Special Article

Lesbian Health Issues for the Primary Care Provider

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Lesbians have unique health concerns that often go unaddressed in a medical setting that assumes heterosexuality. These may include cancer screening, sexually transmitted diseases, human immunodeficiency virus (HIV), depression, substance abuse, relationship issues, pregnancy, and parenting. Awareness of the barriers faced by lesbians seeking care, and an inclusive approach to the patient will allow primary care providers to be more effective in their interactions with all patients.

Key words. Homosexuality, female; lesbian; physician-patient relations; primary health care; sexually transmitted diseases; psychology, social. (*J Fam Pract 1995; 40:486-493*)

There has been much recent debate on the actual number of women in the population who are lesbian or bisexual. Whatever the true percentage, many primary care providers offer services daily to lesbian patients without recognizing their sexual orientation or their unique medical and psychosocial needs.[1] A lesbian is a woman whose sexual and affectional preferences are directed toward other women. Her behavior may range from exclusively homosexual, to bisexual, to situationally heterosexual prompted by economic status, cultural factors, or sexual desire.[2] Not all women who partner with women consider themselves lesbians.

In discussing the health care needs of lesbians, it is necessary to be broadly inclusive in defining the population. This allows for optimal care to all women who partner with women, and to the family and friends of these women as they present in the primary care setting. Lesbians are as diverse as the population at large, crossing all geographic, economic, racial, ethnic, religious, age, and other boundaries. One universal experience is the marginalization and stigmatization of lesbian, gay, bisexual, and transgendered* people in our society, which often leads to diminished access to appropriate medical care.[3]

**A broad term used to describe the continuum of individuals whose gender identity and expression, to varying degrees, does not correspond with their biologic sex.*

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Lesbian health issues are, first, women's health issues. Quality medical services should offer the same health screening and preventive care that is appropriate to all women throughout the life cycle. For example, routine screening for hypertension, coronary artery disease, anemia, hypercholesterolemia, and cancers of the breast or colon should be offered in accordance with the standards of care in your practice. In addition, lesbians face health risks that may not be addressed in medical encounters if the health care provider assumes heterosexuality or is unaware of the lesbian patient's specific needs and concerns.

Barriers to Care

The first step in providing health care to any population is to ensure accessibility. Lesbians are subject to the same barriers to care as are other women. These may include economics, transportation, child care, clinic location and hours of operation, language, and socialization that leads her to defer care for herself in favor of caring for those around her. Women of color are further subjected to the barriers inherent in a medical system that does not acknowledge and validate the cultural context of their lives.

The two main reasons cited by lesbians for not receiving needed care are lack of financial resources or insurance, including no access to coverage under the policy of her significant other, and past negative experiences in the health care setting.[3-6] These experiences include pa-

tronizing treatment, intimidation, attempts to change the patient's sexual orientation, hostility toward the patient or her partner, breach of confidentiality, invasive and inappropriate personal questioning, neglect, denial of care, undue roughness in the physical examination, and sexual assault.[3,5,6] Indeed, for many women who partner with women, the actual or perceived risk and associated fear of entering a homophobic and potentially abusive medical system outweigh the perceived risk of illness.[3,6] This can result in the increased morbidity and mortality associated with delayed or inadequate care.

In a 1982 survey of members of a California county medical society,[7] it was found that 40% of respondents were "sometimes" or "often" uncomfortable in treating homosexual patients. Thirty percent would not admit a qualified homosexual applicant to medical school, and 40% would cease referrals to a colleague they learned was gay or lesbian. A 1988 study of nurse educators[8] showed that one fourth of respondents thought lesbianism was "wrong" or "immoral"; one third judged lesbian behavior as "disgusting." Fifty-two percent indicated that lesbianism is not a natural expression of human sexuality, with 8% suggesting lesbians should undergo treatment to become heterosexual. Almost one third revealed they would find it difficult to converse with someone they knew to be a lesbian. In a 1994 survey of the membership of the American Association of Physicians for Human Rights,[9] the majority of respondents reported instances of antigay bias affecting medical care. Notably, 67% reported knowing of lesbian, gay, or bisexual patients who had received substandard care or been denied care because of sexual orientation. Fifty-two percent had observed colleagues providing reduced care or denying care to patients because of their sexual orientation, and 88% reported hearing colleagues make disparaging remarks about lesbian, gay, and bisexual patients.

Only one third of lesbians have risked disclosure of their sexual orientation to their health care provider.[10,11] Women fear professional, social, and legal repercussions should their confidence not be respected. Many report negative reactions to disclosure from providers, including shock, embarrassment, voyeurism, ostracism, condescension, pity, disgust, and moralizing.[3] Despite this history, a majority of lesbians agree that, given an environment where they felt safe enough to do so, sharing information about their sexual orientation would enhance the medical care they received.[12,13]

An additional barrier to care is the commonly held myth of lesbian "immunity" to human immunodeficiency virus (HIV), sexually transmitted diseases (STDs), and certain cancers.[14,15] This perceived lack of risk results in lesbians avoiding medical services, as well as health care providers giving incorrect advice and underutilizing appropriate health screening for these patients.[15,16]

Approach to the Patient

The assumption of heterosexuality is pervasive in our society. Patient intake forms that query marital status and "husband's" occupation leave no room for the lesbian client. Inclusive language, substituting "partner," "significant other," or "significant relationship" for "husband," provides the clinician with more information about the important relationships of *all* patients, allowing for more insightful care. By signaling openness and acceptance, providers help create the safe environment required for good rapport and the disclosure of information crucial to accurate diagnosis and treatment. Involving a patient's significant other(s) in her care further supports this goal. A thorough social history includes exploration of the patient's home and work environments, support network, relationship with family of origin, stressors (including those related to internalized or societal homophobia), coping strategies, the availability and accessibility of resources, and the patient's own assessment of her overall quality of life and major health concerns.

It is important to discuss with the patient the potential benefits and liabilities of recording her sexual orientation within the medical record. Documentation of this information should not be undertaken without receiving her explicit permission to do so. A discreet personal or office coding system also may be devised to assist with recall.[1,17,18]

Gynecologic Care

The access point to preventive health care for most women is the periodic Papanicolaou (Pap) smear. Research indicates a significantly longer interval between cervical screenings for lesbians than for heterosexual women. The interval varies with the subpopulation studied and has been reported to average 21 to 34 months for lesbians, compared with an average of 8 to 9 months for heterosexuals.[19,20] Twenty-three percent of lesbians in one sample had not had a Pap smear in more than 5 years,[20] and 8% had never had one.[4,12]

Some lesbians report that upon disclosing their sexual orientation to health care providers, they have been told that they do not need pelvic examinations or cytological screening because they are not at risk for STDs or cervical cancer (personal communications to the author). Risk factors for cervical cancer include early age at first coitus, multiple sexual partners, history of STDs, and in-

fection with certain strains of human papillomavirus (HPV). In fact 75% to 90% of lesbians report having had heterosexual activity, and many report a history of multiple male partners.[4,5,10,12] Most commonly, this activity has occurred during younger years and thus conveys more significant risk. A complete history of past and current sexual behaviors is imperative to accurately assess each patient and devise a screening protocol appropriate to her needs. All women, even those who have never engaged in heterosexual intercourse or who are not currently sexually active, need periodic cervical screening and regular bimanual pelvic examination.[14,21] The health care provider must become knowledgeable about the range of human sexual behavior and be comfortable questioning patients and providing explicit information on safer sex, the transmission of STDs, and when it is necessary to treat female sexual partners of their lesbian patients.

The Sexual History

In many clinical settings, the sexual history consists of two questions: "Are you sexually active?" and "What form of contraception are you using?" For women who partner with women, this yields information that is at best incomplete and often wholly inaccurate. As with the social history, unbiased and open-ended questions demonstrating an acceptance of the patient will achieve the best results. Prefacing these sensitive questions with an explanation about their importance in optimizing care may be helpful. Statements such as: "People are at risk for different diseases and need different tests depending on what activities they're engaging in now and in the past. I will need to ask you some personal questions that I ask all my patients about sexual activity to help me give you the best care tailored to your specific needs. Everything you tell me will be kept in confidence" (if this can be promised honestly). This explanation may be followed by questions regarding the age at onset of sexual activity, number and sex of past and present partners, and specific behaviors engaged in, as well as knowledge of and compliance with guidelines for safer sex. Lesbian sexual activity may include, but is not limited to, kissing, breast stimulation, masturbation, digital penetration of the vagina or anus, penetration with sex toys, use of vibrators, genital/genital, oral/genital, and oral/anal contact. Some women engage in sadomasochistic activity.

Sexually Transmitted Diseases

Unsafe sexual activity with men or women may lead to transmission of STDs, including HIV. Most lesbians who contract HIV sexually acquire the infection through unprotected *heterosexual* activity (often with gay or bisexual men or injection drug users).[22,23] The medical literature reports isolated incidences of woman-to-woman transmission of the virus.[24–29] More recently, grassroots lesbian AIDS projects are documenting growing numbers of HIV-positive women whose only risk factor is unprotected sexual activity with an HIV-positive female partner.[30] Existing published statistics on HIV among women who partner with women do not fully reflect the status of the epidemic within this population. The collection of accurate and comprehensive data is hindered by definitions of "lesbian" used to track AIDS incidence. For example, CDC surveillance data count lesbians as women reporting sexual relations exclusively with other women since 1977.[31] Such definitions do not describe the majority of women who partner with women, or even the majority of women who *self-define* as lesbian.

Lack of adequate research leaves us without clear guidelines regarding safer sex for women who partner with women.[32] Current recommendations include: household plastic wrap or latex barriers to protect against oral contact with vaginal fluids, menstrual blood, blood resulting from traumatic penetration, HPV or herpes simplex virus (HSV-1 and HSV-2) lesions, fecal-borne pathogens, and breast milk. Only water-based lubricants should be used with latex or plastic wrap, as oil-based products may degrade the integrity of the barrier. If sex toys are shared, they must be well cleaned between partners with one part bleach to ten parts soapy water, or covered with a fresh condom. Direct genital-to-genital stimulation (tribadism) can be an unsafe practice because it may lead to mucosal exposure to blood or sexual fluids. Intact skin provides a good barrier, and latex gloves or finger cots protect the hands in case of cuts or abrasions. Any woman engaging in heterosexual activity should use a condom and spermacide with every encounter.[33–35]

Although empirical data are needed, clinical experience demonstrates that infecting agents such as vaginal *Candida, Gardnerella vaginalis, trichomonas, Chlamydia,* and hepatitis A can be passed between female partners.[14,21,36–38] In the case of recurrent infections, or if the woman's partner is symptomatic, she should be evaluated and treated as well.[1,21] It is important to keep in mind that recurrent or resistant vaginal infections may indicate the presence of HIV.[21,39] Herpes simplex virus and HPV may be spread by direct contact with the lesions.[15] There is evidence to suggest that fomite (such as sex toy) transmission may also be possible.[40–43]

Breast Cancer

The overall risk of breast cancer among lesbians is not known. There is evidence to suggest that some lesbians

may have a higher incidence of nulliparity, delayed childbearing, and increased alcohol consumption than do heterosexual women.[4,5,15,20,44–46] Further, lesbians who are estranged from their families because of their sexual orientation may not have access to information about their families' medical records, including history of breast cancer.

Unfortunately, currently available research does not represent the full diversity of lesbians and other women who partner with women. Primarily younger, white, well-educated, "out-of-the-closet" lesbians have been sampled. Lesbians who may be at greater risk of morbidity and mortality because of limited access to cancer screening and appropriate medical care have not been adequately studied. Among others, these include lesbians who have disabilities and those who are older, of color, rural, poor, and working-class. Research has indicated that even among women with the greatest access to care, there are significant barriers to cancer screening and medical services; lesbians received fewer mammograms and clinical breast examinations and were less likely to perform regular breast self-examinations in keeping with recommended standards of care.[4,5,15,20,47,48]

Lesbian Families

Many lesbian families include children from previous heterosexual relationships of one or both partners, through adoption, artificial insemination, or heterosexual intercourse for the purpose of conception.[49] The primary care provider may be called on to offer assistance with fertility testing, referral for insemination, and prenatal and well-child care. Women considering insemination should be advised of the potential risk for HIV transmission in using unscreened donors.[50,51] Inclusion of the nonbiological mother as an equal parent and sensitivity to the special legal, financial, and social stresses on the lesbian family are imperative.

As is true for all patients, women who partner with women should be encouraged to file a durable power of attorney for health care granting emergency decision-making and next-of-kin status to a partner or significant other. A separate document confers medical authority over the couple's children to the nonbiological parent.[52] Without this document, partners may be denied access to or information regarding their loved ones in case of illness, hospitalization, or incapacitation.[17]

Psychosocial and Mental Health

Although psychological illness is no more common among lesbians than among heterosexuals, women who partner with women do have unique concerns related to their stigmatized status in a homophobic society.[1,21] Homophobia is the fear or hatred of a person or group based solely on their homosexual orientation or behavior.[53] Women who partner with women are often the victims of hate crimes, including verbal or physical abuse or attack, damage to property, sexual assault, and murder.[4,5,44,54] They may be rejected by family, friends, religious community, co-workers or schoolmates, and they may be denied housing, custody, employment, health care, or legal representation.[4,5,46,55] Equally devastating are the effects of internalized homophobia, which can lead to low self-esteem and isolation. The clinician should assess the patient's degree of self-acceptance and comfort with her orientation as well as the degree to which she is involved in the larger lesbian/gay community and the level of social support available to her. Surveys of adult lesbians reveal that 40% have considered suicide at some point in their lives, with 18% actually attempting suicide.[5,22,44,56]

Lesbian and gay youth in particular are at least three times more likely to commit suicide than are their heterosexual peers.[57–59] Many young lesbians attempt to hide or change their sexuality by dating boys and intentionally or unintentionally becoming pregnant. They may make themselves "too busy" with involvement in school and extracurricular activities to date, or they may withdraw entirely. Many fail to develop close and trusting relationships because they fear they cannot relate honestly to peers without risking disclosure. Instead they suffer isolation, which often leads to depression and despair.[58] Sexual minority youth are at increased risk of homelessness, resulting from either running away from abusive situations or being thrown out of the home. Street youth are at high risk of becoming victims of violence, rape, drug and alcohol use, STDs, and AIDS. They are more likely to engage in "survival sex" in exchange for money, food, shelter, and drugs.[60]

Some studies suggest that women who partner with women may have high rates of alcohol and drug use or dependency.[45,46,61,62] These findings may represent specific subsets of lesbians sampled rather than reflecting the population as a whole.[63] The patient interview should quantify use of any potentially addictive substance, including dysfunctional eating patterns. Injection drug use is the leading reported cause of HIV infection among lesbians.[31,64–66] Harm-reduction measures include providing information about the importance of not sharing needles or works, or at a minimum, cleaning these devices well between partners.

Lesbians deal with many of the issues common to all women. Approximately 38% are survivors of child sexual abuse; the same percentage is described in surveys of women in the general population.[44,67,68] A history of

abuse may affect a woman's ability to form and sustain intimate relationships. The partner of a woman with a history of abuse has her own unique concerns, and additionally, may be a survivor of abuse herself. Referral to a counselor with expertise in issues of abuse and experience in working with lesbian couples is frequently helpful. Some women who partner with women experience domestic violence in their relationships, but are unable to access support services and crisis intervention sensitive to their particular situation.[6,69,70] Battered women's shelters may not provide a safe haven, as a female perpetrator would have the same access to the shelter as her partner.

As with other surveys of women who partner with women, the limited research that has been published on older lesbians tends to select for white, lesbian-identified respondents who are active in the gay community. It is unlikely that these samples are representative of the population as a whole.[71,72] Among those surveyed, key issues of concern include discrimination based on sexual orientation, loneliness, financial worries, age discrimination, and health. Many report their lesbian identity as making the aging process easier. These respondents found they could draw on skills of self-reliance and psychological self-knowledge that they had developed as part of accepting themselves in their "coming out" process.[72–74]

Older lesbian women may have "come out" (ie, recognized their lesbian orientation) in their youth, at midlife, or in later years. While some self-identify as lesbian or gay, others may never adopt these labels, despite a lifetime with female partners. Women whose cultural values or social environment enforce silence around their relationships with women may be at compounded risk of isolation. Some lesbians who come out later in life fear the rejection of their adult children or grandchildren, should family members learn of their relationships with women.[73] The stress of hiding this information may have a negative effect on intimate relationships and self-esteem.

Older women who partner with women must deal with the effects of ageism within both the lesbian community and society at large.[75,76] In the medical setting, older lesbians are likely to be "invisible," assumed to be widows of heterosexual marriages or "old maids." Because old people in general are not seen as sexual, patients may not be questioned about their sexual activity or orientation. Some health care providers fail to recommend regular cervical cytology or mammography screening for their patients over 70.[77–79] In addition, many providers have caps on the number of Medicare patients they will accept, creating further barriers to care.

In lesbians of all ages, the high level of stress that accompanies a stigmatized identity may lead to an increased incidence of stress-related illness.[3–5] For example, gastric complaints, allergies, headaches, and back pain can all be exacerbated and often appear as the presenting complaint in the primary care setting. Careful questioning may reveal an underlying concern that needs to be recognized and dealt with in order to successfully address the physical condition.

Conclusions

It is the responsibility of every health care professional to examine her or his own biases and work to eliminate attitudes and assumptions that interfere with the delivery of compassionate and comprehensive care. It should be the goal of every provider to offer culturally competent health care sensitive to the unique ethnic, religious, race, class, social, and sexual context of each patient; to accept alternative sexual orientation as a matter of routine, neither under- nor overemphasizing it,[3] and if this is not possible, to make an appropriate referral. Educational materials and information regarding community and national resources for women who partner with women and their families should be provided (Appendix). Brochures on lesbian health issues displayed in waiting rooms signal acceptance and understanding.[6,18] When quality services are made available to the woman with the greatest barriers to care, everyone benefits.

References

1. White J, Levinson W. Primary care of lesbian patients. J Gen Intern Med 1993; 8:41–7.
2. Lesbian health issues and recommendations. Washington, DC: National Gay and Lesbian Task Force, 1993.
3. Stevens PE, Hall JM. Stigma, health beliefs and experiences with health care in lesbian women. Image: J Nurs Scholarship 1988; 20(2):69–73.
4. Bybee D. Michigan Lesbian Health Survey. Lansing, Mich: Michigan Organization for Human Rights, 1991.
5. Bradford J, Ryan C. The National Lesbian Health Care Survey. Washington, DC: National Lesbian and Gay Health Foundation, 1987.
6. Denenberg R. Invisible women. Lesbians and health care. Health PAC Bull 1992; 22(1):14–21.
7. Matthews WC, Booth MW, Turner JD, Kessler TP. Physicians' attitudes toward homosexuality: a survey of a California medical society. West J Med 1986; 144:106–10.
8. Randall CE. Lesbian phobia among BSN educators: a survey. J Nurs Educ 1989; 28:302–6.
9. Schatz B, O'Hanlan KA. Anti-gay discrimination in medicine: results of a national survey of lesbian, gay and bisexual physicians. San Francisco, Calif: American Association of Physicians for Human Rights, 1994.
10. Cochran SD, Mays VM. Disclosure of sexual preference to physicians by black lesbian and bisexual women. West J Med 1988; 149:616–9.
11. Reagan P. The interaction of health professionals and their lesbian clients. Patient Counseling Health Educ 1981; 3(1):21–5.
12. Johnson SR, Guenther SM, Laube DW, Keettel WC. Factors influencing lesbian gynecologic care: a preliminary study. Am J Obstet Gynecol 1981; 140:20–8.

13. Johnson SR, Palermo JL. Gynecologic care for the lesbian. Clin Obstet Gynecol 1984; 27:724–31.
14. Edwards A, Thin RN. Sexually transmitted diseases in lesbians. Int J STD AIDS 1990; 1(3):178–81.
15. Johnson SR, Smith EM, Guenther SM. Comparison of gynecologic health care problems between lesbians and bisexual women. J Reprod Med 1987; 32:805–11.
16. Zeidenstein L. Gynecological and childbearing needs of lesbians. J Nurse Midwifery 1990; 35(1):10–8.
17. Smith M, Heaton C, Seiver D. Health concerns of lesbian women. Female Patient 1989; 14:43, 47, 67, 69, 73–4.
18. Simkin RJ. Creating openness and receptiveness with your patients: overcoming heterosexual assumptions. Can J OB/GYN Women's Health Care 1993; 5:485–9.
19. Robertson P, Schachter J. Failure to identify venereal disease in a lesbian population. Sex Transm Dis 1981; 8(2):75–6.
20. Biddle BS. Health status indicators for Washington area lesbians and bisexual women: a report on the Lesbian Health Clinic's first year. Washington, DC: Whitman Walker Clinic, Inc, 1993.
21. Simkin RJ. Unique health care concerns of lesbians. Can J OB/GYN Women's Health Care 1993; 5:516–22.
22. Mills S, Garcia D, Martinez T, et al. Health behaviors among lesbian and bisexual women: a community-based women's health survey. San Francisco, Calif: San Francisco Department of Public Health, AIDS Office, Prevention Services Branch, 1993.
23. Stevens PE. HIV risk reduction for three subgroups of lesbian and bisexual women in San Francisco. San Francisco, Calif: Lyon-Martin Women's Health Services, 1993.
24. Greenhouse P. Female-to-female transmission of HIV. Lancet 1987; 2:401–2.
25. Marmor M, Weiss LR, Lynden M, et al. Possible female to female transmission of human immunodeficiency virus [letter]. Ann Intern Med 1986; 105:969.
26. Monzon OT, Capellan JMB. Female-to-female transmission of HIV. Lancet 1987; 2:40–1.
27. Rich JD, Buck A, Tuomala RE, Kazanjian PH. Transmission of human immunodeficiency virus presumed to have occurred via female homosexual contact. Clin Infect Dis 1993; 17:1003–5.
28. Sabatini MT, Patel K, Hirschman R. Kaposi's sarcoma and T-cell lymphoma in an immunodeficient woman: a case report. AIDS Res 1984; 1(2):135–7.
29. Perry S, Jacobsberg L, Fogel K. Orogenital transmission of human immunodeficiency virus [letter]. Ann Intern Med 1989; 111:951–2.
30. Hollibaugh A. Transmission, transmission, where's the transmission? Sojourner: Women's Forum 1994 June: 5P, 7P–8P.
31. Chu SY, Buehler JW, Fleming PL, Berkelman RL. Epidemiology of reported cases of AIDS in lesbians, United States 1980–89. Am J Public Health 1990; 80:1380–1.
32. Cole R, Cooper S. Lesbian exclusion from HIV/AIDS education. SIECUS Rep 1990/1991; 19(2):18–23.
33. Camlin C. With or without the dam thing: the lesbian safer sex debate. In: Worcester N, Whatley M, eds. Women's health: readings on social economic and political issues. Dubuque, Iowa: Kendall-Hunt Publishing Co, 1994: 339–42.
34. Garland SM, Newnan DM, de Crespigny LC. Plastic wrap for ultrasound transducers. Herpes simplex virus transmission. J Ultrasound Med 1989; 8:661–3.
35. Madansky C, Wood JT. Safer sex handbook for lesbians. New York, NY: Lesbian AIDS Project/Gay Men's Health Crisis, 1993.
36. Degen K, Waitkevicz HJ. Lesbian health care. Sex Med Today 1983; 7:17–22.
37. Sivakumar K, De Silva AH, Roy RB. *Trichomonas vaginalis* infection in a lesbian. Genitourin Med 1989; 65:399–400.
38. Walters MH, Rector WG. Sexual transmission of hepatitis A in lesbians [letter]. JAMA 1986; 256:594.
39. Denenberg R. Gynecological care manual for HIV positive women. Durant, Okla: Essential Medical Information Systems, Inc, 1993.
40. Vermund SH, Kelley KF. Human papillomavirus in women: methodologic issues and the role of immunosuppression. In: Kiley M, ed. Reproductive and perinatal epidemiology. Boca Raton, Fla: CRC Press, 1990.
41. Perniciaro C, Dicken CH. Tanning bed warts. J Am Acad Dermatol 1988; 18:586–7.
42. McCance DJ, Campion MJ, Baram A, Singer A. Risk of transmission of human papillomavirus by vaginal specula. Lancet 1986; 2:816–7.
43. Ferenczy A, Bergeron C, Richart RM. Human papillomavirus DNA in fomites on objects used for the management of patients with genital human papillomavirus infections. Obstet Gynecol 1989; 74:950–4.
44. Bradford J, Ryan C, Rothblum ED. National lesbian health care survey: implications for mental health. J Consult Clin Psychol 1994; 62:228–42.
45. Skinner WF. The prevalence and demographic predictors of illicit and licit drug use among lesbians and gay men. Am J Public Health 1994; 84:1307–10.
46. McKirnan DJ, Peterson PL. Alcohol and drug use among homosexual men and women: epidemiology and population characteristics. Addict Behav 1989; 14:545–53.
47. Haynes SG. Are lesbians at high risk of breast cancer? Presentation at the 14th National Lesbian and Gay Health Foundation Conference, Los Angeles, Calif, July 1992.
48. O'Hanlan KA. Lesbians in health research. Presentation to the Office of Research on Women's Health, National Institutes of Health. Scientific meeting: recruitment and retention of women in clinical studies. Washington, DC: US Department of Health and Human Services. NIH publication No. 95-3756, 1993.
49. Martin A. The lesbian and gay parenting handbook. New York, NY: HarperCollins Publishers, 1993.
50. Chiasson MA, Stoneburner RL, Joseph SC. Human immunodeficiency virus transmission through artificial insemination. J Acquir Immune Defic Syndr 1990; 3(1):69–72.
51. 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; 2:581–5.
52. Curry H. A legal guide for lesbian and gay couples. Berkeley, Calif: Nolo Press, 1991.
53. Blumenfeld WJ, ed. Homophobia: how we all pay the price. Boston, Mass: Beacon Press, 1992.
54. Herek GM, Berrill KT, eds. Hate crimes: confronting violence against lesbians and gay men. Newbury Park, Calif: Sage Publications, 1992.
55. Hunter J. Violence against lesbian and gay male youths. J Interpersonal Violence 1990; 5:295–300.
56. Gillow KE, Davis LL. Lesbian stress and coping methods. J Psychosoc Nurs 1987; 25(9):28–32.
57. Gibson P. Gay male and lesbian youth suicide. In: Report of the Secretary's Task Force on Youth Suicide, vol 3. Washington, DC: Department of Health and Human Services, 1989: 110–42. DHHS publication No. [ADM] 89-1623.
58. Hunter J, Schaecher R. Lesbian and gay youth. In: Rotheram-Borus MJ, Bradley J, Oblensky N, eds. Planning to live: evaluating and treating suicidal teens in community settings. Tulsa, Okla: University of Oklahoma Press, 1990: 297–316.
59. Remafedi G, Farrow JA, Deisher RW. Risk factors for attempted suicide in gay and bisexual youth. Pediatrics 1991; 87:869–75.
60. Kruks G. Gay and lesbian homeless/street youth: special issues and concerns. J Adolesc Health Care 1991; 12:515–8.
61. Mosbacher D. Lesbian alcohol and substance abuse. Psychiatric Annals 1988; 18(1):47–50.
62. Mosbacher D. Alcohol and other drug use in female medical students: a comparison of lesbians and heterosexuals. J Lesbian Gay Psychother 1993; 2(1):37–48.
63. Bloomfield K. A comparison of alcohol consumption between lesbians and heterosexual women in an urban setting. Drug Alcohol Depend 1993; 33:257–69.
64. 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. AIDS 1992; 6:518–9.

65. Dicker BG. Risk of AIDS among lesbians [letter]. Am J Public Health 1989; 79:1569.
66. Raiteri R, Fora R, Gioannini P, et al. Seroprevalence, risk factors and attitude to HIV-1 in a representative sample of lesbians in Turin. Genitourin Med 1994; 70:200–5.
67. Loulan J. Lesbian passion: loving ourselves and each other. San Francisco, Calif: Spinsters/Aunt Lute, 1987.
68. Russell D. The secret trauma: incest in the lives of girls and women. New York, NY: Basic Books, 1986.
69. Renzetti CM. Building a second closet: third party responses to victims of lesbian partner abuse. Fam Relationships 1989; 38:157–63.
70. Renzetti CM. Violent betrayal: partner abuse in lesbian relationships. Newbury Park, Calif: Sage Publications, 1992.
71. Adelman M. Stigma, gay lifestyles, and adjustment to aging: a study of later-life gay men and lesbians. J Homosex 1990; 20(3–4):7–32.
72. Kehoe M. Lesbians over 65: a triply invisible minority. J Homosex 1986; 12(3–4):139–52.
73. Quam JK, Whitford GS. Adaptation and age-related expectations of older gay and lesbian adults. Gerontologist 1992; 32:367–74.
74. Deevey S. Older lesbian women: an invisible minority. J Gerontol Nurs 1990; 16(5):35–9.
75. Macdonald B, Rich C. Look me in the eye: old women, aging and ageism. San Francisco, Calif: Spinsters Book Company, 1983.
76. Facilitators handbook: confronting ageism. Houston, Tex: Old Lesbian Organizing Committee, 1992.
77. Fox SA, Murata PJ, Stein JA. The impact of physician compliance on screening mammography for older women. Arch Intern Med 1991; 151:50–6.
78. Weinberger M, Saunders AF, Samsa GP, et al. Breast cancer screening in older women: practices and barriers reported by primary care physicians. J Am Geriatr Soc 1991; 39:22–9.
79. Weintraub NT, Violi E, Freedman ML. Cervical cancer screening in women aged 65 and over. J Am Geriatr Soc 1987; 35:870–5.

Appendix: Lesbian and Gay Resource Organizations

Youth

The Hetrick-Martin Institute
2 Astor Place
New York, NY 10003
(212) 674-2400

Multi-service youth organization, excellent resource; publishes *National Lesbian, Gay and Bisexual Youth Organization Directory,* available by mail order.

Boston Alliance of Gay and Lesbian Youth (BAGLY)
(800) 42-BAGLY: 24-hour hotline

Indiana Youth Group
(800) 347-TEEN: peer help line 6:00–10:00 PM daily

Out Youth Austin
(800) 96-YOUTH: peer hotline 5:30–9:30 PM daily

National Runaway Switchboard
(800) 621-4000: 24-hour hotline

Families and Friends

Parents and Friends of Lesbians and Gays (P-FLAG)
1101 Fourteenth St, NW, Suite 1030
Washington, DC 20005
(202) 638-4200

Cancer

National Coalition of Feminist and Lesbian Cancer Projects
c/o Mautner Project for Lesbians with Cancer
1707 L St, NW, Suite 1060
Washington, DC 20036
(202) 332-5536

HIV/AIDS

Lesbian AIDS Project (LAP)
c/o Gay Men's Health Crisis
129 West 20th St
New York, NY 10011
(212) 337-3532

Legal

National Center for Lesbian Rights
870 Market St, Suite 570
San Francisco, CA 94102
(415) 392-6257

Chemical Dependency Treatment

PRIDE Institute
1400 Martin Dr
Eden Prairie, MN 55344
(800) 54-PRIDE; in MN: (612) 934-7554

Political Advocacy

National Gay and Lesbian Task Force
2320 17th St, NW
Washington, DC 20009
(202) 332-6483

Elders

Old Lesbians Organizing for Change (OLOC)
PO Box 980422
Houston, TX 77098

Medical Services

Lesbian Services/Lesbian Health Clinic
Whitman Walker Clinic
1407 S St, NW
Washington, DC 20009
(202) 797-3585

Lyon-Martin Women's Health Services
1748 Market St, Suite 201
San Francisco, CA 94102
(415) 565-7667

Professional Organizations

Gay and Lesbian Medical Association (GLMA)
[formerly: American Association of Physicians for Human Rights (AAPHR)]
273 Church St
San Francisco, CA 94114
(415) 255-4547

National Lesbian and Gay Health Association (NLGHA)
[formerly: National Lesbian and Gay Health Foundation (NLGHF) *and* The National Alliance of Lesbian and Gay Health Clinics]
1407 S St, NW
Washington, DC 20009
(202) 939-7880