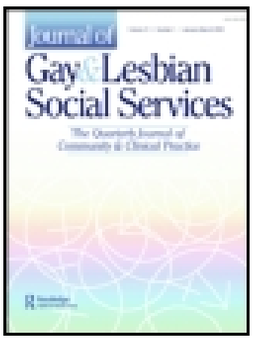

Routledge
Taylor & Francis Group

Journal of Gay & Lesbian Social Services

ISSN: 1053-8720 (Print) 1540-4056 (Online) Journal homepage: http://www.tandfonline.com/loi/wgls20

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To cite this article: Caitlin C. Ryan MSW, ACSW , Judith B. Bradford PhD & Julie A. Honnold PhD (1999) Social Workers' and Counselors' Understanding of Lesbian Needs, Journal of Gay & Lesbian Social Services, 9:4, 1-26, DOI: 10.1300/J041v09n04_01

To link to this article: https://doi.org/10.1300/J041v09n04_01

Social Workers' and Counselors' Understanding of Lesbian Needs

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ABSTRACT. An exploratory survey was conducted in 1994 to assess mental health providers' experience with lesbian clients and understanding of lesbians. Probability samples of 250 licensed clinical social workers and 250 licensed professional counselors were randomly generated from Virginia licensure lists. A total of 183 out of 224 respondents were active practitioners and were included in the analysis. Ninety-seven percent of active practitioners reported their sexual orientation; of these, 7% identified as lesbian, gay, or bisexual. Twenty-two percent of respondents had received training or education in lesbian mental health issues (19% of heterosexuals and 58% of lesbians, gays and bisexuals) and most viewed coming out as more positive than negative. Most heterosexual providers defined lesbianism in terms of sexual attraction only, while lesbian, gay and bisexual providers defined lesbianism in both behavioral (sexual) and affectional terms. Providers who thought certain mental health symptoms varied on the basis of sexual orientation generally thought lesbians experienced these more frequently. Lesbian, gay and bisexual providers reported a larger number of lesbian clients, defined lesbianism more appropriately, and understood lesbian mental health issues more clearly. Based on study results, les-

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Journal of Gay & Lesbian Social Services, Vol. 9(4) 1999

bians who seek mental health care in Virginia can expect to receive more informed mental health services from lesbian, gay and bisexual providers. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-342-9678. E-mail address: getinfo@haworthpress inc.com]*

KEYWORDS. Lesbians, social workers, counselors, attitudes, probability sample

INTRODUCTION

Study Rationale

Although research has demonstrated the reliance of lesbians on mental health services, information on provider knowledge in delivering appropriate care to this population has been limited. Despite clear professional standards and practice guidelines, anecdotal information and results of earlier studies raise concern that long-standing misconceptions about homosexuality continue to shape the theoretical approach to training in professional schools, the attitudes and practices of providers, and the experiences of many lesbian clients.

This article presents results from an exploratory study of mental health providers in the Commonwealth of Virginia. The overall purpose of the study was to assess the current status of mental health practice with lesbian clients and to determine differences in practice patterns based on sexual orientation of providers. The following research questions were explored: (1) had providers received training about sexual orientation and lesbians' needs and experiences? and (2) would providers demonstrate adequate knowledge of lesbians?

If a sufficient number of respondents self-identified as lesbian, gay or bisexual, we would also explore whether lesbian, gay and bisexual providers: (1) have more practice experience with lesbian clients; (2) are more knowledgeable about lesbians; and (3) demonstrate greater understanding of lesbians' needs and experiences as related to mental health care. A thorough review of the literature showed no prior probability studies of knowledge and attitudes of social workers and counselors on lesbian (or gay) issues at the time this study was conducted, and in particular, no representative studies of licensed social workers and counselors.

Literature Review

Until the early 1970s, the mental health literature on lesbians and gay men was limited, and with few exceptions homosexuality was discussed as abnormal or pathological. Landmark studies by Kinsey in the 1940s and Evelyn Hooker in the 1950s challenged previously held assumptions about sexuality and the presumed psychological maladjustment of homosexuals. By 1973, a growing body of evidence led the American Psychiatric Association to remove homosexuality from the list of mental disorders included in the *Diagnostic and Statistical Manual.* Since that time, the quality of research on lesbians and gay men has increased significantly, based on a new understanding of the fluidity of human sexuality and psychological response to stigma. As awareness has evolved that much of the presumed pathology associated with homosexuality was instead internalized symptoms of societal hatred of gay people (homophobia), the major mental health professional associations adopted policy statements that called for nonbiased care and advocated social and legal action for combating antigay prejudice (American Counseling Association, 1996; American Psychiatric Association, 1994; American Psychological Association, 1991; Cabaj, 1996; Krajeski, 1996; National Association of Social Workers, 1977).

Rather than viewing homosexuality as a developmental arrest that required treatment, in a 1973 policy statement mental health practitioners were charged with ''removing the stigma of mental illness that has long been associated with homosexual orientations'' (American Psychological Association, 1991). In particular, social workers were enjoined to ''examine their attitudes and feelings about homosexuality and their understanding of lesbian and gay cultures toward full social and legal acceptance of lesbian and gay people'' and to provide ''comprehensive psychological and social support services for lesbian and gay people and for families headed by lesbian and gay parents that are culturally sensitive and respectful.'' In addition to actively resisting discrimination based on sexual orientation or life style, counselors were required to ''update themselves with respect to the topic of lesbianism and homosexuality'' (National Association of Social Workers, 1993, pp. 164, 202).

Knowledge and Attitudes of Providers. During the past two decades, earlier research on mental health providers' attitudes and prac-

tices has indicated the persistence of overt homophobia, lack of knowledge, ambivalence, and disdain among providers (DeCrescenzo, 1984; Fort, Steiner & Conrad, 1971; Gartrell, 1974; Graham et al., 1984; Rudolph, 1988; Wisniewski & Toomey, 1987). A 1986 survey of 2,544 members of the American Psychological Association found that practice varied widely, but biased and inappropriate care persisted (Garnets et al., 1991). Nearly three-fifths of psychologists surveyed knew of negative or discriminatory care, including incidents where practitioners labeled lesbians or gay men as ''sick'' and in need of change (i.e., regarding their sexual orientation). Consistently, providers who knew someone gay were least likely to be homophobic (DeCrescenzo, 1984), while the least stereotypical and negative perceptions of lesbian and gay clients were held by lesbian and gay providers (Bieschke & Matthews, 1996; Rudolph, 1988; Smith, 1993).

Heterosexism and Heterosexual Bias. Although greater awareness of lesbians and gay men has resulted in increased tolerance, discrimination, hostility and institutional intolerance still characterize their experience (Herek, 1995). Herek defines this systemic (and personal) intolerance for lesbians and gay men as *heterosexism* which ''denies, denigrates and stigmatizes any non-heterosexual form of behavior, identity, relationship or community'' which exists on both the broader societal level and on a personal or individual level. Heterosexism is often expressed in subtler forms than homophobia (e.g., absence of support and lack of validation or neglect rather than overt prejudice). Heterosexist practice can cause therapists to measure lesbian/gay experiences and needs by heterosexual norms and to misinterpret or overlook relevant issues, such as the emotional content in identity development, (e.g., the attendant anger, grief and loss in mourning the privileges and status of a heterosexual identity) as lesbians explore and integrate lesbian identity. In a recent probability survey of 187 heterosexual social workers, one out of ten were found to be homophobic while the majority were heterosexist (Berkman & Zinberg, 1997).

Sexual Orientation and Identity Development. ''Coming out''–acknowledging one's lesbian or gay identity–is an interactive, ongoing process ''through which gay women and men recognize their sexual [orientation] and choose to integrate this knowledge into their personal and social lives'' (deMonteflores & Schultz, 1978). Although identity development and consolidation are key tasks of adolescence, les-

bian/gay identity development represents an *additional* developmental process that can occur at any age. Several models of identity development have been proposed to describe the coming out process, although most have been based on the experiences of white gay men (Gonsiorek & Rudolph, 1991). Such models generally include behavioral, cognitive and affective aspects which reflect the multiple dimensions of homosexuality (behavior, desire, and identity).

Most models propose a progressive identity development process, moving from awareness, to identity confusion (when same-sex thoughts and feelings conflict with negative perceptions of homosexuality), to gradual self-identification, leading to disclosure (''coming out'') to others and interaction with the organized lesbian/gay community (which strengthens self-esteem, reinforces gay identity and helps neutralize negative stereotypes) (Cass, 1979; Coleman, 1982; Troiden, 1989). Self-acceptance generally culminates with integrating sexual identity into other aspects of one's life as lesbian/gay identity is increasingly shared with non-gay friends and close family members. However, integration depends on a number of issues, including access to support and positive role models, personal strengths and vulnerabilities and experiences with discrimination. Moreover, widespread disclosure should not be construed as the only measure of integrated identity. Many factors such as legal and economic realities, racial/ethnic group membership, geographic area, family situation and support systems determine the extent to which disclosure may be possible (Fassinger, 1991).

Coming Out and Positive Mental Health. Lesbian/gay identity resolution (coming out) takes place over a period of time. Successful resolution requires transforming a stigmatized identity into an integrated positive sense of self (Espin, 1993). Because coming out represents a shift in the individual's core identity, it may be accompanied by significant levels of emotional distress (Gonsiorek & Rudolph, 1991), including a range of psychiatric symptoms which generally disappear when the crisis resolves.

Coming out has many positive and beneficial mental health results. It has been strongly associated with psychological adjustment (Miranda & Storms, 1989) and decreased feelings of isolation (Murphy, 1989), while a more positive lesbian/gay identity is correlated with higher ego strength, less depression and higher self-esteem (Savin-Williams, 1989; Schmitt & Kurdek, 1987). Conversely, practitioners

have described the long-term social and psychological cost of staying in the closet (repressing one's lesbian/gay identity and living a compartmentalized life). The constant vigilance, duplicitousness, and pretense exact a significant toll on an individual's sense of congruency and self-esteem (Gartrell, 1984).

Use of Mental Health Services and Need for Training. Studies show that use of mental health services among lesbians is high (Bradford & Ryan, 1987; Morgan & Eliason, 1992). In the National Lesbian Health Care Survey (NLHCS), Bradford and Ryan (1987; 1994) found that nearly three-fourths of a 50-state sample (1,925 lesbians) had received or were currently receiving mental health care. Moreover, lesbians used mental health services for a variety of concerns including relationships, family, career and job-related concerns, decisions about parenting, confusion about sexual identity, personal growth, and as a result of discrimination and anti-gay violence (Bradford & Ryan, 1987; Murphy, 1991).

Previous research has shown that graduate training on sexuality has been minimal for mental health providers (Buhrke & Douce, 1991; Myers, 1982). Although no data have been published since the Council on Social Work Education (CSWE) required inclusion of content on lesbian and gay issues in social work programs (as of July 1995), a pre-implementation survey of diversity content in accredited social work programs found that only one out of three offered what program directors described as "very strong" content related to sexual orientation (Mackelprang, Ray, & Hernandez-Peck, 1996). Moreover, a survey of counselor education programs found that only two-fifths (44%) of departments participating in the survey offered such courses, and only one out of ten schools required them for graduation (Gray et al., 1989; Murphy, 1992).

Purpose of the Study

During the past decade alone, research on sexual orientation issues has increased substantially and new information on identity development, sexual behavior, and risk for health and mental health concerns has become available for practitioners and educators. In light of increased availability of information on sexual orientation and clinical practice, the authors decided to conduct a probability study to assess

the extent to which providers understood basic concepts about lesbian identity and experiences that affect clinical practice.

METHODOLOGY

Probability sampling was used to increase generalizability of results, and a mail survey methodology was selected as the most effective way to obtain a desirable response rate from the study population. Data collection was implemented by the Survey and Evaluation Research Laboratory of Virginia Commonwealth University, during April 1994.

Questionnaire Construction. A 20-question instrument was developed, with a total of 15 fixed response and 5 open-ended questions. One of the fixed-response questions had 14 independently scored items. Average pre-test completion time was about 4 minutes for fixed-response questions and about 14 minutes for open-ended questions, for an overall average completion time of 18 minutes. Open-ended questions were coded and entered into the data set with the closed-ended questions.

Questionnaire topics were demographics (including sexual orientation), practice characteristics (including client gender and sexual orientation), training in lesbian mental health, definition of lesbianism and its effect on mental health, effect of coming out on the mental health of lesbian clients, and perception of mental health symptoms in lesbians and heterosexual women. The question requesting sexual orientation was included last, and was highlighted as an ''Optional Question.'' The question was worded, ''How do you describe your sexual orientation?'' Respondents were offered the choices of: heterosexual, lesbian/gay, bisexual, transgendered, or other.

Sampling. Two mailing lists were obtained of all individuals holding licenses to practice as Licensed Clinical Social Workers (LCSWs) or Licensed Professional Counselors (LPCs) from the Virginia Department of Health Professions. Random samples were drawn of 250 individuals from each list. Three mailings were done sequentially: a first mailing with questionnaire and cover letter to everyone in the sample, a reminder postcard to everyone in the sample one week later, and a second copy of the questionnaire and revised cover letter to non-respondents three weeks after the first mailing. This methodology is referred to as the Modified Total Design Method and is the industry

standard for mail surveys (Dillman, 1978). Completed questionnaires were received from 224 individuals, for a response rate of 45%. This analysis is based on 183 respondents who reported that they had direct contact with clients.

Data Analysis. Of the 183 respondents who had direct client contact, 99 (54%) were LCSWs and 84 (46%) were LPCs. Differences between LCSWs and LPCs for respondent and practice characteristics were assessed for statistical significance with chi-square and t-tests (Tables 1-2). Thirteen respondents in the total sample (seven percent of 178 who answered the sexual orientation question) self-identified as lesbian, gay or bisexual. Because this number was low, LCSWs and LPCs were combined for the remainder of the analysis (Tables 3-9), which focused on a descriptive comparison of heterosexual and lesbian/gay/bisexual respondents. Because relatively few respondents self-identified as lesbian/gay/bisexual, results should be regarded with caution, even though the sample was randomly drawn. Data were analyzed using the Unix

TABLE 1. Respondent Characteristics for Total Sample and Subsamples of Licensed Clinical Social Workers and Professional Counselors

	Total Sample N = 183	Licensed Clinical Social Workers N = 99	Licensed Professional Counselors N = 84
	Percentages		
Age[1]			
29-39	21	28	13
40-49	51	45	59
50-59	21	24	19
60+	6	3	9
Mean age[2]	45.7	44.5	47.0
Gender[3]			
Female	78	89	65
Male	22	11	35
Race/Ethnicity			
White	97	96	98
African-American	2	3	1
Native American	1	0	1
Other	1	1	0
SexualOrientation			
Heterosexual	93	93	93
Lesbian/gay/bisexual	7	7	7

[1]Chi square = 8.486, df = 3, p = .037
[2]t = 2.00, df = 162, p = .048
[3]Chi square = 14.584, df = 1, p = .000

TABLE 2. Practice Characteristics for Total Sample and Subsamples of Licensed Clinical Social Workers and Professional Counselors

	Total Sample N = 183	Licensed Clinical Social Workers N = 99	Licensed Professional Counselors N = 84
	Percentages	Percentages	Percentages
Location of Practice			
Current practice in VA	98	98	98
In VA within last 2 years	2	2	2
Professional Title[1]			
Professional counselor	48	100	4
Professional counselor supervisor	14	29	2
Certified substance abuse counselor	4	6	2
Licensed clinical social worker	56	1	100
Other	4	4	4
Primary Work Setting			
Private practice	48	43	54
Public mental health agency	15	12	18
Student health/school	5	3	7
Hospital	10	13	6
Private nonprofit agency	9	12	5
Other	13	16	10
Number of Current Clients			
1-10	17	16	19
11-20	27	30	23
21-30	24	24	23
31-40	14	14	13
41+	18	16	21
Mean number	29	29	24
Percentage of Clients Who Are Women			
None	2	3	0
1-25	10	12	8
26-50	23	27	18
51-75	30	24	37
76-100	35	33	36
Mean percentage	63	59	66

TABLE 2 (continued)

	Total Sample N = 183	Licensed Clinical Social Workers N = 99	Licensed Professional Counselors N = 84
	Percentages	Percentages	Percentages
Percentage of Clients Who Are/May Be Lesbian[2]			
None	25	32	17
1-5	38	42	33
6-10	19	14	25
11-20	9	5	13
21-50	9	7	12
Mean percentage[3]	8	6	10
Number of Lesbian Clients[4]			
None	9	14	2
1-5	29	31	27
6-19	32	30	33
20+	30	24	37
Mean number	14	13	15
Training/Education in Lesbian Mental Health			
Yes	22	19	26
No	78	81	74

[1]Percentages may sum to more than 100% since respondents could choose more than one professional title
[2]Chi square = 11.582, df = 4, p = .021
[3]t = 2.00, df = 167, p = .047
[4]Chi square = 9.983, df = 3, p = .019

mainframe version of SPSS (Statistical Package for the Social Sciences) and SPSS 6.1 for Windows.

RESULTS

Respondent Characteristics

Personal Characteristics. Personal characteristics for the total sample and for the LCSW and LPC subgroups are displayed in Table 1. Half of the total sample were in their 40s, with 21 percent in their 30s,

TABLE 3. Practice Characteristics–Comparison of Heterosexuals and Lesbian/Gay/Bisexuals

Characteristics (Means)	All Respondents	Heterosexuals	Lesbian/Gay/Bisexuals
Age	45.7	45.9	42.9
Number clients currently seen	29.0	29.3	29.3
Percent current clients who are women	62.6	62.0	63.5
Percent women clients known or thought to be lesbian	7.8	7.2	14.8
Number clients ever seen known or thought to be lesbian	14.0	12.7	26.3
Percent current clients known or thought to be lesbian	5.1	4.5	11.2

TABLE 4. How Would You Define a "Lesbian" or "Lesbianism"?

Category of Definitions	Heterosexuals N = 157	Lesbian/Gay/Bisexuals N = 11
	Number of Mentions	Number of Mentions
Sexual attraction/interest/ preference/orientation	97	91
Emotional/ psychological/ romantic attraction/interest	11	73
Primary relationships with women	6	27
Self-identification	1	9[a]

[a]n = 1

21 percent in their 50s, and 6 percent age 60 or older. LPCs as a group had a significantly higher mean age (47.0) than LCSWs (44.5; p = .048). More than three-fourths of the total sample were women (78%); 22 percent were men. A significantly higher percentage of LCSWs were female (89%) than LPCs (65%). Nearly all respondents were white (97%), and most were heterosexual (93%). Seven percent identified as lesbian, gay or bisexual. The LCSW and LPC subgroups were not significantly different on race/ethnicity or sexual orientation.

TABLE 5. Sexual versus Nonsexual Content of Definitions

Comparison of Heterosexuals and Lesbian/Gay/Bisexuals

	Heterosexuals	Lesbian/Gay/Bisexuals
	Percentages	**Percentages**
Number of sexual mentions in lesbian definition		
0	11	39
1	86	46
2+	3	15
Number of nonsexual mentions in lesbian definition		
0	84	31
1	14	54
2+	3	15
Sexual versus nonsexual definitions		
1 + sexual and 0 nonsexual	83	18
1 + sexual and 1 + nonsexual	11	55
0 sexual and 1 + nonsexual	6	27

Comparison of Heterosexuals Who Have and Have Not Had Special Training on Lesbian Mental Health

	Heterosexuals without training	Heterosexuals with training
	Percentages	**Percentages**
Number of sexual mentions in lesbian definition		
0	11	10
1	86	84
2+	2	6
Number of nonsexual mentions in lesbian definition		
0	86	71
1	12	23
2+	2	6
Sexual versus nonsexual definitions		
1 + sexual and 0 nonsexual	86	71
1 + sexual and 1 + nonsexual	9	19
0 sexual and 1 + nonsexual	6	1

Percentages may sum to more than 100% due to rounding of numbers

Practice Characteristics. Practice characteristics for the total sample and for the LCSW and LPC subgroups are displayed in Table 2. Ninety-eight percent of the total sample and both subgroups were currently practicing in Virginia. The total sample was evenly divided between those who worked in private practice settings and those who did not. LCSWs and LPCs were not significantly different in this

TABLE 6. Positive Contributions of Being a Lesbian to Mental Health

Positive Contribution	All Respondents N = 154	Heterosexuals N = 139	Lesbian/Gay/Bisexuals N = 12
	Percentages	Percentages	Percentages
Increased emotional strength	60	59	67
Potential for community/relationships	18	19	17
Increased tolerance	16	15	25
Not different from heterosexual women	17	18	8[a]
Other	3	2	8[a]

[a]n = 1
Percentages may sum to more than 100% because respondents could identify more than one contribution

TABLE 7. Negative Contributions of Being a Lesbian to Mental Health

Negative Contribution	All Respondents N = 159	Heterosexuals N = 144	Lesbian/Gay/Bisexuals N = 12
	Percentages	Percentages	Percentages
Discrimination against lesbians	75	76	67
Uncomfortable with lesbian identity	31	29	50
Lack of social support	16	16	25
General emotional problems	9	9	17
Negative reactions toward society	6	5	8[a]
Not different from heterosexual women	8	8	8[a]
Other	1[a]	1[a]	0

[a]n = 1
Percentages may sum to more than 100% because respondents could identify more than one contribution

regard. Respondents not in private practice were most likely to be working for a public mental health agency, a private nonprofit agency, or a hospital. Sixty-eight percent of the total sample reported seeing 30 or fewer clients, while 32% reported having 31 or more. Nearly one in five (18%) reported more than 40 clients. Most respondents were seeing primarily women. For 35% of practitioners, women made up 76-100% of their clientele; for an additional 30%, women made up 51-75 percent. Only 12 percent reported that women made up 25% or

TABLE 8. Effect of "Coming Out" on Lesbians' Mental Health

Effects	All Respondents N = 129	Heterosexuals N = 111	Lesbian/Gay/Bisexuals N = 12
	Percentages	Percentages	Percentages
Positive effects (% who gave 1 or more positives)			
Improved self-esteem	41	36	83
Increased social support	16	17	8[a]
Comfortable with lesbian identity	14	16	0
Positive emotional effects	5	6	0
Other positive effects	29	28	25
Negative effects (% who gave 1 or more negatives)			
Lack of social support	34	38	17
Negative emotional effects	15	15	17
Discrimination against lesbians	10	10	8[a]
Other negative effects	7	6	17
Mixed effects	9	10	8[a]

[a]n = 1
Percentages may sum to more than 100% because respondents could identify more than one contribution

less of their client base. There were no significant differences between LCSWs and LPCs in their number of clients or percentage of clients who were women.

When asked how many clients either self-identify or might be lesbians, 25% of the total sample thought that none were lesbians and 38% that 1-5% were lesbians–almost 2/3 of respondents reported that five percent or less of their women clients were lesbians. About one in 10 seemed to "specialize" in seeing lesbians, reporting that 21-50% of their women clients were or might be lesbian. LPCs felt that a larger proportion of their female clients were lesbians (mean of 9.8%) than did LCSWs (mean of 6.3%, p = .047). The total number of lesbian clients reported by all respondents ranged from none (9% of respondents) to 20 or more (30%). Well over half of all respondents (62%) had seen at least 6 lesbian clients. Seventy percent of LPCs had seen at least 6 lesbian clients, compared to 54% of LCSWs (chi square p = .019). However, the average number of lesbian clients ever seen by LPCs and LCSWs was not significantly different. Only about one in five of all respondents (22%) had any special training or education in

TABLE 9. Mental Health Concerns Experienced by Lesbians and Heterosexual Women

Concerns	All Respondents			Heterosexuals			Lesbian/Gay/Bisexuals		
	Same	Less	More	Same	Less	More	Same	Less	More
	Percentages			Percentages			Percentages		
Money problems	85	4	11	86	4	9	70	0	30
Problems with lovers	73	3	24	74	3	24	73	9[a]	18
Depression	72	2	26	73	2	25	64	0	36
Eating disorders	71	15	15	71	15	14	80	10[a]	10[a]
Suicidal ideation	70	4	26	71	3	26	55	9[a]	36
Physical abuse	69	6	25	67	6	28	91	9[a]	0
Work-related stress	67	2	32	68	2	30	55	0	45
Frequent anxiety or fear	66	1	33	64	2	34	73	0	27
Emotional abuse	64	1	35	62	2	36	82	0	18
Alcohol/drug problems	61	4	35	67	4	29	10[a]	0	90
Sexual abuse or rape	60	1	39	58	1[a]	41	82	0	18
Violence in relationships	57	27	16	59	24	17	36	64	0
Discrimination	19	1	81	20	1[a]	79	0	0	100

[a]n = 1.
Within rounding error, percentages total 100% for each row.

lesbian mental health. LCSWs and LPCs did not significantly differ in this regard.

Descriptive Analysis of Heterosexual and Lesbian/Gay/Bisexual Providers

Personal and Practice Characteristics. Heterosexual and non-heterosexual providers were close in average age, number of clients currently seen, and percent of current clients who are women (Table 3). However, the mean percentage of lesbians among all women clients, the mean number of lesbian clients ever seen, and the mean percentage of current clients known or thought to be lesbian were higher for lesbian, gay, and bisexual providers.

Training About Sexual Orientation and the Special Needs of Lesbian Clients. As indicated earlier, about one in 5 (22%) of all respondents had received special training or education in lesbian mental health issues. There was a marked difference on the basis of respondent

sexual orientation–19% of heterosexuals and 58% of lesbian, gay, and bisexual providers had received such training.

Knowledge About Lesbians: Definitions. An open-ended question was used to elicit respondents' definitions of ''lesbian'' and ''lesbianism.'' As shown in Table 4, content analysis of responses resulted in four categories: (1) sexual attraction, interest, preference, or orientation, (2) emotional, psychological, or romantic attraction or interest, (3) primary relationships with women, and (4) self-identification as lesbian.[1]

Noticeable differences were found in responses from heterosexual and lesbian, gay and bisexual providers. Nearly all respondents–97% of heterosexuals and 91% of non-heterosexuals–included something about sexual behavior or attraction in their responses. Only 18% of heterosexuals added other (non-sexual) dimensions, including information about emotional attraction, relationships, or self-identification in their definitions, compared with 73% of lesbian, gay, and bisexual providers who noted emotional or psychological attraction/interest, 27% who referred to primacy of same-gender relationships, and 9% who mentioned self-identification.[2]

Heterosexual providers were more likely than non-heterosexuals to give one or more sexual definitions of lesbianism and no nonsexual definitions (Table 5), while non-heterosexual providers were more likely to give one or more nonsexual definitions. Among heterosexuals, those with special training or education in lesbian mental health were somewhat more likely to mention at least one nonsexual definition of lesbianism (29%) than those without such training (14%). Heterosexuals with training were no less likely than those without training to mention at least one sexual definition.

Positive Contributions to Mental Health. Open-ended questions were also used to elicit respondents' views about the positive and negative effects of being a lesbian on a woman's mental health. Through content analysis, positive contributions were grouped into five categories, shown in Table 6: (1) increased emotional strength, (2) access to community or relationships, (3) increased tolerance, (4) no difference from heterosexual women, and (5) other. Increased emotional strength was noted by 60% of all respondents, while access to community and relationships and increased tolerance were noted by much smaller proportions of the sample (18% and 16% overall). Sev-

enteen percent noted that lesbians were not different from other women.

Slight differences were observed between the responses of heterosexual and non-heterosexual providers. These groups were similar in recognizing the potential for access to the community and relationships, but lesbian, gay and bisexual providers were slightly more likely to note positive contributions toward increased emotional strength and increased tolerance.

Negative Contributions to Mental Health. Negative contributions to mental health of being a lesbian were grouped into seven categories, shown in Table 7: (1) discrimination against lesbians, (2) discomfort with lesbian identity, (3) lack of social support, (4) general emotional problems, (5) negative reactions toward society, (6) no difference from heterosexual women, and (7) other.

Overall, higher proportions of respondents noted negative contributions than had noted positive contributions and again, differences were found based on their sexual orientation. Discrimination against lesbians was reported by the highest proportion–75% overall (76% for heterosexuals and 67% for non-heterosexuals), followed by lack of comfort with one's lesbian identity, reported by 29% of heterosexuals and 50% of non-heterosexuals. Lack of social support was also noted as a negative by a substantial proportion–25% of lesbian, gay, and bisexual providers and 16% of heterosexual providers.

Effect of Coming Out on Clients' Mental Health. An open-ended question was asked to elicit respondents' experiences with lesbian clients and coming out. Content analysis of their answers resulted in a differentiation of positive from negative effects, shown in Table 8. Forty-one percent of all respondents thought that coming out improved lesbians' mental health. Lesbian, gay, and bisexual providers were more likely to identify this effect (83%) than were heterosexuals (36%). The most common negative effect was lack of social support, mentioned by 34 percent of all respondents, with heterosexual providers being more likely (38%) than non-heterosexuals (17%) to include it. In general, respondents tended to see coming out as having both positive and negative effects, with somewhat more emphasis on positive effects.

Mental Health Concerns in Lesbians and Heterosexual Women. Respondents were asked to indicate from a list of 13 mental health concerns whether they believe lesbians experience these "less often,"

"more often," or "about as often," as heterosexual women. Results can be seen in Table 9, where they are listed in descending order based on percentages of all respondents who thought lesbians experienced these about as often as heterosexual women (labeled "same" in the table). There was a very strong consensus of opinion about specific concerns. Eighty-five percent of all respondents thought lesbians and heterosexual women experienced money problems about as often (of 15% who disagreed, all but four percent thought lesbians experienced this more). Eighty-one percent thought lesbians experienced discrimination more often; of 20% who disagreed, only one percent thought they experienced it less.

On a number of other items where smaller proportions of respondents (60-73%) thought sexual orientation *did not* influence frequency (i.e., "heterosexual women and lesbians experience this about the same"), there was nevertheless a strong consensus among providers who did not perceive these experiences as being the "same" that lesbians actually experience them more often. Examples are problems with lovers, depression, suicidal ideation, physical abuse, work-related stress, frequent anxiety or fear, emotional abuse, and sexual abuse or rape.

Although there was considerable variability among responses, a majority of providers believed that these mental health concerns, with the exception of discrimination, are equally problematic for lesbians and heterosexual women. Among those who did not believe these concerns to be equally likely, providers were more likely to perceive them as being problems for lesbians. Exceptions were for eating disorders, where dissenters were evenly split on the issue of whether these occur more or less often in lesbians, and violence in relationships, where more dissenters felt it was less common in lesbian relationships.

Two concerns seem to be perceived differently, based on provider sexual orientation. Ninety percent of lesbian, gay, and bisexual respondents thought lesbians experienced problems with alcohol or drugs *more often* than heterosexual women; the most common response from heterosexual respondents on alcohol or drug problems was "about as often." Moreover, 64% of lesbian, gay, and bisexual respondents thought lesbians experienced violence in relationships *less often* than heterosexual women; the most common response from heterosexual respondents on violence in relationships was "about as often."

Differences between the perceptions of heterosexual providers and lesbian, gay and bisexual providers highlight the lack of understanding of lesbians' needs and experiences reported by many heterosexual providers and their unfamiliarity with the literature on lesbian and gay issues. For example, three times as many lesbian, gay, and bisexual providers perceived that lesbians had money problems more often than heterosexual women. Actually, concerns about money were the primary concern of lesbians participating in the National Lesbian Health Care Survey, reported by 57% of respondents (Bradford, Ryan, & Rothblum, 1994). And according to an economic analysis of same-sex data from the General Social Survey, lesbians have an average income of $15,056, which averages about 12-30% less than heterosexual women (though differences drop in size and significance when selection control factors are included; Badgett, 1995).

More than twice as many heterosexual providers believed that lesbians were more frequent victims of sexual abuse and rape (while similar proportions perceived that lesbians have higher levels of emotional and physical abuse). This perception may be fueled by stereotypes of lesbians whose sexual identity is shaped by childhood sexual abuse (Herman & Hirschman, 1981) or male-female sexual violence, however, this perception is unfounded. The rate of incest reported by lesbians in the National Lesbian Health Care Survey (18.7%; Bradford, Ryan, & Rothblum, 1994) was comparable to the rate among the general female population (16%; Russell, 1984). Moreover, the reported rate for sexual abuse and rape was the same for lesbians in Bradford and Ryan's (1987; 1994) survey and heterosexual women in Russell's (1984) sample of the general female population (34%).

Significant differences were also seen related to substance abuse, based on providers' sexual orientation. While early studies of lesbians and gay men showed high rates of chemical dependency (Fifield, 1975; Lohrenz, 1978), more recent studies with larger and more diverse samples found comparable rates of heavy drinking, with differences in rates of problem drinking between heterosexuals, lesbians and gay men (McKirnan & Peterson, 1989). Fewer lesbians and gay men abstained from alcohol use, and they reported rates of alcohol problems nearly twice as high as heterosexuals. Unlike heterosexual women, use in lesbians increased with age, a finding seen in other studies (Bradford, Ryan, & Rothblum, 1994; McKirnan & Peterson, 1989).

In terms of domestic violence, lack of available data and an assump-

tion that most perpetrators were men, led to a belief that domestic violence was extremely low among lesbians. More recently, research has demonstrated the presence of domestic violence in some lesbian relationships (Brand & Kidd, 1986; Renzetti, 1992), although the lack of probability samples precludes generalizing beyond the study sample and lack of gender specificity may obscure results. For example, among NLHCS respondents who reported abuse by a lover (8% of all who had been physically abused), gender was not identified (Bradford & Ryan, 1987). Because another response option was ''husband,'' it can be assumed that most of those abused by lovers had been abused by other women, although this cannot be stated with certainty.

Attitudes Towards Lesbians. Although the current study was not intended to assess use of language per se, open-ended questions allowed providers to define and describe lesbian experiences in their own words. Use of stereotypical constructs was not uncommon, nor were negative comments about lesbians which were expressed by one out of 10 practitioners. Of concern, as well, is the use of language that suggests little understanding of emotional correlates of minority group identification (i.e., coming out). For example, several providers mentioned anger and militancy in describing negative effects of lesbian identity on mental health. However, anger is commonly expressed as ethnic/racial minorities consolidate minority group identity and acknowledge experiences of oppression and victimization within the dominant culture (Atkinson, Morten, & Sue, 1983). Similarly, lesbians and gay men experience anger which may be expressed through increased politicization and militancy as they struggle with growing awareness of their oppression. The role of the practitioner is not to side-step or discount negative effect, but to provide a safe environment where devalued parts of the self can be expressed, explored, and ultimately integrated into a positive sense of self.

Conversion Therapy. One practitioner, an LCSW in private practice who had worked with 30 lesbian clients, reported that she engaged in conversion therapy (treatment focused on changing sexual orientation from homosexual to heterosexual). Although this is not surprising (other studies have consistently reported negative bias and perceptions that lesbians and gay men are ''sick'' and ''in need of change,'' including the American Psychological Association membership survey which showed both exemplary as well as homophobic practice; Garnets et al., 1991), the use of ''conversion'' or ''reparative'' therapy has

been consistently challenged as unscientific as well as unsuccessful, unethical, and harmful (Haldeman, 1991).

Outcome of Research Questions. Most providers had not received training related to sexual orientation and the needs of lesbian clients. Respondents' lack of understanding of lesbian identity and limited knowledge of the role of coming out in identity development and mental health suggest that many heterosexual providers lack adequate information about lesbians' needs and experiences. However, further exploration is needed. Although the proportion of non-heterosexual practitioners is small, lesbian, gay and bisexual providers have more practice experience with lesbian clients and are more knowledgeable about lesbians' needs and experiences than heterosexual providers.

Limitations of the Study. Although this represents the first probability study of LCSWs and LPCs knowledge and understanding of lesbians, these data should not be considered representative of all LCSWs and LPCs either within or beyond the state of Virginia. First, results are based on a 45% return rate which may exclude providers whose knowledge and attitudes differ from those reflected here. In particular, non-respondents' attitudes may have been more negative and they may have had less training or experience than respondents. Second, Virginia is considered highly intolerant of lesbians and gay men based on a review of adoption law and custody decisions (Lambda Legal Defense & Education Fund, 1996); thus, attitudes of practitioners may be more reflective of cultural mores than practice characteristics of providers in other areas.

DISCUSSION/IMPLICATIONS FOR RESEARCH AND PRACTICE

Like earlier studies (Bieschke & Matthews, 1996; Rudolph, 1988; Smith, 1993), findings show that lesbian and gay mental health providers were more informed and had more positive perceptions of lesbian experiences and concerns than heterosexuals. Moreover, lesbian, gay and bisexual providers were three times as likely to have obtained training on lesbian issues and five times as likely as their heterosexual counterparts to understand that sexual orientation encompasses more than a sexual component (e.g., affectional, emotional and social). Reducing lesbian (and gay) identity to a purely sexual experience is a pervasive stereotype that dehumanizes lesbians and

gay men. Unfortunately, mental health practitioners are as predisposed to stereotypes as others in society (Sundberg, 1981 in Casas) and have been shown to be more likely to rely on stereotypes when making judgments about lesbians and gay men (Casas et al., 1983). Although some heterosexual providers in the current study had a more inclusive understanding of lesbians' sexual identity and experiences and positive perceptions of how being a lesbian could contribute to mental health, the majority did not understand the basic dimensions of lesbian identity and substantial proportions expressed misconceptions about lesbians' mental health concerns. These include perceptions that lesbians have higher rates of sexual, physical and emotional abuse and experience more frequent anxiety and fear than heterosexual women. While lesbian and gay providers generally showed greater understanding of lesbians' experiences and concerns, they can also be susceptible to heterosexism and homophobia and are also in need of appropriate training and supervision (Murphy, 1991).

The finding that self-identified lesbian clients or those whom respondents perceived to be lesbians were more than twice as likely to receive mental health care from lesbian, gay and bisexual mental health providers is not surprising. Lesbians in need of mental health services are likely to seek openly identified lesbian, gay or bisexual providers if such providers are available. However, openly lesbian mental health providers comprise a small proportion of available mental health practitioners, and access to them is limited in many areas and settings. Since research has shown that use of mental health services is high among lesbians, they are likely to be included in a mental health provider's caseload, whether or not they disclose their sexual identity to providers. As lesbians and gay males self-identify and come out at increasingly younger ages, knowledgeable providers are needed in a wide range of mental health settings where these individuals and their families are likely to present for care.

Both the social work and counseling professions need to expand policies and standards, pro-actively incorporate lesbian and gay content into graduate training and continuing education, and actively regulate unethical practice. The inclusion of a licensed provider practicing conversion therapy in a probability sample of social workers and counselors suggests that this is not an isolated incident. Lesbian and gay clients, particularly those who are in early stages of coming out, are especially vulnerable to false claims of conversionists (Haldeman, 1991). Accord-

ing to the American Psychiatric Association (1994), "There is no evidence that any treatment can change a homosexual person's deep seated sexual feelings for others of the same sex. Clinical experience suggests that any person who seeks conversion therapy may be doing so because of social bias that has resulted in internalized homophobia . . . " Moreover, NASW's current policy on lesbian, gay and bisexual issues states that social workers should neither attempt to practice such therapy nor make referrals to programs that claim to do so. NASW and ACA have a responsibility to safeguard the well-being of clients and to integrate solid research findings into ethical practice; such findings show that conversion therapy is fallacious and contraindicated.

Study results underscore the need for ongoing training and supervision on lesbian and gay issues in social work and counseling programs and continuing education. Data should also be used to inform curriculum development and, in particular, to address long-standing misconceptions that practitioners continue to report. Research on lesbian, gay, and bisexual issues is rapidly expanding; however, based on these findings, practitioners do not appear to be familiar with advances in the field. The proliferation of journals on sexual orientation may serve to limit distribution to "specialists" in lesbian and gay issues; thus, more sexual orientation content is needed in mainstream journals to counteract misinformation and prevailing stereotypes held by providers who are serving lesbian, gay, and bisexual clients.

NOTES

1. Lists of unrecorded responses for this and subsequent questions are available from the corresponding author.

2. Slight differences in percentages should not be over interpreted, given the low number of lesbian, gay and bisexual providers. For example, one percent (N = 2) of heterosexual providers included self-identification in their definitions compared to nine percent of lesbian, gay and bisexual providers (N = 1). Note also in this table, 8% of lesbian, gay and bisexual providers represents an N of 1.

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