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"I Only Read About Myself on Bathroom Walls": The Need for Research on the Mental Health of Lesbians and Gay Men

Esther D. Rothblum

The very recent history of pathologizing homosexuality still has a strong impact on the public in general and mental health professionals in particular. In contrast to the early research on sexual reorientation of lesbians and gay men, there is relatively little empirical research on the mental health issues of lesbians and gay men. Whether researchers choose to define sexual orientation by sexual behavior, self-definition, or membership in lesbian and gay community groups will have an impact on the results. Research on mental health issues that includes lesbians, gay men, and heterosexual women and men would allow an examination of the relative salience of gender versus sexual orientation. Finally, the experiences of lesbians and gay men in society may place them at increased risk for some mental health problems and may protect them from other mental health problems.

In the past 2 decades, there has been an increasing research focus on issues in the lives of lesbians and gay men, such as the coming-out process, aging, relationships, social interaction, and parenting (see Morin, 1977; Watters, 1986-1987, for reviews of research on lesbians and gay men cited in *Psychological Abstracts*). However, there has been comparatively little research on the mental health of lesbians and gay men. Despite a growing body of knowledge about the prevalence, assessment, etiology, and intervention of psychopathology in heterosexual women and men, virtually no research has focused on lesbians and gay men in these areas. For example, several hundred studies on women and depression are reviewed in the *Women and Depression Task Force Report of the American Psychological Association* (McGrath, Keita, Strickland, & Russo, 1990), but none have focused on lesbians and depression.

Researchers are understandably reluctant to focus on mental health problems of an already stigmatized population. In fact, the history of pathologizing homosexuality is recent enough to have affected the training of most mental health professionals who are currently practicing. I will briefly review the attitudes about homosexuality existing today.

A further challenge to researchers on mental health is how to define and recruit samples of lesbians and gay men. Some of the issues in conceptualizing sexual orientation and in finding representative samples of research participants will be discussed.

The current lack of research on the mental health of lesbians and gay men assumes (by default) that their experiences and methods of coping with mental health problems are similar to those of heterosexual women and men. This article provides some suggestions for conducting research with lesbians and gay men and argues that the research design can increase our understanding of the relative importance of gender versus sexual orientation. Furthermore, membership in the lesbian and gay communities may provide both risks and protective factors for mental health. Finally, it is important to study the processes related to mental health that are unique to lesbians and gay men.

Recent History of Pathology

Public attitudes toward lesbians and gay men are extremely negative and did not improve in the years immediately following the removal of homosexuality as a diagnostic category from the *Diagnostic and Statistical Manual of Mental Disorders* (2nd ed.; *DSM-II*) in 1973; see also Glenn & Weaver, 1979. Gay men are often disliked more than lesbians (Laner & Laner, 1980; Page & Yee, 1986). Lesbians are rated more negatively than heterosexual women when the lesbians appear less traditionally feminine (Laner & Laner, 1980). Male college students were more likely to express dislike of male students depicted as gay than of those depicted as heterosexual (Kite & Deaux, 1986). Furthermore, Kite and Deaux found that college men who had scored low on tolerance of gay men on an attitude scale were less likely to want to interact with male students (regardless of these students' sexual orientation) than college men who scored high on tolerance. Men are more likely to rate lesbians and gay men negatively than women are, although this gender difference disappears when the magnitude of the sample size increases (Kite, 1984). Kite (1984) and Laner and Laner (1980) have argued that the negative attitudes about lesbians and gay men are a result of gender nonconformity, with men who appear less stereotypically masculine being more disliked than women who appear less stereotypically feminine. Similarly, Taylor's (1983) review of the research on attitudes toward lesbians and gay men indicates that a major factor is incongruity with sex-role stereotypes.

A survey of 2,500 members of the American Psychiatric Association (Time, 1978, as cited by Marmor, 1980) found that the majority of members considered homosexuality pathological and also perceived homosexuals to be less happy and less capable of mature and loving relationships than heterosexuals. More recently, the American Psychological Association (APA)

Correspondence concerning this article should be addressed to Esther D. Rothblum, Department of Psychology, John Dewey Hall, University of Vermont, Burlington, Vermont 05405.

Task Force Report on Heterosexual Bias in Psychotherapy (Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991) surveyed over 2,500 members of APA and found that psychologists differed in their use of gay-affirmative practice. Biased, inappropriate, or inadequate practice was found in the understanding, assessment, and intervention of a wide range of topics such as identity development, lesbian and gay relationships, and parenting.

Lesbians and gay men are well aware of the attitudes held by the public in general and by health and mental health professionals in particular. Lesbians and gay men may internalize the heterosexist attitudes toward themselves or other lesbians or gay men (Sophie, 1987). They may use several coping strategies to counter these negative attitudes. Surveys of lesbians and gay men indicate that they use caution when seeking therapy or health care (Weinberg & Williams, 1974, as cited by Sarason & Sarason, 1984). In a study of over 2,000 lesbian and bisexual women, over 40% of the sample believed that disclosing their sexual orientation to their gynecologist would hinder the quality of their medical care, and one third of the sample had not disclosed their sexual orientation for this reason (Smith, Johnson, & Guenther, 1985).

Despite the research on negative attitudes toward lesbians and gay men, studies have found no differences in the psychological adjustment of lesbians and gay men from that of heterosexual women and men, respectively (see Hart et al., 1978, and Ross, Paulsen, & Stalstrom, 1988, for reviews of the adjustment of nonpatient studies). As early as 1969 (i.e., before the removal of homosexuality as a diagnostic category from the *DSM-II*), Hopkins matched 24 lesbians and 24 heterosexual women on age, intelligence, and professional and educational background. She found the lesbian sample to be more independent, resilient, reserved, dominant, "bohemian," self-sufficient, and composed on Cattell's Personality Factor Questionnaire. In another early study using a larger sample (Thompson, McCandless, & Strickland, 1971), lesbians and gay men were matched with heterosexual women and men, respectively, on age and education. Gay men were found less defensive and less self-confident than heterosexual men; lesbians were found more self-confident than heterosexual women. There were no significant differences between the matched groups on personal adjustment. Given the extremely negative attitudes held by the public and by mental health professionals, it is remarkable that lesbians and gay men have adjusted so well. This ability of lesbians and gay men to cope adaptively with stigma may have implications for the mental health of other minority groups.

Methodological Issues in Research on Lesbians and Gay Men

Definition of Sexual Orientation

Research on the mental health of lesbians and gay men raises several issues of definition. Researchers have come a long way in improving the selection biases of earlier studies when the majority of subjects were prisoners or therapy clients who were compared with normal controls (see Hart et al., 1978, for a review). Nevertheless, there has been little discussion of sexual orientation as a theoretical construct or of a specific definition of who is included in samples of lesbians and gay men.

Should sexual orientation be considered to fall on a continuum, or should heterosexual women and men, bisexual women and men, lesbians, and gay men be studied as discrete groups? Kinsey, Pomeroy, and Martin (1948) assessed sexual orientation on a continuum and found that half their male sample was exclusively heterosexual, 37% had had at least one same-gender sexual experience, 13% had same-gender sexual fantasies but no experiences, 10% had predominantly same-gender sexual experiences during adolescence, and 4% had exclusively same-gender experiences.

Do researchers view sexual orientation as a choice (sexual preference) or as beginning at birth or in early childhood (essentialism)? In general, lesbians tend to view sexual orientation as a political choice, whereas gay men are more likely to have an essentialist perspective (e.g., Roscoe, 1988). For example, Chapman and Brannock (1987) found that 63% of the lesbians in their survey stated that they had chosen to be lesbians, 28% felt they had no choice, and 11% did not know why they were lesbians. Consequently, researchers need to take care in the wording of questionnaire and interview items to avoid alienating research participants.

There is no universal agreement on the terminology related to sexual orientation, and this terminology changes over time and across region. The APA Committee on Lesbian and Gay Concerns (CLGC) has developed recommendations for language concerning lesbians, gay men, and bisexuals (CLGC, 1991). Generally, the recommendations (which will be incorporated into the next edition of the *Publication Manual of the American Psychological Association* distinguish between identity and sexual activity. The CLGC (1991) gives this example:

> The terms *gay male* and *lesbian* refer primarily to identities and to the modern culture and communities that have developed among people who share those identities. They should be distinguished from sexual behavior. Some men and women have sex with others of their own gender but do not consider themselves to be gay or lesbian. (p. 973)

Furthermore, Golden (1987) has presented a model of sexual orientation formation that is multidimensional. Sexual identity (I am a lesbian), sexual behavior (I have sex with women), and community participation (I am a member of the lesbian community) may be congruent or incongruent. Thus, people may have same-gender sexual partners but not participate in gay or lesbian social or political events. Similarly, bisexual people may be currently sexually involved with a person of the opposite gender, but they may not disclose this information to friends so as to remain a part of the lesbian or gay communities. Finally, the terms *sex* and *gender* are often used synonymously, yet sex can be confused with sexual activity and this can be troublesome when discussing sexual orientation. Thus, the CLGC guidelines on avoiding heterosexual bias in language prefer use of the word *gender.*

Gay men and lesbians differ in how openly identified they are about their sexual orientation. Although level of "outness" is unrelated to chronological age, people who identified themselves as lesbian or gay before 1969 (the year of the Stonewall Bar uprisings, which is often used as the beginning of the modern lesbian and gay movement) could not generally be both "out" and publicly respected (see Grube, 1991, for a comparison of pre- and post-Stonewall gay communities).

Some preliminary data indicate that level of outness may be correlated with positive mental health. Schmitt and Kurdek (1987) surveyed 51 gay men who differed in level of comfort with being gay and degree of communication about sexual orientation to others. Gay men who were more "out" were lower on social anxiety, trait anxiety, and depression and higher on self-concept than gay men who were more "closeted" (i.e., gay men who had not disclosed their sexual orientation). This study suggests a useful methodology for studying degree of outness with larger sample sizes.

Recruitment of Research Participants

What are the implications of the multidimensionality of sexual orientation for mental health practitioners and researchers? I argue here that researchers have a choice of selecting research participants on one (or more) of three dimensions: (a) membership in lesbian and gay organizations; (b) self-identity as lesbian or gay; or (c) involvement in same-gender sexual activity. The nature of the research question determines which of these dimensions to emphasize. It is important to emphasize that these dimensions overlap and that it is not known how many people are members of each category (or of more than one category).

Membership in the Lesbian or Gay Communities

Most of the existing research on lesbians and gay men has been conducted with research participants recruited from lesbian and gay community groups (Albro & Tully, 1979). For example, Christie and Young (1986) recruited women in Arkansas through gay churches, a lesbian land collective, lesbian support groups, and lesbian groups at universities. Other researchers have collected data at regional or national gay or lesbian events that drew people from a large region (Smith et al., 1985). The National Lesbian Health Care Survey (National Institute of Mental Health [NIMH], 1987) used the following recruitment procedure:

> The survey questionnaire was distributed through a number of women's centers, lesbian and gay organizations, and personal networks. Volunteer distributors described the project and handed out questionnaires to lesbians through social and organizational contacts. Special outreach efforts through bookstores, women's organizations, prisons, and gay newspapers were used to reach lesbians who may not participate in lesbian and gay community events. (p. v)

This method resulted in 1,917 completed questionnaires.

These methods of data collection are sometimes considered to be nonrepresentative or nonrandom because they are limited to lesbians, gay men, and bisexuals who are open enough about their sexual orientation to attend community events or who subscribe to lesbian and gay newspapers and magazines. The authors of the National Lesbian Health Care Survey apologize for their sample when they state that "results of the survey, therefore, cannot be generalized to represent all lesbians in the United States" (p. v).

In fact, the participants of such studies are representative of "out" lesbians and gay men who are active in their communities. This is an important group for clinical psychologists to study, for several reasons. They are most visible to the public and thus may affect how heterosexual women and men view lesbians and gay men. Both proponents and opponents of election campaigns and producers of news shows use footage from lesbian and gay community organizations, and therapists often refer newly "out" clients to such community resources.

Second, the visibility (or invisibility) of an openly identified lesbian and gay community will determine where a person in a local area can go to meet others like him or her. Third, acts of violence against gay men and lesbians are often, but not exclusively, targeted at lesbian and gay institutions (e.g., gay bookstores or lesbian restaurants).

Research that focuses on visible members of the lesbian and gay communities has also been criticized as consisting of predominantly young, White, and college-educated participants, and this is generally the case. Albro and Tully (1979) found the typical lesbian in their survey to be in her 20s, White, single, living on the East coast, college educated, unaffiliated with an organized religion, and employed as a professional. Nevertheless, in the 1980s and 1990s, it is possible to find multiple organizations that include or are focused on lesbians and gay men from underrepresented groups. To study aging among gay men, Pope and Schulz (1991) mailed questionnaires to over 200 members of an organization of older gay men in Chicago. For her study of lesbian adolescents, Schneider's (1989) subjects were 25 lesbians of ages 15 to 20 who were members of the youth group Lesbian and Gay Youth Toronto, which has over 200 members. Mays and Cochran (1988) formed the Black Women's Relationship Project to collect information about Black lesbians. Their questionnaire was distributed at major national lesbian events, press releases were sent to gay and lesbian periodicals that had a sizable Black readership, and announcements were sent to gay and lesbian radio programs. In addition, a large mailing was sent to the National Coalition of Black Lesbians and Gays and other social and political groups with Black lesbian membership.

Psychologists who study members of the visible lesbian and gay communities can focus on the effects of the stress of being "out" and ways of coping with this stress. They can examine attitudes toward gays and lesbians held by the public and attitude change over time or due to specific interventions. By virtue of being openly lesbian or gay, members of these communities are often at the forefront of testing societal acceptance. For psychologists studying children raised by lesbian or gay parents, these are the parents who are raising these children and challenging the legal system. These are the people willing to be public about their homosexuality in the military. APA has published several amicus curiae briefs to advance the civil rights of lesbians and gay men (see Bersoff & Ogden, 1991, for a review). In sum, there are several ways in which the mental health of members of the lesbian and gay communities is representative of a specific minority group in the United States.

Self-Identity as Lesbian or Gay

People who identify themselves as gay or lesbian may not be part of organized community groups. A large proportion of all self-identified lesbians and gay men is the sample considered ideal by many researchers; the authors of the National Lesbian Health Care Survey (NIMH, 1987) state that "since it was im-

possible to devise a strategy for reaching a random sample of a 'hidden' population, survey respondents include lesbians who could be reached and who were willing to participate in the project" (p. v).

Often, researchers have recruited participants who identify themselves as lesbian or gay through social network groups (Schmitt & Kurdek, 1987; Thompson et al., 1971). This method is sometimes referred to as the "snowball" technique (e.g., Finlay & Scheltema, 1991) because research participants are asked to pass on additional copies of questionnaires to their friends and acquaintances. Hopkins (1969) recruited her lesbian sample from the Minority Research Group, consisting of lesbians who volunteered to participate in research studies.

Focusing on people who identify themselves as lesbian or gay but who are not closely associated with lesbian or gay organizations is the method of choice when conducting epidemiologic or large-scale community surveys of mental health problems. For example, researchers on substance abuse have postulated that alcohol use among lesbians and gay men is high (McKirnan & Peterson, 1989a, 1989b) because the gay bar may be the most visible and accessible place for people who are not "out" to meet other lesbians or gay men. Fifield's (1975) research indicated that 90% of lesbians and gay men who went to gay bars had no other contact with gay organizations. Bar patrons in her sample went to bars on average 19 times each month, had gone to gay bars for a mean of 10 years, went to bars to socialize and meet new people, and drank six drinks per bar visit. Kus (1988), on the other hand, found rates of alcoholism among 20 gay men unrelated to bar use but, instead, negatively related to self-acceptance of being gay.

Recruiting research participants who identify themselves as lesbian or gay but who may not be part of the lesbian or gay community is also important when studying the impact on mental health of "being closeted" or the process of being newly "out". There are several models of gay and lesbian identity formation, and most present a stage model of development in which being part of the lesbian and gay communities is one of the final stages (e.g., Cass, 1979). The stages of identity formation as gay or lesbian may also differ for people who are younger (Browning, 1987) older (Friend, 1991), or from multicultural backgrounds (Tremble, Schneider, & Appathurai, 1989).

Sexual Behavior

What about people who have had same-gender sexual experiences but do not consider themselves to be lesbian or gay? As mentioned earlier, the APA CLGC (1991) distinguished between self-identity and sexual behavior. As the data of Kinsey et al. (1948) indicate, many people, especially men, have had same-gender sexual experiences.

Models of lesbian and gay identity formation often view same-gender sexual encounters as one of the earliest stages, before self-identity or coming out. Troiden (1979) viewed early same-gender sexual experiences serving as sources of later self-identity. Certainly the heterosexual public defines lesbians and gay men in terms of sexual behavior. Ficarrotto (1990) gave male and female college students questionnaires measuring homophobia, racism, sexism, and sexual conservatism. He found sexual conservatism to account for the largest percentage of the variance in determining homophobia. Thus, attitudes about sexual behaviors are related to attitudes about homosexuality among college students.

In the conducting of research that includes people engaging in same-gender sexual behavior who do not identify themselves as lesbian or gay, very large surveys are necessary. Harry (1990) included one question about sexual orientation during a national probability survey of over 1,500 respondents from all 50 of the United States. The survey focused on the policies of the administration of former U.S. president Ronald Reagan, smoking, and AIDS. The last interview question was as follows:

> I have only one more question. You may consider it somewhat personal to answer but most people have been willing to answer it once we remind them that this is a totally confidential survey. We reached you on the phone simply by chance and don't know your identity. Here's the question: Would you say that you are sexually attracted to members of the opposite sex or members of your own sex?

Note that this item focuses on sexual attraction rather than sexual behavior.

Harry's results indicated that 3.7% of all men who were surveyed indicated that they were attracted to the same gender or volunteered to state that they were attracted to members of both genders. Of the men who felt same-gender attraction, 42% were married to and living with a wife, compared with 60% of men attracted to women. About 30% of men in both groups had school-age children, and the men were distributed across age, household income, and level of education. Men attracted to men were less likely to be veterans and more likely to have a gay friend. Sixty-two percent of men attracted to men and 82% of men attracted to women were White.

In many respects, this study interviewed groups more often considered "hidden" by researchers: men who were married, Black and Hispanic, from small towns, less educated, and older and younger than most surveys of members of gay organizations. A drawback of this methodology is that to the achievement of even a small proportion of respondents requires a very large sample size. Even with the phrasing of the question about same-gender attraction and the anonymity of the survey, it is not clear how many men were willing to disclose this information.

For researchers who are studying sexual behavior, sexual dysfunction, and sexual attitudes, the group of people who engage in same-gender sexual behavior is important to include. The high frequency of same-gender sexual behavior in the population at large (including people who are married and those who self-identify as heterosexual) indicates that all research on sexual behavior should ensure that this research is free from heterosexual bias (see Herek, Kimmel, Amaro, & Melton, 1991, for a review of ways to avoid heterosexual bias in research). For example, research on sexual behavior should not assume that all people need to use contraceptives or equate sex with penile-vaginal intercourse only. Research specifically on people who engage in same-gender sexual behavior should also focus on large-scale community surveys, because this population is not readily definable by any demographic data.

It is important to emphasize that just as people engage in same-gender sexual behavior but do not identify themselves as gay or lesbian, so several people who self-identify themselves as

lesbian or gay, including those who are active in the lesbian and gay communities, are not engaging in same-gender sexual behaviors. This includes people who are currently celibate, and research indicates that lesbian couples are less likely to be sexually active than are gay male, married heterosexual, or cohabiting heterosexual couples (Blumstein & Schwartz, 1983). Furthermore, Loulan's (1988) research of over 1,500 lesbians indicated that 78% had been celibate for some time. Of these 35% were celibate from 1 to 5 years and 8% had been celibate for 6 years or more. There are a number of reasons why lesbians have sex less frequently than do gay men or heterosexuals. Lesbians may define intimacy in broader ways than do researchers. Women are not socialized to initiate sexual encounters. Lesbians may initiate sex to establish a relationship but then focus on other ways of relating with a partner (for a review of this literature, see Rothblum & Brehony, 1991, 1993).

People may also participate in the lesbian or gay communities for political or social reasons, yet not engage in same-gender sexual behavior. Some people may keep their bisexuality or heterosexuality hidden from the lesbian or gay communities in order to remain part of these organizations. Thus, it is important that researchers realize that the three dimensions of sexual behavior, self-identity, and participation in lesbian and gay communities are not ever-increasing circles but instead are somewhat overlapping but separate criteria. In sum, as Roscoe (1988) has stated, "the behaviors that have been lumped into the modern category of homosexuality need to be specified in much more detail—to distinguish between 'sex' as a physiological reaction, as an emotional orientation, as a social function, as a basis for identity, or as a symbolic statement" (p. 23).

Appropriate Control Groups

Researchers on lesbians and gay men may have difficulties conceptualizing an appropriate control group in their research. Obviously, the research question may be specific to lesbians or to gay men (e.g., the coming-out process). However, particularly in the case of research on mental health, researchers may want to compare lesbians and gay men to heterosexual women and men, where comparison data are already available.

Some researchers have focused on college students, and compared heterosexual students with members of gay, lesbian, and bisexual student groups (e.g., Brannock & Chapman, 1990). Because many mental health data, particularly questionnaire studies, are normed on college students, this is a useful methodology. Furthermore, college students are high-risk populations for certain mental health problems such as eating disorders and sexual trauma.

Some researchers have compared lesbian and gay samples to heterosexual samples about which normed data were available and covaried demographic differences such as age or education (e.g., Brand, Rothblum, & Solomon, 1992).

An interesting control group that has not been used to date is that of lesbians and gay men to be compared with their heterosexual siblings. This would control for race and ethnicity, age cohort, parental socioeconomic status, and parental education. Because most lesbians and gay men have heterosexual siblings, this may prove to be a useful control group in future research.

Need for Increased Mental Health Research

Most areas of mental health have not been investigated with regard to lesbians or gay men. Both Gonsiorek (1982) and Smith (1988) have conceptualized the diagnostic categories of the *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed.; *DSM-III;* American Psychiatric Association, 1980) with regard to lesbians and gay men. There has been some research on substance use among lesbians and gay men, but there has been little research on depression, anxiety disorders, and eating disorders. Other than the psychoanalytic theory about paranoia and homosexuality, there is no research on sexual orientation in delusions, hallucinations, and psychotic disorders. The same is true for somatoform, dissociative, and personality disorders. Silverstein (1988) has conceptualized borderline personality disorder in light of sexual identity confusion and diffusion and same-gender sexual behavior, but there has been no research on sexual orientation and personality disorders. Finally, there is a need for research on the role of being lesbian, gay, or bisexual on disorders of childhood and adolescent.

Salience of Gender Versus Sexual Orientation

Research comparing lesbians, gay men, and heterosexual women and men on mental health allows for the examination of the relative salience of gender versus sexual orientation. For example, the large literature on weight and eating disorders has found women to predominate in rates of dieting, preoccupation with weight, and eating disorders, compared with men. Dworkin (1988) proposed that lesbians, like heterosexual women, would be at risk for eating disorders, given women's socialization to emphasize their appearance and the importance of appearance in relationships, employment, and other societal roles. On the other hand, Brown (1987) predicted that lesbians would be underrepresented among women with eating disorders and more accepting of their weight. If concern with body weight reflects a need to be desirable to men, then heterosexual women and gay men would be at risk for eating disorders, whereas heterosexual men and lesbians would be more protected from these disorders. In fact, the recent literature indicates that although there are gender differences in weight and preoccupation with weight, there are also Gender × Sexual Orientation interactions. Brand et al. (1992) found heterosexual women and gay men to be more preoccupied with their weight and to report lower ideal weights than did lesbians or heterosexual men. A much larger sample by Siever (1994) found the same interaction across a number of variables. Herzog, Norman, Gordon, and Pepose (1984) found that men who were anorectic or bulimic were more likely to be gay than were women with eating disorders. In sum, research on mental health that includes lesbians and gay men and compares them with heterosexual women and men would add much to our knowledge of the effect of gender on mental health by varying sexual orientation.

Salience of Risk Factors Versus Protective Factors

A large body of epidemiologic research has identified factors that place people at risk for mental health problems, and gender differences were found in these risk factors. Again, lesbians and

gay men have been absent from these epidemiologic studies; yet many of the factors that are assumed to place women and men at risk for mental health disorders may not be true for lesbians and gay men.

For heterosexual women, being married is a risk factor for mental health problems, including depression, agoraphobia, anxiety, insomnia, and sexual abuse (see Rothblum, 1983, for a review of this literature). Possible reasons for the relationship between marriage and mental health problems for women have been considered to be either the fact that employed married women have two work shifts (employment plus major responsibility for housework and child care; Radloff, 1975), or the fact that the role of homemaker (a term that is curiously used to describe only people who are legally married) is one that carries little prestige in our society (e.g., Gove, 1972). Lesbians, like unmarried heterosexual women, are not homemakers, and research has demonstrated that lesbian couples are more likely to share housework and child care than are married heterosexual couples (Peplau, Cochran, Rook, & Padesky, 1978). Thus, the fact that most lesbians are not married to men may serve a protective function for lesbian physical and mental health.

The presence of young children in the home is a major risk factor for stress among women, who tend to do most of the childrearing in families (see Rothblum, 1983). Lesbians are less likely to have children than heterosexual women are, and lesbians who do have children tend to share child care with their partners (Peplau et al., 1978). Thus, childrearing may be less of a risk factor for physical and mental health problems among lesbians. However, this protective factor may lessen as increasing numbers of lesbians and gay men become parents. Also, lesbians and gay men who do rear children may be at increased risk for factors such as custody battles over competency to rear children or homophobic remarks made to the children (Hall, 1981).

Although lesbians and gay men, like heterosexual women and men, belong to all income groups, men in our society on average earn significantly higher incomes than do women. Income in the United States is highly correlated with access to physical and mental health resources such as health insurance, use of preventive health care, and quality of health care. Two-income gay male couples are thus likely to earn higher incomes than are lesbian and heterosexual couples. Gay male couples are also less likely than are lesbian or heterosexual couples to be supporting children.

These are only a few of the demographic factors that have been viewed as risks for the mental health of heterosexual women and men. Clearly, inclusion of sexual orientation into studies of risk factors would increase our understanding of the role of lesbian and gay identity in influencing societal roles such as relationships, parenting, employment, and psychological adjustment.

Emphasis on Similarities Versus Differences Between Lesbians, Gay Men, and Heterosexual Women and Men

Should researchers emphasize the similarities or differences between lesbians, gay men, and heterosexual women and men? Both D'Augelli (in press) and Murphy (in press) have argued that mental health professionals tend to emphasize similarities in an attempt not to further pathologize an already stigmatized group; yet both argue for the need to create an accepting climate in which differences can be taught. As Murphy has stated, "difference can be used to pathologize, normalize, or valorize" (p. 7).

Factors Unique to Lesbians and Gay Men

In addition to facing many of the same stressors as heterosexual women and men, people who identify themselves as lesbian or gay, and particularly those who are visible in the lesbian and gay communities, also experience issues that are not commonly faced by heterosexual women and men. It is important that research focus on these factors that are unique to lesbians and gay men.

A major area in need of research is the effect of living as a stigmatized group on mental health. The process of "coming out" as lesbian or gay may involve several stages and can be extremely stressful, yet there is virtually no research on the stressors involved or on effective ways of coping with this process. Finally, integration into the gay and lesbian communities seems to be associated with positive mental health, as mentioned earlier, but much more research is needed to examine factors that prevent people from becoming integrated or finding a visible community.

There has been little research on the mental health of lesbians and gay men who are non-White, adolescent, elderly, or coping with disabilities. Lukes and Land (1990) have presented a model of biculturality and homosexuality. They argue that, whereas members of many minority groups need to learn the customs of the dominant culture, lesbians and gay men need to recognize and learn the customs of lesbian or gay communities to find these communities.

The identity of the lesbian and gay communities differ across geographical regions, in cities and rural areas, and across age groups. Research on the unique stressors and protective factors of lesbian and gay communities needs to consider this diversity.

It should also be emphasized that there are factors unique to lesbians that are not experienced by gay men, and vice versa. Finally, there has been so little research on bisexual women and men (even when compared to the research on lesbians and gay men) that it is difficult to speculate on factors unique to them.

Summary and Recommendations

Given the recent history of pathology of homosexuality, what are some ways to advance a lesbian and gay-affirmative psychology?

Training of Mental Health Professionals

Textbooks vary widely in the ways in which they discuss lesbian and gay issues, and it is important that teachers and supervisors consider this coverage when selecting course texts. Often, lesbian and gay issues are limited to sections on pathology or only discussed in the context of sex. It is important that lesbian and gay issues are discussed across the curriculum (e.g., in courses on assessment, psychotherapy, aging, public health, and ethnic minority psychology, to use just a few examples).

Clinical Practice

The APA Task Force on Bias in Psychotherapy (Garnets et al., 1991) identified several examples of lesbian and gay-affirmative practice. This included sensitivity in assessment and intervention, recognition of issues facing lesbians and gay men in identity development, relationship formation and maintenance, and the importance of practitioner education and expertise. However, there has been no research examining issues in clinical intervention with lesbians and gay men.

Research

A recent APA task force has provided guidelines for conducting nonheterosexist research (Herek et al., 1991). The report indicated that research should not ignore the existence of lesbians, gay men, and bisexual women and men or stigmatize or stereotype these populations. Related to the area of research is the fact that academics are often warned that conducting research on lesbian and gay issues may adversely affect their careers.

Protective Factors

The factors mentioned earlier that protect lesbians and gay men from mental health risks should be recognized and serve as a model for affirming the lesbian and gay communities. These factors should be cited in the training of health and mental health professionals, rather than only when the topic area is pathology or sexual activity.

Risk Factors

Other than substance use and suicide, there is little research on mental health problems that affect lesbians and gay men. This is a wide area for improvement and involves clinical practice, research, and prevention.

Diversity

The 1970s often portrayed the lesbian and gay communities as predominantly young, White, middle-class, and able-bodied. The past decade has resulted in an exponential increase in research, writing, and grass-roots-organizing that reflects the diversity of these communities. There are now many newsletters and magazines for Asian-American, Hispanic, and African-American lesbians and gay men, for lesbians with physical disabilities, and for older gay men and lesbians. The same is true for organizations and events. It is no longer possible to conceptualize lesbians and gay men as homogeneous groups.

In sum, it is easy to forget the normativeness of heterosexuality. Rich (1980) termed this process the "bias of compulsory heterosexuality" (p. 632). An understanding of the mental health needs of lesbians and gay men will not only improve the services for these populations but serve to affirm the lesbian and gay experience as a model for positive mental health.

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