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Review

A Review of the Medical Consequences of Homophobia with Suggestions for Resolution

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Purpose: This review highlights the effects of homophobia, the antipathy or disdain for gay men and lesbians, which is a widespread response to this largely unfamiliar and previously hidden segment of society. *Data Sources:* Peer-reviewed and non-peer-reviewed journal articles, published and unpublished survey reports, current newspaper coverage of events, U.S. census data, are all integrated to produce an overview of societal, psychosocial, and medical consequences of homophobia. *Data Synthesis:* The available information has been analyzed from a psychiatric, medical, and sociocultural perspective in order to provide an update on the known science about homosexuality and the medical effects of homophobia. *Conclusions:* The medical and psychological effects of homophobic prejudice are profound on the developing self-concept of youths as well as adults who recognize a same-sex orientation. Medical practitioners are not immune from societal prejudice and may demonstrate disdain for gay men and lesbians as patients. Patients perceive this disdain, which alienates them from the medical system, reducing utilization of screening modalities, risking higher morbidity and mortality from infections, cancers, and heart disease. Being gay or lesbian is not genetically or biologically hazardous, but risk factors are conferred through homophobia. Therefore, the process of homophobia—the socialization of heterosexuals against homosexuals and concomitant conditioning of gays and lesbians against themselves—poses a legitimate health hazard. Governmental, institutional, educational, and medical resolutions of homophobia are discussed which would improve the quality of medical care provided to gay men and lesbians, and have a favorable impact on the health and quality of life of this population.

KEY WORDS: Homosexuality; lesbianism; gays; prejudice.

INTRODUCTION

Physicians providing care in the last 30 years have seen a segment of society coalesce with a new social and cultural identity—gay men, lesbians, and bisexual people. Early psychoanalytic constructs—often working from *a priori* assumptions of psychopathology in all people who were not heterosexuals—and poor research methodology—often studying only mentally ill gay men and lesbians—cast homosexuals as mentally ill, immoral, untrustworthy, unreliable, and lacking in integrity. As a result, gay men and lesbians developed a hidden subculture for emotional

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and peer support. Negative stereotypes persist today because most people are unfamiliar with, and uneducated about, homosexuality. Prejudice against gay men and lesbians from family, educational, religious, and governmental organizations causes homosexuals to develop low self-esteem and depressive distress, and impedes their effective negotiation in society. Homophobic prejudice ultimately can result in poor health habits and poor compliance with standard screening recommendations, reduced access to and utilization of health care systems, and higher risk profiles for many cancers and heart disease with potentially higher morbidity and mortality. Multiple surveys of the homosexual community reveal the perception that medical practitioners lack knowledge of the salient issues in the lives of gay men and lesbians and have largely inadvertently—but sometimes purposely—alienated their patients.

The gay and lesbian community needs medical care that recognizes its unique medical demographic profile and is provided with the same degree of knowledge, sensitivity, and respect afforded other segments of our large and diverse society (1). In this review of available literature, the medical and psychological effects of prejudice within family, educational, religious, and governmental organizations will be discussed. It will be shown how they negatively affect the lives of gay men and lesbians. Steps to reduce these consequences will be described, with specific suggestions for medical practitioners and for physician leadership. With greater understanding and knowledge of this segment of society, physicians can set a nondiscriminatory social standard and provide the highest quality medical care to all of their patients, including gay and lesbian patients.

HOMOPHOBIA: DEFINITION AND IMPACT

Homophobia is the "irrational fear of, aversion to, or discrimination against homosexuality or homosexuals" (2). Such antipathy derives, in part, from such mistaken beliefs or perceptions that gay men and lesbians are child molesters, immoral individuals, or threats to traditional family values and the "natural order." Homophobia operates on two levels: internally and externally (3). Internal homophobia represents prejudices that all individuals learn (internalize) from their families, friends, teachers, colleagues, religious institutions, government, and the popular media. External homophobia is the overt expression of those biases, ranging from social avoidance, legal and religious proscription, to outright violence.

Various theories of the causes of prejudice against gay men and lesbians suggest that some individuals may express hatred or fear of homosexuals in order to reassure themselves that they are "normal" or "moral" (4). Homophobia has been described as a variant of sexism, a reaction against perceived femininity in men and masculinity in women (5). The Attitudes Toward Lesbians and Gay Men Scale (ATLG) was developed to objectively observe heterosexuals' attitudes (6) and has been found to be a reliable scale, with good construct validity (coefficient alpha of .95). The ATLG data reveal that greater hostility toward homosexuals correlates with higher acceptance of traditional gender roles, high religiosity or membership in a conservative or fundamentalist denomination, political conservatism, lack of known personal contact with homosexuals, and a perception that friends agree with their attitudes. While many individuals would not identify themselves as homophobic, a lack of familiarity with members of the gay and lesbian community can result in acceptance of misinformation and unintentionally biased attitudes. Other studies have confirmed that simply knowing one or more gay men or lesbians personally is associated with less hostility toward homosexuals (7). While only about one-third of Americans believed they knew a gay man or lesbian in 1978 (8), about two-thirds report that they know someone who is gay or lesbian in 1996 (9).

It is also important to measure internalized homophobia, or the level of self-hatred or loathing learned by lesbians and gay men. The Nungesser Homosexuality Attitudes Inventory was developed for this purpose and has the best empirical support for face, content, and construct validity (10). This Inventory shows that levels of internalized homophobia vary significantly; high levels correlate with overall psychological distress, depression, somatic symptoms, poor self-esteem, loneliness, distrust, poor social support, and separation from gay and heterosexual support networks. Internalized homophobia is also associated with sexually risky behavior (10).

As the definition of homophobia suggests, there are no rational or scientific bases for the attitudes underlying the phenomenon. A review of the extensive psychiatric literature over the last 50 years consistently reveals no major differences in levels of maturity, neuroticism, adjustment, goal orientation, or criminality between heterosexual and homosexual

people (11). Though homosexuality was listed as a mental disorder in some of the older editions of the *Diagnostic and Statistical Manual* (DSM), it was removed from the DSM in 1974 based on scientific review; the original inclusion of homosexuality as a mental disorder was found to be reflective only of the social mores of the time in which it was inserted, and not of scientific study (12).

In the currently used DSM IV, Sexual Disorder Not Otherwise Specified is used for conditions described as consisting of "feelings of inadequacy concerning sexual performance or other traits related to self-imposed standards of masculinity or femininity" and "persistent and marked distress about sexual orientation" (13). Homophobia may be a key feature of both of these problems for gay and bisexual people. Another diagnostic area in earlier editions of the DSM was called Identity Disorder and consisted of problems associated with adolescent development of identity and included problems with sexual orientation (14, 15). It remains in DSM IV as a V code called Identity Problem and continues to contain language referencing difficulties in relation to sexual orientation (13).

PSYCHOLOGY AND HEALTH

Environmental stresses are known to interact with personal resources to produce behaviors which result in a particular coping style in order to manage acute life crises, chronic life events, and major life transitions (16) (Fig. 1). Studies of adolescent development, alcoholism recovery, and depression all support this kind of interactive formulation of environmental stress and health (17). Homophobia can then

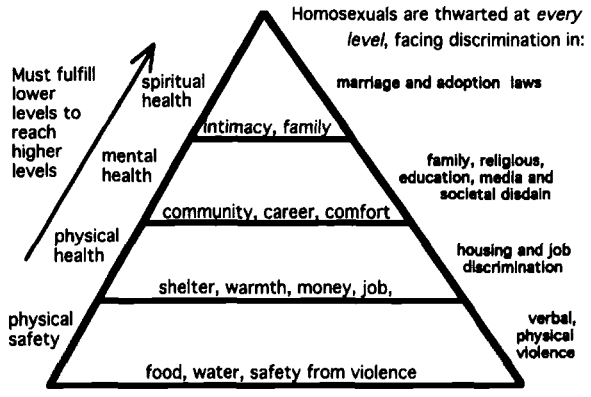

Fig. 1. Maslow's hierarchy of human need fulfillment.

be viewed as an environmental and social stressor which increases disease vulnerability and results in poor coping styles, and thus is a health-related risk factor for gays and lesbians (17). Although most gay and lesbian individuals are content with their orientation and function well in society, those who describe themselves otherwise cite victimization by violence and familial, governmental, employment, or social discrimination as the reasons for their dissatisfaction (8). Some older studies revealed slightly higher lifetime rates of depression, attempted suicide, psychological help-seeking, and substance abuse among homosexuals (18, 19). Newer, more specific studies of this phenomenon suggest that this questionable increase may be caused by chronic stress from societal hatred (20), the consequences of accepting an inferior status that homophobia imposes (21), as well as anxiety, depression, and guilt associated with being perceived as immoral and deviant, an effect that has been compounded by the HIV epidemic (21). These types of life stress may have worse mental health implications because of the associated frequent loss of familial support systems (22, 23) and the frequent concealment and suppression of feelings and thoughts (23). On the other hand, decreased levels of homophobia are associated with proactive coping style and by decreasing avoidant coping (24). Of note, individuals who carry multiple socially marginalized statuses, such as from a combination of race, ethnicity, and sexual orientation, may carry an even higher risk of depressive distress (25, 26). In one study, lesbians of color scored as high on depression scales as HIV-positive gay men of color, and both groups scored significantly higher in depression than heterosexual African-Americans (25).

The decision to "come out" has been associated with significantly less anxiety and depression, a higher self-concept (27), greater relationship satisfaction (28), sense of community, and integration into family and society (23, 29). It is interesting to note, however, that in two large surveys of lesbians, only 15–28% of lesbians had disclosed their orientation to everyone in their lives (22, 29).

EFFECTS ON YOUTH

Many children who experience homosexual feelings report to their pediatrician a sense of painful alienation from their family, believing the societal perspective that heterosexuality is the only accept-

able "norm" (that is, the effects of heterosexism) (30). Very few educational or religious institutions teach children about diversity of orientation, particularly at the ages when most youths begin to discern their orientation (31). The stereotypes of homosexuality are sensationalized and misrepresented in television, theater, and print media. The virtual absence of gay and lesbian role models in popular media and in society reduces the successful negotiation of a positive self-concept by gay and lesbian youth and diminishes their ability to gain respect and understanding from their peers (32). Additionally, when homosexuality or gay and lesbian people are discussed by the popular media, children are subject to the same imbalanced reporting, such as when hearing or reading news about the proscription against homosexuals serving in the military, without hearing the peer-reviewed data substantiating absence of security risk or performance inadequacy (33–35). As another example, news accounts and editorials voicing objection to same-sex marriage similarly may leave children wondering if homosexuals are deserving human beings. Opinions proffered without the known facts, cast as moral thinking, certainly can reinforce in children the belief in the unworthiness of homosexuals.

In a 1988 survey of 500 adolescents applying to the Hetrick-Martin Institute, a New York City high school for gay and lesbian teens, 46% of the respondents reported experiencing violence from their family, peers, or strangers related to their sexual orientation (36). Other studies find increased high school dropout rates, substance abuse, and family discord among gay youth and adolescents (37). Most gay youth feel they must conceal their orientation from family and friends (23), but this concealment carries the price of isolation. In one study, awareness of sexual orientation typically occurred at age 10 years; however, disclosure to another person did not occur until 6 years later (38). Suicide attempts were acknowledged by 42% of this same sample, particularly during this critical time of concealment.

The strongest risk factors for gay and lesbian suicide before age 20 years have been shown to be early adolescent discovery of same-sex attraction, experience of violence from peers for gender atypicality, use of drugs or alcohol to cope, and familial disapproval, with parental nonacceptance of paramount importance (20, 32, 39–41). Some studies of gay and lesbian youth reveal a suicide attempt rate of 25–42% (37, 38). When compared to the rates in other studies suicide attempts by high school students in general, usually 8–13% (39, 42–44), a worrisome picture suggesting higher suicide rates among gay and lesbian youth develops (Table I). Debate continues on the higher rate of suicide among gay, lesbian, and bisexual youth (45), since others have contested this concern and find rates comparable to rates in the general population (46). Study of adolescent suicide is difficult due to the problem of clearly identifying gay and lesbian youth; a methodology for specifically studying this subject is currently under investigation by the Centers for Disease Control. Regardless of the actual percentages, the frequent association of suicide behaviors among gay and lesbian youth who experience and report violence and social disdain reinforces the implication of homophobia as a risk factor for suicide.

Physicians may wonder whether children are adversely impacted by exposure to information about homosexuality or seeing openly identified gay and lesbian people. In studies comparing over 300 children raised in gay or lesbian households with children raised in heterosexual households, no difference in self-concept, locus of control, moral judgment, intelligence, sex-role behavior, or orientation was observed (47). The same studies suggested that children fare much better when informed of their parents' orientation in early childhood, when their fathers are not homophobic, and when their mothers are psychologically healthy (47). Age-appropriate information about same-gender attraction and relationships can reduce name-calling and learned oppression of

Table I. Suicide Rates as Percent of Adolescents Stratified by Orientation

	MMWR (117) (all)	Remafedi (40) (gay)	Schneider (39) (gay)	Hammelman (117) (gay/lesbian)	National (22) (lesbian)
Suicide ideation	27	—	55	48	21
Attempted suicide	8	29	20	20	18
Required medical	2	21	—	—	—

gay and lesbian youth in the elementary school setting (48).

Youth with a sexual orientation that is different from the majority or who may be questioning their sexual orientation may be particularly vulnerable to so-called "reparative" or "conversion" therapy, an attempt to change an individual's sexual orientation by psychotherapy, behavioral interventions, aversive therapy, and other methods. Such treatment may be sought by confused youth or fearful and concerned parents, but it has been found to be both ineffective (49) and frankly harmful (32) because it further stigmatizes the individual as defective. The American Medical Association has condemned this "therapy" as unethical (1).

In conclusion, for gay and lesbian youth, the adverse effects of homophobia can lead to potentially life-long detriment to emotional development, health, and educational and occupational performance and fulfillment.

EFFECTS ON RELATIONSHIPS

Physicians may also be concerned about the health and quality of the primary relationships that gay men and lesbians experience. Despite the absence of the legal, social, and financial perquisites of legal marriage, survey data suggest that the majority of lesbians and gay men are in long-term committed relationships (22, 26, 29). A 1991 survey of gay and lesbian couples revealed that 90% of surveyed couples shared income, lived together, were mutually dependent, and were committed to each other for life (50). While relationship instability in homosexual couples can occur because of the same kinds of relational conflicts affecting all couples, stress or problems between the partners can be compounded by coming out issues, homosexual self-concept issues, and the absence of wedding traditions and marital role models (28, 51, 52).

The definition of "family" for gay and lesbian people necessarily involves creation of a network of close and accepting friends as a family-of-choice, especially if their family-of-origin has rejected them. Because this concept of "family" is not legally recognized, hospitals and clinics may restrict visitation privileges of gay and lesbian partners as "nonrelatives." Unless a couple has signed contracts for mutual medical conservatorship, any blood relative can override the role and input of a domestic partner, even though the domestic partner may be the primary caretaker and more knowledgeable of his or her partner's religious and ethical beliefs and medical wishes. Only a fraction of gay men and lesbians have taken these often costly legal steps to circumvent such problems. Extending legal marriage rights to homosexuals could obviate these expensive steps to confer kinships.

SUBSTANCE ABUSE

Substance use by gay and lesbian people is commonly linked to homophobia; use of alcohol or other drugs of abuse can provide a sense of relief from stress as well as foster a sense of acceptance. More importantly, drug or alcohol use, through the numbing and dissociative effects, numbs painful feelings, tempers the sting of homophobia, facilitates social interaction, and supports denial, possibly even producing physiological or emotionally related blackouts (53). Historically, legal prohibitions and societal disdain have restricted gay and lesbian social outlets to bars and private homes or clubs which typically promote alcohol use. Although there are increasing alternatives to bars and parties, these sites remain the usual initial social outlet for many gay or lesbian individuals who, in reality, are seeking a wider network of friends.

Substance abuse rates across gender, geographic, and class lines for gay and lesbian individuals have previously been reported at 20–30%, in contrast to 10% for the population at large (54, 55). Epidemiologists have criticized these studies, which used the opportunistic sampling technique of surveying bar patrons, as unrepresentative of the gay and lesbian community, because bar patrons are known to be more likely to abuse alcohol as well as other drugs (56). More recent and more representative studies have revealed alcoholism rates of 19% among gay men versus 11% for heterosexual men in the same census areas in San Francisco (57), 15% versus 14% in a survey of Chicago's regional newspaper readers (58), and 12% among a New York City gay male population first surveyed in 1986, which declined to 9% at follow-up survey in 1987 (59), though use—not abuse—was greater in all reviews for gay men (53). More recent data regarding lesbian alcohol abuse indicate similar rates to heterosexual women surveyed in the Chicago or San Francisco areas (58, 60). Besides the medical consequences of alcohol or drug use itself,

alcohol abuse has been associated with higher risk of domestic violence in gay and lesbian households, further adding to the medical and psychiatric concerns of gay men and lesbians (61).

The failure to acknowledge sexual orientation and related issues in alcoholism treatment makes recovery more difficult and increases likelihood of relapse; the difficulty of coming out or accepting one's sexual orientation may be the trigger or excuse for resuming drinking or drug use (53, 62). Rehabilitation and detoxification programs frequently show little sensitivity to issues of sexual orientation, and usually do not encourage disclosure (63). While insensitivity of therapists to issues of orientation does not specifically suggest that homophobia is the root cause of treatment failure, abundant evidence confirms that homophobic behavior on the part of providers contributes to noncompliance and avoidance of medical and psychiatric care on the part of gay and lesbian patients in a variety of clinical situations (64–70).

VIOLENCE

Battery and murder of gay men and lesbians occur at a significant rate, but are not regularly tracked as hate crimes because federal regulations do not require states to record homophobic-motivated violence as a hate crime. The 1994 National Gay and Lesbian Task Force Report on Violence described 1813 instances of homophobic harassment, threats, assault, vandalism, arson, kidnapping, extortion, and murder over 12 months in the six cities they monitor: New York, Minneapolis/St. Paul, Chicago, Denver, Boston, and San Francisco (71). When compared with homicides against heterosexuals, homicides against gay men and lesbians appear to be more violent and more likely to involve mutilation and torture, and are more likely to go unsolved, according to a 2-year national study (72). The Task Force concludes: "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" (71).

In a review of 23 surveys of gay men and lesbians, it was observed that 17% had been physically assaulted, 44% had been threatened with violence, and 80% had been verbally assaulted (73). In one recent study of 15- to 20-year-old gay and lesbian youth, 80% had experienced verbal insults, 44% had been threatened with violence, 33% had had objects thrown at them, 31% reported having been chased or followed, and 17% reported having been physically assaulted—punched, kicked, or beaten—specifically due to their sexual orientation, as compared with overall estimates from a comparative sample of youth of verbal and physical assaults for any reason (presumably including sexual orientation) at 34% being threatened and 13% physically assaulted (74). Though the perpetrators of antigay violence often fit the usual profile of homophobic people (7), such perpetrators may be well-educated; 37% of college freshman and 9% of college women admitted to having verbally harassed a person they believed to be homosexual (75). A survey of Yale lesbian and gay male students revealed that many reported living their college years in secretiveness and fear because they feared antigay violence and harassment on their campus (76). All of these studies support the idea that homophobia contributes as a specific and temporally related risk factor for violent assault and injury of persons perceived to be homosexual.

ECONOMIC ISSUES

Socioeconomic stratum and medical insurance coverage are important correlates of good health. The Michigan Lesbian Health Survey reports that the lesbian population surveyed had a median annual income $10,000 lower than that reported by all Michigan women in 1989 even though the lesbian population was more likely to have completed a college education (29). Lesbians also had significantly lower rates of medical insurance coverage than heterosexual women in Michigan. In an analysis of the 1990 census data, it was found that while 38% of lesbian respondents were college graduates, compared to 34% of male homosexuals and 18% of married heterosexuals, lesbian couples had the lowest income of all three groups (77). Reduced earning potential may result from experienced discrimination (22, 29, 78, 79), or, of equal importance, anticipated discrimination, which inhibits gays and lesbians from seeking more assimilated but higher profile, higher paying jobs (79). Barriers to insurance such as lower income and lack of domestic partner coverage may keep the lesbian/gay patient from obtaining yearly screening tests or seeking care early in the course of a disease; in the Michigan study, 58% of lesbians reported not seeking medical care when they felt they needed it,

because they lacked insurance or the financial resources (29). Some health insurers have been known to deny insurance to men *perceived* to be gay (e.g., over 30 years of age and unmarried), regardless of their HIV status (80).

HEALTH CARE

Homophobia can lead to misrepresentation of facts by patients and misinterpretation of facts by physicians. Health care providers are not immune to misinformation received in their early socialization, and typically do not receive information in their medical training regarding gay and lesbian health issues, with the possible exception of HIV/AIDS. A 1987 questionnaire of Midwest bachelor-degree nursing school faculty members revealed that many believed lesbianism was a disease (17%), immoral (23%), disgusting (34%), and unnatural (52%); fully 17% surveyed thought lesbians molest children, and 8% thought them unfit to be registered nurses (81). More than half said they would never discuss lesbian issues in their classrooms, and more than a quarter said they were uncomfortable providing care to lesbian patients. In another survey, nursing student respondents believed lesbian patients were preoccupied with seducing heterosexual women and were a high-risk group for AIDS, even though scientific evidence of either belief is lacking or to the contrary (82).

In a 1986 questionnaire returned by 930 physicians of the San Diego County Medical Society, 23% scored as "severely homophobic," with 30% reporting that they would not admit a highly qualified gay or lesbian applicant to medical school; 40% would discourage a gay or lesbian medical student from entering a pediatric or psychiatric residency; and 40% stated they would not refer patients to a gay or lesbian colleague (83). Fully 40% surveyed reported being uncomfortable providing care to gay or lesbian patients. Among obstetrician/gynecologists and family practice/internists, the primary care providers and gate-keepers in most comprehensive health care plans, one-third self-reported having hostile attitudes toward gay and lesbian patients (83).

A 1987 survey of 119 second- and third-year medical students in Mississippi showed that homosexual patients, whether they had AIDS or leukemia, were more likely to be perceived as responsible for their illness, dangerous to others, and suffering less pain than heterosexual patients (84). These students had a much more negative view of homosexual patients with AIDS than of drug abusers with AIDS and felt that the homosexual patients were more deserving of losing their jobs, being quarantined, and ultimately dying. Patients who identified themselves as homosexuals were rated as less appropriate, more offensive, less truthful, less likable, less assertive, less attractive, and less intelligent than heterosexual patients (84).

In the 1994 survey of the membership of the Gay and Lesbian Medical Association, over one-half of the 711 respondents reported observing denial of care or provision of reduced or substandard care to gay or lesbian patients because of their orientation, with 88% reporting that their physician colleagues had made public disparaging remarks in the past about gay or lesbian patients relating to their orientation (85). While 98% of respondents felt that it was medically important for patients to inform their physicians of their orientation, 64% believed that in so doing, patients risked receiving substandard care.

The homophobic attitudes of nurses, medical students, and physicians are perceived by patients and negatively affect their health care experience, the quality of their medical care, and their likelihood of

Table II. Percent of Lesbians Reporting Negative Experiences with Health Care Workers

	Stevens (86)	Cochran (60)	Johnson (70)	Glascock (118)	Bybee (29)	Bradford (119)
Treated rudely	72	—	25	—	—	—
Hesitant to return	84	—	—	—	—	—
Not disclosed to provider	—	67	72	50	—	13
Fearful to disclose	—	38	40	50	61	16
Providers ignorant re lesbians	—	—	—	—	20	14
Providers tried to "cure"	—	—	—	—	6	—
Providers refused to acknowledge partner	—	—	—	—	18	9

obtaining follow-up care (Table II). In one study, 72% of lesbians surveyed reported experiencing ostracism, rough treatment, and derogatory comments, as well as disrespect for their partners by their medical practitioners (65). Several studies document negative reactions from health care practitioners commencing after gay male or lesbian patients revealed their orientation (22, 66–68, 85, 86). Numerous studies reveal that 67–72% of lesbians withheld information about their sexual behavior from their health care provider, citing a fear of sanctions or repercussions if they revealed their homosexuality (69, 70). As a result, 84% of lesbians in one study said they were hesitant to return to their physicians' offices for new ailments (86), and were less likely to return for indicated medical screening tests, such as Pap smears, blood pressure, cholesterol, stool blood assays, and so on. One respondent declared "it's like putting your health in the hands of someone who really hates you" (65).

RESEARCH

Outside the context of HIV, representative data on health and psychology issues have not been obtained from the gay and lesbian community in national probability health surveys. These gaps in knowledge sometimes lead to incorrect assumptions by well-meaning health care providers. Many physicians tell 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. Heterosexual intercourse has been implicated because it is the likely route of transmission of the human papilloma virus (HPV) (87, 88), the initiator of cervical precancer, called dysplasia, and cervical carcinoma (89). However, while most studies reveal that 77–91% of lesbians have had at least one prior sexual experience with men and may be at risk for cervical dysplasia (22, 26, 29, 79, 90), transmission of HPV may also occur during lesbian sexual activity (91). The interval between Pap smears for lesbians was reported to be nearly three times that for heterosexual women in a 1981 study (92). In one survey, rates of dysplasia among groups of homosexual and bisexual women were not different, though screening rates were significantly lower in Iowa lesbians (90). As many as 5–10% of respondents in two large surveys had never had a Pap smear or had had one over 10 years ago (22, 29). It would be important to have prospective data on which to base the recommendations for frequency of Pap smears in women who no longer have sex with men, and well as to determine the need for safer sex precautions among lesbians with regard to sexually transmitted diseases such as AIDS or those associated with human papilloma virus. Rates of cervical carcinoma have been significantly reduced by identifying the known precursor of cervical cancer, dysplasia, and following formal guidelines for annual screening Pap smears with treatment of those with cervical abnormalities (93, 94).

Among gay men, the risk of anorectal carcinoma was shown to be 25–50 times higher than that for heterosexual men, and is associated with the presence of HPV (95). There are no formal guidelines for screening gay men for precursor lesions, despite the fact that transition to invasive carcinoma is accelerated in those with HIV infection (96).

Similarly, quality data regarding risk for and rates of breast cancer in the lesbian subpopulation are lacking even though lesbians appear to have a high concentration of breast cancer risk factors. Nulliparity is a known risk factor for endometrial, breast, colon, and ovarian cancers (97, 98). The three major lesbian health surveys all reported obstetrical nulliparity rates among lesbian respondents between 69% and 90% (22, 26, 29). The use of oral contraceptives reduces the risk for developing endometrial and ovarian carcinoma (99). Although no data are available documenting lesbian use of oral contraceptives, lesbians are likely to use contraceptives less frequently. Some national studies have suggested that unmarried women when compared to married women have higher rates of cigarette abuse and lower rates of breast self-exam, screening mammography, and clinical exam (100). Since lesbians are more likely to be counted as unmarried, these data suggest that lesbians utilize screening less often. One-fourth of lesbians over age 40 in the Michigan study had never had a mammogram (29).

An annual examination by a qualified clinician entails many screening modalities, as endorsed by the American Cancer Society, American Heart Association, and the many specialty societies. Screening tests of proven value in reducing disease include serum cholesterol screening, blood pressure measurement, weight measurement, skin exam, diet assessment, exercise and activity assessment, stool exam for occult blood, rectal exam, and prostate exam, and usually include counseling for abnormalities and deficiencies in each area in order to reduce disease incidence.

The gay man or lesbian who is alienated from the medical profession will miss each of these opportunities. Considering all of these factors, lesbians and gay men may experience greater risk for, as well as greater morbidity or mortality from, multiple cancers and possibly heart disease, especially if they defer seeing a physician until symptoms become severe. If demographic studies were to be performed and showed a higher incidence, morbidity, or mortality from cancers or heart disease, then screening or health education programs could be instituted and targeted to the population at risk.

HIV ISSUES

In the context of the HIV epidemic, when early warning signs of AIDS were detected among gay men in 1981, scientists at the U.S. Centers for Disease Control (CDC) recognized its potential for rapid spread and requested funds to research and prevent an epidemic (101). Given the perception of AIDS as a gay disease, such funding was nearly impossible to obtain.

While AIDS research funding has increased dramatically in recent years, persistent antipathy toward gay people has made it difficult to obtain federal funds for prevention of HIV infection among gay and bisexual men. In 1987, a legislative amendment was passed by the U.S. Senate prohibiting the CDC from funding any materials that would appear to "promote or encourage . . . homosexual activities" (102). This precluded creation of prevention information specific to the gay community. Such a law ignored the scientific evidence that exposure to information about homosexuality does not predispose heterosexual individuals to become homosexual (47). While this law eventually expired, it demonstrates the obstacles to confronting public health issues that affect gay men and lesbians.

Upon inquiry regarding the absence of HIV prevention materials directed toward individuals and communities at highest risk, U.S. Assistant Secretary for Health James O. Mason, M.D., responded: "There are certain areas which, when the goals of science collide with moral and ethical judgment, science has to take a time out" (103). Health and Human Services spokesperson William Grigg explained that "when you're fighting a fire, you control it from the outside and let the center burn. The same holds true for medicine" (103).

Although research on a partially hidden population may be difficult to design, reliable inferences may still be generated with careful and respectful research design (104). The medical and psychological needs of the gay and lesbian population should be addressed more effectively by funded research projects which stratify by sexual behavior and by sexual identity (104).

CREATING AND IMPLEMENTING SOLUTIONS

Medical Education

Peer-reviewed evidence confirms that being gay or lesbian is not inherently (genetically, biologically) hazardous, but that risk factors are conferred through societal, familial, and medical homophobia (Figs. 2 and 3). The very process of homophobia—the socialization of heterosexuals to have negative feelings about homosexuality and gay and lesbian people as well as the concomitant internalization by gays and lesbians of such negative feelings against themselves—is a legitimate health hazard and must be recognized as such. Based on demographics and epidemiology (105), as many as 3–6% of the patients seen by physicians today, some 11 million Americans, are gay or lesbian. These individuals are within the normal variation of human sexual orientation, and, as is true for anyone else, deserve the highest standard of health care.

Progress in combating homophobia in medicine has been made in three precedent-setting examples. In 1973, the American Psychiatric Association issued its landmark position paper on homosexuality and civil rights, which said in part: "the APA supports and urges the enactment of civil rights legislation at the local, state, and federal level that would offer homo-

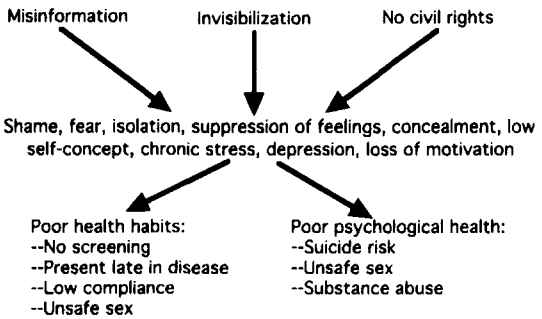

Fig. 2. How homophobia poses a public health hazard.

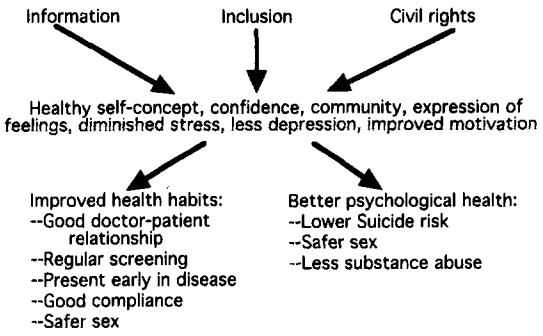

Fig. 3. How reduced homophobia improves public health.

sexual citizens the same protection now guaranteed to others on the basis of race, creed, color, etc. Further the APA supports and urges the repeal of all discriminatory legislation singling out homosexual acts by consenting adults in private" (106). In 1992, the American Medical Women's Association (AMWA) passed, without opposition, a policy statement urging "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" (107). The American Medical Association (AMA) voted to include the words "sexual orientation" in its nondiscrimination statement in 1993, and in 1994 issued a Policy Statement committing itself "to taking a leadership role in educating physicians on the current state of research and knowledge of homosexuality . . . which should start in medical school [and] must be part of continuing medical education" (1).

Organized curriculum in medical school and residency training programs must incorporate a genuine literature-based teaching of orientation diversity. For example, the Temple University School of Medicine now provides its medical students and the medical community with a resource guide which addresses many of the issues described above (108). The American Psychiatric Association has sponsored "A curriculum for learning in psychiatric residencies about homosexuality, gay men, and lesbians," which describes educational objectives, learning experiences, and implementation strategies for sound clinical practice (64). There are several medical and psychiatric textbooks which discuss homosexuality. Many present outdated or even prejudicial and incorrect information. Only one textbook to date aimed at medical and mental health providers and trainees is devoted to presenting clear and scientifically validated information about homosexuality and the care of gay men, lesbians, and bisexuals (109).

Research

Efforts to obtain specific morbidity information about gay men and lesbians are underway. The 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 out of fear that respondents would withdraw from the study. However, after a review of information on recruitment and retention of lesbians in health trials (104) and piloting questions about orientation to test groups, the National Institutes of Health agreed to include a sexual orientation question. After significant negotiation, the investigators of the Nurses' Health Study have also decided to stratify their ongoing longitudinal study by sexual orientation to determine morbidity differences. Similarly, investigators in the longitudinal studies of men's health could stratify their data by orientation, looking at variability in myocardial infarction rates and distribution of cancer and cardiac disease risk factors.

The Department of Health and Human Services has already sponsored a conference on recruitment and retention of subpopulations of women, including lesbians, in research trials. Members of the Gay and Lesbian Medical Association have been calling for a National Institutes of Health-sponsored Consensus Conference on Health and Homosexuality. The requirements for this type of multidisciplinary consensus conference, that the health problem be (a) significant, (b) controversial, and (c) have sufficient data available to resolve the controversies, have been met. Only through such a recognized and credible source as the National Institutes of Health can significant information be presented, analyzed, and disseminated nationally to create the necessary changes so broadly needed in medicine and in society. Currently there is no plan for such a conference.

Practice Guidelines

Physicians can do much to reduce homophobia within their individual practices. The need for a trusting, supportive, and open doctor–patient relationship is critical in compiling a thorough and accurate medical history of each patient. Physicians should routinely inquire about sexual *behavior,* and not worry as much about labeling the sexual orientation, and receive the information with neutrality. When discussing sexual behavior, each patient should be asked whether they are sexual with men, women, both, or neither. Physicians should never make assumptions about sexual behavior or orientation based on the gender-atypical behavior or presentation of individuals, such as effeminate men and masculine women. All patients benefit from the nonbiased demonstration of the health care provider's positive attitude toward issues of presentation, orientation, and behavior. Though a prerequsite, simply *having* a nonjudgmental, nonhomophobic attitude is not enough; the responsible practitioner must *convey* a non-judgmental attitude to all patients.

Using generic terms such as "partner" or "spouse" rather than "boyfriend" or "girlfriend" for *any* patient will encourage trust in the physician by removing assumptions. Registration forms and questionnaires that assume heterosexuality with such terms as "married" or "divorced" should be revised to include "living together" or "domestic partner," in order to avoid making invisible the gay or lesbian patient. Such changes would underline the physician's accepting attitude to both heterosexual and homosexual patients. It would also be useful for providers to become familiar with the actual words and terms commonly used in describing sexual behaviors. Comfortable use of these terms will facilitate the health history by enhancing clarity of communication.

If the lesbian or gay patient is partnered, the provider should also, with the identified patient's permission, welcome the patient's partner and routinely encourage couples to consider obtaining a medical power of attorney document—especially prior to any elective surgery or obstetrical delivery. Just as for married individuals, the physician should provide support for the stability of the patient's relationship. The physician should have the skills to counsel on gay-related anxieties, and safeguard against referrals to homophobic colleagues. Psychotherapy may be necessary to help gay or lesbian individuals to become more comfortable with their orientation and to deal with society's prejudicial response.

Patient information brochures–especially those dealing with aspects of human sexuality—need to include information about homosexuality. Educational pamphlets in offices of gynecologists', pediatricians, and family practitioners can and should provide life-affirming information to youth and provide an educational source for parents (32). The Committee on Adolescence of the American Academy of Pediatrics acknowledges in its position paper that gay and lesbian youth 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" (32). Pediatricians and family practitioners can begin to address sexuality issues among youth at the time these concerns develop (31, 110). Physician-supported educational programs initially directed toward educators, clergy, and professionals, and later toward the youth themselves, can dispel misinformation about homosexuality (78, 111).

Just as homosexuality cannot be considered abnormal, gender-atypical behavior in youth should not be viewed as abnormal (112). Negative parental and peer attitudes observed at an early age can alienate and isolate such children, whether they later identify as heterosexual or homosexual adults (112). With ample evidence as to the genetic and biological components in the formation of sexual orientations, most clinicians recognize that sexual orientation cannot be changed by clinical intervention, but is expressed in different ways in the life cycle; if the maturing individual who will be gay or lesbian but has not yet recognized this differing orientation can experience a sense of acceptance and support about being different and expressing those different sexual and affectional needs, such an individual will eventually become aware of his or her innate feelings, become more comfortable acknowledging them, and eventually safely act on them (32). School-based family counseling programs and school support programs for gender-atypical and gay or lesbian youth may help frightened youth come to grips with their fears about their sexual identity and sexual orientation and begin to confront their own internalized homophobia, as their self-concept strengthens (25, 113, 114). Such proposals are already being implemented: the state of Massachusetts requires schools to write poli-

cies that protect students from harassment, violence, and discrimination because of sexual orientation, to train teachers in crisis intervention and violence prevention, to create school-based support groups for gay or lesbian as well as heterosexual students, to provide information in the school libraries, and to utilize curricula which promote understanding of gay and lesbian issues (115).

With physician support and education, parents and teachers can provide a more supportive atmosphere at home and at school where taunting about sexual orientation or gender identification is forbidden. Parents' acceptance and love is the most powerful source of support for children (38, 40). All children would benefit from hearing their parents say: "No matter whom you love, I will love you."

The American Academy of Pediatrics (AAP) recommends psychotherapy for 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 (32). The AAP also recognizes that families may experience some stress and need information while supporting an individual's newly expressed orientation, and recommends that families contact organizations such as Parents and Friends of Lesbians and Gays (P/FLAG) or seek therapy (32).

Physician Leadership

Physicians can become aware of the range of medical problems that result from homophobia when they access unbiased scientific information. Open physician support of legislation which would make discrimination against gay men and lesbians illegal, and which requires inclusion of homophobic violence as a hate crime, could significantly reduce the health hazards faced by lesbians and gay men. Many universities, corporations, cities, states, and federal agencies have this awareness and include sexual orientation in their nondiscrimination policy statements. Some of these also provide domestic partner medical insurance. Currently, the U.S. Departments of Justice, the Interior, Transportation, and Health and Human Services include sexual orientation in their nondiscrimination policies, but do not provide benefits. Though some physicians may hesitate to voice supportive and accepting opinions about homosexuality, a principled stand would result in improved physical and psychological health of some 11 million citizens. As was noted in the 1992 Report of the Subcommittee on Faculty and Staff Benefits regarding domestic partner benefits at Stanford University, "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" (116).

CONCLUSION

Physicians, regardless of their sexual orientation or political or religious affiliation, must provide the highest standard of care to all patients by discarding those views which science does not validate. Physicians have a responsibility to examine their attitudes about homosexuality and reconcile their own views that are not consistent with fact. Physicians then have a unique opportunity to influence others in our society to align their attitudes with this objective information. Supporting the research-based education of adults and children about the diversity of sexual orientation will reduce the pervasive, unmerited disdain for homosexuals. It will also help to improve and maintain lesbian and gay individuals' self-concept and self-respect. Physician support for legislation that proscribes discrimination and provides legal recognition for the unions of lesbian and gay families will restore legal, societal, financial, and health care equity to this marginalized population. The resultant increased visibility of lesbians and gays will increase their familiarity in the community and promote greater understanding and acceptance (113).

Improved access to health care, increased integration into family and society, and heightened life-satisfaction, productivity, and health will result when homophobia is recognized and confronted as the major health hazard it poses to gay and lesbian individuals.

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