college (Table 5). Using the United States Census data from 1990 for comparison, 17% of heterosexual women have completed college or graduate work. Typically, a higher rate of educational advancement correlates with higher income, but this does not hold true for the lesbian population surveyed. While most lesbians earned near or under $30,000, most heterosexual women earn over that amount with nearly a third of them earning over $50,000. In comparison, only 4% of lesbians earned over $50,000. In a specific analysis of the 1990 census data, in which gay and lesbian couples could identify themselves as such, it was found that while 38% of lesbian respondents were college graduates, compared to 34% of male homosexual and 18% of married heterosexuals, lesbian couples had the lowest income of the three groups.[24]

The observed reduced earning potential may result from experienced discrimination, or anticipated discrimination, which inhibits gays and lesbians from seeking higher-profile, higher-paying jobs.[9, 10, 108, 109] This lack of income can directly impact on health. In the Michigan study, over one third of lesbians reported not seeking medical care when they felt they needed it, mainly because they lacked insurance or the financial resources.[10]

Behavior vs Identity. Seventy-seven to 95% of surveyed women identified themselves as lesbian or primarily lesbian, and 5-12% as bisexual.(Table 5) Lifetime sexual behaviors included sex with men for 78-80% of lesbians and 21-30% of lesbians reporting having sex with men in the recent one to five years. This confirms that orientational identity and sexual behavior are not synonymous and require separate and specific inquiry in research protocols. The rates of lesbians in primary relationships, typically 60-72%, is similar to the U. S. Census statistic for heterosexual women who are married, nearly 62%.

<u>Obstetric and gynecological issues</u>.

Parity. The major lesbian health surveys consistently observed that between 6 and 46% of lesbians are parous,[9-12] with another 30-62% interested in undergoing insemination at some later time (Table 6).

Pelvic pain/Dysmenorrhea Lesbians may endure menstrual and chronic pelvic pain because they are unaware therapy is available or because they hesitate to present or return for care (Table 7). Endometriosis and dysmenorrhea are more common in nulliparous lesbians.[105] Severe dysmenorrhea was reported by 38-54% of surveyed lesbians. While only one study queried respondents about a clinical diagnosis of endometriosis,[105] the high rate of nulliparity and severe dysmenorrhea among lesbian respondents suggests an epidemic of endometriosis. Johnson et al. report a higher rate of hysterectomy among lesbians than bisexual women, although the indications varied.[105] It may be prudent to offer definitive surgical therapy for significant menstrual pain sooner rather than later to lesbians who have with certainty elected not to bear children.

Irregular menses/Premenstrual Syndrome. Serum hormone levels of testosterone, androstenedione, oestradiol and progesteronelifelong of lifelong lesbians, lesbians who realized their orientation at a later age, and heterosexual women were measured at the same point in the menstrual cycle for levels and revealed no differences.[36] There is thus no reason to expect a difference in menstrual irregularities or menstrual prodromata.

Vaginitis/STDs. While the overall incidence of vaginitis appears quite low in the lesbian population, all types of vaginitis have been diagnosed. Exclusive homosexual activity is associated with the lowest rates of all types of vaginitis although it must be noted that lesbians have developed bacterial vaginosis or Trichomonas during exclusive lesbian activity.[66] Bisexual women were more likely to contract Trichomonas, yeast, herpes and gonorrhea with rates correlating with extent of their heterosexual activity.[105] Although the yeast pathogen is potentially transmitted sexually between heterosexuals, some have incorrectly theorized it may cause oropharyngeal yeast in lesbians. There is no documentation for this.

Chlamydia was not found in a series of screened lesbians.[110] Syphilis and gonorrhea are extremely rare in the lesbian population, and non-existent in those lesbians who were never sexual with men.[66, 110]

Herpes transmission is possible through oro-genital contact and was diagnosed among 7.4% of screened lesbians.[110] Lesbians with either oral or genital lesions should be cautioned about sexual activity during times of clinical ulcers as well as the risk of occult transmission during subclinical disease.

Routine screening for Chlamydia, herpes, Trichomonas, gonorrhea and syphilis does not seem indicated for lesbians who have never been sexual with men. Treatment for each type of vaginitis is the same for lesbians as for heterosexual women. Treatment of a female sexual partner is not routinely indicated for Trichomonas, but inquiry about the sexual partner should be made and testing offered if symptoms are present.

HIV/AIDS.

The AIDS virus is present in small quantities in menstrual blood, the white blood cells of vaginal effluent and saliva. It is reasonable to suspect that the virus is present and transmissible during lesbian sexual activity at times of menses, vaginitis (more WBCs present) or during traumatic sex practices. Lesbians are believed to be at low risk for contracting the AIDS virus because women in general rarely transmit the virus and because lesbians are believed to have less sex with men.

The Centers for Disease Control have collected data stratified by sexual orientation but found no cases clearly attributable to lesbian sexual transmission among 164 women with AIDS who reported having sexual relations only with a female partner since the year 1977.[111] All of these women became infected by injection drug use or heterosexual activity with infected men. The CDC uses the category of "no identified risk" for women who do not contract the virus by sex with infected men or injection drug use and currently does not have a specific risk category for lesbian sex, potentially missing detecting those women who were safely sexual with men after 1977 but who contracted the virus from lesbian sex. There are many cases of suspected lesbian sexual transmission[Marmor, 1986 #1169; Sabatini, 1983 #1170; Perry, 1989 #1176; Monzon, 1987 #1177] and a recent report of HIV transmission to a male performing oral sex on a seropositive positive woman.[112]

There is no science upon which to base any recommendation about safer sex for those lesbians who are known to be HIV positive or for lesbians whose HIV status is unknown. Many lesbians have advocated use of various latex barriers such as dental dams, gloves, and even plastic kitchen wrap. There are, however, very clear risks for HIV within the lesbian population.

In a survey of patterns of HIV risk behavior among 1086 lesbians and bisexual women, 16% of women reported having sex with a bisexual man, 2.5% had injected drugs, 4% had sex with an injection drug using male, and 8% had sex with an injection drug using female.[113](Table 8) In that study, 21% engaged in some form of sexual risk behavior, with 75 and 96% of this cohort failing to use safer sex techniques, and only 9% using safer sex techniques during subsequent homosexual activity.

In a random sidewalk survey of 498 lesbians and 17 bisexual women in San Francisco, 1.2% of women were HIV positive, a figure three times the comparable number from general populations of women.[114] Ten percent had injected drugs, and of these 71% shared their needles, and 31% had sex with gay or bisexual men. Many of these women subsequently engaged in unprotected sex with both men and women.

Until reliable data is generated by careful investigation of the lesbian population, it is prudent to recommend use of a latex barrier during monogamous sexual activity between lesbians for the first six months, discarding these techniques when an HIV test at that time is negative.

Weight and obesity.

Lesbian women, in one study, weighed more, desired a significantly heavier ideal body weight, and had less concern for appearance and thinness than heterosexual women.[115] In a survey of men and women of both orientations evaluating priorities used in selecting potential partners, the men were noted to place priority on physical attractiveness while women placed greater emphasis on other factors such as personality, status, power, and income.[116] As a consequence, lesbians and heterosexual men were found to be less concerned with their own

physical attractiveness, were less dissatisfied with their bodies and were less vulnerable to eating disorders.

Weight issues become problematic in the lesbian community because high body mass index increases the risk for breast and endometrial cancer, heart disease, diabetes, gall bladder disease, and hypertension.[117, 118] It is not known whether lesbians develop these diseases at higher rates than heterosexual women.

Risk of cancers

Ovary. Having one child is known to reduce by half one's risk for developing endometrial, breast, and ovarian cancers.[118] Long duration of oral contraceptive use and tubal ligation also significantly reduce the risk for developing ovarian carcinoma.[119] Although little data is available documenting lesbian rates of tubal ligation and use of oral contraceptives, lesbians appear unlikely to have employed any contraceptive method extensively. If this deomgraphic profile is accurate, then it is reasonable to expect a higher rate of ovarian carcinoma in the lesbian population.

Endometrium. The risk factors for endometrial cancer include obesity, a high fat diet, and low parity.[118] Additionally, lesbians may delay reporting their symptoms or assume that dysfunctional uterine bleeding in the menopause is another change to be expected unless they have a functional doctor-patient relationship and communicate their symptoms.

Cervical Dysplasia. The incidence of dysplasia among lesbians is very low. Two studies have shown that less than 2.7% developed dysplasia, usually bisexual women.[66, 110] Many physicians have informed their lesbian patients that they do not require Pap smears because they are assumed to be in a low risk category, having no sex with males. However, 77-91% of lesbians have had at least one prior sexual experience with men.[9, 10, 17] Sex with men and smoking are both strong risk factors for contracting the human papilloma virus, the initiating agent for cervical dysplasia and cancer;[118] however, HPV, like herpes, can be transmitted by oral-genital contact.[120] Some national studies have suggested that *single women*, in comparison to married women, have higher rates of cigarette abuse, a risk factor for cervical dysplasia.[121] While it has

not been clearly demonstrated that *lesbians* smoke more than heterosexual women, the rates appear at least as high, indicating the need for continued surveillance despite recognition of a homosexual orientation.

The interval between Pap smears for lesbians was reported to be nearly three times that for heterosexual women.[110] As many as 5-10% of lesbian respondents in two large surveys had never had a Pap smear or had had one over ten years ago.[9, 10] These long intervals between pap smears or the absence of any routine screening program may delay diagnosis of cervix carcinoma in lesbians increasing both the morbidity and mortality in this population.There is no prospective data on which to base reccommendations for Pap smear frequency to women who no longer have sex with men. There is no science on which to base advice for lesbians who currently have HPV regarding need for safer sex precautions with other women. In view of the above, it would be prudent to stratify patients based on their clinical histories, recommending yearly Pap tests to women with *any* of the known risk factors for cervical cancer and offering triennial paps to those lesbians with none of the risk factors and a history of normal Paps over the three prior years.

Breast. Risk factors for breast cancer include nulliparity or delayed parity, alcohol abuse, obesity and high fat intake.[118, 122, 123] Single women have lower rates of obtaining mammograms and clinical breast exams and of performing breast self-exams in comparison to married women.[121] One-fourth of lesbians over age 40 in the Michigan study had never had a mammogram.[10] (Table 9) Both morbidity and mortality are lower in women who obtain regular mammograms.[124] If lesbians are more likely to weigh more, have fewer children, and get less screening, then breast cancer may be epidemic among lesbians.

In a recent report from the Northern California Cancer Center analysis of local cancer rates and those from the National Cancer Institute's Surveillance, Epidemiology and End Results (SEER) Program, it was found that white women in the San Francisco/Oakland area have the highest breast cancer rate in the world.[125] San Francisco Black women have the fourth highest breast cancer rates reported in the world, while Asian and Latina women in San Francisco have the highest reported rates among all Asian and Latina women in California. The 1990 census

data reveal that San Francisco has the highest concentration of gay and lesbian households in the United States.[126] Unfortunately, no analysis correlating orientation can be undertaken in the Cancer Registry Report because the question was never asked in their survey.

Colon. A high fat diet and a history of colon polyps are two of the risk factors for colon cancer observed in the lesbian population. Smoking and high alcohol intake have been shown to increase rates of colon polyp formation as well as colon cancer.[127, 128] Obesity increase colon cancer rates in women.[129] Despite carrying multiple risk factors for colon cancer, many lesbians will not be screened for this third most common cancer in women because few lesbians present for routine care. Screening guaiac cards have been shown to result in earlier diagnosis of colon cancer and subsequent higher survival rates.[130] Digital rectal exam revealing polyps or a lesion may be the earliest sign of a small cancer. These are parts of the routine screening exams and counseling sessions performed by clinicians at annual visits.

Heart Disease and Stroke

Smoking and obesity are two major risk factors for coronary atherosclerosis.[131, 132] Clinical assessment of the serum cholesterol, blood pressure, and dietary history are part of routine annual screening check-ups which lesbians miss when they forego annual doctor visits.

Considering all of these factors, lesbians may experience greater morbidity or mortality from multiple cancers and heart disease, especially if they defer seeing a physician until symptoms or signs become extreme or acute.[133-135] Representative data on health and psychology issues have not been obtained from the gay and lesbian community because researchers have not considered sexual orientation an important question in national probability health surveys.[136, 137] If reliable demographic information about lesbian health showed a higher incidence, morbidity, or mortality from various cancers or heart disease, then screening or health education programs could be instituted and targeted to the lesbian population.

ADOLESCENT HEALTH

Development Issues

A brief description of the developmental steps which lesbians must negotiate helps to explain the psychological injuries to which young girls become vulnerable:[5, 20, 138, 139]

1) Recognition and acceptance of their lesbian orientation despite pervasive familial and societal condemnation.
2) Development of a new identity as a lesbian, a personal process known as "coming out."
3) Frequent confrontation with societal homophobia.

Children as young as 2-8 years old can recognize their homosexual feelings and subsequently become isolated and alienated from their family perceiving that heterosexuality is the only acceptable "norm" (heterosexism).[8, 20, 49, 61, 140-145] Most parents, believing that information about lesbianism may predispose their children to pursue such behavior, will not inform their children about diversity of affectional or sexual orientation, leaving their children's education about this topic to uninformed peers. The implicit message is that homosexuality is unspeakable.

Many religious institutions depict homosexuality as immoral, a proclivity which must be resisted, telling gay and lesbian children they are "wicked and condemned to hell," unfit to be ministers, unfit to participate in the larger community, and unfit to marry their loved ones.[85, 146-151] Youth read that "...homosexual sex is gruesome, violent, and downright sadistic...but 'monogamous' homosexuals are in the minortiy--and thier relationships are generally short-lived. Even when same-sex unions last, they could hardly be a result of the love described in the Bible."[73] Nor do schools teach children about diversity of orientation, even though most elementary school children have already begun to recognize their orientation.[152-156] Young lesbians also observe the practice of government-enforced military discrimination against its gay and lesbian service members with the message that homosexuals are undeserving citizens despite the documented absence of any security risk or performance inadequacy.[82, 157]

The absence of accurate and positive depictions of lesbian role models in society, with over-representation of negative stereotypes of lesbians in television, theater, and print media,

further diminishes the ability of lesbian youth to develop a positive self-identity and to gain respect and understanding from their peers.[61, 85, 108, 158-162]

The Committee on Adolescence of the American Academy of Pediatrics believes that while homosexual youth are attempting to reconcile their feelings with all of these negative societal influences, they confront a "lack of accurate knowledge, [a] scarcity of positive role models, and an absence of opportunity for open discussion. Such rejection may lead to isolation, run-away behavior, homelessness, domestic violence, depression, suicide, substance abuse, and school or job failure"[162] (Table 10).

Psychological Health and the "Closet". The psychology of learning to live in a society that does not welcome diversity shapes identity development as the lesbian child emerges into adolescence.[141, 150, 163, 164] Conformity, with repression of her feelings, is encouraged. Many children will conceal their orientation from friends and relatives for fear of reprisals and discrimination, allowing the presumption of their heterosexuality to prevail.[64, 159] In one study, awareness of sexual orientation occurred at an average age of 10 years; however, disclosure to another person did not occur until age 16, with suicide attempts acknowledged during this period by 42% of this sample of gay and lesbian youth.[20, 140] It becomes very difficult to maintain a positive self-image with a double-life that is unsatisfactory in both realms.[144, 145, 160, 162, 164, 165] Family members and peers tend to view the withdrawn, secretive individual as socially inadequate. For some girls, this stage of hiding "in the closet" can last well into adulthood.

Multiple oppressive forces are encountered by lesbians of color.[108, 109, 136] More intense disapproval of homosexuality is reported in the Hispanic and African American cultures than in European American culture.[166-170] Christian religiosity, a strong emphasis on family and community commitment, sexism, and heterosexual privilege are said to promote bias against lesbians within the African American community and can create a painful conflict of loyalties when Black lesbians are confronted with homophobia from their own community.[12] Asian Americans, in contrast, reported more discrimination due to their race than to their orientation.[171]

Consistently, Hispanic and Black, but not Asian American youths, are over-represented victims in studies of gay and lesbian suicide.[108, 142, 144, 145, 160]

It is also important to recognize the effect of mass hiding of the true identity of a culture of people. In the absence of reasonable familiarity, biases thrive, even among well-intentioned individuals. The invisibility of lesbians in society contributes to their unfamiliarity in the medical arena and lends to the persistence of the negative experiences they relate.[134] Such a cascade of unfavorable cause and effect can only be halted by mutual efforts: lesbians must self-identify more, and physicians must facilitate disclosure.

"***Coming out.***" The decision to "come out" integrates the separate parts of one's life and results in significant self-image amelioration,[77, 108, 160, 172] greater relationship satisfaction,[173] lower social anxiety,[55] trait anxiety and depression,[64, 77, 174] a greater sense of community, and broader integration into both family and society [64, 77, 162, 174] (Table 11). Because their physical appearance does not typically reveal their minority status as homosexuals, most lesbian individuals must constantly renegotiate the decision to "come out of the closet" in many situations every day of their lives.[172] In two large surveys of lesbians, 15-28% of lesbians had disclosed their orientation to everyone in their lives, 29-32% remained hidden from their co-workers and 19% had still not disclosed their orientation to their families.[9, 10]

Suicide among lesbian youth.

A 1989 Report to Louis Sullivan from the Secretary's Task Force on Youth Suicide[163] suggested, but provided no data, that homosexual youth account for a disproportionate one-third of youth suicides. Many authors attribute risk for gay and lesbian youth suicide to their experience of familial disapproval and societal hatred.[61, 140, 164, 175] Many parents, reflecting societal norms, are unable to provide acceptance and approval to their lesbian daughters, which may constitute the most crucial loss these young girls experience.[126, 143, 146, 149, 160] Of those adolescents surveyed at the Hetrick Martin Institute who were rejected by their families, 44% had suicidal ideation, and 41% of young lesbians had attempted suicide.[176] The National Lesbian

Health Survey reported that more than 50% of lesbian respondents had suicide ideation at some time in their lives, and 18% had attempted suicide.[9](Table 12)

In comparison, in the Morbidity and Mortality Weekly Report from the Centers for Disease Control, a random survey of high school students (presumably 90-97% heterosexual), reveals that 8% of teens reported suicide attempts, and 2% had required medical attention for their attempt.[177] Whether lesbian children are committing suicide at higher rates than heterosexual youth remains unclear and deserves further scientific investigation.

Substance use and abuse among lesbians

Substance abuse rates across geographic and class lines for lesbians has previously been reported at 20-30% in contrast to 10% for heterosexual women.[178-180] Epidemiologists have criticized these studies which used opportunistic sampling techniques, e.g., surveys of bar-patrons.[181] Opportunistic studies are not representative of the lesbian community, as bar patrons are known to be more likely to abuse alcohol as well as other drugs.[182] Recent data regarding lesbian alcohol abuse indicate rates no higher than those of heterosexual women surveyed in the Chicago or San Francisco areas.[183, 184] (Table 13)

Most detoxification and rehabilitation programs show little sensitivity to issues of sexual orientation and generally do not encourage its disclosure.[185-187] A questionnaire administered to 98 addiction center treatment providers revealed that 26% scored in the homophobic or marginally homophobic range. Some of the surveyed providers refused to answer the questionnaire citing that their personal attitudes about homosexuality were not relevant to the quality of care they provided to gay and lesbian patients.[185]

Homophobia reduces the success of treatment and recovery for lesbian substance abusers.[188, 189] Failure to acknowledge lesbian identity makes recovery more difficult and increases likelihood of relapse.[178] Lesbian clients are more willing to attend a treatment program which addresses lesbian social issues and provides lesbian counselors.[170, 171, 173-178]

Public Violence

The Hate Crime Statistics Act requires the federal government to collect data obtained by police agencies about hate crimes. However, only twelve states include homophobic violence in their definition of hate-crimes. Seventeen other states have hate-crime laws which do not count violence based on sexual orientation, and twenty-one states do not count hate crimes.

In a 1984 random nationwide survey of 2000 lesbians and gay men by the National Gay and Lesbian Task Force, 19% of respondents had been punched, kicked or beaten, 27% reported objects thrown at them, 54% had been threatened with physical violence, and 9% had been assaulted with a weapon because of their sexual orientation. Overall, 94% had experienced some type of verbal or physical assault.[190] The 1992 report from the Philadelphia Lesbian and Gay Task Force documents that 50% of lesbians experienced public verbal abuse, and 35% experienced physical violence.[191] Homicides against gay men and lesbians were recently reviewed and found to be more likely to involve mutilation and torture, and are more likely to go unsolved than the homicides of heterosexuals, reflecting the intensity of anti-gay hatred.[192]

Psychological and emotional injury can also occur to victims of hate violence. These include phobias, post-traumatic stress syndromes, chronic pain syndromes, eating disorders, and, most commonly, depression.[10, 193, 194] A Yale survey revealed that many lesbians and gay male students reported living in secretiveness and fear because they feared anti-gay violence and harassment on campus.[195] National documentation of hate crimes would provide valuable information regarding the need to institute specific interventional programs.[196] "Each anti-gay episode sends a message of hatred and terror intended to silence and render invisible not only the victim, but all lesbians, gay men and bisexuals."[197] Such violence against any other minority group would not be tolerated.

PRIMARY RELATIONSHIPS OF LESBIANS AND THEIR FAMILY CONSTRUCTS

Lesbian Relationships: Qualitative and Quantitative Analysis

Despite the prohibition against same-sex marriage denying lesbians the essential ability to form socially legitimate relationships and the subsequent legal, financial and psychological perquisites of heterosexual marriage, a majority of lesbians are observed to be in long-term relationships.[9, 10, 170] Misconceptions abound regarding the ability of lesbians to form committed and stable involvements. In 1970, researchers from the Kinsey Institute surveyed lesbians from ages 36 to 45 and found that 82% of women were living with a partner.[65] More recently, the Michigan Lesbian Survey,[10] the National Lesbian Healthcare Survey,[9] and the Black Women's Relationships Project[12] report that 60-65% of lesbian respondents were in typically monogamous committed long-term relationships. A 1991 survey of gay and lesbian couples revealed that 75% of lesbian couples shared their income, 88% had held a wedding ceremony or ritual celebrating their union, 91% were monogamous, 7% broke their agreement, and 92% were committed to their partners for life.[198] Power-sharing in lesbian relationships was investigated by survey of 70 lesbian couples, which demonstrated that arrangements could not be explained by usual variables of age, income, education, and asset differences between partners.[199, 200] Egalitarianism was considered the ideal in most relationships and butch-femme role playing was not observed.[200] In another study, relational satisfaction was observed to relate more strongly to essential qualities of the relationship itself rather than to an individual partner's attitudes or assets, with greatest satisfaction associated with equality of both involvement and power in the relationship.[201]

Lesbians typically begin to self-identify as homosexual and engage in homosexual sex at a later age than gay men self-identify and become sexually active, although both genders experience same sex attraction at a similar early age.[37] Lesbians more often become aware of their orientation first in the context of a emotional relationship, compared to men who recognize their homosexuality in the context of a sexual experience. In fact, 78% of lesbians in one survey revealed that their first same-sex sexual/romantic relationship often grew out of a previously established friendship between the women. Similarly, friendship was found to be an important maintenance factor in the women's current relationships with 77% describing their current lover as their closest friend.

Co-dependency. Intimacy in lesbian relationships can be so intense that some lesbians lose a sense of themselves. In fact, some stresses in the lesbian dyad are due to difficulties in maintaining a sense of self.[202] Co-dependency in lesbian relationships occurs when a woman's desires to partner are pathologically and unreasonably carried forth.[155] Such merger or fusion problems can result in clinical dysfunction. Intimacy in such relationships can usually be restored by each partner creating some distance between them, enhancing their personal space, and focusing on individual autonomy.[203]

Lesbian women and heterosexual women have much in common in their relational profferings and may differ in their partners response to such profferings. Using a questionnaire employing a cost/reward investment model, it was observed that women, whether lesbian or heterosexual, reported investing more in their relationships and having greater commitment to maintaining their relationships than either heterosexual or homosexual men.[204] Females more so than males reported relationship costs were more strongly related to satisfaction and commitment. Relational satisfaction, in turn, was associated with higher levels of rewards and lower levels of costs. Relational commitment was associated with greater satisfaction and greater investments, but poorer quality of alternatives. All heterosexuals reported greater costs and marginally greater investments in their relationships. Interestingly, this model effectively predicted satisfaction and commitment for all four groups of respondents. The authors concluded that gender was a more important predictor of the behaviors explored in this study than was sexual orientation.[204] In another study, persons with a female partner, whether they were lesbians or heterosexual males, had higher expectations and greater accuracy in these expectations than either women or men with male partners.[205] The homosexual women in a survey of 34 couples demonstrated greater interpersonal dependency, compatibility, and intimacy in their intimate relationships, while heterosexual women evidenced more positive dispositions toward sexual fantasy, stronger sexual desire, greater sexual assertiveness, and higher frequencies of sexual activity.[206]

In an interview report with eight African American lesbians, preference for primary relationship partners was clearly expressed for other lesbians of African American descent, even though most had previously been in a relationship with a white woman.[170] Cultural differences caused relationship conflicts which were not easily or eagerly dealt with, reflecting the complexity of interacting influences of ethnicity, orientation, and external and internalized homophobia.

Relationship instability in lesbian couples can also occur because of the same common relational conflicts observed in all couples, but it can be compounded by effects of cultural homophobia: coming out issues, self-concept issues, and the absence of wedding traditions and marital role models.[173, 207-210] Lesbians who did not hide their homosexuality were more likely to report satisfaction with their relationships according to a questionnaire of "closeted" and "out" lesbian and gay men.[173] Internalized homophobia manifesting as self-doubt and shame may make some lesbians feel they cannot develop any relationship at all.

Lesbian sexuality. The rate of anorgasmia is low for both heterosexual and lesbian women, 12 versus 3%. Most lesbians report higher rates of regular orgasm compared to heterosexual women.[211] This is likely because the preponderance of lesbian sexual activity consists of manual, digital and mostly oral stimulation of the clitoris. Only 30% of heterosexual women orgasm regularly from intercourse, with the majority requiring additional oral or manual stimulation to the clitoris.[212]

Some lesbians theorize an added benefit of heightened knowledge of desirable sexual activity given the similarity of their genital anatomy.[212] Masters and Johnson reported that lesbian couples were less goal oriented and had better communication during sexual activity than heterosexual couples.[213]

Nonetheless sexual dysfunction occurs in the lesbian population. Kinsey observed 10% of lesbians reporting some dysfunction.[214] By comparison, a Seattle survey of heterosexual women revealed a 63% incidence of self-reported dysfunction. Johnson et al. found 23% of their cohort had dysfunction.[215]

Domestic Violence. Although there is growing awareness in the medical community concerning domestic violence among heterosexuals, there is little awareness that domestic violence also occurs in lesbian relationships.[216-218] Victims and perpetrators were more likely to experience violence in the context of alcohol use.[219] This perpetuates a cycle of denial and continuing violence. The 1988 National Lesbian Health Care Survey reported that 11% of lesbians had been victims of domestic violence by their lesbian partner.[9]

Lesbian Families

According to Maslow's hierarchy of needs, once the basic physical survival needs for food, shelter, and safety are met, then an individual naturally seeks to fulfill higher needs such as community and social order, with the highest needs being intimacy and procreation.[Davis-Sharts, 1986 #772] With this in mind, it is reasonable to expect lesbians and gay men to desire marriage and even children when their relationships reach a mutual point of satisfaction, intimacy and commitment. To lesbians, the absence of a legal right to marry each other is unsettling. Recalling the 1967 Supreme Court case of Loving v. Virginia, in which it was ultimately decided that citizens should not be denied the right to marriage on the basis of the physical condition of the color of their loved one's skin, most lesbians believe they should not be denied the right to marriage on the basis of the physical condition of their loved one's gender.

Some individuals worry that legal marriage might "endorse homosexuality," possibly resulting in higher numbers of homosexuals. Some are worried about erosion of traditional family values and the concept of the nuclear family. Conversion to homosexuality does not occur. Instead, for some, there is a natural evolution of the self into more honest and full expression. No scientific basis supports the idea that marriage would be devalued if such a right were to be extended to those citizens desiring that for which the institution of marriage stands: a monogamous, long-term, mutually supportive committed relationship. The impact of denial of the institution of marriage, implies this class of humans does not deserve validation of their highest human function. It is deeply corrosive to the self-concept of lesbians and precludes the fulfillment of their natural psychosocial needs.

Family-of-choice. The definition of "family" for lesbian couples necessarily more often involves creation of a network of close and accepting friends as a family-of-choice, especially if their family-of-origin has rejected them.[220] The most frequent sources of support for lesbians in a survey of couples were, in order, friends, partners, family, and co-workers.[221] A very diverse family picture can emerge. Lesbians in a relationship may incorporate their previous partners and children from that relationship, a current partner's family-of-choice, and their children into their "familial network."

Complications due to isolation from the family-of-origin of lesbians can manifest in times of medical crisis. Unless the lesbian couple has contracts for mutual medical conservatorship, which are sometimes costly, any blood relative becomes legal next of kin. The family-of-origin can override the role and input of the domestic partner, even though the domestic partner may be the primary caretaker and more knowledgeable of her partner's religious and ethical beliefs. Hospitals may also restrict visitation privileges of "non-relatives." Although lesbians can circumvent some of these obstacles by designating their medical power of attorney to the person of their choice, unfortunately only a fraction have taken these legal steps.

Children in Lesbian Households. There are many ways in which lesbians parent.(Table 6) Many lesbians have children from previous marriages. Many lesbians in relationships desire to inseminate using either known or unknown donor sperm.[104] A few lesbians in the surveys would have sex with a man to become pregnant, either by engaging his permission or without it. Adoption and foster parenting are used by many lesbians, but these routes can be very costly and are legally reversible to varying extents in many states. Some adoption laws and clinics refuse to allow lesbians to adopt.

Impregnation with sperm donated by friends or unsuspecting men leaves custody questions unanswered and may result in a successful paternity suit by a sperm donor. This route is also riskier in terms of infectious diseases. Transmission of HIV by banked sperm has been reported[222] but is extremely rare.[223] Use of banked sperm also confers legal protection in cases of disputed custody. For these reasons, it is recommended that lesbians desiring insemination

employ the services of an established sperm bank. Obstetrician/Gynecologists and midwives can best provide a safe environment for insemination and subsequent delivery.[224] Physicians providing insemination services could provide valuable advice by familiarizing themselves with some of the medico-legal issues pertinent to the lesbian client.

In one study of 35 lesbians delivering in the past five years, most conceived through donor insemination, and all sought care within the first 16 weeks, with 89% participating in childbirth classes and 80% breast feeding for six months or more.[89] All lesbian mothers obtained obstetrical care from physicians or midwives, with 91% disclosing their relationships to their providers. Most of the women were very satisfied with their obstetrical experiences. There is no scientific basis for refusal to inseminate lesbians.

Studies of the children in lesbian households provide useful information about the effects of lifelong exposure of children of all ages to homosexuals and to information about homosexuality. There are concerns that children in lesbian households, of which there are an estimated 6-14 million in the United States, may develop differently from their peers.[225-227] Such concerns derive from the false perception of lesbians as abnormal and immoral, even though this thinking has been repudiated by the American Psychiatric Association and The American Psychological Association.[1, 4, 86, 228] In a study of 269 cases of molestation, between 0% to 3.1% children identified homosexual adults as their abuser with 95% confidence limits.[229] This rate approximates current estimates of the prevalence of homosexuality in the general community.

Patterson reviewed the studies of over 300 children raised in gay and lesbian households, ages 5-17, concluding that the children's gender identity developed no differently than children from heterosexual households.[227] There was no observed difference or greater femininity in sex-role behavior observed in female offspring studied between ages 6-9,[230-234] ages 10-20,[235] and ages 18-44.[236]

Patterson also reviewed studies examining other psychological differences in the offspring of lesbian parents and found no significant difference in self-concept,[237, 238] locus of control,[235, 238] moral judgment,[235] or intelligence.[231] Children of lesbians, in one study, appeared to

have a greater sense of well-being.[236] Although 5% of children were taunted by their peers because of their parents' sexual orientation, two studies have suggested that children still fare better when they are told about their parents' orientation in early childhood rather than later,[237, 239] when their mothers are psychologically healthy,[240] and when their biological fathers are not homophobic.[237] Using the California Psychological Inventory, it was found that the psychological health of the lesbian mother correlated positively with openness to her employer, ex-husband, and children, having a lesbian community and involvement in feminist activism.[240]

Lastly, rates of homosexuality among the children with lesbian parents were similar to those of the offspring of heterosexual parents.[225, 230, 232, 235, 237, 239] Most psychiatrists believe that sexual orientation is not influenced by parents behavior or orientation, but as individuals mature, they become more aware of their own basic innate feelings, more comfortable owning them and later acting upon them.[162]

Aging lesbians. Age, poverty, and health issues can render the older lesbian invisible.[241] For aging lesbians, acceptance of the aging process and high levels of life satisfaction are associated with connection to and activity in the lesbian community.[242] While sex, per se, may become less important, older lesbians still prefer the companionship of other lesbians within 10 years of their own age.[243] It is important to provide a safe environment for older lesbian patients by educating nursing home attendants and nursing personnel. Most lesbians over 60 stated they would prefer an intergenerational homosexual retirement community.[244]

SYSTEMWIDE SOLUTIONS

It is important to recognize that being a lesbian is not inherently (genetically, biologically) hazardous but that risk factors are conferred through "homophobic fallout." The process of homophobia–the socialization of heterosexuals against homosexuals and concomitant conditioning of gays and lesbians against themselves–must be recognized by health care providers as a legitimate and potent health hazard.

Much progress has already been made in the field of medicine: the American Medical Association (AMA) voted in 1993 to include sexual orientation in its non-discrimination statement despite rejecting this motion for four consecutive years. The AMA also passed a policy statement regarding medical care for gay men and lesbians which very well reflects the limited current science. The American Medical Women's Association (AMWA) passed without opposition a policy statement urging an end to discrimination by sexual orientation. Moreover, AMWA encouraged:

> national, state, and local legislation to end discrimination based on sexual orientation in housing, employment, marriage and tax laws, child custody and adoption laws; to redefine family to encompass the full diversity of all family structures; and to ratify marriage for lesbian, gay and bisexual people...creation and implementation of educational programs... in the schools, religious institutions, medical community, and the wider community to teach respect for all humans.[99]

Enhancing Medical Education

Knowledge about diversity of sexual orientation is essential in clinical practice.[245, 246] Obstetrician/Gynecologists must recognize that as much as 1-3% of their patients are lesbians or bisexual women, expressing a part of the broad normal range of human sexuality. A prerequisite to quality care is the learned genuine appreciation of the diversity that exists in America today.[247] This information should come from organized curricula in medical school and/or residency training programs.[248, 249] Obstetric and Gynecology residencies should also specifically include educational information about lesbian health.

The Temple University School of Medicine provides the local medical community with a resource guide which addresses many of the issues described above.[250] Currently the Ohio University College of Osteopathic Medicine Section of Obstetrics and Gynecology offers students a lecture on lesbian health care issues. The American Psychiatric Association has sponsored "A Curriculum for Learning About Homosexuality and Gay Men and Lesbians in Psychiatric Residencies" which describes educational objectives, learning experiences, and

implementation strategies for sound clinical practice.[251] The University of Vermont, Harvard University and the University of California in San Francisco have each planned one to three day academic symposia during 1995 regarding health issuesof gay and lesbian patients, heterosexism and homophobia. These important strides will generate physicians who will be better prepared to provide care to *all* of their patients.

Changes in the Provider-Patient Relationship

Obstetrician/Gynecologists can do much to reduce homophobia within their individual practices. The need for a trusting and supportive relationship is crucial to obtaining a thorough medical history.[149] The AMA policy statement issued December 1994 about gay and lesbian health recognized the alienation of gay men and lesbians from the medical system as one of the psychological effects of ubiquitous prejudice against homosexuals.[O'Neill, 1994 #585] There are numerous ways physicians can make their practices more welcoming of lesbian patients:[252]

1. Physicians should routinely ask when discussing sexual behavior[253] whether each woman is sexual with men, women, both or neither. This simple, objective question clearly dispels the common assumption of heterosexuality, which can be psychologically difficult to rebut for some lesbians, and which compounds the patient's vulnerability in the doctor-patient relationship.[66] The clinician obtains information about the patient's sexual behavior with neutrality by inquiring specifically about *behavior,* not labeling the orientation.[254] Simply *having* a non-judgmental, non-homophobic attitude is not enough. The responsible practitioner needs to *convey* his or her non-judgmental attitude to all patients.
2. Using inclusive language with all patients and generic terms such as "partner" or "spouse" rather than "boyfriend" for *any* patient will encourage trust in the physician by removing assumptions. As an additional benefit, these terms also signify to heterosexual patients this physician’s accepting attitude. Comfortable use of language in naming some sexual behaviors will further facilitate taking the health history by enhancing clarity of communication.[255]

3. Office registration forms and questionnaires which require patients to identify themselves in heterosexual terms such as single, widowed, or divorced can be revised to include "significantly involved" or "domestic partner" in order to avoid making the lesbian patient feel invisible.

4. The informational brochures for patients, especially those dealing with aspects of human sexuality, will need to include information about lesbianism. Patients believe there is no more reliable source of information than the educational pamphlets in the gynecologists', pediatricians' and family practitioners' offices. These pamphlets in could provide life-affirming information to youth and be an educational source for parents of all children, not just the parents of gay or lesbian children. this step could possibly reduce rates of youth suicide as well as public violence and discrimination.[162] Fortunately, the American College of Obstetricians and Gynecologists has just undertaken an exhaustive review the available literature and will be generating a brochure on lesbian health similar to those which cover so many other salient topics for women. The College will also be revising the brochures about teenage sexuality to include information for lesbians who are questioning their orientation. The American Association of Family Practitioners, and the American Academy of Pediatricians would benefit their patients if they were to follow suit. Perhaps the most effective transmission of reliable information would come from the National Institutes of Health (NIH), which provides educational brochures for such health issues as ovarian carcinoma which afflicts 18,000 women yearly. The NIH brochures are authoritative and useful. Such brochures focussing on the available scholarship regarding homosexuality could benefit over 5 million homosexuals and, in fact, all citizens.

5. If the lesbian patient is partnered, the provider can welcome her spouse and routinely encourage the couple to consider obtaining a medical power of attorney document, particularly prior to elective surgery or obstetrical delivery.

> Just as for married individuals, the physician should be ready to provide support for the stability of the patient's relationship during stressful times. Most physicians could develop the skills to counsel for gay-related anxieties, and safeguard against referrals to homophobic colleagues.[90]

With this awareness, obstetric and gynecologic practitioners can serve as leaders and positive examples in both the medical realm and the larger community in signaling the need for reduction of societal homophobia.[158]

Stratify research protocols

Efforts are being made to obtain specific morbidity information about lesbians, but obstacles have been plentiful. For example, principal investigators of the National Institutes of Health Women's Health Initiative, the largest study (n=160,000) on women's health ever planned, had initially declined to ask participants their sexual orientation due to concerns that respondents would quit the study and the fact that there was no validated question about orientation or behavior. However, after a review of information on recruitment and retention of lesbians in health trials[13] and after piloting a question to test groups, the NIH will be including a sexual orientation question. Similarly, the investigators of the Nurses' Health Study will also stratify their ongoing longitudinal study by sexual orientation to determine disease differences.[256] At Secretary of Health and Human Services Donna Shalala's Conference for a National Action Plan for Breast Cancer, the Committee for Access to Mammography recommended that all future and ongoing studies be stratified by orientation because of the presence of multiple risk factors for breast cancer within the lesbian community. The Office of Research on Women's Health is also offering supplemental money to all current grantees who will addend their studies to obtain information about the health of minority women, which includes lesbians. In the next decade much will be learned about lesbian health, and there will very likely be a reduction in the intensity of the perceived social stigma.

Treatment of Adolescent Girls

In order to provide general information as well as specific health education for all adolescents, clinicians should not reserve their questions about orientation for the gender-atypical youths, the "sissy" males and the "tomboy" females.[257] It is irrational to classify gender-atypical behavior in youth as abnormal when homosexuality in adults is not considered abnormal.[258] While gender atypical youth may ultimately develop a homosexual orientation, negative parental attitudes serve only to alienate the parent and isolate the child.[258, 259] Physicians can offer parents of gender-atypical youth information and reassurance that their children are normal, enabling the parents to accept and enjoy their children who need their support and consistent love. It is not possible to predict which youth are struggling with issues of orientation. All youth will benefit from the non-biased demonstration of the health care provider's positive attitude toward issues of orientation.

Recognizing homosexuality as a natural sexual expression, the American Academy of Pediatrics (AAP) recommends psychotherapy only for those gay and lesbian youth who are uncertain about their orientation, or who need help addressing personal, family, and environmental difficulties which are concomitant with coming out.[162] The AAP also understands that families may experience stress and require information while supporting a child's questioning of sexual orientation. Concerned families are urged to contact Parents, Family, and Friends of Lesbians and Gays (P-FLAG) for information and support or obtain therapy.[260, 261]

The AAP further states: "Therapy directed at changing sexual orientation is contraindicated, since it can provoke guilt and anxiety while having little or no potential for achieving changes in orientation."[162] Conversion therapy has been found to be ineffective, unethical and harmful.[46] Concurring that aversion therapy, or behavioral tharapy to change sexual orientation is no longer reccommended, the AMA updated its policy statement regarding the dedical treatment of gay men and lesbians in December, 1994. The new policy states that psychotherapy may be necessary to help gay men and lesbains with ego-dystonic homosexuality to enhance thier comfort with their orientation and to deal with society's prejudicial response to them.[O'Neill, 1994 #585]

Sex Education in the Schools

School sex education programs have been shown to be beneficial because evidence suggests that students of these programs are less likely to engage in sex or will engage in sex at a later age than other children and will be more likely to use appropriate protection from infection and unwanted gestation.[Kirby, 1994 #1157] In one study of gay or lesbian youth ages 14-21, one third knew their orientation between the ages of four and ten years.[262] Most children are aware of homosexuality and have learned homophobia during the elementary school ages, calling each other "fag" or "lezzy" in jest or as derogation.[Morrow, 1993 #553; Ellis, 1993 #559; Griffin, 1992 #583; Cranston, 1992 #580; Uribe, 1992 #579] Young girls need access to accurate information in their school libraries and in social studies classes, as well as in sex education curricula.[Grossman, 1994 #550; Uribe, 1992 #579; Cranston, 1992 #580; Sanford, 1989 #594; Remafedi, 1993 #629; Remafedi, 1990 #632] Educators are urging that multicultural diversity training programs in elementary schools must include orientation issues in their curricula.[263]

To facilitate acculturation of gay and lesbian youth and the children of gay and lesbian parents, school libraries need to include story-books of positive role models which resemble their families.[108, 263] School-based family counseling programs and after-school social support programs for gay and lesbian youth will promote an more accurate image of homosexuals. These educational programs can be initially directed toward educators, clergy, and professionals, and later toward the youth themselves and society at large.[Morrow, 1993 #553; Cranston, 1992 #580; Harbeck, 1992 #539; Uribe, 1992 #579; Griffin, 1992 #583; Gibson, 1989 #127; Harry, 1989 #31] In one study only 20% of homosexual children could identify an adult who had been supportive of them.[262] A comfortable familiarity with issues of orientation and the openly respectful attitudes of teachers, parents, local organizations, peers, and friends can help frightened youth come to grips with their fears about their sexual identity and confront their own internalized homophobia as their self-concept strengthens.[3, 153, 154, 158, 264, 265]

The state of Massachusetts now requires schools to write policies protecting students from harassment, violence, and discrimination because of orientation, training teachers in crisis intervention and violence prevention, creating school-based support groups for gay or lesbian as well as heterosexual students, providing information in the school libraries and writing curricula which include gay and lesbian issues.[266]

There is no evidence such policies will cause more children to become homosexual. There is evidence that these policies will facilitate the healthy adjustment of all the children who attend.

Changes in Government for the health of our patients

Government enforced discrimination delivers a message to children that homosexual adults are unfit and undeserving citizens. Denial of marriage and the practice of military discharge of gay and lesbian service members needs to be examined in light of the message to both homosexual and heterosexual citizens. Immigration laws prohibit even temporary entry to the United States to HIV positive immigrants even though it has been shown that the cost to the government is very similar to the costs of therapy for immigrants' rates of coronary artery disease.[Zowall, 1992 #1160] Based in tradition and prejudice, these practices perpetuate misinformation among American youth while undermining confidence and psychological health. Such biases imposed on any other minority would be considered entirely intolerable.

The APA and the AMWA have concluded that the most effective solution to the problems that result from homophobia is legislation which would make discrimination against gay men and lesbians illegal.[1]

Many universities, corporations, cities, and federal agencies now include sexual orientation in their non-discrimination policy statements. Some provide domestic partner benefits, including medical insurance, to all registered families. Recently, the United States Departments of Justice, of the Interior, of Transportation, and of Health and Human Services have included sexual orientation in their non-discrimination policies, but do not yet provide benefits. Montefiore Medical Center was the first hospital to offer medical insurance to domestic

partners of their employee. Stanford University was the first university to offer its entire benefit package to all its employees and their families. The Stanford 1992 Report of the Subcommittee on Faculty and Staff Benefits regarding domestic partner benefits stated:

> One imagines, for example, that a decision by Stanford 40 years ago to take the lead in eradicating discrimination against blacks, women or Jews in admissions, hiring, memberships in sororities and fraternities, etc., would have been politically unpopular with many alumni, as well as with the larger political community. One also imagines that had Stanford taken such a leadership role, few in the Stanford community would look back on that decision now with anything but pride.[267]

CONCLUSION

Obstetrician/Gynecologists must begin to discard those old views they innocently learned but which science does not validate. Health care providers have a responsibility to examine their attitudes about homosexuality and recognize the views it holds which are not consistent with facts. Doctors have a unique opportunity to influence others to align their attitudes with objective information. Education of adults and children about diversity of orientation can reduce the pervasive, unfounded disdain for homosexuals and maintain lesbian and gay individuals' self-respect. Legislation proscribing discrimination and providing legal recognition for the unions of lesbian and gay families would restore legal, societal, and financial equity to this marginalized population. The resultant increased visibility of lesbians would increase their familiarity in the community and promote greater understanding.

Each of these steps will decrease the oppression of lesbians and gay men from society, as well as the learned self-oppression of the individual from within. Greater access to health care, integration into family and society, heightened life-satisfaction, productivity, and health will

result, once homophobia is recognized as the major health hazard it poses not only to gay and lesbian individuals, but to our entire society.

The author gratefully acknowledges the editorial assistance of Barbara Canida, M. D., Lisa Hinman, and Becki Legg.

BIBLIOGRAPHY

1. Bersoff D and Ogden D. APA amicus curiae briefs. Furthering lesbian and gay male civil rights. *Am Psychol*. 1991;46:950-6.

2. Albro J and Tully C. A study of lesbian lifestyles in the homosexual micro-culture and the heterosexual macro-culture. *J Homosex*. 1979;4:331-44.

3. Ellis AL and Vasseur RB. Prior interpersonal contact with and attitudes towards gays and lesbians in an interviewing context. *J Homosex*. 1993;25:31-45.

4. Suppe F. Classifying sexual disorders: the Diagnostic and Statistical Manual of the American Psychiatric Association. *J Homosex*. 1984;9:9-28.

5. De Cecco JP and Shively MG. From sexual identity to sexual relationships: a contextual shift. *J Homosex*. 1983;9:1-26.

6. Madans JH, Cox CS, Kleinman JC. 10 years after NHANES I: mortality experience at initial followup, 1982-84. *Public Health Rep*. 1986;101:474-81.

7. Cornoni-Huntley J, La Croix AZ and Havlik RJ. Race and sex differentials in the impact of hypertension in the United States. The National Health and Nutrition Examination Survey I Epidemiologic Follow-up Study. *Arch Intern Med*. 1989;149:780-8.

8. Rothblum ED. "I only read about myself on bathroom walls": the need for research on the mental health of lesbians and gay men. *J Consult Clin Psychol*. 1994;62:213-20.

9. Bradford J, Ryan C and Rothblum ED. National Lesbian Health Care Survey: implications for mental health care. *J Consult Clin Psychol*. 1994;62:228-42.

10. Bybee D. Michigan lesbian survey: a report to the Michigan Organization for Human Rights and the Michigan Department of Public Health. Michigan Department of Health and Human Services; 1990.

11. Warshafsky L. Lesbian health needs assessment. The Los Angeles Gay and Lesbian Community Services Center; 1992.

12. Mays VM and Cochran SD. The Black Women's Relationships Project: A national survey of black lesbians. In: Shernoff M, Scott WA, eds. *A Sourcebook of Gay/Lesbian Health Care*. 2nd ed. Washington, DC: National Gay and Lesbian Health Foundation; 1988.

13. O'Hanlan KA. Recruitment and retention of lesbians in health research trials. *Recruitment and Retention of Women in Clinical Studies*. 1995;National Institutes of Health, NIH Publication # 95-3756:101-104.

14. Byrd WM and Clayton LA. The African-American cancer crisis, Part II: A prescription. *J Health Care Poor Underserved*. 1993;4:102-16.

15. Roccella EJ and Lenfant C. Regional and racial differences among stroke victims in the United States. *Clin Cardiol*. 1989;12:IV18-22.

16. Wade JC. Institutional racism: an analysis of the mental health system. *Am J Orthopsychiatry*. 1993;63:536-44.

17. Cochran SD and Mays VM. Disclosure of sexual preference to physicians by black lesbian and bisexual women. *West J Med*. 1988;149:616-9.

18. Stevens PE and Hall JM. Abusive health care interaction experienced by lesbians: a case of institutional violence in the treatment of women. *Response*. 1990;13:23.

19. Seaborg DM. Sexual orientation, behavioral plasticity, and evolution. *J Homosex*. 1984;10:153-8.

20. Chapman BE and Brannock JC. Proposed model of lesbian identity development: an empirical examination. *J Homosex*. 1987;14:69-80.

21. Friedman RC and Downey J. Neurobiology and sexual orientation: current relationships. *J Neuropsychiatry Clin Neurosci*. 1993;5:131-53.

22. Office of Research on Women's Health. Report of the National Institutes of Health: Opportunities for research on women's health. National Institutes of Health; 1991.

23. Diamond M. Homosexuality and bisexuality in different populations. *Arch Sex Behav*. 1993;22:291-310.

24. Usdansky M. Gay couples, by the numbers, data suggest they're fewer than believed, but affluent. *USA Today*. 1993;1a.

25. Hamer DH, Hu S, Magnuson VL, Hu N and Pattatucci AM. A linkage between DNA markers on the X chromosome and male sexual orientation [see comments]. *Science*. 1993;261:321-7.

26. Mac Culloch MJ and Waddington JL. Neuroendocrine mechanisms and the aetiology of male and female homosexuality. *Br J Psychiatry*. 1981;139:341-5.

27. Dittmann RW, Kappes ME and Kappes MH. Sexual behavior in adolescent and adult females with congenital adrenal hyperplasia. *Psychoneuroendocrinology*. 1992;17:153-70.

28. Goodman RE. Biology of sexuality inborn determinants of human sexual response. *Br J Psychiatry*. 1983;143:216-20.

29. Herzog DB, Norman DK, Gordon C and Pepose M. Sexual conflict and eating disorders in 27 males. *Am J Psychiatry*. 1984;141:989-90.

30. Allen LS and Gorski RA. Sexual orientation and the size of the anterior commissure in the human brain. *Proc Natl Acad Sci U S A*. 1992;89:7199-202.

31. Levay S. A difference in hypothalamic structures between heterosexual and homosexual men. *Science*. 1991;253:1034-1937.

32. Swaab DF, Gooren LJ and Hofman MA. Gender and sexual orientation in relation to hypothalamic structures. *Horm Res*. 1992;38:51-61.

33. Bailey JM and Bell AP. Familiality of female and male homosexuality. *Behav Genet*. 1993;23:313-22.

34. Bailey JM, Pillard RC, Neale MC and Agyei Y. Heritable factors influence sexual orientation in women. *Arch Gen Psychiatry*. 1993;50:217-23.

35. Mac Intyre F and Estep KW. Sperm competition and the persistence of genes for male homosexuality. *Biosystems*. 1993;31:223-33.

36. Whitam FL, Diamond M and Martin J. Homosexual orientation in twins: a report on 61 pairs and three triplet sets. *Arch Sex Behav*. 1993;22:187-206.

37. Dancey C. Sexual orientation in women: an investigation of hormonal and personality variables. *Biol Psychol*. 1990;30:251-64.

38. Gonsiorek JC. The use of diagnostic concepts in working with gay and lesbian populations. *J Homosex*. 1981;7:9-20.

39. Wagner G, Serafini J, Rabkin J, Remien R and Williams J. Integration of one's religion and homosexuality: a weapon against internalized homophobia? *J Homosex*. 1994;26:91-110.

40. Shavelson E, Biaggio MK, Cross HH and Lehman RE. Lesbian women's perceptions of their parent-child relationships. *J Homosex*. 1980;5:205-15.

41. Gundlach RH. Sexual molestation and rape reported by homosexual and heterosexual women. *J Homosex*. 1977;2:367-84.

42. Brannock J and Chapman B. Negative sexual experiences with men among heterosexual women and lesbians. *J Homosex*. 1990;19:105-10.

43. newPeters DK and Cantrell PJ. Factors distinguishing samples of lesbian and heterosexual women. *J Homosex*. 1991;21:1-15.

44. Newcomb MD. The role of perceived relative parent personality in the development of heterosexuals, homosexuals, and transvestites. *Arch Sex Behav*. 1985;14:147-64.

45. Kinsey A, Pomeroy W and Martin C. Sexual behavior in the human male. Philadelphia, PA: W. B. Saunders Co.; 1948.

46. Berger J. The psychotherapeutic treatment of male homosexuality. *Am J Psychother*. 1994;48:251-61.

47. Haldeman DC. The practice and ethics of sexual orientation conversion therapy. *J Consult Clin Psychol*. 1994;62:221-7.

48. D'Emilio J. Capitalism and gay identity. In: Abelove H, Barale MA, Halperin DM, eds. *The lesbian and gay studies reader*London: Routledge, Inc.; 1993:467-476.

49. Kaplan GT and Rogers LJ. Breaking out of the dominant paradigm: a new look at sexual attraction. *J Homosex*. 1984;10:71-5.

50. Ross MW. Beyond the biological model: new directions in bisexual and homosexual research. *J Homosex*. 1984;10:63-70.

51. Van Gelder L. The "born that way" trap. *Ms. Magazine*. 1991;May/June:86-87.

52. Savin-Williams RC. Theoretical perspectives accounting for adolescent homosexuality. *J Adolesc Health Care*. 1988;9:95-104.

53. Byne W and Parsons B. Human sexual orientation. The biologic theories reappraised. *Arch Gen Psychiatry*. 1993;50:228-39.

54. Eliason M, Donelan C and Randall C. Lesbian stereotypes. *Health Care Women Int*. 1992;13:131-44.

55. Viss DC and Burn SM. Divergent perceptions of lesbians: a comparison of lesbian self-perceptions and heterosexual perceptions. *J Soc Psychol*. 1992;132:169-77.

56. Adelman M. A comparison of professionally employed lesbians and heterosexual women on the MMPI. *Arch Sex Behav*. 1977;6:193-201.

57. Kretzschmar RM. Discussion comment in: Factors influencing lesbian gynecologic care: a preliminary study. *Am J Obstet Gynecol*. 1981;140:20-8.

58. Ferguson KD and Finkler DC. An involvement and overtness measure for lesbians: its development and relation to anxiety and social zeitgeist. *Arch Sex Behav*. 1978;7:211-27.

59. Thompson N, McCandless B and Strickland B. Personal adjustment of male and female homosexuals and heterosexuals. *J Abnorm Psychol*. 1971;78:237.

60. Evans R. Adjective check list scores of homosexual men. *J Pers Assess*. 1971;35:344.

61. Saghir MT, Robins E, Walbran B and Gentry KA. Homosexuality: IV. psychiatric disorders and disability in the female homosexual. *Am J Psychiat*. 1972;120:477.

62. Saghir MT, Robins E, Walbran B and Gentry KA. Homosexuality: III. psychiatric disorders and disability in the male homosexual. *Am J Psychiat*. 1970;127:147.

63. Nurius P. Mental health implications of sexual orientation. *J Sex Res*. 1983;19:119.

64. Savin-Williams RC. Verbal and physical abuse as stressors in the lives of lesbian, gay male, and bisexual youths: associations with school problems, running away, substance abuse, prostitution, and suicide. *J Consult Clin Psychol*. 1994;62:261-9.

65. DiPlacido J. Stress, behavioral risk factors, and physical and psychological health outcomes in lesbians. APA Women's Health Conference; 1994.

66. Brooks V. Minority stress and lesbian women. Lexington, MA: D. C. Heath & Co.; 1981.

67. Larson D and Chastain R. Self-concealment: conceptualization, measurement, and health implications. *J Soc Clin Psych*. 1990;9:439-455.

68. Bell A and Weinberg M. Homosexualities: a study of diversity among men and women. New York: Simon & Schuster; 1978.

69. Johnson SR, Guenther SM, Laube DW and Keettel WC. Factors influencing lesbian gynecologic care: a preliminary study. *Am J Obstet Gynecol*. 1981;140:20-8.

70. Landers A. Readers answer the poll: are you happy to be gay? *San Francisco Sunday Examiner and Chronicle*. San Francisco: 1992:D-2.

71. Random House Dictionary of the English Language. 2nd ed. New York, NY: Random House, Inc; 1987.

72. Grossman AH. Homophobia: a cofactor of HIV disease in gay and lesbian youth. *J Assoc Nurses Aids Care*. 1994;5:39-43.

73. Sophie J. Internalized homophobia and lesbian identity. *J Homosex*. 1987;14:53-65.

74. Isay R. Being homosexual: gay men and their development. New York: Avon Books; 1989.

75. Gross L. Out of the mainstream: sexual minorities and the mass media. *J Homosex*. 1991;21:19-46.

76. Fyfe B. "Homophobia" or homosexual bias reconsidered. *Arch Sex Behav*. 1983;12:549-54.

77. Watchtower Bible and Tract Society of New York Inc. Homosexuality: Is it really so bad? *Awake!* 1995:12-14.

78. Ferenczi S. Sex and psychoanalysis. In: Jones E, edNew York: Basic Books; 1950:154-84.

79. Smith GB. Homophobia and attitudes toward gay men and lesbians by psychiatric nurses. *Arch Psychiatr Nurs*. 1993;7:377-84.

80. Hooker E. Parental relations and male homosexuality in patient and nonpatient samples. *J Consult Clin Psychol*. 1969;33:140-2.

81. Gartrell N. The lesbian as a "single" woman. *Am J Psychother*. 1981;35:502-16.

82. Siegelman M. Adjustment of homosexual and heterosexual women. *Br J Psych*. 1979;120:477.

83. Freedman M. Homosexuality among women and psychological adjustment. *Dis Abs Int*. 1971;28:347.

84. Hart M, Roback H, Tittler B. Psychological adjustment of non-patient homosexuals: critical review of the research literature. *J. Clin. Psychiat*. 1978;39:604-608.

85. Ross MW, Paulsen JA and Stalstrom OW. Homosexuality and mental health. *J. Homosex*. 1988;15:131-152.

86. Herek GM. Gay people and government security clearances. A social science perspective. *Am Psychol*. 1990;45:1035-42.

87. Kurdek LA and Schmitt JP. Interaction of sex role self-concept with relationship quality and relationship beliefs in married, heterosexual cohabiting, gay, and lesbian couples. *J Pers Soc Psychol*. 1986;51:365-70.

88. Pagelow MD. Heterosexual and lesbian single mothers: a comparison of problems, coping, and solutions. *J Homosex*. 1980;5:189-204.

89. Stokes K, Kilmann PR and Wanlass RL. Sexual orientation and sex role conformity. *Arch Sex Behav*. 1983;12:427-33.

90. Silverstein C. The ethical and moral implications of sexual classification: a commentary. *J Homosex*. 1984;9:29-38.

91. Schwanberg SL. Attitudes towards homosexuality in American health care literature 1983-1987. *J Homosex*. 1990;19:117-36.

92. Trippet SE and Bain J. Reasons American lesbians fail to seek traditional health care. *Health Care Women Int*. 1992;13:145-53.

93. Harvey SM, Carr C and Bernheine S. Lesbian mothers. Health care experiences. *J Nurse Midwifery*. 1989;34:115-9.

94. Randall CE. Lesbian phobia among BSN educators: a survey. *J Nurs Educ*. 1989;28:302-6.

95. Eliason MJ and Randall CE. Lesbian phobia in nursing students. *West J Nurs Res*. 1991;13:363-74.

96. Matthews W, Booth MW and Turner J. Physicians attitudes toward homosexuality: survey of a California county Medical Society. *West J Med*. 1986;144:106.

97. Schatz B and O'Hanlan K. Anti-gay discrimination in medicine: results of a national survey of lesbian, gay and bisexual physicians. The Gay and Lesbian Medical Association, 273 Church St. San Francisco, CA 94114; 1994.

98. Tinmouth J and Hamwi G. The experience of gay and lesbian students in medical school. *JAMA*. 1994;271:714-5.

99. Stevens PE and Hall JM. Stigma, health beliefs and experiences with health care in lesbian women. *Image J Nurs Sch*. 1988;20:69-73.

100. Glascock E. Access to the traditional health care system by nontraditional women: perceptions of a cultural interaction. *American Public Health Association*. Los Angeles: 1981.

101. Deevy S. Older lesbian women: an invisible minority. *J Geront Nurs*. 1990;16:35-39.

102. Kass N, Faden R, Fox R and Dudley J. Homosexual and bisexual men's perceptions of discrimination in health services. *Am J Pub Health*. 1992;82:1277-1279.

103. Dardick L and Grady K. Openness between gay persons and health professionals. *Ann Int Med*. 1980;93:115-119.

104. Smith EM, Johnson SR and Guenther SM. Health care attitudes and experiences during Gynecologic care among lesbians and bisexuals. *Am J Public Health*. 1985;75:1085-7.

105. Walsh-Bowers RT and Parlour SJ. Researcher-participant relationships in journal reports on gay men and lesbian women. *J Homosex*. 1992;23:93-112.

106. Whatley MH. Images of gays and lesbians in sexuality and health textbooks. *J Homosex*. 1992;22:197-211.

107. Sears JT. Educators, homosexuality, and homosexual students: are personal feelings related to professional beliefs? *J Homosex*. 1992;22:29-79.

108. O'Hanlan KA. Personal correspondence with members of the ACOG Patient Education Committee. 1991-1993.

109. Rhinehart R. personal communication. Director of Patient Education Materials of the American College of Obstetricians and Gynecologists; 1995.

110. Suppe F. The Bell and Weinberg study: future priorities for research on homosexuality. *J Homosex*. 1981;6:69-97.

111. Morin SF. Heterosexual bias in psychological research on lesbianism and male homosexuality. *Am Psychol*. 1977;32:629-37.

112. Johnson SR and Palermo JL. Gynecologic care for the lesbian. *Clin Obstet Gynecol*. 1984;27:724-31.

113. Johnson SR, Smith EM and Guenther SM. Parenting desires among bisexual women and lesbians. *J Reprod Med*. 1987;32:198-200.

114. Johnson SR, Smith EM and Guenther SM. Comparison of gynecologic health care problems between lesbians and bisexual women. A survey of 2,345 women. *J Reprod Med*. 1987;32:805-11.

115. Prevention Services Branch of the AIDS Office. Health Behaviors among lesbian and bisexual women: A community-based women's health survey. San Francisco Department of Public Health; 1993.

116. Gage S. Preliminary Findings: The national lesbian and bi women's health survey. In: Lesbian Health Project of Los Angeles, ed *National Lesbian and Gay Health Conference*. New York: 1994.

117. Phillip M. Gay issues: out of the closet, into the classroom, racism, fear of reprisals force black gays and lesbians to keep low profile on campus. *Black Issues In Higher Education*. 1993;20-25.

118. Mays VM, Jackson JS and Coleman LS. Perceived discrimination, employment status and job stress in a national sample of black women. *J Occup Health Psychol*. 1995;in press:.

119. Robertson P and Schachter J. Failure to identify venereal disease in a lesbian population. *Sex Transm Dis*. 1981;8:75-6.

120. Chu SY, Hammett TA and Buehler JW. Update: epidemiology of reported cases of AIDS in women who report sex only with other women, United States, 1980-1991 [letter]. *Aids*. 1992;6:518-9.

121. Marmor M, Weiss LR, Lyden M. Possible female-to-female transmission of human immunodeficiency virus [letter]. *Ann Intern Med*. 1986;105:969.

122. Sabatini MT, Patel K and Hirschman R. Kaposi's sarcoma and T-cell lymphoma in an immunodeficient woman: a case report. *Aids Res*. 1983;1:135-7.

123. Perry S, Jacobsberg L and Fogel K. Orogenital transmission of human immunodeficiency virus (HIV) [letter]. *Ann Intern Med*. 1989;111:951-2.

124. Monzon OT and Capellan JM. Female-to-female transmission of HIV [letter]. *Lancet*. 1987;2:40-1.

125. Spitzer PG and Weiner NJ. Transmission of HIV infection from a woman to a man by oral sex [letter]. *N Engl J Med*. 1989;320:251.

126. Einhorn L and Polgar M. HIV-risk bahavior among lesbians and bisexual women. *AIDS Education and Prevention*. 1994;6:514-523.

127. Surveillance Branch. HIV Seroprevalence and risk behaviors among lesbians and bisexual women: The 1993 San Francisco/Berkeley womens survey. AIDS Office of the San Francisco Department of Public Health; 1993.

128. Herzog D, Newman K, Yeh C and Warshaw M. Body image satisfaction in homosexual and heterosexual women. *Int J Eating Disorders*. 1992;11:391.

129. Siever MD. Sexual orientation and gender as factors in socioculturally acquired vulnerability to body dissatisfaction and eating disorders. *J Consult Clin Psychol*. 1994;62:252-60.

130. Namnoum A. Obesity: a disease worth treating. *The Female Patient*. 1993;18:33-44.

131. Holleb A, Fink D and Murphy G. American Cancer Society Textbook of Clinical Oncology. Atlanta, GA: American Cancer Society; 1991:177,485,488.

132. Coker AL, Harlap S and Fortney JA. Oral contraceptives and reproductive cancers: weighing the risks and benefits. *Fam Plann Perspect*. 1993;25:17-21.

133. Edwards A and Thin RN. Sexually transmitted diseases in lesbians. *Int J Std Aids*. 1990;1:178-81.

134. United States Department of Health and Human Services. Health: United States Prevention Profile for l991. Department of Health and Human Services; 1991.

135. Willett WC, Stampfer MJ, Colditz GA. Moderate alcohol consumption and the risk of breast cancer. *N Engl J Med*. 1987;316:1174-80.

136. London SJ, Colditz GA, Stampfer MJ. Prospective study of relative weight, height, and risk of breast cancer [see comments]. *Jama*. 1989;262:2853-8.

137. Tabar L, Fagerberg CJ, Gad A. Reduction in mortality from breast cancer after mass screening with mammography. Randomised trial from the Breast Cancer Screening Working Group of the Swedish National Board of Health and Welfare. *Lancet*. 1985;1:829-32.

138. Greater Bay Area Cancer Registry. Breast cancer in the greater bay area. *Greater Bay Area Cancer Registry Report*. 1994;5:1-8.

139. Krieger L. San Francisco remains a mecca for gay couples. *San Francisco Examiner*. San Francisco: 1993:A-1, A-19.

140. Giovannucci E, Rimm EB, Stampfer MJ. A prospective study of cigarette smoking and risk of colorectal adenoma and colorectal cancer in U.S. men [see comments]. *J Natl Cancer Inst*. 1994;86:183-91.

141. Giovannucci E, Stampfer MJ, Colditz GA. Folate, methionine, and alcohol intake and risk of colorectal adenoma [see comments]. *J Natl Cancer Inst*. 1993;85:875-84.

142. Chute CG, Willett WC, Colditz GA. A prospective study of body mass, height, and smoking on the risk of colorectal cancer in women. *Cancer Causes Control*. 1991;2:117-24.

143. Fry RD, Fleshman JW and Kodner IJ. Cancer of the colon and rectum. *Clinical Symposia*. 1989;41:29-30.

144. Leaverton PE, Sorlie PD, Kleinman JC. Representativeness of the Framingham risk model for coronary heart disease mortality: a comparison with a national cohort study. *J Chronic Dis*. 1987;40:775-84.

145. Manson JE, Colditz GA, Stampfer MJ. A prospective study of obesity and risk of coronary heart disease in women [see comments]. *N Engl J Med*. 1990;322:882-9.

146. O'Hanlan KA. Risk of cancers and heart disease in the lesbian population. In: American Association of Physicians for Human Rights, ed *Annual Meeting of the Lesbian Physicians' Conference*. Taos, NM: 1991.

147. Robertson MM. Lesbians as an invisible minority in the health services arena. *Health Care Women Int*. 1992;13:155-63.

148. Haynes S. Risk of breast cancer in lesbians. In: National Gay and Lesbian Health Education Foundation, ed *Annual Meeting of the National Gay and Lesbian Health Education Foundation*. Los Angeles, CA: 1992.

149. Greene B. Ethnic-minority lesbians and gay men: mental health and treatment issues. *J Consult Clin Psychol*. 1994;62:243-51.

150. Rothblum ED. Introduction to the special section: mental health of lesbians and gay men. *J Consult Clin Psych*. 1994;62:211-212.

151. Sophie J. A critical examination of stage theories of lesbian identity development. *J Homosex*. 1985;12:39-51.

152. Kahn MJ. Factors affecting the coming out process for lesbians. *J Homosex*. 1991;21:47-70.

153. Faderman L. The "new gay" lesbians. *J Homosex*. 1984;10:85-95.

154. D'Augelli AR and Hershberger SL. Lesbian, gay, and bisexual youth in community settings: personal challenges and mental health problems. *Am J Community Psychol*. 1993;21:421-48.

155. Remafedi G, Resnick M, Blum R and Harris L. Demography of sexual orientation in adolescents. *Pediatrics*. 1992;89:714-21.

156. Rotheram-Borus M, Rosario M and Koopman C. Minority youths at high risk: gay males and runaways. In: M.E. Colten & S. Gore, ed. *Adolescent Stress: Causes and Consequences*New York: Aldine de Gruyter; 1991:181-200.

157. Rotheram-Borus MJ. Suicidal behavior and risk factors among runaway youths. *Am J Psychiatry*. 1993;150:103-7.

158. Rotheram-Borus MJ and Trautman PD. Hopelessness, depression, and suicidal intent among adolescent suicide attempters. *J Am Acad Child Adolesc Psychiatry*. 1988;27:700-4.

159. Rosario M, Rotheram-Borus M and Reid H. Emotional distress, multiple problem behaviors, stress and self esteem among gay and bisexual male adolescents. *J Consult Clin Psychol*. 1994;in press:.

160. O'Brien T. A survey of gay/lesbian Catholics concerning attitudes toward sexual orientation and religious beliefs. *J Homosex*. 1991;21:29-44.

161. Newman BS and Muzzonigro PG. The effects of traditional family values on the coming out process of gay male adolescents. *Adolescence*. 1993;28:213-26.

162. Pattison EM and Pattison ML. "Ex-Gays": Religiously mediated change in homosexuals. *Am J Psychiatry*. 1980;137:1553-62.

163. Erwin K. Interpreting the evidence: competing paradigms and the emergence of lesbian and gay suicide as a "social fact". *Int J Health Serv*. 1993;23:437-53.

164. Gibson P. Gay male and lesbian youth suicide. *Report of the Secretary's Task Force Report on Youth Suicide*. 1989;3:.

165. Swaggart J. Homosexuality: its cause and its cure. Baton Rouge LA: Jimmy Swaggart Ministries; 1982.

166. Uribe V and Harbeck KM. Addressing the needs of lesbian, gay, and bisexual youth: the origins of PROJECT 10 and school-based intervention. *J Homosex*. 1992;22:9-28.

167. Remafedi G. The impact of training on school professionals' knowledge, beliefs, and behaviors regarding HIV/AIDS and adolescent homosexuality. *J Sch Health*. 1993;63:153-7.

168. Remafedi G. Fundamental issues in the care of homosexual youth. *Med Clin North Am*. 1990;74:1169-79.

169. Creatsas GK. Sexuality: sexual activity and contraception during adolescence. *Curr Opin Obstet Gynecol*. 1993;5:774-83.

170. Fejes F. Gays, lesbians, and the media: a selected bibliography. *J Homosex*. 1991;21:261-77.

171. United States Government Accounting Office. Report to Congress on Homosexuality in the Military. United States Congress; 1992.

172. Morrow DF. Social work with gay and lesbian adolescents. *Soc Work*. 1993;38:655-60.

173. Sanford ND. Providing sensitive health care to gay and lesbian youth. *Nurse Pract*. 1989;14:30-2.

174. Schneider SG, Farberow NL and Kruks GN. Suicidal behavior in adolescent and young adult gay men. *Suicide Life Threat Behav*. 1989;19:381-94.

175. Taylor BA and Remafedi G. Youth coping with sexual orientation issues. *J Sch Nurs*. 1993;9:26-7.

176. American Academy of Pediatrics: Committee on Adolescence. Homosexuality and Adolescence. *Pediatrics*. 1993;92:631-634.

177. Harry J. Sexual identity issues. In: Department of Health and Human Services, ed. *Report to Louis Sullivan from the Secretary's Task Force on Youth Suicide* U. S. Department of Health and Human Services; 1989.

178. Remafedi G, Farrow JA and Deisher RW. Risk factors for attempted suicide in gay and bisexual youth. *Pediatrics*. 1991;87:869-75.

179. Hunter J and Schaecter R. Lesbian and gay youth. In: Rotheram-Borus M, Bradley J, Obolensky N, eds. *Planning to Live: Evaluating and Treating Suicidal Teens in Community Settings*Tulsa: University of Oklahoma Press; 1990:297-316.

180. Espin O. Cultural and historical influences of sexuality in Hispanic/Latina women: implications for psychotherapy. In: Vance C, ed. *Pleasure and Danger: Exploring Female Sexuality*London: Routledge; 1984:149-163.

181. Hidalgo H. The Puerto Rican lesbian in the United States. In: Darty T, Potter S, eds. *Woman Identified Women*. Palo Alto, CA: Mayfield; 1984:105-150.

182. Morales E. Latino Gays and Latina Lesbians. In: Dworkin S, Gutierrez F, eds. *Counseling Gay Men and Lesbians: Journey to the End of the Rainbow*Alexandria, VA: American Association for Counseling and Development; 1992:125-139.

183. Acosta E. Affinity for black heritage: Seeking lifestyle within a community. *The Washington Blade*. Washington, D. C.: 1979:A-1, 25.

184. Mays VM, Cochran SD and Rhue S. The impact of perceived discrimination on the intimate relationships of black lesbians. *J Homosex*. 1993;25:1-14.

185. Chan C. Cultural considerations in counseling Asian American Lesbians and Gay Men. In: Dworkin S, Gutierrez F, eds. *Counseling Gay Men and Lesbians*Alexandria, VA: American Association for Counseling and Development; 1992:115-124.

186. Stephany TM. Faculty support for gay and lesbian nursing students. *Nurse Educ*. 1992;17:22-3.

187. Berger R. Passing: Impact on the quality of same-sex couple relationships. *Soc Work*. 1990;35:328-32.

188. Schmitt J and Kurdek L. Personality correlates of positive identity and relationship involvement in gay men. *J Homosex*. 1987;13:101-109.

189. Schneider SG, Taylor SE, Hammen C, Kemeny ME and Dudley J. Factors influencing suicide intent in gay and bisexual suicide ideators: differing models for men with and without human immunodeficiency virus. *J Pers Soc Psychol*. 1991;61:776-88.

190. Hammelman T. Gay and lesbian youth: contributing factors to serious attempts or considerations of suicide. *J Gay Lesbian Psychiat*. 1993;2:77.

191. Hunter J. Violence against lesbian and gay youth: a report from the Hetrick Martin Institute. The Hetrick Martin Institute; 1989.

192. Centers for Disease Control. Attempted suicide among high school students in the United States. *Morbidity and Mortality Weekly Report*. 1991;40:1-8.

193. Cabaj R. Substance abuse in the gay and lesbian community. In: Lowinson J, Ruiz P, Millman R, eds. *Substance Abuse: A Comprehensive Textbook*. Second ed. Baltimore, MD: Williams and Wilkins; 1992:852-860.

194. Lesbian & Gay Substance Abuse Planning Group. San Francisco lesbian, gay and bisexual substance abuse needs assessment. In: EMT Associates, ed *Lesbian & Gay Substance Abuse*. Sacramento, CA: 1991:Executive Summary: Appendices A, B, C.

195. Diamond DL and Wilsnack SC. Alcohol abuse among lesbians: a descriptive study. *J Homosex*. 1978;4:123-42.

196. Paul J, Stall R and Bloomfield K. Gay and alcoholic: epidemiologic and clinical issues. *Alcohol Health and Research*. 1991;5:151-160.

197. Clark W. The contemporary tavern. In: Israel Y, Glaser F, Kalant H, et al., eds. *Research Advances in Alcohol and Drug Problems*. New York, NY: Plenum Press; 1981:425-470.

198. Bloomfield K. A comparison of alcohol consumption between lesbians and heterosexual women in an urban population. *Drug Alcohol Depend*. 1993;33:257-69.

199. McKirnan D and Peterson P. Alcohol and drug use among homosexual men and women: epidemiology and population characteristics. *Addictive Behaviors*. 1989;14:545-553.

200. Morales E and Graves M. Substance abuse: patterns and barriers to treatment for gay men and lesbians in San Francisco. Report to Community Substance Abuse Services. San Francisco Department of Public Health; 1983.

201. Hellman R, Stanton M, Lee J, Tytun A and Vachon R. Treatment of homosexual alcoholics in government funded agencies: provider training and attitudes. *Hospital and Community Psychiatry*. 1989;40:1163-1168.

202. Fifield L, de Crescenzo T and Latham J. Alcoholism and the gay community. Summary of "On my way to nowhere: alienated, isolated, drunk: an analysis of gay alcohol abuse and evaluation of alcoholism rehabilitation services for Los Angeles County. Los Angeles Gay Community Services Center; 1975.

203. Hall JM. Alcoholism in lesbians: developmental, symbolic interactionist, and critical perspectives. *Health Care Women Int*. 1990;11:89-107.

204. de Monteflores C. Notes on the management of difference. In: Stein TS, Cohen CC, eds. *Contemporary Perspectives on Psychotherapy with Lesbians and Gay Men* Plenum, New York: 1986:73-101.

205. Hall M. The lesbian corporate experience. *J Homosex*. 1986;12:59-75.

206. Hall JM. Alcoholism recovery in lesbian women: a theory in development. *Sch Inq Nurs Pract*. 1990;4:109-22.

207. Hall JM. An exploration of lesbians' images of recovery from alcohol problems. *Health Care Women Int*. 1992;13:181-98.

208. Hall JM. Lesbians and alcohol: patterns and paradoxes in medical notions and lesbians' beliefs. *J Psychoactive Drugs*. 1993;25:109-19.

209. Hall JM. Lesbians recovering from alcohol problems: an ethnographic study of health care experiences. *Nurs Res*. 1994;43:238-44.

210. Hall JM. How lesbians recognize and respond to alcohol problems: a theoretical model of problematization. *Ans Adv Nurs Sci*. 1994;16:46-63.

211. National Gay and Lesbian Task Force. Report on anti-gay/lesbian victimization: a study by the National Gay and Lesbian Task Force in cooperation with the gay and lesbian organizations in eight U.S. cities. National Gay and Lesbian Task Force Policy Institute; 1984.

212. Gross L and Aurand S. Discrimination and violence against lesbian women and gay men in Philadelphia and the Commonwealth of Pennsylvania: a study by the Philadelphia Lesbian and Gay Task Force. The Philadelphia Lesbian and Gay Task Force; 1992.

213. Dunlap D. Survey on slayings of homosexuals finds high violence and low arrest rate. *The New York Times*. New York: 1994:A-10.

214. LeBlanc S. 8 in 10, A special report of the Victim Recovery Program of the Fenway Community Health Center. The Victim Recovery Program of the Fenway Community Health Center; 1991.

215. Barnes A and Ephross PH. The impact of hate violence on victims: emotional and behavioral responses to attacks. *Soc Work*. 1994;39:247-51.

216. Herek GM. Documenting prejudice against lesbians and gay men on campus: the Yale Sexual Orientation Survey. *J Homosex*. 1993;25:15-30.

217. Herek GM. Hate crimes against lesbians and gay men. Issues for research and policy. *Am Psychol*. 1989;44:948-55.

218. National Gay and Lesbian Task Force. Anti-gay/lesbian violence, victimization, & defamation in 1993. National Gay and Lesbian Task Force Policy Institute in Washington D. C.; 1994.

219. Bryant S and Demian. Summary of results, Partners' national survey of lesbian & gay couples. *Partners*. 1990;2-6.

220. Reilly ME and Lynch JM. Power-sharing in lesbian partnerships. *J Homosex*. 1990;19:1-30.

221. Lynch JM and Reilly ME. Role relationships: lesbian perspectives. *J Homosex*. 1985;12:53-69.

222. Peplau LA, Padesky C and Hamilton M. Satisfaction in lesbian relationships. *J Homosex*. 1982;8:23-35.

223. McCandlish BM. Therapeutic issues with lesbian couples. *J Homosex*. 1981;7:71-8.

224. Kaufman PA, Harrison E and Hyde ML. Distancing for intimacy in lesbian relationships. *Am J Psychiatry*. 1984;141:530-3.

225. Duffy SM and Rusbult CE. Satisfaction and commitment in homosexual and heterosexual relationships. *J Homosex*. 1985;12:1-23.

226. Schullo SA and Alperson BL. Interpersonal phenomenology as a function of sexual orientation, sex, sentiment, and trait categories in long-term dyadic relationships. *J Pers Soc Psychol*. 1984;47:983-1002.

227. Hurlbert DF and Apt C. Female sexuality: a comparative study between women in homosexual and heterosexual relationships. *J Sex Marital Ther*. 1993;19:315-27.

228. Hall J and Stevens P. The coupled lesbian. In: Kus R, ed. *Keys to Caring: Assisting Your Gay and Lesbian Clients*Boston, MA: 1990: 215-223.

229. Cabaj R. Gay and lesbian couples: Lessons on human intimacy. *Psych Ann*. 1988;18:21-25.

230. Klinger R and Cabaj RP. Characteristics of gay and lesbian relationships, special section: changing perspectives on homosexuality. In: Stein T, ed. *Psychiatry*Washington DC: American Psychiatric Press, Inc; 1993.

231. McWhirter D and Mattison A. Psychotherapy for male couples: an application of the staging theory. In: Hetrick ES, Stein TS, eds. *Innovations in Psychotherapy with Homosexuals*Washington, DC: American Psychiatric Press, Inc.; 1984:115-131.

232. Ford CS and Beach FA. Homosexual behavior. *Patterns of sexual behavior*. Scranton, Pa: Harper & Brothers and Paul B. Hoeber Medical Books; 1952.

233. Hite S. The Hite Report. New York: Macmillan; 1981.

234. Masters W and Johnson V. Homosexuality in Perspective. Boston: Little, Brown & Company; 1979.

235. Kinsey A, Pomeroy W and Martin C. Sexual behavior in the human female. Philadelphia, PA: W. B. Saunders Co.; 1953.

236. Frank E, Anderson C and Rubinstein D. Frequency of sexual dysfunction in "normal" couples. *N Engl J Med*. 1978;299:111-5.

237. Island D and Letellier P. Men who beat the men who love them. *Battered Gay Men and Domestic Violence*. New York: Harrington Park Press; 1991.

238. Morrow J. Identifying and treating battered lesbians. *San Francisco Medicine*. 1994;April:17-21.

239. Leeder E. Enmeshed in pain: counseling lesbian battering couples. *Women and Therapy*. 1988;7:81-89.

240. Schilit R, Lie GY and Montagne M. Substance use as a correlate of violence in intimate lesbian relationships. *J Homosex*. 1990;19:51-65.

241. Martorano JT, Ahlgrimm M and Myers D. Differentiating between natural progesterone and synthetic progestogens: clinical implications for premenstrual syndrome management. *Compr Ther*. 1993;19:96-8.

242. Kurdek LA and Schmitt JP. Perceived emotional support from family and friends in members of homosexual, married, and heterosexual cohabiting couples. *J Homosex*. 1987;14:57-68.

243. Kurdek LA. Perceived social support in gays and lesbians in cohabitating relationships. *J Pers Soc Psychol*. 1988;54:504-9.

244. Stewart GJ, Tyler JP, Cunningham AL. Transmission of human T-cell lymphotropic virus type III (HTLV-III) by artificial insemination by donor. *Lancet*. 1985;2:581-5.

245. Eskenazi B, Pies C, Newstetter A, Shepard C and Pearson K. HIV serology in artificially inseminated lesbians. *J Acquir Immune Defic Syndr*. 1989;2:187-93.

246. Zeidenstein L. Gynecological and childbearing needs of lesbians. *J Nurse Midwifery*. 1990;35:10-8.

247. Bozett F. Children of gay fathers. In: Bozett FW, ed *Gay and Lesbian Parents*. New York: Praeger; 1987:39-57.

248. Harvard School of Law. Sexual orientation and the law. In: University H, ed. *The Harvard Law Review*Cambridge MA: Harvard University Press; 1990.

249. Patterson CJ. Children of lesbian and gay parents. *Child Dev*. 1992;63:1025-42.

250. American Psychiatric Association. Sexual Disorders. *Diagnostic and Statistical Manual of Mental Disorders-III Edition*. Washington DC: American Psychiatric Association; 1987:279-296.

251. Jenny C, Roesler TA and Poyer KL. Are children at risk for sexual abuse by homosexuals? [see comments]. *Pediatrics*. 1994;94:41-4.

252. Golombok S, Spencer A and Rutter M. Children in lesbian and single-parent households: psychosexual and psychiatric appraisal. *J Child Psychol Psychiatry*. 1983;24:551-72.

253. Green R, Mandel JB, Hotvedt ME, Gray J and Smith L. Lesbian mothers and their children: a comparison with solo parent heterosexual mothers and their children. *Arch Sex Behav*. 1986;15:167-84.

254. Green R. Sexual identity of 37 children raised by homosexual or transsexual parents. *Am J Psych*. 1978;135:692-697.

255. Kirkpatrick M, Smith C and Roy R. Lesbian mothers and their children: a comparative survey. *Am J Orthopsych*. 1981;51:545-551.

256. Kirkpatrick M. Clinical implications of lesbian mother studies. *J Homosex*. 1987;14:201-11.

257. Rees R. A comparison of children of lesbian and single heterosexual mothers on three measures of socialization. California School of Professional Psychology, Berkeley CA; 1979.

258. Gottman J. Children of gay and lesbian parents. In: Bozett FW, Sussman MB, eds. *Homosexuality and Family Relations*New York, NY: Harrington Park Press; 1990:1177-1196.

259. Huggins SL. A comparative study of self-esteem of adolescent children of divorced lesbian mothers and divorced heterosexual mothers. *J Homosex*. 1989;18:123-35.

260. Puryear D. A comparison between the children of lesbian mothers and the children of heterosexual mothers. California School of Professional Psychology, Berkeley CA; 1983.

261. Paul J. Growing up with a gay, lesbian or bisexual parent. University of California at Berkeley, Berkeley, CA; 1986.

262. Rand C, Graham DL and Rawlings EI. Psychological health and factors the court seeks to control in lesbian mother custody trials. *J Homosex*. 1982;8:27-39.

263. Deevey S. Older lesbian women. An invisible minority. *J Gerontol Nurs*. 1990;16:35-9.

264. Quam JK and Whitford GS. Adaptation and age-related expectations of older gay and lesbian adults. *Gerontologist*. 1992;32:367-74.

265. Kehoe M. Lesbians over 65: a triply invisible minority. *J Homosex*. 1986;12:139-52.

266. Kehoe M. Lesbians over 60 speak for themselves. *J Homosex*. 1988;16:1-111.

267. O'Hanlan KA. Position paper on lesbian health. *J Amer Med Womens' Assoc*. 1993;49:86.

268. Seidman S and Reider R. A review of sexual behavior in the United States. *Am J Psychiat*. 1994;151:330-341.

269. Davison GC and Friedman S. Sexual orientation stereotypy in the distortion of clinical judgment. *J Homosex*. 1981;6:37-44.

270. Wallick MM, Cambre KM and Townsend MH. How the topic of homosexuality is taught at U.S. medical schools. *Acad Med*. 1992;67:601-3.

271. Gibson G and Saunders DE. Gay patients. Context for care. *Can Fam Physician*. 1994;40:721-5.

272. Murphy BC. Educating mental health professionals about gay and lesbian issues. *J Homosex*. 1992;22:229-46.

273. Office of Student Affairs. A community of equals: a resource guide for the Temple medical community about gay, lesbian and bisexual people. Temple University School of Medicine; 1992.

274. Stein TS. A curriculum for learning in psychiatric residencies about homosexuality, gay men and lesbians. *Academic Psychiatry*. 1994;18:59-70.

275. O'Neill J. Health care needs of gay men and lesbians in the U. S. American Medical Association; 1994.

276. Stewart DC. Sexuality and the adolescent: issues for the clinician. *Prim Care*. 1987;14:83-99.

277. Cass VC. Homosexual identity: a concept in need of definition. *J Homosex*. 1983;9:105-26.

278. Meijer H. Can seduction make straight men gay? *J Homosex*. 1993;24:125-36.

279. Committee on Lesbian and Gay Concerns. Avoiding heterosexual bias in language. *American Journal of Psychology*. 1991;46:973-4.

280. O'Hanlan KA. Personal communication with Walter Willett, MD and Patricia Case, MPH. Nurses Health Study II, Harvard Medical School and School of Public Health; 1994.

281. Cwayna K, Remafedi G and Treadway L. Caring for gay and lesbian youth. *Medical Aspects of Human Sexuality*. 1991;1:50-57.

282. McConaghy N and Silove D. Opposite sex behaviours correlate with degree of homosexual feelings in the predominantly heterosexual. *Aust N Z J Psychiatry*. 1991;25:77-83.

283. McConaghy N and Silove D. Do sex-linked behaviors in children influence relationships with their parents? *Arch Sex Behav*. 1992;21:469-79.

284. Neisen JH. Resources for families with a gay/lesbian member. *J Homosex*. 1987;14:239-51.

285. Hammersmith SK. A sociological approach to counseling homosexual clients and their families. *J Homosex*. 1987;14:173-90.

286. Kirby D, Short L, Collins J. School-based programs to reduce sexual risk behaviors: a review of effectiveness. *Public Health Rep*. 1994;109:339-60.

287. Telljohann SK and Price JH. A qualitative examination of adolescent homosexuals' life experiences: ramifications for secondary school personnel. *J Homosex*. 1993;26:41-56.

288. Griffin P. From hiding out to coming out: empowering lesbian and gay educators. *J Homosex*. 1992;22:167-96.

289. Cranston K. HIV education for gay, lesbian, and bisexual youth: personal risk, personal power, and the community of conscience. *J Homosex*. 1992;22:247-59.

290. Goodman JM. Lesbian, gay & bisexual issues in education. Thrust for Educational Leadership; 1993.

291. Harbeck KM. Gay and lesbian educators: past history/future prospects. *J Homosex*. 1992;22:121-40.

292. Remafedi G and Blum R. Working with gay and lesbian adolescents. *Pediatr Ann*. 1986;15:773-83.

293. Cochran SD and Mays VM. Depressive distress among homosexually active African American men and women. *Am J Psychiatry*. 1994;151:524-9.

294. Massachusetts State House. Governor's Commission on Gay and Lesbian Youth. Room 111, Boston, MA: Massachusetts State House; 1993.

295. Zowall H, Coupal L, Fraser RD. Economic impact of HIV infection and coronary heart disease in immigrants to Canada [see comments]. *Can Med Assoc J*. 1992;147:1163-72.

296. Fried B. Report of the subcommittee on domestic partners' benefits. *University Committee for Faculty and Staff Benefits*. 1992;37-38.

1. Bersoff DN, Ogden DW. APA Amicus Curiae Briefs: Furthering lesbian and gay male civil rights. *Am Psychol*. 1991;46(9):950-956.

2. Albro J, Tully C. A study of lesbian lifestyles in the homosexual micro-culture and the heterosexual macro-culture. *J Homosex*. 1979;4(4):331-344.

3. Ellis AL, Vasseur RB. Prior interpersonal contact with and attitudes towards gays and lesbians in an interviewing context. *J Homosex*. 1993;25(4):31-45.

4. Suppe F. Classifying sexual disorders: the Diagnostic and Statistical Manual of the American Psychiatric Association. *J Homosex*. 1984;9(4):9-28.

5. Faderman L. The "new gay" lesbians. *J Homosex*. 1984;10(3-4):85-95.

6. Madans JH, Cox CS, Kleinman JC, et al. 10 years after NHANES I: mortality experience at initial followup, 1982-84. *Public Health Rep*. 1986;101(5):474-481.

7. Cornoni-Huntley J, La Croix AZ, Havlik RJ. Race and sex differentials in the impact of hypertension in the United States. The National Health and Nutrition Examination Survey I Epidemiologic Follow-up Study. *Arch Intern Med*. 1989;149(4):780-788.

8. Rothblum ED. "I only read about myself on bathroom walls": the need for research on the mental health of lesbians and gay men. *J Consult Clin Psychol*. 1994;62(2):213-220.

9. Bradford J, Ryan C, Rothblum ED. National Lesbian Health Care Survey: implications for mental health care. *J Consult Clin Psychol*. 1994;62(2):228-242.

10. Bybee D. *Michigan lesbian survey: a report to the Michigan Organization for Human Rights and the Michigan Department of Public Health*: Michigan Department of Health and Human Services, Detroit, MI; January 1990.

11. Warshafsky L. *Lesbian health needs assessment*: The Los Angeles Gay and Lesbian Community Services Center; April 1992.

12. Mays VM, Cochran SD. The Black Women's Relationships Project: A national survey of black lesbians. In: Shernoff M, Scott WA, eds. *A Sourcebook of Gay/Lesbian Health Care*. 2nd ed. Washington, DC: National Gay and Lesbian Health Foundation; 1988.

13. O'Hanlan KA. Recruitment and retention of lesbians in health research trials. *Recruitment and Retention of Women in Clinical Studies*. January 1995;95-3756:101-104.

14. Byrd WM, Clayton LA. The African-American cancer crisis, Part II: A prescription. *J Health Care Poor Underserved*. 1993;4(2):102-116.

15. Roccella EJ, Lenfant C. Regional and racial differences among stroke victims in the United States. *Clin Cardiol*. 1989;12(12 Suppl 4):IV18-22.

16. Wade JC. Institutional racism: an analysis of the mental health system. *Am J Orthopsychiatry*. 1993;63(4):536-544.

17. Cochran SD, Mays VM. Disclosure of sexual preference to physicians by black lesbian and bisexual women. *West J Med*. 1988;149(5):616-619.

18. Stevens PE, Hall JM. Abusive health care interaction experienced by lesbians: a case of institutional violence in the treatment of women. *Response*. 1990;13(3):23.

19. Seaborg DM. Sexual orientation, behavioral plasticity, and evolution. *J Homosex*. 1984;10(3-4):153-158.

20. Chapman BE, Brannock JC. Proposed model of lesbian identity development: an empirical examination. *J Homosex*. 1987;14(3-4):69-80.

21. Friedman RC, Downey J. Neurobiology and sexual orientation: current relationships. *J Neuropsychiatry Clin Neurosci*. 1993;5(2):131-153.

22. Office of Research on Women's Health. *Report of the National Institutes of Health: Opportunities for research on women's health*: National Institutes of Health; September 4-6 1991. 92-3457A.

23. Diamond M. Homosexuality and bisexuality in different populations. *Arch Sex Behav*. 1993;22(4):291-310.

24. Usdansky M. Gay couples, by the numbers, data suggest they're fewer than believed, but affluent. *USA Today*. April 12, 1993: 1a.

25. Hamer DH, Hu S, Magnuson VL, Hu N, Pattatucci AM. A linkage between DNA markers on the X chromosome and male sexual orientation [see comments]. *Science*. 1993;261(5119):321-327.

26. Mac Culloch MJ, Waddington JL. Neuroendocrine mechanisms and the aetiology of male and female homosexuality. *Br J Psychiatry*. 1981;139(1):341-345.

27. Dittmann RW, Kappes ME, Kappes MH. Sexual behavior in adolescent and adult females with congenital adrenal hyperplasia. *Psychoneuroendocrinology*. 1992;17(2-3):153-170.

28. Goodman RE. Biology of sexuality inborn determinants of human sexual response. *Br J Psychiatry*. 1983;143(1):216-220.

29. Allen LS, Gorski RA. Sexual orientation and the size of the anterior commissure in the human brain. *Proc Natl Acad Sci U S A*. 1992;89(15):7199-7202.

30. Levay S. A difference in hypothalamic structures between heterosexual and homosexual men. *Science*. 1991;253:1034-1937.

31. Swaab DF, Gooren LJ, Hofman MA. Gender and sexual orientation in relation to hypothalamic structures. *Horm Res*. 1992;38(1):51-61.

32. Bailey JM, Bell AP. Familiality of female and male homosexuality. *Behav Genet*. 1993;23(4):313-322.

33. Bailey JM, Pillard RC, Neale MC, Agyei Y. Heritable factors influence sexual orientation in women. *Arch Gen Psychiatry*. 1993;50(3):217-223.

34. Mac Intyre F, Estep KW. Sperm competition and the persistence of genes for male homosexuality. *Biosystems*. 1993;31(2-3):223-233.

35. Whitam FL, Diamond M, Martin J. Homosexual orientation in twins: a report on 61 pairs and three triplet sets. *Arch Sex Behav*. 1993;22(3):187-206.

36. Dancey C. Sexual orientation in women: an investigation of hormonal and personality variables. *Biol Psychol*. 1990;30(3):251-264.

37. Gonsiorek JC. The use of diagnostic concepts in working with gay and lesbian populations. *J Homosex*. 1981;7(2-3):9-20.

38. Dickemann M. Reproductive strategies and gender construction: an evolutionary view of homosexualities. *J Homosex*. 1993;24(3-4):55-71.

39. Shavelson E, Biaggio MK, Cross HH, Lehman RE. Lesbian women's perceptions of their parent-child relationships. *J Homosex*. 1980;5(3):205-215.

40. Gundlach RH. Sexual molestation and rape reported by homosexual and heterosexual women. *J Homosex*. 1977;2(4):367-384.

41. Brannock JC, Chapman BE. Negative sexual experiences with men among heterosexual women and lesbians. *J Homosex*. 1990;19(1):105-110.

42. Peters DK, Cantrell PJ. Factors distinguishing samples of lesbian and heterosexual women. *J Homosex*. 1991;21(4):1-15.

43. Newcomb MD. The role of perceived relative parent personality in the development of heterosexuals, homosexuals, and transvestites. *Arch Sex Behav*. 1985;14(2):147-164.

44. Kinsey A, Pomeroy W, Martin C. *Sexual behavior in the human male*. Philadelphia, PA: W. B. Saunders Co.; 1948.

45. Berger J. The psychotherapeutic treatment of male homosexuality. *Am J Psychother*. 1994;48(2):251-261.

46. Haldeman DC. The practice and ethics of sexual orientation conversion therapy. *J Consult Clin Psychol*. 1994;62(2):221-227.

47. Kaplan GT, Rogers LJ. Breaking out of the dominant paradigm: a new look at sexual attraction. *J Homosex*. 1984;10(3-4):71-75.

48. Ross MW. Beyond the biological model: new directions in bisexual and homosexual research. *J Homosex*. 1984;10(3-4):63-70.

49. Savin-Williams RC. Theoretical perspectives accounting for adolescent homosexuality. *J Adolesc Health Care*. 1988;9(2):95-104.

50. Byne W, Parsons B. Human sexual orientation. The biologic theories reappraised. *Arch Gen Psychiatry*. 1993;50(3):228-239.

51. Eliason M, Donelan C, Randall C. Lesbian stereotypes. *Health Care Women Int*. 1992;13(2):131-144.

52. Viss DC, Burn SM. Divergent perceptions of lesbians: a comparison of lesbian self-perceptions and heterosexual perceptions. *J Soc Psychol*. 1992;132(2):169-177.
53. Adelman M. A comparison of professionally employed lesbians and heterosexual women on the MMPI. *Arch Sex Behav*. 1977;6(3):193-201.
54. Kretzschmar RM. Discussion comment in: Factors influencing lesbian gynecologic care: a preliminary study. *Am J Obstet Gynecol*. 1981;140(1):20-28.
55. Ferguson KD, Finkler DC. An involvement and overtness measure for lesbians: its development and relation to anxiety and social zeitgeist. *Arch Sex Behav*. 1978;7(3):211-227.
56. Thompson N, McCandless B, Strickland B. Personal adjustment of male and female homosexuals and heterosexuals. *J Abnorm Psychol*. 1971;78:237.
57. Evans R. Adjective check list scores of homosexual men. *J Pers Assess*. 1971;35:344.
58. Saghir MT, Robins E, Walbran B, Gentry KA. Homosexuality: IV. psychiatric disorders and disability in the female homosexual. *Am J Psychiat*. 1972;127:477.
59. Saghir MT, Robins E, Walbran B, Gentry KA. Homosexuality: III. psychiatric disorders and disability in the male homosexual. *Am J Psychiat*. 1970;120:147.
60. Nurius P. Mental health implications of sexual orientation. *J Sex Res*. 1983;19:119.
61. Savin-Williams RC. Verbal and physical abuse as stressors in the lives of lesbian, gay male, and bisexual youths: associations with school problems, running away, substance abuse, prostitution, and suicide. *J Consult Clin Psychol*. 1994;62(2):261-269.
62. DiPlacido J. *Stress, behavioral risk factors, and physical and psychological health outcomes in lesbians*: APA Women's Health Conference; May 1994.
63. Brooks V. *Minority stress and lesbian women*. Lexington, MA: D. C. Heath & Co.; 1981.
64. Larson D, Chastain R. Self-concealment: conceptualization, measurement, and health implications. *J Soc Clin Psych*. 1990;9:439-455.
65. Bell A, Weinberg M. *Homosexualities: a study of diversity among men and women*. New York: Simon & Schuster; 1978.
66. Johnson SR, Guenther SM, Laube DW, Keettel WC. Factors influencing lesbian gynecologic care: a preliminary study. *Am J Obstet Gynecol*. 1981;140(1):20-28.
67. Landers A. Readers answer the poll: are you happy to be gay? *San Francisco Sunday Examiner and Chronicle*. April 27, 1992: D-2.
68. Grossman AH. Homophobia: a cofactor of HIV disease in gay and lesbian youth. *J Assoc Nurses Aids Care*. 1994;5(1):39-43.
69. Sophie J. Internalized homophobia and lesbian identity. *J Homosex*. 1987;14(1-2):53-65.
70. Isay R. *Being homosexual: gay men and their development*. New York: Avon Books; 1989.
71. Gross L. Out of the mainstream: sexual minorities and the mass media. *J Homosex*. 1991;21(1-2):19-46.
72. Fyfe B. "Homophobia" or homosexual bias reconsidered. *Arch Sex Behav*. 1983;12(6):549-554.
73. Watchtower Bible and Tract Society of New York Inc. Homosexuality: Is it really so bad? *Awake!* Vol 76; 1995:12-14.
74. Ferenczi S. *Sex and Psychoanalysis*. New York, NY: Basic Books; 1950.
75. Smith GB. Homophobia and attitudes toward gay men and lesbians by psychiatric nurses. *Arch Psychiatr Nurs*. 1993;7(6):377-384.

76. Hooker E. Parental relations and male homosexuality in patient and nonpatient samples. *J Consult Clin Psychol*. 1969;33(2):140-142.
77. Gartrell N. The lesbian as a "single" woman. *Am J Psychother*. 1981;35(4):502-516.
78. Siegelman M. Adjustment of homosexual and heterosexual women. *Br J Psych*. 1979;120:477.
79. Freedman M. Homosexuality among women and psychological adjustment. *Dis Abs Int*. 1971;28:347.
80. Hart M, Roback H, Tittler B, Wietz L, Walston G, McKee E. Psychological adjustment of non-patient homosexuals: critical review of the research literature. *J. Clin. Psychiat*. 1978;39:604-608.
81. Ross MW, Paulsen JA, Stalstrom OW. Homosexuality and mental health. *J. Homosex*. 1988;15:131-152.
82. Herek GM. Gay people and government security clearances. A social science perspective. *Am Psychol*. 1990;45(9):1035-1042.
83. Kurdek LA, Schmitt JP. Interaction of sex role self-concept with relationship quality and relationship beliefs in married, heterosexual cohabiting, gay, and lesbian couples. *J Pers Soc Psychol*. 1986;51(2):365-370.
84. Pagelow MD. Heterosexual and lesbian single mothers: a comparison of problems, coping, and solutions. *J Homosex*. 1980;5(3):189-204.
85. Stokes K, Kilmann PR, Wanlass RL. Sexual orientation and sex role conformity. *Arch Sex Behav*. 1983;12(5):427-433.
86. Silverstein C. The ethical and moral implications of sexual classification: a commentary. *J Homosex*. 1984;9(4):29-38.
87. Schwanberg SL. Attitudes towards homosexuality in American health care literature 1983-1987. *J Homosex*. 1990;19(3):117-136.
88. Trippet SE, Bain J. Reasons American lesbians fail to seek traditional health care. *Health Care Women Int*. 1992;13(2):145-153.
89. Harvey SM, Carr C, Bernheine S. Lesbian mothers. Health care experiences. *J Nurse Midwifery*. 1989;34(3):115-119.
90. Randall CE. Lesbian phobia among BSN educators: a survey. *J Nurs Educ*. 1989;28(7):302-306.
91. Eliason MJ, Randall CE. Lesbian phobia in nursing students. *West J Nurs Res*. 1991;13(3):363-374.
92. Schatz B, O'Hanlan K. *Anti-gay discrimination in medicine: results of a national survey of lesbian, gay and bisexual physicians*: The Gay and Lesbian Medical Association, 273 Church St. San Francisco, CA 94114; May 1994.
93. Tinmouth J, Hamwi G. The experience of gay and lesbian students in medical school. *JAMA*. 1994;271(9):714-715.
94. Stevens PE, Hall JM. Stigma, health beliefs and experiences with health care in lesbian women. *Image J Nurs Sch*. 1988;20(2):69-73.
95. Glascock E. Access to the traditional health care system by nontraditional women: perceptions of a cultural interaction. Paper presented at: American Public Health Association, 1981; Los Angeles.
96. Walsh-Bowers RT, Parlour SJ. Researcher-participant relationships in journal reports on gay men and lesbian women. *J Homosex*. 1992;23(4):93-112.

97. Whatley MH. Images of gays and lesbians in sexuality and health textbooks. *J Homosex*. 1992;22(3-4):197-211.
98. Sears JT. Educators, homosexuality, and homosexual students: are personal feelings related to professional beliefs? *J Homosex*. 1992;22(3-4):29-79.
99. O'Hanlan KA. Personal correspondence with members of the ACOG Patient Education Committee; 1991-1993.
100. Rhinehart R. personal communication: Director of Patient Education Materials of the American College of Obstetricians and Gynecologists; 1995.
101. Suppe F. The Bell and Weinberg study: future priorities for research on homosexuality. *J Homosex*. 1981;6(4):69-97.
102. Morin SF. Heterosexual bias in psychological research on lesbianism and male homosexuality. *Am Psychol*. 1977;32(8):629-637.
103. Johnson SR, Palermo JL. Gynecologic care for the lesbian. *Clin Obstet Gynecol*. 1984;27(3):724-731.
104. Johnson SR, Smith EM, Guenther SM. Parenting desires among bisexual women and lesbians. *J Reprod Med*. 1987;32(3):198-200.
105. Johnson SR, Smith EM, Guenther SM. Comparison of gynecologic health care problems between lesbians and bisexual women. A survey of 2,345 women. *J Reprod Med*. 1987;32(11):805-811.
106. Prevention Services Branch of the AIDS Office. *Health Behaviors among lesbian and bisexual women: A community-based women's health survey*: San Francisco Department of Public Health; October 1993.
107. Gage S. Preliminary Findings: The national lesbian and bi women's health survey. Paper presented at: National Lesbian and Gay Health Conference, 1994; New York.
108. Phillip M. Gay issues: out of the closet, into the classroom, racism, fear of reprisals force black gays and lesbians to keep low profile on campus. *Black Issues In Higher Education*. 1993;April 8:20-25.
109. Cochran SD, Mays VM, Leung L. Sexual practices of heterosexual Asian-American young adults: implications for risk of HIV infection. *Arch Sex Behav*. 1991;20(4):381-391.
110. Robertson P, Schachter J. Failure to identify venereal disease in a lesbian population. *Sex Transm Dis*. 1981;8(2):75-76.
111. Chu SY, Hammett TA, Buehler JW. Update: epidemiology of reported cases of AIDS in women who report sex only with other women, United States, 1980-1991 [letter]. *Aids*. 1992;6(5):518-519.
112. Spitzer PG, Weiner NJ. Transmission of HIV infection from a woman to a man by oral sex [letter]. *N Engl J Med*. 1989;320(4):251.
113. Einhorn L, Polgar M. HIV-risk bahavior among lesbians and bisexual women. *AIDS Education and Prevention*. 1994;6(6):514-523.
114. Surveillance Branch. *HIV Seroprevalence and risk behaviors among lesbians and bisexual women: The 1993 San Francisco/Berkeley womens survey*: AIDS Office of the San Francisco Department of Public Health; October 19 1993.
115. Herzog D, Newman K, Yeh C, Warshaw M. Body image satisfaction in homosexual and heterosexual women. *Int J Eating Disorders*. 1992;11(4):391.

116. Siever MD. Sexual orientation and gender as factors in socioculturally acquired vulnerability to body dissatisfaction and eating disorders. *J Consult Clin Psychol*. 1994;62(2):252-260.
117. Namnoum A. Obesity: a disease worth treating. *The Female Patient*. 1993;18(33):33-44.
118. Holleb A, Fink D, Murphy G. *American Cancer Society Textbook of Clinical Oncology*. Atlanta, GA: American Cancer Society; 1991.
119. Coker AL, Harlap S, Fortney JA. Oral contraceptives and reproductive cancers: weighing the risks and benefits. *Fam Plann Perspect*. 1993;25(1):17-21.
120. Edwards A, Thin RN. Sexually transmitted diseases in lesbians. *Int J Std Aids*. 1990;1(3):178-181.
121. United States Department of Health and Human Services. *Health: United States Prevention Profile for l991*: Department of Health and Human Services; 1991.
122. Willett WC, Stampfer MJ, Colditz GA, Rosner BA, Hennekens CH, Speizer FE. Moderate alcohol consumption and the risk of breast cancer. *N Engl J Med*. 1987;316(19):1174-1180.
123. London SJ, Colditz GA, Stampfer MJ, Willett WC, Rosner B, Speizer FE. Prospective study of relative weight, height, and risk of breast cancer [see comments]. *Jama*. 1989;262(20):2853-2858.
124. Tabar L, Fagerberg CJ, Gad A, et al. Reduction in mortality from breast cancer after mass screening with mammography. Randomised trial from the Breast Cancer Screening Working Group of the Swedish National Board of Health and Welfare. *Lancet*. 1985;1(8433):829-832.
125. Greater Bay Area Cancer Registry. Breast cancer in the greater bay area. *Greater Bay Area Cancer Registry Report*. 1994;5(1):1-8.
126. Krieger L. San Francisco remains a mecca for gay couples. *San Francisco Examiner*. September 12, 1993: A-1, A-19.
127. Giovannucci E, Rimm EB, Stampfer MJ, et al. A prospective study of cigarette smoking and risk of colorectal adenoma and colorectal cancer in U.S. men [see comments]. *J Natl Cancer Inst*. 1994;86(3):183-191.
128. Giovannucci E, Stampfer MJ, Colditz GA, et al. Folate, methionine, and alcohol intake and risk of colorectal adenoma [see comments]. *J Natl Cancer Inst*. 1993;85(11):875-884.
129. Chute CG, Willett WC, Colditz GA, et al. A prospective study of body mass, height, and smoking on the risk of colorectal cancer in women. *Cancer Causes Control*. 1991;2(2):117-124.
130. Fry RD, Fleshman JW, Kodner IJ. Cancer of the colon and rectum. *Clinical Symposia*. 1989;41(5):29-30.
131. Leaverton PE, Sorlie PD, Kleinman JC, et al. Representativeness of the Framingham risk model for coronary heart disease mortality: a comparison with a national cohort study. *J Chronic Dis*. 1987;40(8):775-784.
132. Manson JE, Colditz GA, Stampfer MJ, et al. A prospective study of obesity and risk of coronary heart disease in women [see comments]. *N Engl J Med*. 1990;322(13):882-889.
133. O'Hanlan KA. Risk of cancers and heart disease in the lesbian population. Paper presented at: Annual Meeting of the Lesbian Physicians' Conference, 1991; Taos, NM.
134. Robertson MM. Lesbians as an invisible minority in the health services arena. *Health Care Women Int*. 1992;13(2):155-163.

135. Haynes S. Risk of breast cancer in lesbians. Paper presented at: Annual Meeting of the National Gay and Lesbian Health Education Foundation, 1992; Los Angeles, CA.
136. Greene B. Ethnic-minority lesbians and gay men: mental health and treatment issues. *J Consult Clin Psychol*. 1994;62(2):243-251.
137. Rothblum ED. Introduction to the special section: mental health of lesbians and gay men. *J Consult Clin Psych*. 1994;62(2):211-212.
138. Sophie J. A critical examination of stage theories of lesbian identity development. *J Homosex*. 1985;12(2):39-51.
139. Kahn MJ. Factors affecting the coming out process for lesbians. *J Homosex*. 1991;21(3):47-70.
140. D'Augelli AR, Hershberger SL. Lesbian, gay, and bisexual youth in community settings: personal challenges and mental health problems. *Am J Community Psychol*. 1993;21(4):421-448.
141. Remafedi G, Resnick M, Blum R, Harris L. Demography of sexual orientation in adolescents. *Pediatrics*. 1992;89(4 Pt 2):714-721.
142. Rotheram-Borus M, Rosario M, Koopman C. Minority youths at high risk: gay males and runaways. In: M.E. Colten & S. Gore, ed. *Adolescent Stress: Causes and Consequences*. New York: Aldine de Gruyter; 1991:181-200.
143. Rotheram-Borus MJ. Suicidal behavior and risk factors among runaway youths. *Am J Psychiatry*. 1993;150(1):103-107.
144. Rotheram-Borus MJ, Trautman PD. Hopelessness, depression, and suicidal intent among adolescent suicide attempters. *J Am Acad Child Adolesc Psychiatry*. 1988;27(6):700-704.
145. Rosario M, Rotheram-Borus M, Reid H. Emotional distress, multiple problem behaviors, stress and self esteem among gay and bisexual male adolescents. *J Consult Clin Psychol*. 1994;in press.
146. O'Brien T. A survey of gay/lesbian Catholics concerning attitudes toward sexual orientation and religious beliefs. *J Homosex*. 1991;21(4):29-44.
147. Newman BS, Muzzonigro PG. The effects of traditional family values on the coming out process of gay male adolescents. *Adolescence*. 1993;28(109):213-226.
148. Pattison EM, Pattison ML. "Ex-Gays": Religiously mediated change in homosexuals. *Am J Psychiatry*. 1980;137(12):1553-1562.
149. Erwin K. Interpreting the evidence: competing paradigms and the emergence of lesbian and gay suicide as a "social fact". *Int J Health Serv*. 1993;23(3):437-453.
150. Gibson P, ed. *Gay male and lesbian youth suicide, vol 3-DHHS Pub. No. (ADM) 89-1622*. Washington, D. C.: U. S. Department of Health and Human Services; 1989. ADAMHA, Report of the Secretary's Task Force Report on Youth Suicide.
151. Swaggart J. *Homosexuality: its cause and its cure*. Baton Rouge LA: Jimmy Swaggart Ministries; 1982.
152. Uribe V, Harbeck KM. Addressing the needs of lesbian, gay, and bisexual youth: the origins of PROJECT 10 and school-based intervention. *J Homosex*. 1992;22(3-4):9-28.
153. Remafedi G. The impact of training on school professionals' knowledge, beliefs, and behaviors regarding HIV/AIDS and adolescent homosexuality. *J Sch Health*. 1993;63(3):153-157.
154. Remafedi G. Fundamental issues in the care of homosexual youth. *Med Clin North Am*. 1990;74(5):1169-1179.

155. Creatsas GK. Sexuality: sexual activity and contraception during adolescence. *Curr Opin Obstet Gynecol*. 1993;5(6):774-783.
156. Fejes F. Gays, lesbians, and the media: a selected bibliography. *J Homosex*. 1991;21(1-2):261-277.
157. United States Government Accounting Office. *Report to Congress on Homosexuality in the Military*: United States Congress; June 1992.
158. Morrow DF. Social work with gay and lesbian adolescents. *Soc Work*. 1993;38(6):655-660.
159. Sanford ND. Providing sensitive health care to gay and lesbian youth. *Nurse Pract*. 1989;14(5):30-32.
160. Schneider SG, Farberow NL, Kruks GN. Suicidal behavior in adolescent and young adult gay men. *Suicide Life Threat Behav*. 1989;19(4):381-394.
161. Taylor BA, Remafedi G. Youth coping with sexual orientation issues. *J Sch Nurs*. 1993;9(2):26-27.
162. American Academy of Pediatrics: Committee on Adolescence. Homosexuality and Adolescence. *Pediatrics*. October 1993;92(4):631-634.
163. Harry J, ed. *Sexual identity issues, vol 2-DHHS publication ADM89-1622*. Washington, D. C.: U. S. Department of Health and Human Services; 1989. ADAMHA, Report of the Secretary's Task Force on Youth Suicide.
164. Remafedi G, Farrow JA, Deisher RW. Risk factors for attempted suicide in gay and bisexual youth. *Pediatrics*. 1991;87(6):869-875.
165. Hunter J, Schaecter R. Lesbian and gay youth. In: Rotheram-Borus M, Bradley J, Obolensky N, eds. *Planning to Live: Evaluating and Treating Suicidal Teens in Community Settings*. Tulsa: University of Oklahoma Press; 1990:297-316.
166. Espin O. Cultural and historical influences of sexuality in Hispanic/Latina women: implications for psychotherapy. In: Vance C, ed. *Pleasure and Danger: Exploring Female Sexuality*. London: Routledge; 1984:149-163.
167. Hidalgo H. *The Puerto Rican lesbian in the United States*. Palo Alto, CA: Mayfield; 1984.
168. Morales E. Latino Gays and Latina Lesbians. In: Dworkin S, Gutierrez F, eds. *Counseling Gay Men and Lesbians: Journey to the End of the Rainbow*. Alexandria, VA: American Association for Counseling and Development; 1992:125-139.
169. Acosta E. Affinity for black heritage: Seeking lifestyle within a community. *The Washington Blade*. October 11, 1979: A-1, 25.
170. Mays VM, Cochran SD, Rhue S. The impact of perceived discrimination on the intimate relationships of black lesbians. *J Homosex*. 1993;25(4):1-14.
171. Chan C. Cultural considerations in counseling Asian American Lesbians and Gay Men. In: Dworkin S, Gutierrez F, eds. *Counseling Gay Men and Lesbians*. Alexandria, VA: American Association for Counseling and Development; 1992:115-124.
172. Stephany TM. Faculty support for gay and lesbian nursing students. *Nurse Educ*. 1992;17(5):22-23.
173. Berger RM. Passing: impact on the quality of same-sex couple relationships. *Soc Work*. 1990;35(4):328-332.
174. Schmitt J, Kurdek L. Personality correlates of positive identity and relationship involvement in gay men. *J Homosex*. 1987;13:101-109.

175. Schneider SG, Taylor SE, Hammen C, Kemeny ME, Dudley J. Factors influencing suicide intent in gay and bisexual suicide ideators: differing models for men with and without human immunodeficiency virus. *J Pers Soc Psychol*. 1991;61(5):776-788.
176. Hunter J. *Violence against lesbian and gay youth: a report from the Hetrick Martin Institute*: The Hetrick Martin Institute, New York, NY; January 1989.
177. Centers for Disease Control. Attempted suicide among high school students in the United States,1990. *Morbidity and Mortality Weekly Report*. Sept 20 1991;40(37):1-8.
178. Cabaj R. Substance abuse in the gay and lesbian community. In: Lowinson J, Ruiz P, Millman R, eds. *Substance Abuse: A Comprehensive Textbook*. Second ed. Baltimore, MD: Williams and Wilkins; 1992:852-860.
179. Lesbian & Gay Substance Abuse Planning Group. San Francisco lesbian, gay and bisexual substance abuse needs assessment. Paper presented at: Lesbian & Gay Substance Abuse, 1991; Sacramento, CA.
180. Diamond DL, Wilsnack SC. Alcohol abuse among lesbians: a descriptive study. *J Homosex*. 1978;4(2):123-142.
181. Paul J, Stall R, Bloomfield K. Gay and alcoholic: epidemiologic and clinical issues. *Alcohol Health and Research*. 1991;5(2):151-160.
182. Clark W, ed. *The contemporary tavern*. New York, NY: Plenum Press; 1981. Israel Y, Glaser F, Kalant H, Popham R, Schmidt W, Smart R, eds. Research Advances in Alcohol and Drug Problems; No. 6.
183. Bloomfield K. A comparison of alcohol consumption between lesbians and heterosexual women in an urban population. *Drug Alcohol Dependency*. 1993;33(3):257-269.
184. McKirnan D, Peterson P. Alcohol and drug use among homosexual men and women: epidemiology and population characteristics. *Addictive Behaviors*. 1989;14(5):545-553.
185. Morales E, Graves M. *Substance abuse: patterns and barriers to treatment for gay men and lesbians in San Francisco. Report to Community Substance Abuse Services*: San Francisco Department of Public Health; January 1983.
186. Hellman RE, Stanton M, Lee J, Tytun A, Vachon R. Treatment of homosexual alcoholics in government-funded agencies: provider training and attitudes. *Hosp Community Psychiatry*. 1989;40(11):1163-1168.
187. Fifield L, de Crescenzo T, Latham J. *Alcoholism and the gay community. Summary of "On my way to nowhere: alienated, isolated, drunk: an analysis of gay alcohol abuse and evaluation of alcoholism rehabilitation services for Los Angeles County*: Los Angeles Gay Community Services Center; January 1975.
188. Hall JM. Alcoholism in lesbians: developmental, symbolic interactionist, and critical perspectives. *Health Care Women Int*. 1990;11(1):89-107.
189. de Monteflores C. Notes on the management of difference. In: Stein TS, Cohen CC, eds. *Contemporary Perspectives on Psychotherapy with Lesbians and Gay Men*. Plenum, New York; 1986:73-101.
190. National Gay and Lesbian Task Force. *Report on anti-gay/lesbian victimization: a study by the National Gay and Lesbian Task Force in cooperation with the gay and lesbian organizations in eight U.S. cities*: National Gay and Lesbian Task Force Policy Institute; June 1984.
191. Gross L, Aurand S. *Discrimination and violence against lesbian women and gay men in Philadelphia and the Commonwealth of Pennsylvania: a study by the Philadelphia*

Lesbian and Gay Task Force: The Philadelphia Lesbian and Gay Task Force; September 1992.

192. Dunlap D. Survey on slayings of homosexuals finds high violence and low arrest rate. *The New York Times*. December 21, 1994: A-10.

193. LeBlanc S. *8 in 10, A special report of the Victim Recovery Program of the Fenway Community Health Center*: The Victim Recovery Program of the Fenway Community Health Center; March 1991.

194. Barnes A, Ephross PH. The impact of hate violence on victims: emotional and behavioral responses to attacks. *Soc Work*. 1994;39(3):247-251.

195. Herek GM. Documenting prejudice against lesbians and gay men on campus: the Yale Sexual Orientation Survey. *J Homosex*. 1993;25(4):15-30.

196. Herek GM. Hate crimes against lesbians and gay men. Issues for research and policy. *Am Psychol*. 1989;44(6):948-955.

197. National Gay and Lesbian Task Force. *Anti-gay/lesbian violence, victimization, & defamation in 1993*: National Gay and Lesbian Task Force Policy Institute, Washington D. C.; January 1994.

198. Bryant S, Demian. Summary of results, Partners' national survey of lesbian & gay couples. *Partners*. 1990:2-6.

199. Reilly ME, Lynch JM. Power-sharing in lesbian partnerships. *J Homosex*. 1990;19(3):1-30.

200. Lynch JM, Reilly ME. Role relationships: lesbian perspectives. *J Homosex*. 1985;12(2):53-69.

201. Peplau LA, Padesky C, Hamilton M. Satisfaction in lesbian relationships. *J Homosex*. 1982;8(2):23-35.

202. McCandlish BM. Therapeutic issues with lesbian couples. *J Homosex*. 1981;7(2-3):71-78.

203. Kaufman PA, Harrison E, Hyde ML. Distancing for intimacy in lesbian relationships. *Am J Psychiatry*. 1984;141(4):530-533.

204. Duffy SM, Rusbult CE. Satisfaction and commitment in homosexual and heterosexual relationships. *J Homosex*. 1985;12(2):1-23.

205. Schullo SA, Alperson BL. Interpersonal phenomenology as a function of sexual orientation, sex, sentiment, and trait categories in long-term dyadic relationships. *J Pers Soc Psychol*. 1984;47(5):983-1002.

206. Hurlbert DF, Apt C. Female sexuality: a comparative study between women in homosexual and heterosexual relationships. *J Sex Marital Ther*. 1993;19(4):315-327.

207. Hall JM. Alcoholism recovery in lesbian women: a theory in development. *Sch Inq Nurs Pract*. 1990;4(2):109-122.

208. Cabaj R. Gay and lesbian couples: Lessons on human intimacy. *Psych Ann*. 1988;18(1):21-25.

209. Klinger R, Cabaj RP. Characteristics of gay and lesbian relationships, special section: changing perspectives on homosexuality. In: Stein T, ed. *Psychiatry*. Vol 12. Washington DC: American Psychiatric Press, Inc; 1993.

210. McWhirter D, Mattison A. Psychotherapy for male couples: an application of the staging theory. In: Hetrick ES, Stein TS, eds. *Innovations in Psychotherapy with Homosexuals*. Washington, DC: American Psychiatric Press, Inc.; 1984:115-131.

211. Ford CS, Beach FA. *Homosexual behavior*. Scranton, Pa: Harper & Brothers and Paul B. Hoeber Medical Books; 1952.
212. Hite S. *The Hite Report*. New York: Macmillan; 1981.
213. Masters W, Johnson V. *Homosexuality in Perspective*. Boston: Little, Brown & Company; 1979.
214. Kinsey A, Pomeroy W, Martin C. *Sexual behavior in the human female*. Philadelphia, PA: W. B. Saunders Co.; 1953.
215. Frank E, Anderson C, Rubinstein D. Frequency of sexual dysfunction in "normal" couples. *N Engl J Med*. 1978;299(3):111-115.
216. Island D, Letellier P. *Men who beat the men who love them*. New York: Harrington Park Press; 1991.
217. Morrow J. Identifying and treating battered lesbians. *San Francisco Medicine*. 1994;April:17-21.
218. Leeder E. Enmeshed in pain: counseling lesbian battering couples. *Women and Therapy*. 1988;7(1):81-89.
219. Schilit R, Lie GY, Montagne M. Substance use as a correlate of violence in intimate lesbian relationships. *J Homosex*. 1990;19(3):51-65.
220. Kurdek LA, Schmitt JP. Perceived emotional support from family and friends in members of homosexual, married, and heterosexual cohabiting couples. *J Homosex*. 1987;14(3-4):57-68.
221. Kurdek LA. Perceived social support in gays and lesbians in cohabitating relationships. *J Pers Soc Psychol*. 1988;54(3):504-509.
222. Stewart GJ, Tyler JP, Cunningham AL, et al. Transmission of human T-cell lymphotropic virus type III (HTLV-III) by artificial insemination by donor. *Lancet*. 1985;2(8455):581-585.
223. Eskenazi B, Pies C, Newstetter A, Shepard C, Pearson K. HIV serology in artificially inseminated lesbians. *J Acquir Immune Defic Syndr*. 1989;2(2):187-193.
224. Zeidenstein L. Gynecological and childbearing needs of lesbians. *J Nurse Midwifery*. 1990;35(1):10-18.
225. Bozett F. *Children of gay fathers*. New York: Praeger; 1987.
226. Harvard School of Law. Sexual orientation and the law. In: University H, ed. *The Harvard Law Review*. Cambridge MA: Harvard University Press; 1990.
227. Patterson CJ. Children of lesbian and gay parents. *Child Dev*. 1992;63(5):1025-1042.
228. American Psychiatric Association. Sexual Disorders. *Diagnostic and Statistical Manual of Mental Disorders-III Edition*. Washington DC: American Psychiatric Association; 1987:279-296.
229. Jenny C, Roesler TA, Poyer KL. Are children at risk for sexual abuse by homosexuals? [see comments]. *Pediatrics*. 1994;94(1):41-44.
230. Golombok S, Spencer A, Rutter M. Children in lesbian and single-parent households: psychosexual and psychiatric appraisal. *J Child Psychol Psychiatry*. 1983;24(4):551-572.
231. Green R, Mandel JB, Hotvedt ME, Gray J, Smith L. Lesbian mothers and their children: a comparison with solo parent heterosexual mothers and their children. *Arch Sex Behav*. 1986;15(2):167-184.
232. Green R. Sexual identity of 37 children raised by homosexual or transsexual parents. *Am J Psych*. 1978;135:692-697.

233. Kirkpatrick M, Smith C, Roy R. Lesbian mothers and their children: a comparative survey. *Am J Orthopsych*. 1981;51:545-551.
234. Kirkpatrick M. Clinical implications of lesbian mother studies. *J Homosex*. 1987;14(1-2):201-211.
235. Rees R. *A comparison of children of lesbian and single heterosexual mothers on three measures of socialization* [Unpublished doctoral dissertation], California School of Professional Psychology, Berkeley CA; 1979.
236. Gottman J. Children of gay and lesbian parents. In: Bozett FW, Sussman MB, eds. *Homosexuality and Family Relations*. New York, NY: Harrington Park Press; 1990:1177-1196.
237. Huggins SL. A comparative study of self-esteem of adolescent children of divorced lesbian mothers and divorced heterosexual mothers. *J Homosex*. 1989;18(1-2):123-135.
238. Puryear D. *A comparison between the children of lesbian mothers and the children of heterosexual mothers* [Unpublished doctoral dissertation], California School of Professional Psychology, Berkeley CA; 1983.
239. Paul J. *Growing up with a gay, lesbian or bisexual parent* [Doctoral Dissertation], University of California at Berkeley, Berkeley, CA; 1986.
240. Rand C, Graham DL, Rawlings EI. Psychological health and factors the court seeks to control in lesbian mother custody trials. *J Homosex*. 1982;8(1):27-39.
241. Deevey S. Older lesbian women. An invisible minority. *J Gerontol Nurs*. 1990;16(5):35-39.
242. Quam JK, Whitford GS. Adaptation and age-related expectations of older gay and lesbian adults. *Gerontologist*. 1992;32(3):367-374.
243. Kehoe M. Lesbians over 65: a triply invisible minority. *J Homosex*. 1986;12(3-4):139-152.
244. Kehoe M. Lesbians over 60 speak for themselves. *J Homosex*. 1988;16(3-4):1-111.
245. Seidman S, Reider R. A review of sexual behavior in the United States. *Am J Psychiat*. 1994;151:330-341.
246. Davison GC, Friedman S. Sexual orientation stereotypy in the distortion of clinical judgment. *J Homosex*. 1981;6(3):37-44.
247. Wallick MM, Cambre KM, Townsend MH. How the topic of homosexuality is taught at U.S. medical schools. *Acad Med*. 1992;67(9):601-603.
248. Gibson G, Saunders DE. Gay patients. Context for care. *Can Fam Physician*. 1994;40(1):721-725.
249. Murphy BC. Educating mental health professionals about gay and lesbian issues. *J Homosex*. 1992;22(3-4):229-246.
250. Office of Student Affairs. *A community of equals: a resource guide for the Temple medical community about gay, lesbian and bisexual people*: Temple University School of Medicine, Philadelphia, PA; 1992 1992.
251. Stein TS. A curriculum for learning in psychiatric residencies about homosexuality, gay men and lesbians. *Academic Psychiatry*. 1994;18(2):59-70.
252. Stewart DC. Sexuality and the adolescent: issues for the clinician. *Prim Care*. 1987;14(1):83-99.
253. Cass VC. Homosexual identity: a concept in need of definition. *J Homosex*. 1983;9(2-3):105-126.
254. Meijer H. Can seduction make straight men gay? *J Homosex*. 1993;24(3-4):125-136.

255. Committee on Lesbian and Gay Concerns. Avoiding heterosexual bias in language. *American Journal of Psychology*. 1991;46(9):973-974.
256. O'Hanlan KA. Personal communication with Walter Willett, MD and Patricia Case, MPH: Nurses Health Study II, Harvard Medical School and School of Public Health; 1994.
257. Cwayna K, Remafedi G, Treadway L. Caring for gay and lesbian youth. *Medical Aspects of Human Sexuality*. 1991;1:50-57.
258. McConaghy N, Silove D. Opposite sex behaviours correlate with degree of homosexual feelings in the predominantly heterosexual. *Aust N Z J Psychiatry*. 1991;25(1):77-83.
259. McConaghy N, Silove D. Do sex-linked behaviors in children influence relationships with their parents? *Arch Sex Behav*. 1992;21(5):469-479.
260. Neisen JH. Resources for families with a gay/lesbian member. *J Homosex*. 1987;14(1-2):239-251.
261. Hammersmith SK. A sociological approach to counseling homosexual clients and their families. *J Homosex*. 1987;14(1-2):173-190.
262. Telljohann SK, Price JH. A qualitative examination of adolescent homosexuals' life experiences: ramifications for secondary school personnel. *J Homosex*. 1993;26(1):41-56.
263. Goodman JM. Lesbian, gay & bisexual issues in education. *Thrust for Educational Leadership*. 1993;April:24-28.
264. Remafedi G, Blum R. Working with gay and lesbian adolescents. *Pediatr Ann*. 1986;15(11):773-783.
265. Cochran SD, Mays VM. Depressive distress among homosexually active African American men and women. *Am J Psychiatry*. 1994;151(4):524-529.
266. Governor's Commission on Gay and Lesbian Youth. Report on Gay and Lesbian Youth. Massachusetts State House, Room 111, Boston, MA: State of Massachusetts; 1993.
267. Fried B. Report of the subcommittee on domestic partners' benefits. *University Committee for Faculty and Staff Benefits of Leland Stanford Jr. University*. 1992;June:37-38.