Journal of the Gay and Lesbian Medical Association, Vol. 5, No. 1, 2001

Lesbian Disclosure to Health Care Providers and Delay of Care

Mary Ann A. van Dam, RN, MS, PNP,[1,4] Audrey S. Koh, MD,[2] and Suzanne L. Dibble, RN, DNSc[3]

Purpose/Objective: 1) To identify if lesbians delay seeking health care because of sexual identity issues. 2) To examine the frequency of sexual identity disclosure for both lesbians and heterosexual women to health care provider (HCP). 3) To identify the methods used by HCPs, lesbians, and heterosexual women to disclose sexual identity. 4) To identify lesbians' perceptions of how disclosure of sexual identity could be made easier for them. *Design*: Descriptive study with convenience sample. Data gathered by survey. *Setting*: Thirty-three health care offices or clinics across the United States. *Sample*: The typical participant ($n = 1161$) was 40.14 years old (SD = 11.32, range = 15–92). Of this sample, 45.1% ($n = 524$) identified as lesbian and 54.9% ($n = 637$) identified as heterosexual. Most identified as white (83.6%) and educated, with variability in income levels. *Measurement*: Written survey was designed by expert clinicians and refined after two pilot studies. *Results*: Seventeen percent of HCPs inquired about client's sexual identity verbally; only 43% of HCPs (inclusive of this 17%) inquired about sexual identity in writing or in some other way. Lesbians reported that HCPs were less likely to know their sexual identity than heterosexual women. Lesbians were more likely to voluntarily report their sexual identity to HCPs than heterosexual women. Lesbians reported that ease of disclosure could be assisted by asking verbally, asking in writing, and by "improvement of HCP attitude." Lesbians reported more delays in seeking health care because of sexuality issues, specifically, fear of discrimination against them because of their sexual identity compared to heterosexual women. Lesbians were more likely to conceal their lesbian identity from HCPs when they were less disclosed to family, co-workers, and friends. *Conclusion*: Most HCPs did not assess for sexual identity, even though related issues are important to discuss with clients. HCPs can ease disclosure by asking about sexual identity and by awareness of their expression of attitudes toward lesbianism. Delay of care related to discrimination can be considered a social risk factor for lesbian health and well-being.

KEY WORDS: lesbian, delay of care, discrimination, HCP.

INTRODUCTION

Women who identify as lesbian are members of a "hidden minority group," that is, one which does not have obvious characteristics and therefore creates a need for disclosure (1, 2). A lesbian is often assumed to be heterosexual, and so she must evaluate each interaction to decide about disclosing her sexual identity. Disclosure negotiations occur in many situations throughout a lesbian's lifetime, and a lesbian must engage in risk assessment of the environment and the

[1]School of Nursing, University of California, San Francisco, San Francisco, California, 94143.
[2]Department of Obstetrics and Gynecology, California Pacific Medical Center, San Francisco, California 94115.
[3]Institute for Health and Aging, School of Nursing, University of California, San Francisco, San Francisco, California 94143-0646.
[4]Correspondence should be directed to M. A. van Dam, RN, MS, PNP, 819 Dell Road, Pacifica, California, 94044.

1090-7173/01/0300-0011$19.50/1

negative and positive consequences of her decision (1–3).

Despite a reported increase in the social acceptance of homosexuality, disclosure processes remain difficult (2, 4, 5). When a lesbian chooses not to disclose her sexual identity, she closes off potential opportunities for clear communication (6–9). Along with questions regarding her personal integrity (9), a lesbian's nondisclosure interferes with the development of supportive, congenial, and intimate relationships with family, friends, health care providers, colleagues, and acquaintances (2, 5, 10–13). For lesbians who believe they have the ability to conceal their lesbianism, the tasks of nondisclosure remain highly complex since they must be vigilant about how they act, how they look, what they say, who they are with, and where they go (14). There is not a parallel experience for the heterosexual woman (2, 3, 15).

Health care providers (HCPs) have been reported to hold negative views about lesbians (2, 3, 16). These negative views may be communicated through attitudes, verbal cues and/or silence. Because effective interaction is necessary to provide appropriate health care for all clients, HCPs must demonstrate willingness to identify and discuss lesbians' health care risks and concerns (17).

Many researchers have documented the psychological benefits of disclosure (9, 15, 18). Ability to disclose has been associated with a greater sense of personal power which is also associated with greater lifestyle satisfaction (18). Jordan and Deluty (1998) reported a significant association between disclosure and less anxiety, more positive affectivity, greater self-esteem, and greater levels of social support (9). A higher degree of disclosure has been associated with less fear of exposure and with more choices about mental health counseling (15). Self-disclosure as a lesbian to HCPs is a decision made by the lesbian who has examined the risks and benefits of disclosure in that particular situation and has decided that this information is important to share. Studies show that lesbians fear that their health care will become substandard, the provider will moralize, or they will be treated as if their sexual identity is an illness (14, 17, 19). Some lesbians have created a complex repertoire of protective strategies so that they can avoid any potential for mistreatment, such as controlling information and bringing witnesses (20, 21). Lesbian parents may be concerned about jeopardizing their children's health care when they disclose parental sexual identity (22). Lack of disclosure and lack of family health insurance coverage (via domestic partnership) can interfere with the benefits of family-focused care (23). Lesbians may delay seeking health care (13) possibly interfering with preventative care and early diagnostics for themselves and their children.

HCPs are aware that chronic stress and anxiety can create and exacerbate negative emotional and somatic conditions including gastrointestinal upsets, headache, depression, high blood pressure, suicide, drug and alcohol addiction, and many more. Along with all the possible reasons for stress in any population, issues of lesbian disclosure may generate chronic stress in their lives (5, 15). Negation of their day-to-day existence and the threat of physical and verbal violence may produce stressful burdens in the lesbian experience. Antilesbian attitudes demonstrated by those in the legal system toward disclosure of lesbianism have been reported to be a direct threat to the integrity of the lesbian family (24, 25). It has been reported that these attitudes provoke chronic and situational stress for lesbian mothers and their children (8, 9, 26). The presence of social support, particularly from a lesbian community, has been related to positive disclosure experiences (9).

The purpose of this study was to identify any delay in seeking care among a sample of lesbians, examine frequency of sexual identity disclosure with HCPs among a sample of lesbians and heterosexual women, the methods used by lesbian clients to disclose sexual identity, and lesbians' perceptions regarding how disclosure could be made easier for them.

METHODS

Design

This was a secondary analysis of data from a descriptive study in order to 1) identify delay of health care related to sexual identity issues and 2) explore the differences, similarities, and characteristics about disclosure of sexual identity to HCPs in a group of lesbian and heterosexual women.

Settings

Thirty-three health care sites across the United States contributed data for this study, providing diversity among women outpatients. The data predominately represent clients from private offices providing primary care services, but also included were community clinics, two chiropractic offices, and one naturopathic health care office.

Surveys were distributed on-site. Sites that were known to have greater than 30% female patients identifying as lesbian (approximately one half of the sites) provided surveys to all female patients. The remaining sites distributed the survey to each known lesbian and the following two female patients. The stated purpose of the 98-item survey was twofold: to describe 1) characteristics of women's preventative health behaviors, and 2) factors that may encourage women to seek health care. The survey did not state that sexual identity was a characteristic of interest. Completed surveys were anonymously returned in a drop box at the site or by business reply envelopes.

Sample

A total of 2716 surveys were distributed from May 1, 1996 until February 14, 1997 of which 1362 were completed and returned, yielding a 50% response rate. Forty-one respondents who left the sexual identity question blank and 17 respondents who answered the sexual identity question as "unsure" were omitted. For this analysis, another 143 bisexual women were omitted, leaving a total of 524 lesbian women and 637 heterosexual women respondents.

Instruments

Data were collected by a written survey instrument developed by expert clinicians and refined after two pilot tests. Content validity was established by a multidisciplinary panel of experts.

Procedure

Data entry was done with 100% verification via double-keyed entry by a commercial data processing service using SAS (6.12 version) statistical software. The study protocol was approved by the Institutional Review Board of California Pacific Medical Center in San Francisco.

Data Analysis

Statistical analyses were done using SPSS (Tm) base 8.0 (1998). Statistics were calculated to describe the demographic characteristics of the sample. Comparisons in the demographics by sexual identity were generated using *t*-tests and chi-square tests as appropriate for the level of data. Since age and education level were different by sexual identity, comparisons of disclosure behavior and issues between the two groups were completed with age and education as covariates. Logistic regression was used to compare disclosure issues between groups. The criterion for significance was preset at $p < .05$.

RESULTS

Sample Information

The typical participant ($n = 1161$) was 40.14 years old (SD = 11.32, range 15–92) white (83.6%), and represented a wide range of household and individual incomes. A majority of the sample participants lived in major cities (78.8%) and were in married or committed relationships (72.4%). Of this sample, 45.1% ($n = 524$) self-identified as lesbian and 54.9% ($n = 637$) described themselves as heterosexual. Table I contains a comparison of demographic information by self-reported sexual identity. Sample sizes had small variations due to missing data. There were significant differences in age, with the lesbian group being approximately 2 years older than the heterosexual group. Although 36.7% of the entire sample were parents, 49.2% of the heterosexual sample were parents compared to 21.6% of lesbian parents ($P < .0005$). Most (89.7%) of the heterosexual women reported sex only with men, whereas 54.1% of the lesbians reported sex with both men and women during their lifetime.

Disclosure Results

After controlling for age and education, there were some significant differences in disclosure of sexual identity to HCPs between lesbian and heterosexual women in this sample (see Table II). Lesbians were 2.75 times more likely to report that their sexual identity was never or only sometimes known by their HCPs compared with heterosexual women (95% confidence interval [CI] = 2.13–3.56). Disclosure to HCPs was similar between lesbians and heterosexual women when the provider took an active role to learn this information. That is, when providers or their staff asked verbally (of 16.8% of lesbians and 17.1% of heterosexual women) or asked in writing (of 33.3% of lesbian and 35.9% of heterosexual women) or either verbally or in writing (of 41.7% for lesbians and 42.9% for heterosexual women), there were no significant differences between the two groups. However, significant differences were noted when the provider

Table I. Demographics

Variable	Lesbian ($n = 524$)	Heterosexual ($n = 637$)	Statistic	Significance	95% Confidence Interval
Age (years)					
Mean	41.08	39.02	$t = 3.189$	$P < .0005$	0.794–3.332
SD	13.09	8.64			
Education (years)					
Mean	16.89	15.94	$t = 6.753$	$P < .0005$	1.22–0.672
SD	2.22	2.54			
Ethnicity	*n* (%)	*n* (%)			
Women of Color	77 (14.7)	113 (17.9)	$\chi^2 = 3.11$	$P < .078$	
Caucasian	445 (85.3)	518 (82.1)			
Married or in committed relationship					
Yes	405 (77.7)	436 (68.8)	$\chi^2 = 11.6$	$P < .001$	
No	116 (22.3)	198 (31.2)			
Have Children					
Yes	113 (21.6)	311 (49.2)	$\chi^2 = 93.85$	$P < .0005$	
No	410 (78.4)	321 (50.8)			
Household income					
Up to 19.9K	75 (14.5)	104 (16.8)			
20K–39.9K	94 (18.1)	159 (25.7)			
40K–59.9K	112 (21.6)	138 (21.5)	$\chi^2 = 16.05$	$P < .003$	
60.K–100K	114 (27.8)	133 (21.5)			
Over 100k	93 (18.0)	85 (13.7)			
Individual income					
Up to 19.9K	119 (22.8)	212 (34.5)			
20K–39.9K	178 (34.1)	218 (35.5)			
40K–59.9K	128 (24.5)	120 (19.5)	$\chi^2 = 31.63$	$P < .0005$	
60.K–100K	73 (14.0)	42 (6.8)			
Over 100k	24 (4.6)	22 (3.6)			
Living environment					
Major City	418 (80.1)	490 (77.4)			
Small City	62 (11.9)	90 (14.2)	$\chi^2 = 1.745$	$P < .783$	
Rural	31 (5.9)	37 (5.8)			
Other	16 (3.1)	11 (1.7)			
Sex partners, lifetime					
None	2 (0.4)	11 (1.7)			
Men only	17 (3.3)	567 (89.7)	$\chi^2 = 883.46$	$P < .0005$	
Women only	220 (42.2)	18 (2.9)			
Both	282 (54.1)	36 (5.7)			

did not actively seek sexual identity information of their clients. Heterosexual women were 5.69 times more likely to report that providers assumed their sexual identity correctly compared to lesbian women in this sample (95% CI = 3.83–8.46). Lesbians were 3.73 times more likely to report their sexual identity to their HCP compared to heterosexual women (95% CI = 2.82–4.94).

Analyses reflected significant differences between lesbian and heterosexual women's responses to close-ended questions regarding methods by which HCPs could make sexual identity disclosure easier. Lesbians were 3.52 times more likely than heterosexual women to report written questions as a helpful method to disclose their sexual identity (95% CI = 1.61–7.68). Lesbians were also 2.91 times more likely to consider verbal questions helpful to disclose their sexual identity than heterosexual women (95% CI = 1.25–6.79). The largest difference between lesbians and heterosexual women regarding methods to ease disclosure was reflected in their responses to "improvement of provider attitude," where lesbians in this sample were 8.47 times more likely to report that this method would help (95% CI = 3.36–21.35).

Two questions were created to obtain information about the reasons that the participant delayed seeking health care. Thirty-six percent of lesbians, in contrast to 2.7% of heterosexual women, delayed seeking health care because of concerns about the response of the HCP to their sexual identity. Lesbians

Table II. Disclosure Results

Variable	Lesbian [*n* (%)]	Heterosexual [*n* (%)]	Statistic (Logistic Regression Adjusted odds ratio)	95% CI	Significance
How often have your previous health care providers known your sexual orientation?					
Never/sometimes	332 (64.7)	222 (40.0)			
Always/most of the time	181 (35.3)	334 (60.0)	2.75	2.13–3.56	$P < .0005$
How did your providers learn your sexual identity?					
Assumed correctly	37 (7.6)	166 (33.6)	5.69	3.83–8.46	$P < .0005$
Asked in writing	116 (33.3)	175 (35.9)	1.12	.85–1.48	$P < .416$
Provider/staff asked verbally	83 (17.1)	82 (16.8)	1.05	.74–1.48	$P < .799$
Offered without being asked	282 (58.0)	134 (27.5)	3.73	2.82–4.94	$P < .0005$
Provider/staff asked verbally or in writing	202 (41.7)	209 (42.9)	1.10	.85–1.43	$P < .458$
What would make disclosure of your sexual identity to your health care provider easier?					
Written questions	43 (78.2)	66 (52.0)	3.52	1.61–7.68	$P < .002$
Verbal questions	37 (77.1)	70 (56.9)	2.91	1.25–6.79	$P < .013$
Improve provider attitude	20 (57.1)	17 (17.2)	8.47	3.36–21.35	$P < .0005$
In the past 12 months did you delay medical attention because of concerns regarding your sexual identity?					
Yes	190 (36.8)	16 (2.7)			
No	326 (63.2)	568 (97.3)	7.51	3.00–18.76	$P < .0005$
If you delayed health care, how much did fear of discrimination against your sexual identity contribute to this delay?					
Never/sometimes	87 (69.6)	108 (99.1)			
Always/most of the time	38 (30.4)	1 (.9)	59.02	7.58–459.61	$P < .0001$
About what proportion of people in each of the following groups know your sexual identity?					
Family					
Less than all	230 (44.3)	54 (9.2)			
All	289 (55.7)	535 (90.8)	7.91	5.63–11.12	$P < .0005$
Friends					
Less than all	156 (30.2)	54 (10.6)			
All	361 (69.8)	525 (89.4)	3.60	2.58–5.02	$P < .0005$
Co-workers					
Less than all	243 (66.8)	125 (21.9)			
All	170 (33.2)	446 (78.1)	6.81	5.16–8.99	$P < .0005$

were 7.51 times more likely to delay seeking health care because of concerns regarding their sexual identity than heterosexual women (95% CI = 3.00–18.76). Participants who did delay heath care ($n = 206$) were asked how often fear of discrimination against their sexual identity contributed to this delay. Lesbians were 59.02 times more likely to respond that they "always" or "most of the time" delayed health care because of sexual identity discrimination fear compared to heterosexual women (95% CI = 7.58–459.61).

Knowledge of participants sexual identity by family, friends, and co-workers was also investigated in this sample. Heterosexual women participants were 7.91 times more likely to report that "all" their family members knew their sexual identity when compared to the lesbian participants (95% CI = 5.63–11.12). Heterosexual women, compared to the lesbian sample, were 3.60 times more likely to report that "all" their friends had knowledge of their sexual identity (95% CI = 2.58–5.02) and 6.81 times more likely to report that "all" their co-workers had knowledge of their sexual identity (95% CI = 5.16–8.99).

Lesbians who had disclosed their sexual identity to half or less of their family members were more likely to conceal their lesbian identity from their HCP (77%; $p < .001$). Those who had disclosed their sexual identity to more than half of their family members remained unlikely to disclose to HCPs, yet they were more likely to do so than lesbians who were less disclosed to family members (58.7%; $p < .001$). Similar

lesbian disclosure to HCP associations were found in relation to disclosure to co-workers and friends. Lesbians who were disclosed to half or less of their co-workers and friends were likely to conceal their lesbian identity from HCPs (co-workers = 77.7%; $p < .0005$, and friends = 89.7%; $p < .001$). Lesbians who were disclosed to more than half of their co-workers and friends remained unlikely to disclose to their HCP (co-workers = 58.4%; $p < .0005$, and friends = 62.5%; $p < .001$), yet were more likely to disclose to HCP than those who were less disclosed to friends and co-workers.

DISCUSSION

Why Disclose

Lesbians may have important aspects related to their health and well-being that remain unknown unless they can disclose their sexual identity. Lesbians are often in committed relationships (2, 15), as reflected in this study's demographic results (Table I). A lesbian's life partner, although not legally defined or sanctioned, is often a major source of support in her daily life (5, 13, 27, 28). HCPs who ask about partnership status, can utilize this support system to assist with many aspects of care, including issues that arise in acute and chronic illnesses. The lesbian's family of origin may or may not be a source of support because the issue of lesbianism and disclosure may create family rifts that have diminished trust and dependance (5, 9, 13, 23).

The multidimensional process of the lesbian's original "coming out" to self, along with the various issues of disclosure in her past and present life, may create some level of chronic stress (5, 14, 15, 17, 23, 29). Chronic stress creates potential for both effective and ineffective coping strategies (15). HCPs who understand the lesbian client's potential for chronic stress are able to assess health care problems associated with stress and ineffective coping strategies. An empathic provider who openly addresses these issues with the lesbian client can promote a trusting client–provider relationship, better enabling optimization of the client's health and well-being (2, 14, 21, 30, 31).

As with many cultures and minority groups, lesbians have specific risk factors that interfere with health and well-being (29), which must be assessed by HCPs. Therefore, it is imperative that HCPs ask about sexual identity and the sexual behaviors of any client seeking health care. In order for HCPs to become a part of the lesbian's network of support, providers must consider the concerns and hesitation of the lesbian client. Heterosexist assumptions and personal bias, insightfully examined and omitted, can promote an open, relaxed, and trusting relationship, increasing the HCP's ability to optimize health care for the lesbian client.

Physical health risks may be different for lesbians than for heterosexual women (27, 30, 32). Although these differences seem to be associated with childbirth and sexual behavior with men, providers should be aware that some lesbians have sex with men and that many are parents (30, 31). Sexual behaviors for both lesbian and heterosexual women may not be limited to self-identified sexual identity or societal expectation of monogamy. Therefore, assumptions about lesbian parenthood and sexual behaviors need to be discussed once sexual identity has been delineated so that physical health risks for the individual lesbian can be assessed accurately.

Measurement Issues

Research issues including data measurement, comparative analyses, and interpretation can be difficult because the concept of sexual identity disclosure for heterosexual women differs from sexual identity disclosure for lesbians (3, 15). As a risk-benefit decision, disclosure of sexual identity in surveys may overrepresent lesbians who are more comfortable and willing to disclose, and hence create a sampling skew (23). Researchers must consider differences in social reality in the concept of sexuality disclosure for the two groups when planning for recruitment of study participants.

Comparison of lesbian and heterosexual women's disclosure of sexual identity can create data interpretation problems because the concept of sexual identity disclosure is an issue unique to lesbians (3, 15). There is a pervasive assumption of heterosexuality in society that may cloud interpretation of study results. Many answers to questions regarding disclosure of heterosexuality in the control group have questionable interpretation because disclosure for most heterosexuals does not incorporate an active negotiated decision, weighing risk and benefits, as it often does for lesbians. Disclosure of heterosexuality then, is often by proxy and heterosexuality, is assumed to be true until otherwise stated. Interpretation of answers to disclosure questions for people who are correctly assumed to be heterosexual may then become confused

by mixing the confirmed status (i.e., telling someone) versus the passive status (i.e., societal assumption).

Discussion of Study Results

In this study, heterosexual women were more likely than lesbians to report that HCPs knew their sexual identity and much more likely than lesbians to report that knowledge of their sexual identity came from a correct assumption of the HCP. Lesbians were more likely to offer sexual identity information to HCP than heterosexual women. This decision to offer disclosure of lesbian sexual identity to HCPs may reflect the importance that lesbians place on the differences between themselves and heterosexual women, be that from an emotional or physical stance (14, 31). Although the HCP may have been aware of the client's sexual identity, it does not imply that issues pertaining to sexual identity were discussed. The frequency and content of discussions regarding pertinent sexual identity issues following disclosure was not measured.

Forty-three percent of clients in this sample, whether heterosexual or lesbian, were asked their sexual identity by the HCP or office staff, including 17% who were asked about their sexual identity verbally. Disclosure of sexual identity in response to written questions occurred more frequently. However, written information, because of a lack of verbal acknowledgment, may be easier to ignore or overlook. Of the 43% of clients who were asked their sexual identity, there were no significant differences between reported rates of sexual identity questions between lesbian and heterosexual women, whether asked verbally or in writing. However, merely asking sexual identity without discussion of pertinent sexuality issues diminishes the potential benefit of sexual identification. Benefits to clients, such as assessment of sexuality issues, identification of health risks, evaluation of support systems, and opportunities for needed education cannot occur without further discussion. Therefore, although 43% of clients were asked their sexual identity, all of those clients may not have benefited from their disclosure. Low rates of questions regarding sexual identity may reflect an awkwardness, embarrassment, heterosexual presumption, lack of vocabulary, and/or lack of knowledge about sexuality in general by HCPs (31, 33). Because sexuality, including sexual identity, provides essential assessment information for health and well-being, some HCPs may benefit their clients and themselves by sexuality education, sensitivity training, and personal insight (2, 3, 6, 20, 31, 33, 34). Lesbians may hesitate or avoid responses to sexual identity questions because of concerns that this information will become part of their permanent medical record. The HCP's request for permission from lesbians to chart their sexual identity and systems to codify sexual identity in the medical record may acknowledge and relieve some of these concerns by lesbians (17, 30).

Lesbians were more likely than heterosexual women to report that HCPs could ease their disclosure by asking verbal and written questions in this sample. Along with the high rate of lesbians who offered their sexual identity to HCPs without being asked, this point may lend further support for the idea that sexual identity may be seen by lesbians as an important aspect of health and well-being in their lives (14, 31). In this sample, lesbians reported significantly more often than heterosexual women that "improvement of provider attitude" would ease disclosure of sexual identity. Interpretation of "attitude" is a subjective phenomenon where the use of silence, body gestures, words, and intonation may have different meaning for provider and client. In their personal history, many lesbians have experienced negativity and loss of important relationships with disclosure of their sexual identity (21, 30, 31). Along with this historical negativity and loss, the potential for lesbian internalized homophobia may heighten lesbian sensitivity to true and perceived negative "attitude" of the HCP (2, 30, 31, 35). HCPs can promote their client's comfort with insight into their own true and expressed "attitude." Sensitivity to the possible discomfort and fear about sexual identity disclosure by the lesbian client may enhance an open and trusting client/HCP relationship and encourage regular and preventative care of lesbian clients (21, 30, 31).

In societies where a heterosexual imperative is pervasive, negative consequences to disclosure of heterosexuality to HCPs do not exist. Lesbians in this study, in contrast, delayed seeking health care because of fear of discrimination against their sexual identity, a concept which Stevens (1992) supported and summarized from previous qualitative studies. Delay of health care may increase morbidity and mortality from many acute and chronic illnesses. Although few studies have been done in regards to lesbian health risks for various illnesses (23), further study should consider delay of care as a social health risk seen in lesbians. HCPs need to be aware of possible health care delays in the lesbian population. HCPs who gain a reputation for respectful understanding for lesbian

health issues may be able to diminish some access to care barriers for lesbian clients. Once the client is in the HCP's office, disclosure could be encouraged through sensitive questions, written or verbal, followed by discussions with nonjudgmental attitudes. Development of open and trusting relationships with HCPs may discourage delay of care and promote preventative health care (31) thereby optimizing the health and well-being of the lesbian client.

HCPs who find a client hesitant and uncomfortable with disclosure of her sexual identity, should proceed in their assessment with a calm and nonjudgmental demeanor (2, 30). A HCPs' assessment of the support network for those who have difficulty disclosing, may be important because of lack of disclosure may interfere with development of a lesbian's support network (9, 27, 35). In this sample, lesbians were less likely to have disclosed their sexual identity to all their family, friends, and co-workers than were heterosexual women, perhaps diminishing the potential support from these sources. HCPs who have assessed the support network of their lesbian client, may refer them to various groups or therapists within the lesbian community for specific support such as lesbians with breast cancer and lesbians with alcoholism (30). HCPs in small towns and rural areas where few lesbian supports are available may be the only support for the lesbian client (5), enhancing the importance of an open and trusting client/provider relationship.

LIMITATIONS

The women in this study were mostly white; only 16.4% were women of color representing various ethnicities. The women were educated, most having about 4 years of formal education beyond high school. This study's generalizability to the population of lesbians could have been strengthened by a sample more inclusive of ethnic diversity and women with a broader range of years of education.

Sampling issues are inherent in studies with a "hidden minority group." Although the participants were blinded to the specific purposes of this anonymous study, participants who were willing to disclose their sexual identity may have been more comfortable with sexuality disclosure in general. Therefore, the sample may represent inflated numbers of those lesbians for whom disclosure is more comfortable than actually exists in a general population.

The sample in this study was generated from HCP settings, mostly private offices. Delay of care data were generated from women who had already engaged themselves into a primary health care setting. Therefore these women were no longer delaying care. This sample did not capture women who continue to delay. The delay-of-care statistics, therefore, may be a conservative estimate of women who delay care. The difference between lesbian and heterosexual women who delay care due to fear of discrimination against their sexual identity therefore, needs further study.

CONCLUSION

Sexuality issues have important implications for the health and well-being of clients. Less than half of the HCPs in this study actively sought sexual identity information from their clients. HCPs must recognize that discussion regarding sexual identity and behavior are as basic to health care as discussing other aspects of health, such as nutrition and exercise. Medical schools provide very little education on homosexuality issues, if any at all (21). HCPs who have difficulty speaking to lesbian clients about sexual identity issues, whether from ignorance, embarrassment, or moral disdain, are encouraged to be personally insightful and seek education, collegial advice, and support to overcome this professional limitation.

Lesbian clients have aspects of their emotional, social, and physical health that may differ from heterosexual women and are important for the HCP to recognize. Although disclosure of sexuality is often difficult for lesbians, this study presents some evidence that lesbians want their HCP to know information regarding their sexual identity. HCPs who ease lesbian disclosure may be more effective in providing appropriate, individualized health care.

This study found that lesbians delayed health care because of fear of discrimination. This finding has far-reaching implications for lesbian health care and further research. Although replication studies are necessary for further understanding of this finding, future studies in lesbian differences in incidence of disease morbidity and mortality should consider delay of care as a social risk factor that may contribute to these differences.

Delay of access to health care for lesbians in response to fear of discrimination reflects social factors that interfere with health and well-being. HCPs understand that delay of care can promote morbidity and mortality for many illnesses. Just as HCPs argue against smoking advertisement in order to prevent lung disease, HCPs are challenged to speak out

against heterosexism and homophobia in order to prevent delay of health care.

ACKNOWLEDGMENTS

Special thanks to Jeanne deJoseph CNM, Ph.D, FAAN for her generous support through editing skills and manuscript wisdom. Funding for the original study was provided by the Lesbian Health Fund, a project of the Gay and Lesbian Medical Association. Partial support for this analysis was provided by the Center for Lesbian Health Research at the University of California, San Francisco.

REFERENCES

1. Morris J. Lesbian coming out as a multidimensional process. *J Homosex*. 1997;33(2):1–23.
2. O'Hanlan K. Lesbian health and homophobia: Perspectives for the treating obstetrician/gynecologist. *Curr Probl Obstet, Gynecol Fertil* 1995;July/August:100–33.
3. Stevens PE. Lesbian health care research: A review of the literature from 1970 to 1990. *Health Care for Women International* 1992;13:91–120.
4. Herek GM. Psychological heterosexism in the United States. In: D'Augelli, A, Patterson C, editors. *Lesbian, Gay, and Bisexual Identities Throughout the Lifespan: Psychological Perspectives*. New York: Oxford University Press, 1995; 321–46.
5. Gartrell N. The lesbian as a "Single" woman. *Am J Psychother.* 1981;35(4):502–09.
6. Eliason M. Lesbian and gay family issues. *J Fami Nurs* 1996;2(1):1–29.
7. Lyons TA. Lesbian mothers' custody fears. *Women and Therapy* 1983; 2:231–40.
8. Steinhorn A. Lesbian mothers—The invisible minority: Role of the mental health worker. *Women Ther* 1983;1(4):35–48.
9. Jordan KM, Deluty RH. Coming out for lesbian women: Its relation to anxiety, positive affectivity, self-esteem, and social support. *J Homosex* 1998;35(2):41–63.
10. Brown L. Lesbian identities: Concept and issues. In: D'Augelli A, Patterson C, editors. *Lesbian, Gay and Bisexual Identities Over the Lifespan: Psychological Perspectives*. New York: Oxford University Press, 1995:3–23.
11. D'Augelli, AR, Hershberger SL. Lesbian, gay and bisexual youth in community settings: Personal challenges and mental health problems. *Am J Community Psychol* 1993;21(4): 421–48.
12. Gonsiorek J. Gay male identities: concepts and issue. In: D'Augelli A, Patteron C, editors. *Lesbian, Gay and Bisexual Identities Over the Lifespan: Psychological Perspectives*. New York: Oxford University Press, 1995:24–47.
13. Kurdek LA, Schmitt PJ. Perceived emotional support from family and friends in members of homosexual, married and heterosexual cohabitating couples. *J Homosex* 1987;14(3/4):57–68.
14. Stevens PE, Hall JM. Stigma, health beliefs and experiences with health care in lesbian women. *Image J Nurs Sch* 1988;20(2):69–73.
15. Bradford J, Ryan C, Rothblum E. National lesbian health care survey: Implications for mental health. *J Consult Clin Psychol* 1994;62(2):228–42.
16. Eliason M, Randall CE. Lesbian phobia in nursing students. *West J Nurs Res* 1991;13(3):363–74.
17. Gentry SE. Caring for lesbians in a homophobic society. *Health Care Women Int* 1992;13:173–80.
18. Anderson MK, Mavis BE. Sources for coming out self-efficacy for lesbians. *J Homosex* 1996;32(2):37–52.
19. Lucas V. An investigation of the health care preferences of the lesbian population. *Health Care Women Int* 1992;13:221–8.
20. Stevens PE. Protective strategies of lesbian clients in health care environments. *Res Nurs Health* 1994;17:217–29.
21. Hitchcock JM, Wilson HS. Personal risking: Lesbian self-disclosure of sexual orientation to professional health care providers. *Nurs Res* 1992;41(3):178–83.
22. Perrin EC, Kulkin H. Pediatric care for children whose parents are gay or lesbian. *Pediatrics* 1996;97(5):629–35.
23. Institute of Medicine. *Lesbian Health: Current Assessment and Directions for the Future*. Washington, DC: National Academy Press, 1999.
24. Erlichman KL. Lesbian mothers: Ethical issues in social work practice. *Women Ther* 1989;8(3):207–24.
25. Falk PJ. Lesbian mother: Psychosocial assumptions in family law. *Am Psychol* 1989;44(6):941–7.
26. Rand C, Graham DLR, Rawlings EI. Psychological health and factors the courts seek to control in lesbian mothers custody trials. *J Homosex* 1982;8(1):27–39.
27. White JC, Levinson W. Lesbian health care: What a primary care physician needs to know. *West J Med* 1995;162:463–6.
28. Slater S, Mencher J. The lesbian family life cycle: A contextual approach. *Am J Orthopsychiatry* 1991;61(3):372–82.
29. Krieger N, Rowley D, Herman A, Avery B, Phillips M. Racism, sexism and social class: Implications for studies of health, disease and well-being. *Am J Prev Med* 1993;9(6 suppl): 82–122.
30. White JC, Levinson W. Primary care of lesbian patients. *J Gen Intern Med* 1993;8:41–7.
31. White JC, Dull VT. Health risk factors and health-seeking behavior in lesbians. *J Women's Health* 1997;6(1):103–12.
32. Roberts SA, Dibble SL, Scanlon JL, Paul SM, Davids H. Differences in risk factors for breast cancer: Lesbian and heterosexual women. *J Gay Lesbian Med Assoc* 1998;2(3):93–101.
33. Matthews WC, Booth MW, Turner JD, Kessler, L. Physician's attitudes toward homosexuality—Survey of the California County Medical Society. *West J Med* 1986;144:106.
34. Wallick M, Cambre K, Townsend M. How the Topic of Homosexuality is Taught at U.S. Medical Schools. *Acad Med* 1992; 67(9):601–63.
35. Gonsiorek JC. Mental health issues of gay and lesbian adolescents. *J Adolesc Health Care* 1988;9:114–22.