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National Lesbian Health Care Survey: Implications for Mental Health Care

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This article presents demographic, lifestyle, and mental health information about 1,925 lesbians from all 50 states who participated as respondents in the National Lesbian Health Care Survey (1984–1985), the most comprehensive study on U.S. lesbians to date. Over half the sample had had thoughts about suicide at some time, and 18% had attempted suicide. Thirty-seven percent had been physically abused as a child or adult, 32% had been raped or sexually attacked, and 19% had been involved in incestuous relationships while growing up. Almost one third used tobacco on a daily basis, and about 30% drank alcohol more than once a week, 6% daily. About three fourths had received counseling at some time, and half had done so for reasons of sadness and depression. Lesbians in the survey also were socially connected and had a variety of social supports, mostly within the lesbian community. However, few had come out to all family members and coworkers. Level of openness about lesbianism was associated with less fear of exposure and with more choices about mental health counseling.

Until very recently, homosexuality in itself was considered to be a form of mental illness, and although mental health professionals no longer consider this to be true, research on the mental health of lesbians is limited. Most of the literature on lesbian mental health has been theoretical in nature, and research studies have been small in scale. For example, several authors have written about societal factors that may place lesbians and gay men at risk for suicide (e.g., Saunders & Valente, 1987), particularly lesbian and gay adolescents (Kourany, 1987). Using a sample of 27 men and 142 women with anorexia and bulimia, Herzog, Norman, Gordon, and Pepose (1984) found gay men (but not lesbians) to predominate among those with eating disorders. There has been some research on battering within lesbian relationships (e.g., Lobel, 1986), but virtually none on other forms of violence against women, such as physical abuse, rape, and incest.

One exception to the paucity of research on lesbian mental health has been alcohol abuse. In the 1970s, Fifield (1975) studied alcohol use among people who frequented gay bars. The lesbians and gay men in her survey consumed an average of six drinks per bar visit and went to bars an average of 19 times a month. Furthermore, Fifield found her sample of bar users to be relatively isolated from most other lesbian and gay community events, so that the gay bar took on an important social function. Studies such as this one resulted in several theoretical articles (e.g., Glaus, 1988) that discussed reasons why lesbians were at risk for alcohol abuse. Recently, McKirnan and Peterson (1989a, 1989b) surveyed 748 lesbians and 2,652 gay men, and compared the data on their alcohol and drug use with data from the general population (Clark & Midanik, 1982). The results indicated that a higher percentage of lesbians and gay men used alcohol, marijuana, and cocaine than did the general population. Lesbians and gay men did not have higher rates of heavy use of alcohol than the general population, but they did have more alcohol-related problems. In the general population, alcohol use declines with age, and this was not the case for lesbians and gay men (McKirnan & Peterson, 1989a).

Recognition of the need for normative information about the health and mental health care needs of lesbians served as the primary purpose of the National Lesbian Health Care Survey. Although it was assumed that lesbians must have health and mental health care needs, it was not known whether or not these needs were different from those of heterosexual women. The study was designed to explore the community and social life of lesbians, including their mental health and mental health needs. No previous research has been large enough in scale and comprehensive enough in scope to permit development of a broad definition of lesbian mental health which is not reactive to the concept of lesbians as deviant. As a result, information which could provide a basis for the development of sensitive and effective services to lesbians has not been widely available.

Furthermore, the present study wanted to examine the prevalence of social supports for lesbians. Public attitudes about lesbians are still negative, and lesbians are openly barred from participation in the community institutions (e.g., organized religion) that sustain heterosexuals. Finally, "outness" is a critical concept for understanding lesbians, as it refers to an aspect of daily reality that has no counterpart in the lives of heterosexu-

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als. It is within this dimension of lesbian life that social marginality can best be understood, for although some people see lesbians as another minority group, many more still view lesbians as profoundly different and disgusting. Thus, lesbians risk rejection whenever they disclose their sexual orientation ("come out") to heterosexuals. To live a two-world existence requires a great deal of psychic energy and is thereby inherently stressful. A number of researchers have documented the psychological benefits which accompany being out (e.g., Lewis, 1984). Although being out may offer an opportunity for personal integration, coming out presents lesbians with difficult challenges. Other studies of lesbians have documented the anticipated and actual experiences of discrimination which have happened to many lesbians who have either come out or been found out (e.g., Gartrell, 1981). In addition, lesbians who are members of ethnic minority groups may experience racism to an even greater degree than heterosexism (Mays & Cochran, 1986).

The importance of disclosure of lesbian sexual orientation to health and mental health professionals has been emphasized (Dardick & Grady, 1980), and a linkage has been presumed between being out and access to needed health and mental health information, as well as increased emotional and psychological health (Bradford, 1986). Clearly, understanding the role of outness in the lives of lesbians has important implications for mental health, and so, in this study, we measured outness to correlate it with measures of mental health.

We focused on six mental health components (for the results of physical health and health care measures, see Ryan & Bradford, 1988, 1993): (a) current stressors, (b) depression and anxiety, (c) suicide ideation and attempts, (d) physical and sexual abuse, (e) alcohol and drug abuse, and (f) eating disorders. We examined community and social supports and outness to assess the role of these variables in the lives of lesbians and their impact on mental health. Finally, we assessed use of professional mental health services.

Method

Subjects

Four thousand and six hundred surveys were distributed and completed surveys were received from 1,925 lesbians from all 50 U.S. states; this represents a response rate of 42%. Because the survey was titled National Lesbian Health Care Survey, only two participants were exclusively heterosexual (7 on the item about sexual orientation); the majority were lesbian (94.5% circled 1–3 on this item). Table 1 displays demographic data of respondents and also compares demographic characteristics of the sample with the 1980 U.S. census data for women (U.S. Department of Commerce, 1984). Eighty-eight percent of the sample were White, 6% were African American, and 4% were Latina. Very small numbers of Asian Americans and Native Americans were also included. The age range of the sample was 17–80 years; 80% were between the ages of 25 and 44. A high percentage (69%) had graduated from college. Most respondents worked full-time, in professional or managerial positions. Nevertheless, all but 12% earned less than $30,000 per year, and 64% earned less than $20,000. In comparison with 1980 U.S. census data, the lesbian sample was younger, more educated, and employed in more professional and managerial occupations than the general female population. The percentage of White, Asian-American, Latina, and Native-American lesbians was roughly similar to that in the census data, but the lesbian sample had only half the percentage of African Americans, compared with those in the census data.

Sixty percent of the sample were involved in a primary relationship with another woman. Less than 20% were single and uninvolved. Two percent were legally married to men at the time of the survey. Since marriage between lesbians is not legal in any U.S. state, direct comparisons between marital status could not be made. However, the percentage of lesbians in primary relationships was similar to the percentage of married women in the census data.

Sixty-six percent of the sample reported no current religious affiliation, although all but 8% had been raised in connection to a religious community (75% had been raised Catholic or Protestant). Eight percent of the sample was Catholic, 11.6% Protestant, 7.4% Jewish, 2.5% participated in gay churches, and 1% or less participated in other religions (Islamic, pagan/witch, Unitarian, Buddhist, Christian Science, Quaker, Unity, Mennonite, or other). Only a few participants lived in the same town or city where they had been born, and most lived in metropolitan areas. Overall, there had been a migration from the Northeast, where 31% were born and 25% lived at the time of the study, to the Pacific states, where 10% had been born and 19% lived at the time of the study. The remainder of participants were living in the North Central states (21%), South (28%), and Mountain states (7%). At the time of the survey, nine respondents were in prison, 19 were living in a shelter, and two on an Indian reservation.

Measures

Questions for the survey were formulated from the existing knowledge, experience, and perceptions of health and mental health care workers who had direct contact with lesbians, as well as informed consumers. The survey was constructed from a different conceptual framework than had traditionally been applied to the discussion of lesbianism. Within this framework is a core assumption of normalcy, of difference rather than deviance, of diversity rather than social conformity. The connection between living on the margins of society and the impact of this upon daily life and an adequate sense of psychosocial security warrants exploration, and the survey was designed to examine how lesbians live in relationship to this tension. Because of its broad agenda, incorporating both social and personal information about lesbians, the survey could provide implications for mental health treatment and planning.

Preliminary versions of the survey were pretested in locations throughout the United States. In addition to mailing early versions to contacts in various cities, the second author travelled to several major cities to conduct focus group meetings related to survey design and distribution. One focus was to keep the language free from jargon and understandable to people of diverse educational levels. Efforts were made to use language that would reflect the terminology of lesbians, including subgroups of lesbians in different regions of the country. Strategies were suggested for distributing surveys to women in prisons and shelters, in the military, in rural areas, and to those who were so closeted as to be practically unreachable through organizational contacts. About 100 people participated in constructing the survey, through direct participation or written feedback.

The resulting survey was a 10-page measure consisting of the following categories: (1) demographic information; (2) participation in community activities and social life; (3) outness; (4) current concerns and worries; (5) depression, anxiety, and general mental health; (6) suicide; (7) physical and sexual abuse; (8) anti-gay discrimination; (9) impact of AIDS; (10) substance use; (11) eating disorders; and (12) counseling. For exact wording of items and a copy of the questionnaire, see Bradford and Ryan (1987, 1988), or contact the authors directly.

Table 1
Demographic Characteristics of Lesbian Sample Compared With U.S. Census Data for Women

Characteristic	Unweighted percentage of total (N = 1,917)	Weighted percentage of total (N = 1,917)	U.S. Census data on the adult female in 1980[a]
Age			
17–24	8.8	8.9	12.5
25–34	48.0	48.4	16.6
35–44	32.2	32.5	12.0
45–54	7.0	7.1	9.7
55 or older	3.1	3.1	23.4
Education			
Less than high school	2.4	2.5	29.1
High school	9.5	9.5	37.9
Vocational training	2.5	2.5	—
Some college	16.3	16.4	15.3
College	26.0	26.2	—
Advanced studies	11.6	11.6	17.7
Advanced degree	31.2	31.3	—
Type of work			
Professional	39.5	53.3	25.2
Manager/official	14.8	19.9	—
Clerical	6.9	9.3	42.5
Craftsperson	3.8	5.1	2.3
Operative/unskilled worker	2.9	4.1	9.7
Farmer	0.1	0.1	—
Service worker	5.2	7.0	16.8
Private household worker	0.8	1.1	2.1
Worker status			
Employed full time	66.6	—	—
Employed part time	18.5	—	—
Student	21.6	—	—
Unemployed	9.0	—	—
Personal income			
$9,999 or less	27.6	27.9	—
$10,000–$19,999	35.8	36.2	—
$20,000–$29,999	23.5	23.8	—
$30,000–$39,999	7.9	8.0	—
$40,000 or more	4.1	4.2	—
Marital status			
Married	—	—	61.9
Single and never married	—	—	17.6
Divorced	—	—	
Separated	—	—	8.0
Widowed	—	—	12.5
Relationship status			
Primary relationship with a woman	59.9	—	—
Single, somewhat involved with a woman	17.5	—	—
Single and uninvolved	19.1	—	—
Living with a male lover	0.4	—	—
Legally married to a man	2.2	—	—
Number of people in household			
1	20.9	22.7	23.2
2	45.7	49.7	31.7
3	13.0	14.1	17.5
4–5	8.7	9.4	22.7
6 or more	3.7	4.0	4.9
Race/ethnicity			
Asian/Pacific Islander	0.8	0.8	1.2
Aleut, Eskimo, or American Indian	0.6	0.6	0.6
Latina	4.2	4.2	6.4
African American (non-Hispanic)	5.6	5.6	11.7
White (non-Hispanic)	88.2	88.5	83.1
Other	0.3	0.3	3.0
Religious affiliation			
None	64.5	66.2	—
Protestant	11.2	11.5	—
Catholic	7.8	8.0	—
Islamic	0.2	0.2	—
Jewish	7.3	7.4	—
Pagan, witch	0.8	0.8	—
Unitarian	1.0	1.0	—
Buddhist	0.5	0.5	—
Gay church	2.4	2.5	—
Christian Science	0.2	0.2	—
Quaker	0.5	0.5	—
Mormon	0.2	0.2	—
Unity	0.3	0.3	—
Mennonite	0.2	0.2	—
Other Christian	0.6	0.6	—

Note. From *The National Lesbian Health Care Survey: Final Report* (pp. 11–13) by J. Bradford and C. Ryan, 1988, Washington, DC: National Lesbian and Gay Health Foundation. Copyright 1988 by J. Bradford and C. Ryan. Reprinted by permission. Dashes indicate that comparable data were not available.
[a] Data in this column were taken from the *1984 Statistical Abstract of the United States* (104th edition), published by the U.S. Department of Commerce.

Procedure

Initially, the survey was targetted for distribution in 10 major cities, but as requests for copies increased, surveys were sent to contacts all over the United States. Copies were distributed during 1984–1985 to lesbian and gay health and mental health organizations and practitioners across the country. A number of professional organizations publicized the study. For example, the National Coalition of Black Gays and Lesbians sponsored a mailing to its entire membership, endorsing the study and recommending that members participate. Some local agencies and government agencies provided staff support for distribution of surveys.

The survey was also distributed by means of personal networks, with specific instructions to reach as diverse a group as possible. 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 les-

Table 2
Percentages of Participants With Current Mental Health Concerns

Demographic	Money	Family	Job	Illness	Responsibility	Lover
Age (years)						
17–24	69	40	24	12	2	28
25–34	62	24	29	14	23	28
35–44	52	20	29	18	23	25
45–54	50	14	28	24	24	29
55+	15	5	7	14	8	19
Race/ethnicity						
Latina	57	20	28	1	21	35
African American	79	16	28	21	19	32
White	56	23	27	16	23	26

Note. From *The National Lesbian Health Care Survey: Final Report* (p. 47) by J. Bradford and C. Ryan, 1988, Washington, DC: National Lesbian and Gay Health Foundation. Copyright 1988 by J. Bradford and C. Ryan. Adapted by permission.

bian and gay community events. Since it was impossible to devise a strategy for reaching a random sample of a hidden population, survey respondents included lesbians who could be reached and who were willing to participate in the project. Results of the survey, therefore, cannot be generalized to represent all lesbians in the United States.

Results

Current Concerns and Worries

Current concerns. Participants were asked if any of 12 items were currently bothering them. The most common concern was money, identified by over half the sample (57%).[1] Concerns listed by at least one fifth of respondents included job or school worries (31%), problems with lover (27%), too much work responsibility (23%), and problems with family (21%). Only 12% of respondents indicated that they were concerned about people knowing that they were lesbian. However, few were out to all family members or coworkers. Other concerns were job dissatisfaction (18%), worry about illness or death (16%), legal problems (9%), not being able to find a job (7%), problems with children (7%), feeling unsafe (7%), problems with friends (2%), loneliness (2%), basic needs (1%), stress (1%), and worry about the future (1%).

Table 2 displays data for the seven most common concerns separately by age, and race or ethnicity. Money was the most common concern for lesbians in all age groups, except for those aged 55 or older, who were most concerned about problems with their lovers. More African-American lesbians were concerned with money than were White or Latina lesbians. A much smaller percentage of Latina women (1%) were concerned about illness than were African American (21%) or White (16%) women.

Inability to accomplish ordinary tasks because of worry. In response to the question "In the past year, how often were you so worried or nervous that you could not do necessary things?" more than half the sample reported that during the past year they "often" (18%) or "sometimes" (38%) couldn't get things done because of nervousness or worry. Only 12% of the sample reported that they had "never" been too nervous to accomplish the things they had to do during the past year. Older women reported more frequent worrying. Forty-five percent of those aged 55 or older reported frequent worrying, compared with 13% of those aged 17–24 and 23% of those aged 45–55.

Depression and Anxiety

Over one third of the sample reported that they had experienced a "long depression or sadness" at some point in the past, 11% were experiencing depression currently, and 11% were currently receiving treatment for depression. Similar percentages for "constant anxiety or fear" were 11%, 7%, and 7%, respectively. Table 3 contains percentages of depression, anxiety, and "other mental health problems" by age and race or ethnicity. Depression and anxiety were least likely to be reported by the oldest group of lesbians.

Suicide

Data on the presence of suicidal thoughts and suicide attempts are presented in Table 4. Less than half the sample (43%) indicated that they "never" had thoughts about suicide. Thirty-five percent had such thoughts only rarely, 19% had them sometimes, and 2% often. Women aged 55 or older were most likely to report never having thoughts about suicide (60%).

Eighteen percent of the sample had attempted suicide. Older women were less likely to have attempted suicide. African-American (27%) and Latina (28%) women were more likely to have attempted suicide than were White women (16%).

The most common means of attempted suicide was drugs, which represented 63% of all attempts. Ten percent of suicide attempts involved the use of a razor blade, 4% alcohol, 3% a gun, 3% a knife, 2% gas, 4% a car, and 10% involved other means.

Physical and Sexual Abuse

Physical abuse. Table 5 displays the frequency of physical abuse by age and race or ethnicity. Thirty-seven percent of the

[1] All results, unless otherwise specified, refer to frequencies and percentages. Thus, statements such as "most" or "the highest percentage" should not be interpreted to mean statistically significant differences.

Table 3
Percentages of Participants With Depression, Anxiety, and Other Mental Health Problems

Demographic	In the past			At present			Current treatment		
	Dep	Anx	Other	Dep	Anx	Other	Dep	Anx	Other
Age (years)									
17–24	31	17	10	14	9	6	12	7	6
25–34	38	20	13	11	7	7	10	7	7
35–44	40	19	12	13	7	8	13	8	8
45–54	33	17	11	10	4	8	11	4	5
55+	24	8	8	4	1	7	3	3	8
Race/ethnicity									
Latina	36	23	10	14	9	6	11	6	5
African American	35	18	9	11	10	7	14	12	4
White	37	18	12	11	7	8	11	7	8
Total	37	19	12	11	7	8	11	7	7

Note. From *The National Lesbian Health Care Survey: Final Report* (pp. 20–22) by J. Bradford and C. Ryan, 1988, Washington, DC: National Lesbian and Gay Health Foundation. Copyright 1988 by J. Bradford and C. Ryan. Adapted by permission. Dep = depression; Anx = anxiety.

sample had been harshly beaten or physically abused at least once. Twenty-four percent had been physically abused while growing up, 16% as adults, and 6% as both children and adults. In all, 701 of the 1,925 women stated that they had been harshly beaten or physically abused. White women were the least often abused, both as children and adults. Half of Latina and African-American women had been abused at some time in their lives, compared with one third of White women. One third of Latina and African-American women had been abused as children, compared with one fifth of White women.

Perpetrators of physical abuse. Seventy percent of those who experienced being physically abused while growing up reported that the perpetrator was a male relative, and 45% mentioned a female relative. Seventeen percent were physically abused by a known man who was not a relative, 9% by a male stranger, 4% by a known woman, and 1% by a female stranger. More than half of women who had been abused as adults were abused by their lover (53%; gender unspecified) and 27% had been abused by their husbands. Other perpetrators of adult physical abuse were male relative (9%), female relative (3%), known male (14%), male stranger (26%), known female (13%), and female stranger (3%).

Sources of help after physical abuse. Respondents were asked where they had tried to get help after being physically abused. The largest number (29%) had contacted friends; smaller numbers had sought assistance from police (17%) or from a counselor (16%). Approximately half of those who contacted a friend or counselor stated that they definitely received

Table 4
Number and Percentage of Participants Who Had Suicidal Thoughts and Attempts

Demographic	Frequency of thoughts about suicide					Responses to the question, "Have you ever tried to kill yourself?"		
	Never	Rarely	Sometimes	Often	*n*	Yes	No	*n*
Age (years)								
17–24	41	32	25	2	167	24	76	167
25–34	42	37	10	2	913	17	83	908
35–44	44	37	17	3	613	18	82	614
45–54	47	32	19	1	134	13	87	135
55 or older	60	19	19	2	58	3	97	59
Race/ethnicity								
Latina	43	37	19	1	79	28	72	79
African American	39	36	22	3	102	27	73	106
White	44	35	19	2	1,681	16	84	1,677
Total	43	35	19	2	1,900	18	82	1,898

Note. From *The National Lesbian Health Care Survey: Final Report* (p. 50) by J. Bradford and C. Ryan, 1988, Washington, DC: National Lesbian and Gay Health Foundation. Copyright 1988 by J. Bradford and C. Ryan. Adapted by permission.

Table 5
Experiences With Physical and Sexual Abuse

	Ever		As child		As adult		Both		
Demographic	*n*	%	*n*	%	*n*	%	*n*	%	*N*
Physical abuse									
Age (years)									
17–24	49	29	38	23	15	9	7	4	169
25–34	337	36	220	24	133	14	56	6	921
35–44	235	38	160	26	113	18	51	8	618
45–54	54	40	27	20	28	21	5	4	135
55+	26	35	8	11	13	18	1	1	74
Race/ethnicity									
Latina	39	48	29	36	15	19	9	11	80
African American	52	48	38	36	22	21	11	10	107
White	595	35	372	22	261	15	97	6	1,691
Total	701	37	453	24	302	16	120	6	1,917
Rape and sexual abuse									
Age (years)									
17–24	83	50	54	32	16	10	4	2	169
25–34	377	41	195	21	151	16	43	5	921
35–44	255	41	108	18	105	17	25	4	618
45–54	53	39	30	22	18	13	4	3	135
55+	26	35	11	15	5	7	1	1	74
Race/ethnicity									
Latina	37	46	20	25	11	14	3	4	80
African American	55	51	35	33	18	17	4	4	107
White	681	40	331	20	260	15	68	4	1,691
Total	794	41	398	21	295	15	77	4	1,917

Note. From *The National Lesbian Health Care Survey: Final Report* (pp. 77, 80) by J. Bradford and C. Ryan, 1988, Washington, DC: National Lesbian and Gay Health Foundation. Copyright 1988 by J. Bradford and C. Ryan. Adapted by permission. All percentages were calculated using row *n*s.

help, whereas only 11% of those who contacted the police reported being definitely helped. The most dissatisfaction was reported for contacts with members of the clergy, the police, and private physicians. Although the small number of women who reported contacting a women's health center or women's healing circle may have produced a sampling bias, women who sought help from these groups overwhelmingly reported having received beneficial assistance.

Rape and sexual attack. Table 5 also indicates the frequency of rape and sexual attack by age and race or ethnicity. Forty-one percent of the sample (n = 794) reported that they had been raped or sexually attacked at least once in their lives, with more reporting that this had happened while they were growing up (21%) than during adulthood (15%). Four percent had been raped or sexually attacked both as children and as adults. A smaller percentage of White women (40%) than Latinas (46%) and African-American women (51%) reported having been raped or sexually abused, and this difference was particularly apparent during childhood. One third of African-American lesbians had been sexually abused as children, compared with one fifth of White and one fourth of Latina lesbians.

Perpetrators of sexual abuse. The overwhelming majority of lesbians reported that the perpetrator of sexual abuse was a man. For lesbians sexually abused as children, the perpetrators were male relatives (31%), other known men (45%), and male strangers (33%). Only 1% of lesbians indicated that perpetrators were either female relatives, known women, or female strangers, respectively. For lesbians sexually abused as adults, the perpetrators were lovers (10%; gender unspecified), husbands (8%), male relatives (5%), other known men (42%), and male strangers (47%), with no more than 1% of lesbians sexually abused by female relatives, strangers, or known women, respectively.

Sources of help after rape or sexual attack. Although 794 women reported having been raped or sexually attacked at some point in their lives, only 35% stated that they had sought assistance afterward. Friends were sought most often (19%), followed by police (12%) and counselors (10%). The highest rates of satisfaction were reported by those who sought help from special groups organized to help women (women's healing circles, 75%; women's health centers, 56%; and rape crisis centers, 57%), from friends (63%), and from counselors (59%). Respondents were most dissatisfied with assistance offered by members of the clergy, private doctors, emergency rooms, and the police.

Incest. Of the 1,779 in the sample who responded to the question about having sex with one or more relatives while growing up, 19% (n = 336) reported that this had happened to them. White lesbians had lower rates of incest (16%) than did Latina (29%) or Black (31%) lesbians. The frequency of incest did not vary much across age groups; 18% of lesbians aged 17–24 and 25–34, 17% of lesbians aged 35–44, 18% of lesbians aged 45–54, and 14% of lesbians aged 55 or older reported incestuous experiences while growing up.

Perpetrators of incest. The most common perpetrator of incest were brothers (34%), followed by fathers (28%), uncles

(27%), cousins (18%), stepfathers (9%), grandfathers (8%), mothers (3%), sisters (3%), and aunts (1%). About one half of lesbians who had experienced incest had told someone about it. The percentages of lesbians who had told someone about the incest were 44% when the perpetrator was their father; 48% when the perpetrator was their mother; 45%, grandfather; 32%, uncle; 60%, aunt; 41%, brother; 40%, sister; 48%, stepfather; and 30%, cousin.

Experiences With Discrimination

Respondents were asked if specific discrimination had happened to them because they were lesbians. Over half the sample (52%) had been verbally attacked for being lesbian, and another 4% thought that this might have happened. Eight percent had lost their jobs (another 5% weren't sure), 6% had been physically attacked (another 2% weren't sure), 4% had their health affected (another 4% weren't sure), and 1% had been discharged from the military, for being lesbian.

Impact of AIDS

Although these data were collected in 1984–1985, before AIDS was perceived to have a significant impact on the lesbian and gay communities, six out of ten lesbians in the sample reported that AIDS had affected their lives. Forty percent were worried about gay male friends while others reported increased awareness of the political implications of the epidemic and concern for those affected, expressing a range of emotions from anger to sadness.

One lesbian in the sample had AIDS. She and her lover lived in a Midwestern city at the time of the survey. She reported feelings of isolation from the community, lack of support for lesbians with AIDS, and fear of infecting her lover and son.

Alcohol and Drug Use

Respondents were asked to report on both the frequency of their alcohol and drug use and whether they were worried about their use of these substances. Data are presented in Table 6.

Tobacco. Thirty percent of the sample smoked cigarettes daily, and another 11% were occasional smokers; just over half (58%) reported that they never used tobacco. Twenty-six percent of the sample were worried about their use of tobacco. Middle-aged (36%) and older (38%) lesbians were more frequent daily smokers than younger lesbians. Higher percentages of African-American lesbians (49%) reported regular use of tobacco.

Alcohol. Almost one third of the sample reported regular use of alcohol: 6% drank every day and another 25% drank more than once a week. Eighty-three percent drank alcohol at least occasionally; 14% were worried about their use of alcohol. The percentages of those who drank daily were higher for older women (10% for those aged 45–54 and 21% among those 55 and older).

Other drugs. Nearly half the sample reported at least occasional use of marijuana; 53% stated that they never used this drug. Seven percent of the sample was worried about their marijuana use. Younger lesbians smoked marijuana more often than did older lesbians (e.g., 29% of lesbians aged 17–24 used marijuana less than once a month, compared with 13% of lesbians in the oldest age group), and higher percentages of African-American lesbians reported daily (11%) or more than weekly use (14%).

Nineteen percent of the sample had tried cocaine. One percent used it more than once a week, and another 2% more than once a month. Two percent were worried about their use of this drug. Eleven percent of the sample had used tranquilizers; only 1% reported daily use, and another 1% reported tranquilizer use more than once a week. One percent was worried about their use of tranquilizers. Among the very small number who used tranquilizers daily, most were 45 years old or older.

Almost no one in the sample reported regular use of amphetamines; of the few who did, most were between 17–24 years old. Higher percentages of younger women used amphetamines on occasion; only 78% of those aged 17–24 had never used this type of drug, compared with 90–98% of those in other age groups. No one in the sample reported regular use of heroin. However, a small number reported occasional use, typically less than once a month. Those who did use heroin were either Native American, Latina, or African American; no Whites in the sample reported use of heroin.

Eating Disorders

Within the sample, overeating was reported by a much larger percentage than was undereating or overeating and vomiting. Results are portrayed in Table 7. Two thirds of the sample indicated that they sometimes or often overate, and one third indicated that they sometimes or often underate, but only 4% indicated that they overate and then vomited. Undereating was most prevalent among younger and low-income women and least prevalent among older lesbians. Overeating followed by vomiting was low for all groups, but highest among African-American lesbians (10%).

Counseling

Sources of counseling. Nearly three fourths of the sample (73%) were in counseling or had received some form of mental health support from a professional mental health counselor at some time in the past. Included as professional mental health counselors were private counselors (63%), school counselors (14%), clinics (14%), hospitals (7%), and employee counselors (1%). In addition, 36% of the sample had received help with mental health problems from nonprofessionals, such as friends, support groups, and peer counselors. One third of the sample had sought help from both professionals and nonprofessionals in attempting to deal with mental health problems.

Demographics of lesbians who sought counseling. Table 8 presents information about counseling by demographic category. Age, education, income, religious affiliation, and race or ethnicity all seemed to have an effect on the likelihood of receiving mental health counseling. Women in the youngest (62%) and oldest (64%) age groups saw counselors less frequently than did women aged 25–34 (73%), 35–44 (76%), and 45–54 (75%).

Table 6
Frequency of Substance Abuse

Substance, age, and race/ethnicity	% Subjects who abuse substances					% Worried about their substance abuse
	Daily	>1/week	>1/month	<1/month	Never	
Substance use						
Tobacco	30	3	3	5	58	26
Alcohol	6	25	30	23	17	14
Marijuana	5	9	8	25	53	7
Cocaine	—	1	2	16	81	2
Tranquilizers	1	1	2	8	89	1
Stimulants	—	—	2	6	92	—
Heroin	0	0	—	—	99	—
Use of tobacco (n = 1,791)						
Total	30	3	3	5	58	
Age (years)						
17–24	32	4	4	5	54	
25–34	28	3	3	6	59	
35–44	30	4	2	5	59	
45–54	36	1	2	2	60	
55 or older	38	0	0	2	60	
Race/ethnicity						
Latina	31	8	1	8	51	
African American	49	4	3	4	39	
White	29	3	3	5	60	
Use of alcohol (n = 1,852)						
Total	6	25	30	23	17	
Age (years)						
17–24	3	29	40	17	11	
25–34	3	25	31	24	16	
35–44	7	24	26	24	18	
45–54	10	24	24	25	17	
55 or older	21	19	19	23	18	
Race/ethnicity						
Latina	5	33	28	20	13	
African American	3	25	30	19	23	
White	6	25	29	24	16	

Note. From *The National Lesbian Health Care Survey: Final Report* (pp. 86, 89) by J. Bradford and C. Ryan, 1988, Washington, DC: National Lesbian and Gay Health Foundation. Copyright 1988 by J. Bradford and C. Ryan. Adapted by permission. Dashes indicate that comparable data were not available.

Eighty percent of women with advanced degrees saw counselors, compared with 67% of women with less than a high school degree, but this trend was not apparent with regard to nonprofessional counseling. Higher percentages of Jewish women (85%) and those who identified themselves as Unitarian (84%) or pagan or witch (87%) had received professional counseling than had those of other religious groups, and the same was true of nonprofessional counseling (40%, 53%, and 47% for these three religious groups, respectively). Higher percentages of White (74%) and Latina (61%) lesbians had received professional counseling than African-American lesbians (61%), and White lesbians had used more nonprofessional help (37%) than had African-American (28%) or Latina (27%) lesbians.

Reasons for counseling. Among those who had sought counseling (N = 1,442), half the sample (50%) reported that the most common reason for seeking counseling was feeling sad or depressed. Lesbians had also sought help for other emotional problems: 31% for feeling anxious or scared and 21% for loneliness. Many lesbians sought counseling because of problems in personal relationships: 44% because of problems with lovers, 34% for problems with family, and 10% for problems with friends. Other reasons mentioned were personal growth issues (30%), being gay (21%), alcohol and drugs (16%), upset at work (11%), problems due to racism (3%), and loss of significant other (1%).

Length and frequency of counseling. Most lesbians who had sought counseling had done so for 1 year or less (49%), 18% for 1–2 years, 11% for 2–3 years, 7% for 3–4 years, and 14% for over 4 years. Thirty-seven percent of lesbians who had sought counseling had seen one counselor, 26% had seen two counselors, 18% had seen three, and 22% four or more.

Reasons for not seeking counseling. Respondents were also asked to indicate their reasons for not seeking counseling, if they had thought about it but decided not to go. Twenty-one percent

Table 7
Frequency of Eating Disorders

	% Subjects who:					
	Overeat (n = 1,841)		Undereat (n = 1,517)		Overeat then vomit (n = 1,383)	
Demographic	Never/ rarely	Sometimes/ often	Never/ rarely	Sometimes/ often	Never/ rarely	Sometimes/ often
Age (years)						
17–24	36	64	61	39	96	4
25–34	31	69	63	37	96	4
35–44	33	67	72	28	97	3
45–54	30	70	76	24	99	1
55 or older	34	66	76	24	97	3
Race/ethnicity						
Latina	29	71	63	38	94	6
African American	36	64	52	47	90	10
White	32	68	68	32	97	3
Total	32	68	67	33	96	4

Note. From *The National Lesbian Health Care Survey: Final Report* (p. 94) by J. Bradford and C. Ryan, 1988, Washington, DC: National Lesbian and Gay Health Foundation. Copyright 1988 by J. Bradford and C. Ryan. Adapted by permission.

of the sample (N = 402) responded to this question. The most frequently cited reason was believing there was no need (30%); another 23% had been putting off seeking help. Other reasons for not seeking counseling were not knowing where to go (11%), finances (9%), counselors can't help (8%), don't like the idea of counseling (6%), fear of coming out (3%), and other (8%).

Demographic characteristics of counselors. Respondents were asked about their preferences about the gender, race, and sexual orientation of counselors. Respondents were most concerned about the gender of counselors; 89% preferred to see a woman, and less than 1% preferred to see a man. Only 10% did not care about the gender of their counselor. Gender mattered least to younger women. Sexual orientation was less important. Sixty-six preferred to see a counselor who was lesbian or gay, 33% didn't care, and only 1% preferred to see a heterosexual counselor. Older lesbians, White lesbians, and those with higher incomes were least concerned about the sexual orientation of the counselor. Ethnicity mattered least of all. Seventy-three percent of lesbians indicated no preference for a counselor of the same or a different ethnic background, and 27% preferred a counselor of their ethnic background. Thirty-three percent of Latina lesbians, 31% of African-American lesbians, and 27% of White lesbians preferred a counselor of their ethnic background.

Community and Social Life

Living arrangements. Forty-nine percent of lesbians were living with a lover at the time of the survey, 24% were living alone, and 20% were living with a roommate or friend. Small percentages of lesbians were living with their children (9%), other people's children (5%), their parents (3%), their husband (1%), or with other relatives (2%).

Community and neighborhood activities. Lesbians were most likely to participate in lesbian and gay rights groups (38%), women's support groups (34%), social groups (33%), and women's rights groups (30%). Lesbians also belonged to union, trade, or professional groups (26%), health centers or clubs (24%), other political groups (23%), women's spirituality groups (18%), religious organizations (16%), and other support groups (14%). Smaller numbers of lesbians belonged to neighborhood associations (11%), other minority rights groups (10%), groups for their children (7%), women's martial arts groups (4%), and self-help groups (4%).

Availability of lesbian activities. Seventy-six percent of lesbians lived in a community where there was a lesbian counselor or therapist. Lesbians were also likely to state that their community had lesbian support groups (70%), lesbian cultural events (70%), lesbian sports teams (68%), a lesbian bar or nightclub (67%), lesbian or gay religious groups (66%), lesbian or feminist bookstores (60%), lesbian hotline or information center (55%), and lesbian social clubs (51%). Less than half of lesbians had access to lesbian health care centers (39%) or lesbian healing circles (25%) in their community. Only 18% of lesbians lived in communities in which there were no available lesbian activities. Of those who lived in communities without lesbian activities, 50% lived within 50 miles and 22% lived within 100 miles of communities with lesbian activities.

Frequency of attendance at lesbian-only events. Most of the sample attended lesbian-only events at least several times a year; only 2% never did and only 5% attended such events less than once a year. Nearly two thirds attended lesbian events once or twice a month (38%) or at least once a week (23%). Older lesbians attended these events less frequently than did younger lesbians; 8% of those aged 55 or older never went to lesbian-only events. More highly educated lesbians attended these events more often; only 1–2% of those who had been to college never

Table 8
Percentage of Subjects Who Make Use of Counseling

Demographic	Professional No	Professional Yes	Non-professional No	Non-professional Yes	Both No	Both Yes	No. of cases
Total	27	73	64	36	67	33	1,917
Age (years)							
17–24	38	62	69	31	72	28	169
25–34	27	73	61	39	65	35	921
35–44	24	76	64	36	67	33	618
45–54	25	75	69	31	73	27	135
55 or older	36	64	72	28	72	28	74
Race/ethnicity							
Latina	30	70	72	27	75	25	80
African American	39	61	72	28	77	23	107
White	26	74	63	37	66	34	1,691
Education							
Less than high school	33	67	72	28	74	26	46
High school	37	63	69	31	72	28	182
Vocational training	27	73	54	46	56	44	48
Some college	29	71	59	41	64	36	313
College	31	69	63	37	67	33	499
Advanced studies	28	72	63	37	68	32	222
Advanced degree	20	80	67	33	68	32	598
Religion							
Catholic	41	59	72	28	75	25	149
Jewish	15	85	59	41	60	40	139
Protestant	40	60	71	29	76	24	214
None	25	75	63	37	66	34	1,236
Pagan, witch	13	87	47	53	53	47	15
Unitarian	16	84	42	58	47	53	19
Gay church	28	72	59	41	65	35	46
Personal income							
$9,999 or less	28	72	57	43	61	39	529
$10,000–$19,999	29	71	62	38	66	34	687
$20,000–$29,999	27	73	71	29	74	26	451
$30,000–$39,999	23	77	66	34	68	32	151
$40,000 or more	18	82	78	22	78	22	79

Note. From *The National Lesbian Health Care Survey: Final Report* (p. 53) by J. Bradford and C. Ryan, 1988, Washington, DC: National Lesbian and Gay Health Foundation. Copyright 1988 by J. Bradford and C. Ryan. Adapted by permission.

attended and most of them (61%) did so at least once or twice a month. Only 43% of lesbians who had not graduated from high school attended lesbian-only events; 9% never do.

Sexual orientation and ethnicity of close friends. Most of the sample had female friends who were also lesbians. Sixty-four percent had only or mostly lesbian friends. Thirty percent of the sample had half lesbian and half heterosexual friends; 5% had mostly heterosexual female friends, and 1% had no friends at all. For those who had male friends (78% of the sample did), 31% had mostly gay friends, 19% had both gay and heterosexual male friends, and 22% had mostly heterosexual male friends. Sixty-one percent of the sample had friends who were only or mostly of the same ethnicity, 23% had friends of both the same and other ethnic backgrounds, and 13% had friends who were mostly of a different ethnic background.

Outness

"Outness" was assessed by asking participants to indicate what percentage of (a) family, (b) gay and lesbian friends, (c) heterosexual friends, and (d) coworkers knew that they were lesbian. Choices ranged from 0–100%. Responses to the outness question were scaled from 0 (*out to 0%*) to 6 (*out to 100%*), and the outness score for the four groups was summed for a total score that ranged from 0–24.

The results on degree of outness are displayed in Table 9. Although 88% of the sample was openly lesbian to all gay and lesbian people they knew, much smaller percentages were out to all family members (27%), heterosexual friends (28%), and coworkers (17%). Furthermore, 19% were out to no family members and 29% were out to no coworkers. Table 10 also displays the mean outness scores for each category.

The lowest total outness score was achieved by lesbians aged 55 or older. Lesbians aged 25–34 were most out in all areas of their lives. This also represents an age cohort that would have benefitted most from the organizations and resources developed out of the lesbian and gay civil rights movement. Women with vocational training were more out than those with any other type of educational background. Women with at least some col-

Table 9
Outness: Disclosing Sexual Orientation to Others

People aware of subject's sexual orientation	0 (None)	1 (10% or less)	2 (11%–25%)	3 (26%–50%)	4 (51%–75%)	5 (76%–99%)	6 (100%)
Family members	19	5	16	11	18	5	27
Gay friends	1	0	1	2	4	4	88
Straight friends	7	3	18	18	20	5	28
Coworkers	29	7	20	13	11	3	17

Note. From *The National Lesbian Health Care Survey: Final Report* (pp. 102–103) by J. Bradford and C. Ryan, 1988, Washington, DC: National Lesbian and Gay Health Foundation. Copyright 1988 by J. Bradford and C. Ryan. Adapted by permission.

lege education were most out. Interestingly, women in the lowest and the highest income groups were most out. White lesbians had higher scores of outness than did Latina or African-American lesbians. Most lesbians were out to heterosexual friends before they were out to family or coworkers.

Pearson product-moment correlation coefficients were calculated among the four groups (family, lesbian and gay friends, heterosexual friends, and coworkers) and also with attendance at lesbian events. All five measures were significantly intercorrelated ($p < .002$ or less). Highest correlation coefficients were

Table 10
Outness: Demographics of Subjects Who Have Disclosed Their Sexual Orientation to Others

Demographic	Total outness score	Mean score for coming out to: Family	Gay friends	Straight friends	Coworkers
Age (years)					
17–24	12.06	2.80	5.63	3.47	2.13
25–34	13.52	3.38	5.76	3.81	2.54
35–44	13.18	3.26	5.68	3.73	2.46
45–54	12.27	2.82	5.65	3.37	2.39
55 or older	11.59	3.07	5.50	2.89	2.04
Race/ethnicity					
Latina	12.56	3.23	5.67	3.34	2.30
African American	12.41	3.35	5.38	3.50	2.10
White	13.16	3.22	5.73	3.71	2.47
Education					
Less than high school	12.34	3.72	5.07	3.20	2.20
High school	12.14	3.04	5.53	3.27	2.24
Vocational training	14.83	3.98	5.73	4.21	2.88
Some college	13.67	3.45	5.72	3.74	2.73
College	12.91	3.20	5.73	3.69	2.26
Advanced studies	13.16	3.27	5.73	3.67	2.46
Advanced degree	13.14	3.08	5.77	3.78	2.49
Type of work					
Professional	13.00	3.18	5.76	3.67	2.36
Manager/official	13.27	3.16	5.75	3.65	2.69
Clerical	12.88	3.20	5.67	3.67	2.31
Craftsperson	14.68	3.74	5.67	4.01	3.19
Operative	12.62	3.31	5.69	3.69	1.91
Laborer	14.64	3.73	6.00	4.14	2.77
Farmer	6.00	0.00	6.00	2.00	0.00
Service worker	13.88	3.66	5.54	3.81	2.81
Personal income					
$9,999 or less	13.45	3.42	5.60	3.81	2.57
$10,000–$19,999	13.31	3.24	5.72	3.77	2.55
$20,000–$29,999	12.53	2.98	5.82	3.51	2.23
$30,000–$39,999	12.56	3.21	5.74	3.40	2.19
$40,000 or more	13.87	3.62	5.67	3.84	2.68

Note. From *The National Lesbian Health Care Survey: Final Report* (pp. 102–103) by J. Bradford and C. Ryan, 1988, Washington, DC: National Lesbian and Gay Health Foundation. Copyright 1988 by J. Bradford and C. Ryan. Adapted by permission.

Table 11
Correlations Among Outness and Counseling Variables

Variable	Family	Gay friends	Straight friends	Coworkers	Total outness
Fear of exposure	−.16	−.09	−.23	−.21	−.25
Received counseling	.18	.09	.23	.14	.23
Sources of counseling					
Private	.17	.09	.19	.11	.20
Support	.07	.02	.12	.08	.11
Friends	.09	.04	.16	.12	.15
Psychic	.10	.05	.14	.11	.15
Reasons for counseling					
Problems with lover	.15	.08	.16	.14	.19
Problems with family	.11	.02	.11	.07	.12
Sadness/depression	.09	.03	.14	.06	.12
Growth issues	.11	.08	.19	.13	.17

Note. From *The National Lesbian Health Care Survey: Final Report* (pp. 116–118) by J. Bradford and C. Ryan, 1988, Washington, DC: National Lesbian and Gay Health Foundation. Copyright 1988 by J. Bradford and C. Ryan. Adapted by permission.

.562 (out to coworkers and heterosexual friends), .499 (out to family and heterosexual friends), and .342 (out to family and coworkers).

All measures of outness and total outness were correlated with the individual items of Current Concerns and Worries. Correlations that were significant at $p < .002$ or less are reported in Table 11. The only item of this scale that was significantly correlated with outness was fear of exposure as a lesbian. This item was negatively correlated with all measures of outness, particularly the total score of outness ($r = -.25$), outness to heterosexual friends ($r = -.23$) and outness to coworkers ($r = -.21$). It seems evident that lesbians who are out to people in the workplace and also to heterosexuals are those who have the least fear of exposure.

All measures of outness were also correlated with three measures of counseling: (a) whether participants had ever received counseling, (b) source of counseling, and (c) reason for counseling. These results are also displayed in Table 11. All measures of outness were positively correlated with whether lesbians had received counseling, with the highest correlations for total outness and outness to heterosexual friends (both $rs = .23$). Four types of counseling were also significantly and positively correlated with measures of outness. Being out was associated with receiving help from the following sources: private counselors, support groups, friends, and psychic or spiritual healers. Other potential sources of help (e.g., from clinics or schools) were not significantly correlated with any of the outness measures. A similar pattern of correlations was also the case between outness and reasons for seeking counseling. Statistically significant correlations were found between all outness measures and the following reasons for seeking help: problems with lovers, with family, feeling sad or depressed, and personal growth issues.

Discussion

The lesbians who participated in the National Lesbian Health Care Survey were mostly between the ages of 25 and 44, mostly well-educated and professionally employed, though significantly underpaid relative to educational status. There had been a dramatic shift from traditional religious upbringing to more lesbian-affirmative religions. All but a few lived in or near metropolitan areas and had access to a variety of lesbian community activities. The sample was thus limited to a more privileged group, in every sense other than its minority status, and may represent the "best scenario" for lesbians in the U.S. In its demographics, the sample is similar to most other studies of lesbians. Albro and Tully (1979) described the typical lesbian in their study as White, young, single, living on the East Coast, college educated, professionally employed, and unaffiliated with an organized religion. The response rate of 46% for this stigmatized group compares favorably with the response rate of 16% achieved by McKirnan and Peterson (1989a) in their large-scale community survey of lesbians and gay men in Chicago. Lesbians who were not represented in the current study are more likely to be cut off from a sympathetic community and therefore to be at greater risk for distress and need for supportive help. A major limitation of the current study, then, is that we still know little about the mental health of lesbians in rural and isolated settings.

Among the sample as a whole, there was a distressingly high prevalence of life events and behaviors related to mental health problems. Thirty-seven percent had been physically abused and 32% had been raped or sexually attacked. Nineteen percent had been involved in incestuous relationships while growing up. Almost one third used tobacco on a daily basis, and about 30% drank alcohol more than once a week; 6% drank daily. One in five smoked marijuana more than once a month. Twenty-one percent of the sample had thoughts about suicide sometimes or often, and 18% had actually tried to kill themselves. Half of those who had received counseling had done so for feelings of sadness or depression. More than half had felt too nervous to accomplish ordinary activities at some time during the past year, and over one third had been depressed. Almost everyone

in the sample was concerned about money, relationships, and work. Although most were well-educated, their incomes were not commensurate with the amount of training they had received. In general, lesbians who were older, who earned less money, and who were not White reported higher levels of abuse, mental distress, and reliance upon professional help.

Lesbians as Similar to Heterosexual Women

How do these data compare with mental health statistics on heterosexual women, who are also at risk for a number of mental health problems when compared with men? It must be kept in mind that this lesbian sample is demographically different (e.g., younger, more educated) than women in the general population, and also that it is more difficult to find adequate control groups for lesbians (e.g., should lesbian couples be compared with married heterosexual women, cohabiting heterosexual women, or even single heterosexual women because lesbians are often viewed as "single" by society?).

Depression. A large number of community studies and studies of people in treatment have examined gender ratios of depression, and found that in the United States and Europe, women are twice as likely as men to experience depression (see McGrath, Keita, Strickland, & Russo, 1990, for a review). Field trials conducted for the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-III;* American Psychiatric Association, 1980) found 18%–23% of women and 8%–11% of men to have once had a major depressive episode, using the *DSM-III* criteria for depression. Studies that use broader definitions of depression (as in the current survey), as well as symptom scales, find rates of depression to be even higher. The current study is the first to have examined depression among lesbians in a community survey, and the high rate of depression among lesbians is similar to heterosexual women.

Suicide. Research among heterosexual women has found that the rate of reported suicide attempts is very high among professional women such as physicians, perhaps somewhat comparable to the large percentage of lesbians in professional occupations in the current study. For example, Pitts, Schuller, Rich, and Pitts (1979) found the suicide rate for female physicians to be higher than that of male physicians, and four times higher than White U.S. women of the same age.

The present study did not assess lesbian adolescents, and this group has been viewed as at particularly high risk for suicide (e.g., Kourany, 1987; Saunders & Valente, 1987). The results of the present study do indicate higher percentages of suicidal thoughts and attempts among the youngest age group, which would indicate that more research on suicide and its prevention among adolescent lesbians is necessary.

Sexual abuse. Several people have speculated that lesbianism is somehow related to the experience of incest during childhood (e.g., Herman & Hirschman, 1981) and a not-uncommon stereotype has held that lesbianism is a reaction to this experience. However, the results of the current study indicate that the rate of incest among lesbians (18.7% overall) is quite similar to that among the general female population (16%; Russell, 1984). The percentage of lesbians who reported having been raped or sexually attacked was the same in the current study as it was in Russell's (1984) sample of the general female population (34% in both studies for women under age 25). However, percentages follow different patterns for older lesbians. In Russell's sample, percentages of those who experienced rape or sexual attack increase with age, while for lesbians in the current study, percentages decrease with age. It is possible that lesbians have fewer social contacts with men as they become more involved in the lesbian community, and this may protect lesbians from sexual abuse by men.

Eating disorders. Lesbians in the current study reported similar percentages of eating disorders as did women surveyed in the general population (Ettore, 1980). The range of women in the general population who reported overeating was from 41%–69%, compared with 45% in the current study. One to five percent of Ettore's study reported overeating and then vomiting, compared with 2% in the current study. Eating disorders have been discussed within the context of female socialization, and research has indicated that lesbians are similar to heterosexual women along some dimensions of weight (e.g., dieting) but dissimilar on others (e.g., preoccupation with weight; Brand, Rothblum, & Solomon, 1992). In fact, some authors have speculated that a large component of concern with weight is the need to be sexually attractive to men (e.g., Brown, 1987). This would imply that heterosexual women and gay men would be at greater risk for eating disorders than would lesbians and heterosexual men, and further research is needed to examine the effect of both gender and sexual orientation on eating disorders.

Lesbians as Different from Heterosexual Women

Alcohol and drug use. The results of the current study concur with the other large-scale survey on substance use by McKirnan and Peterson (1989a). Both studies found high rates of alcohol use among lesbians, and both studies also found that rates of alcohol use do not decline with age as they do among heterosexual women. The use of bars for lesbians as a social resource were widely available to lesbians in the current study (67%). McKirnan and Peterson (1989a) have discussed alcohol and drug use among older lesbians as reflecting the independence lesbians may have from age-related social role changes that may affect heterosexual women. In the current study, however, less frequent involvement among older lesbians with the lesbian and gay community and decreased openness about their sexual orientation may lead to increased reliance on alcohol to mitigate the long-term effects of isolation, lack of adequate support, and compartmentalization of their identity.

Use of counseling. About three fourths of the sample reported a history of having used professional mental health services. This high use of counseling by lesbians has been born out by recent research (Morgan, 1992; Morgan & Eliason, 1992). Morgan (1992) compared 100 lesbian and 309 heterosexual women on their use of therapy, and found that 77.5% of lesbians and 28.9% of heterosexual women had been in therapy. Morgan and Eliason (1992) asked lesbians who had and those who had never been in therapy for reasons why so many lesbians seek therapy. Themes mentioned by at least half the sample included the fact that societal oppression causes stress for lesbians, therapy and personal growth are modelled and accepted by the les-

bian community, and lesbians are introspective and have practice facing hard issues. Given the results of these studies, it is understandable why lesbians in the current study who were more out were also more likely to have used counseling. Lesbians who were more out also were more likely to have sought counseling for reasons related to being lesbian, such as difficulties with lovers or family, than were more closeted lesbians.

Furthermore, the present study found over one third of the lesbian sample to report using supportive resources, such as friends and women's groups, for help with mental health concerns. Research by Kurdek and Schmidt (1987) found lesbians three times more likely to list their friends rather than their family as the most frequent providers of social support. In contrast, heterosexuals tended to rate friends and family about equally as sources of support.

Minority status of lesbians. Lesbians who participated in the survey reported on the effects of their minority status in a number of ways. Over half had been verbally attacked for being lesbian, and 13% had lost jobs as the result of antigay discrimination. A small number expressed concern about seeking mental health services in the past because of being discriminated against or stereotyped by counselors. Others were simply afraid to disclose their lesbianism, even to professionals whose help they needed.

Nevertheless, lesbians who participated in the survey appeared to be socially connected and to have enough people to rely on for support with basic needs. Their connections were primarily with lesbian friends and lesbian community activities, however. Many had left traditional religious institutions and now belonged to nontraditional denominations or gay churches. Many had learned how to take care of their own mental health needs. It appeared that this group of mostly young, well-educated, professionally employed, urban lesbians lived in a way that is typical for people who occupy a minority status and who are socially marginal. They had two lives: one in which they earned the money needed for self-sufficiency and another in which they were socially connected to lesbians and lesbian-affirmative people.

Being out had positive aspects. It was associated with less fear of exposure; it was also associated with receiving mental health services and having more choices about where to seek help. Survey findings such as these lead to an enhanced understanding of the relationship between "rational outness" and various aspects of mental health. This concept includes both a personal dimension, in which lesbians come out to themselves and other lesbians in a more or less continuous process over time, and a social dimension, in which lesbians make deliberate decisions about who can be trusted to know without harming them, among all the people they encounter on an ongoing basis. Positive mental health requires that human beings function adequately in both their personal and social lives and that they achieve a workable integration of the two. For some lesbians, behavior within these two dimensions may be very similar, but for others it may be very divergent. Few have the luxury to be completely out to everyone, even though such behavior would be psychologically beneficial if it were safe. These survey data begin to illuminate the complexities of psychosocial decision-making, development of positive coping skills, and survival within a homophobic society, that are inherent in living as a lesbian.

Implications for Treatment

In assessing treatment needs of lesbians, data from this survey suggest several issues to explore. Relationships are a major treatment focus for all lesbians. A large percentage of lesbians had sought treatment because of problems with lovers (44%), family (34%), and friends (10%), as well as loneliness (21%). Depression was a precipitating factor for one out of two lesbians seeking treatment. Among midlife lesbians, higher percentages sought treatment for depression, problems with their lovers, and problems with their sexual orientation, than did younger lesbians (see Bradford & Ryan, 1991, for a review of data on midlife lesbians from this survey). While personal growth was the major treatment issue for nearly one out of three lesbians overall, significantly fewer African-American and Latina lesbians had sought professional help for personal growth issues than had White lesbians.

Sixteen percent of the sample had sought counseling for substance abuse problems. Use of alcohol increased with age, with highest rates of use reported by lesbians aged 55 or older. Not surprisingly, these lesbians were least open about their sexual orientation and were least connected to the organized lesbian community. Lack of support and fear of exposure as a lesbian may lead to increased reliance on alcohol. Inclusion of a substance abuse history during intake and sensitivity to the unreported use of alcohol or drugs to self-medicate for depression are recommended, particularly for practitioners working with midlife and older lesbians.

Although nearly three fourths of the sample had sought mental health services at some time and a majority found these services to be helpful, the low income level of lesbians in the sample presents an inherent barrier to receiving quality mental health care. This represents both a treatment and a policy issue in meeting the mental health needs of lesbians. Worry about money was the primary concern for lesbians in the survey (57%) and was greatest for African-American lesbians and those aged 54 and younger. Although most lesbians preferred a private practitioner than lower-cost options, nearly 9 out of 10 earned less than $30,000 annually, and only 65% had health insurance (see Bradford & Ryan, 1988; Ryan & Bradford, 1988, for results of physical health). Lack of third-party payments and insufficient personal resources may prevent many lesbians from receiving services.

More than 68% of lesbians reported having had a range of mental health problems in the past, including long-term depression and sadness, constant anxiety and fear, and other mental health concerns. At the time of the survey, however, only 23% reported having such problems and they were receiving treatment for these problems. Given the high rate of mental health problems in the past, it is noteworthy that nearly half of lesbians receiving counseling (49%) had been in therapy for one year or less. This suggests the development of coping and survival skills, in addition to reliance on friends and alternative social supports to manage these concerns. The survival strengths of lesbians, while not measured specifically in this survey, warrant further

consideration. In view of their low socioeconomic status and experiences with discrimination and stigma, the capacity of lesbians in this survey to maintain interpersonal and primary relationships, educate themselves, hold responsible jobs and participate in the social, political, and professional activities of their communities should be perceived as adaptive and resilient. Assessing the psychological resources and adaptability of lesbians to survive in a hostile and stressful environment is an area of future research with applicability to the larger society.

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