

Photo by Brenda Funches

## Susan D. Cochran

### Award for Distinguished Contributions to Research in Public Policy

#### Citation

"For her outstanding research and writing on the psychosocial variables that affect the mental and physical health of stigmatized and ethnic minority populations. Susan D. Cochran's scholarly research and writing have been utilized to change guidelines for HIV prevention, helping elucidate factors for successful national HIV campaigns. Her work has consistently sought to focus both psychology and public health on the physical and mental health concerns of vulnerable populations. In doing so, Cochran has effectively used the tool of research to positively impact public policy."

#### Biography

Susan D. Cochran was born in 1951, the fourth of five children, into a family reflecting the social contradictions of America. Her mother, Beatrice, was a proud first-generation American born of poor Russian Jewish immigrants. She passed as non-Jewish during the Great Depression and World War II to find employment. In contrast, Cochran's father, James, a U.S. Naval Academy graduate from a small town in Louisiana, was descended from generations of merchants and tradesmen with traceable roots through Mississippi to 1600s New England, a line that included a long forgotten, or hidden, Native American great-great-grandmother. The unlikely pair, Bea and Jim, met

and married during the social dislocations of World War II. After several years of stateside postings, the family settled in Los Angeles, California, where Cochran matriculated through the odd divides of those times. In Jewish religious school, the admonitions against intermarriage left her presence a prominent contradiction. In the neighborhood, Jewish kids were not always welcome, and girls like her--too athletic, too smart, and too interested in mechanical things--failed miserably in pretending to treasure female privileges. At home, the tension between cultural traditions called most known "facts" into question. Hot debates within the family about social consciousness and civil rights revealed unlikely proponents of social equality, like her father, who had left the South and knew intimately the brutality and stupidity of prejudice.

After high school, Cochran followed three older brothers to the University of California, Los Angeles (UCLA), for undergraduate studies. Her longstanding passion to be a writer, or perhaps an archeologist, led her to major in anthropology and join the staff of the university newspaper. But these were tempestuous times. Student protests against the Vietnam War rocked the campus. Pitched battles raged between students of privilege and police officers. One of Cochran's brothers was drafted and faced the peril of being shipped overseas. Race relations were tense. Angela Davis was fired. A professor lectured that women "were no good 10 days of the month." Germaine Greer published the *Female Eunuch* (1970), which Cochran bought covertly. Close friends tentatively acknowledged they were gay, although she was a few years from coming out. And her mother was now clearly dying from breast cancer. She finished college quickly in three years and left to seek an unknown future.

By 1974, Cochran had joined a lesbian feminist collective that organized weekly rap sessions for lesbians. One evening, an old college friend showed up, abruptly psychotic. The contrast between what her friend needed and the inability of the group to respond because radical feminism dictated the nonexistence of individual psychosis led to a dreaded realization: It was time to go back to school. Cochran entered a master's program in counseling psychology at Loyola Marymount University. Then, as these things are wont to be, Loyola insisted she take a course on learning because she had not majored in psychology. Enrolling in summer school at UCLA, she also took for fun Anne Peplau's Psychology of Gender course. Coincidentally, a graduate student working with Peplau called Cochran up one evening seeking access to the lesbians in the rap group for a study they were conducting. The accidental connections led to a collaborative research relationship with Peplau that continues to this day. Their first paper won two national awards for its innovative look at lesbian life.

On entering UCLA's doctoral clinical program, Cochran began the bifurcated research career that many scholars of gay and lesbian studies are forced to pursue. Although her passion was research on issues significant to the lives of lesbians and gay men, work she continued intermittently with Peplau, her daily efforts, guided by Connie Hammen, focused on methodological and theoretical issues in affective disorders. Along the way, she was privileged to train under Kay Jamison and completed an internship at the UCLA Neuropsychiatric Institute. Cochran's 1982 dissertation, an experimental study of the efficacy of cognitive therapy in preventing medication noncompliance in manic depressives, cochaired by Hammen and Bernie Wiener, remains today one of the few successful efforts published in this area.

On finishing the doctoral program, Cochran accepted an American Cancer Society Fellowship under the mentorship of Neville Hacker, a gynecologic oncologist then at UCLA, and David Wellisch, a psychologist in UCLA's Department of Psychiatry. The field of health psychology was beginning to emerge during these years (1982-1984), and psychologists were pushing their research into new territories. Cochran's own experiences with watching her mother's illness greatly influenced her efforts to understand the effects of gynecologic cancer on the close relationships of women and men. As in her subsequent work, the driving question was quite simple: How is it that people, given all the difficult things that happen to them and all the ways in which life can be unfair, still manage to put together lives that work? Also during this time, Cochran began a collaborative relationship with Vickie Mays at UCLA, originally with the intent of studying relationship issues among African Americans of differing sexual orientations. But with the HIV epidemic beginning to course its way through both the gay male and the African American communities, the focus of the work quickly changed. Together, they were among the first to articulate the behavioral impact of HIV on the African American community and the ways in which psychology would need to address the cultural issues permeating this community's response.

Next, Cochran joined the Department of Family Medicine, University of Southern California, as a research psychologist for a year before moving to the Psychology Department at California State University, Northridge. By this time, 1985, the devastating future of AIDS was coming into sharper focus. Cochran began working with the Shanti Foundation to document how gay men were coping with the epidemic. With Mays, she also continued studying the ways in which African American gay men were responding. At the same time, her work moved in a new direction. She joined a group of psychologists appointed by the Board of Social and Ethical Responsibility of the American Psychological Association to explore psychologists' perspectives on therapeutic practices with lesbians and gay

men. In her 11 years at California State University, Northridge, she was fortunate to have supportive colleagues essential to her survival as an active researcher in a primarily teaching institution, including Patricia Keith-Spiegel, Louann Kennedy, Howard Lee, Edward Sampson, Barbara Tabachnick, and Michele Wittig. During her last five years there, she was awarded a Scientist Development Award from the National Institute of Mental Health to study psychosocial methodology under the mentorship of Peter Bentler at UCLA and Tabachnick. While continuing her HIV research, she obtained a masters of science in epidemiology from the UCLA School of Public Health, with Sander Greenland serving as thesis chair.

Now jointly trained in both clinical psychology and epidemiology, in 1996, Cochran accepted a position in the UCLA Department of Epidemiology, joining a handful of psychologists in the School of Public Health, where she enjoys the interdisciplinary nature of public health and its focus on creating tangible improvements in health. She also holds a joint appointment as a professor of statistics and chairs the Faculty Advisory Committee for Lesbian, Gay, Bisexual, and Transgender Studies at UCLA. In addition, she maintains a small private practice specializing in the treatment of affective disorders. Over the years, she has served as a member and then chair of the Committee on Lesbian, Gay, and Bisexual Concerns of the American Psychological Association; a member of the board of directors of the National Lesbian and Gay Health Association; and a member of the Committee on Lesbian and Gay Concerns in Statistics of the American Statistical Association. She has received the National Lesbian and Gay Health Association's President's Award for outstanding leadership in the field of lesbian and gay health and the American Psychological Association Division 44's Distinguished Scientific Contribution Award.

As a tenured, full professor, Cochran no longer worries about hiding her research passion to improve the lives of sexual minorities, and she is immensely grateful to have gotten to this point without losing her sense of purpose or humor. Her early experiences with social contradictions and the illusionary bases of many biases led her to a career that flaunted expectations about the place of research on lesbian and gay life in psychology. Most recently, she was funded by the National Institute of Mental Health to study psychiatric disorders among lesbians and gay men with a focus on understanding how social inequality generates risk and the basis of resiliency.

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## **Emerging Issues in Research on Lesbians' and Gay Men's Mental Health: Does Sexual Orientation Really Matter?**

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*Theoretical writings and research suggest that the onset, course, treatment, and prevention of mental disorders among lesbians and gay men differ in important ways from those of other individuals. Recent improvements in studies of sexual orientation and mental health morbidity have enabled researchers to find some elevated risk for stress-*

*sensitive disorders that is generally attributed to the harmful effects of antihomosexual bias, Lesbians and gay men who seek mental health services must find culturally competent care within systems that may not fully address their concerns. The affirmative therapies offer a model for intervention, but their efficacy and effectiveness need to be empirically documented. Although methodological obstacles are substantial, failure to consider research questions in this domain overlooks the welfare of individuals who may represent a sizable minority of those accessing mental health services annually.*

The relationship between homosexuality and mental health status is a subject that does not want for controversy. In December 2000, the American Psychological Association (APA) published a set of guidelines for psychotherapy with lesbian, gay, bisexual, and other sexual minority<sup>1</sup> clients reaffirming the profession's position that homosexuality is not a mental illness (Division 44/Committee on Lesbian, Gay, and Bisexual Concerns Joint Task Force, 2000). In that same year, articles were published in psychological journals that labeled homosexuality a form of psychopathology (Stone, 2000) or supported the practice of conversion therapy (Nicolosi, Byrd, & Pons, 2000a, 2000b), a therapeutic approach previously condemned by the APA (APA, 1997). The contradictions embodied by these facts are but a small reflection of the persistent social ambivalence engendered by the topic of homosexuality. A recent *Newsweek* poll of the American public found that nearly half of the people surveyed believed homosexuality is a sin (*Newsweek* Poll, 2000), and approximately a third of those polled in another survey believed it to be a mental or physical illness (*Americans on Values*, 1999).

In this politicized context, research examining factors related to mental health among lesbians and gay men is extremely vulnerable to biased interpretations (Bailey, 1999). Yet there are numerous indications within the field of psychology that mental health needs among lesbians and gay men may differ in some important ways from those of heterosexual women and men (Bieschke, McClanahan, Tozer, Grzegorek, & Park, 2000; Cabaj & Stein, 1996; Haldeman, 1994; Hughes, Haas, & Avery, 1997; S. L.

Morrow, 2000). But until quite recently the topic generated surprisingly little of the hard empirical data that might dispassionately clarify psychologists' understandings of mental health issues affecting lesbians and gay men (Cabaj & Stein, 1996; Rothblum, 1994).

### Why Isn't More Known?

There are several obvious and some subtle obstacles to conducting research on the mental health needs of lesbians and gay men. One is that, historically, the sciences have struggled painfully through changing and often controversial perspectives on homosexuality (American Medical Association House of Delegates, 1996; APA, 1997; Bailey, 1999; Davison, 2001; Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991; Herek, Kimmel, Amaro, & Melton, 1991; Yarhouse, 1998), with scientific arguments colored by the strong opinions surrounding the topic that permeate American culture. Homosexuality is widely stigmatized (Herek et al., 1991; Kite & Whitley, 1996), and only 30 years ago it was viewed as a psychiatric disorder reflecting pathological developmental processes (Stein, 1993). In 1974, APA voted to accept a resolution that "depathologized" homosexuality (Conger, 1975).

The controversies may have hindered professional and research development in psychologists' training. In the field of mental health services, clinicians may still be influenced by negative views of homosexuality in their interactions with lesbian and gay male clients and may lack sufficient training in working competently with this population (Bieschke et al., 2000; Crawford, McLeod, Zamboni, & Jordan, 1999; Garnets et al., 1991; S. L. Morrow, 2000). Researchers, too, who might be interested in studying factors affecting lesbians and gay men are often discouraged

<sup>1</sup> Sexual orientation is a multidimensional concept including intercorrelated dimensions of sexual attraction, behavior, and fantasies, as well as emotional, social, and lifestyle preferences (Sell, 1997). For linguistic simplicity, the terms lesbian, sexual minority, and gay men will be used throughout the address, and distinctions among the diversity of identities that exist will be minimized. To a great extent, this is a reflection of the current body of empirical literature. Some of the research reviewed here used inclusion criteria that relied on respondents' self-identification as lesbian, gay, or bisexual, as determined by various measurement strategies that do not always precisely agree with each other. Other studies used reports of a history of same-gender sexual partners, using different time frames, to classify individuals. Still others used sampling location, such as recruitment from a venue frequented by lesbians or gay men, paired with reports of sexual minority identity or same-gender sexual behavior or desire, to determine eligibility. Many researchers put lesbians or gay men in the same category as bisexuals, whether determined by self-identification or sexual behavior, generally to improve statistical power in examining differences from heterosexuals. Although currently much debate exists in the field over both essentialist and social constructionist views of sexual orientation (Broido, 2000), in the present work I refer to those individuals who experience same-gender sexual desire or behavior or who label themselves with any number of terms (e.g., lesbian, homosexual, gay, bisexual, questioning) that reflect a sense of possessing, at least in part, a same-gender sexual orientation. Given the current state of the field, it would be premature to imply greater specificity.

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#### Editor's Note

Susan D. Cochran received the Award for Distinguished Contributions to Research in Public Policy. Award winners are invited to deliver an award address at APA's annual convention. This award address was delivered at the 108<sup>th</sup> annual meeting, held August 24-28, 2001, in San Francisco, California. Articles based on award addresses are not peer reviewed, as they are the expression of the winners' reflections on the occasion of receiving an award.

from doing so because of both the professional risks that might accrue (Hooker, 1993) and the dearth of available research resources (Solarz, 1999).

A second obstacle is that significant and very real methodological barriers to research with this population exist (Cochran, Keenan, Schober, & Mays, 2000; Solarz, 1999). Relative to other minority populations, such as racial or ethnic minorities, those with minority sexual orientations are relatively more hidden (Herek, 1998). Consequently, most research has had to rely solely on convenience-based sampling of individuals who are reachable through their presence in lesbian and gay community venues or through social networks accessible to researchers (Cochran et al., 2000; Cochran & Mays, 2000b). Often there are no comparable heterosexual groups in these studies, because the methods of sample selection (e.g., recruitment at gay pride events, music festivals, gay social clubs, gay bookstores, or gay bars) have no obvious counterpart outside the lesbian and gay community. Sample sizes, too, have generally not been large enough to explore variation in psychiatric morbidity or service use or to examine factors related to this variation.

Research designs that could sample without reference to participation in gay-related social structures are readily available and have been used for years to estimate the mental health of the American population (Manderscheid & Sonnenschein, 1996). But until the onset of the HIV epidemic, which generated public health needs for surveillance of sexual risk behaviors, these periodic population-based surveys did not directly assess the occurrence of same-gender sexual behavior or sexual orientation identity. Ostensibly, this was due to concerns about lowering response rates, concerns that have proved to be unfounded (Butler, 2001). It is only within the past decade that these commonly collected data sets became available for generating estimates of mental health morbidity and services use among lesbian, gay, and bisexual individuals, because questions were added that assessed markers of homosexuality (Cochran et al., 2000; Cochran & Mays, 2000a, 2000b; Cochran, Sullivan, & Mays, 2001; Faulkner & Cranston, 1998; Fergusson, Horwood, & Beautrais, 1999; Garofalo, Wolf, Kessel, Palfrey, & DuRant, 1998; Garofalo, Wolf, Wissow, Woods, & Goodman, 1999; Gilman et al., 2001; Herrell et al., 1999; Lock & Steiner, 1999; Remafedi, French, Story, Resnick, & Blum, 1998; Saewyc, Bearinger, Heinz, Blum, & Resnick, 1998; Sandfort, de Graaf, Bijl, & Schnabel, 2001). The majority of these recent studies have focused solely on adolescents recruited from middle or high school settings.

Even when explicit questions regarding sexual orientation or same-gender sexual experiences are assessed within these general population-based surveys, problems remain. One is a lack of statistical power due to the low base rate of homosexuality in the population, which, in this context,

translates into extremely few lesbians and gay men identified in each study. Population-based studies designed specifically to compare sexual minorities and heterosexuals on mental health-related questions are the rare exception (Bloomfield, 1993; Stall & Wiley, 1988). A second problem is misclassification bias when self-reports of sexual behavior are used as a proxy for sexual orientation. Even the rare misclassification of heterosexuals tends to greatly reduce the positive predictive value of sexual behavior as a screening measure (i.e., the percentage of individuals classified as lesbian or gay by their sexual behavior alone who, in fact, would self-identify as such if they had been asked), and those who are not sexually active are not classifiable (Cochran et al., 2000).

A third obstacle that has limited psychologists' knowledge of mental health morbidity among lesbians and gay men is, perhaps, an indirect consequence of several studies, beginning in the late 1950s, that repeatedly found few, if any, differences in psychological adjustment between small, nonclinical samples of homosexual and heterosexual men and women (Hooker, 1993). This groundbreaking work sidestepped the obvious research bias injected when sampling lesbians and gay men only from psychiatric settings to examine evidence for psychoanalytic writings that emphasized a pathological etiology for homosexuality (Stein, 1993). When findings did not support theoretical predictions of widespread psychopathology among lesbians and gay men, critical empirical support emerged for efforts to remove homosexuality as a psychiatric diagnosis (Gonsiorek, 1991). But it may also have led to a waning curiosity in research on psychopathology among lesbians and gay men, on the assumption that little of interest would be found.

This is not to say that lesbian and gay men's experiences and needs in therapy were ignored in the published literature. Over the past two decades, mental health professionals have worked extensively to develop specialized treatment modalities, such as gay affirmative therapy (Browning, Reynolds, & Dworkin, 1991; Malyon, 1982), or theoretical perspectives that focus on the special issues that may arise when lesbians and gay men enter psychotherapy (Brown, 1992; Cabaj & Stein, 1996; Greene & Croom, 2000; Perez, DeBord, & Bieschke, 2000). Although the work has significantly raised consciousness about issues and experiences of lesbians and gay men, little of this work has had the benefit of empirical study (Bieschke et al., 2000) that could result in evidence-based practice guidelines.

Beginning a few years ago, the field witnessed the introduction of a new level of methodological rigor, as researchers began to revisit the ways in which homosexuality may function as a risk indicator for psychiatric disorders. In doing so, they brought with them an accelerating degree of sophistication reflecting, in part, the gains in the field of

psychiatric epidemiology in general (Eaton & Merikangas, 2000). Much of this work is coming out of disciplines within the broad domain of public health, where a risk indicator is defined as a determinant or modifier of risk for a particular health outcome; causality is not necessarily implied (Miettinen, 1985). Unlike the earlier "illness model" of homosexuality (Gonsiorek, 1996), this work represents a significant theoretical shift to viewing sexual orientation as being similar to other individual risk indicators (e.g., gender, ethnic or racial background) that might influence the onset, course, or amelioration of psychiatric problems. This approach is compatible with parallel developments in the field of lesbian health and gay affirmative psychologies, where, until quite recently, the expectation was that psychiatric morbidity among sexual minorities did not vary much from that seen in heterosexuals, but issues lesbians and gay men might need to address in therapy did (Rothblum, 2000). The results of this recent research may lead to changes in how the profession conceptualizes the mental health concerns of lesbians and gay men.

### **Do Lesbians and Gay Men Experience Differential Rates of Mental Health Morbidity?**

Affective, anxiety, and substance use disorders and other indicators of subclinical distress appear to be especially reactive to the effects of social stress (Dohrenwend, 2000). One causal factor presumed to play a critical role in placing lesbians and gay men at higher risk than heterosexual people for psychiatric morbidity is the social stigma surrounding homosexuality itself (Greene, 1994; Haldeman, 1994; Mays & Cochran, in press). Studies have shown that lesbians and gay men commonly report experiences with social inequalities arising from their sexual orientation, including incidents of victimization and discrimination (Bradford, Ryan, & Rothblum, 1994; Cochran & Mays, 1994; Herek, Gillis, & Cogan, 1999; Hershberger & D'Augelli, 1995; Krieger & Sidney, 1997; Mays, Cochran, & Rhue, 1993), particularly in adolescence or young adulthood (D'Augelli, Hershberger, & Pilkington, 1998; Lock & Steiner, 1999). In addition, research sometimes directly relevant to sexual orientation (Kessler, Mickelson, & Williams, 1999; Mays & Cochran, in press; Meyer, 1995; Otis & Skinner, 1996) has documented that social stigma is a risk factor for psychological distress, especially for depression and perhaps anxiety.

Researchers conducting recent epidemiologic studies using several population-based surveys have directly examined the association between psychiatric morbidity and sexual orientation. In all of these studies researchers found some evidence for elevated risk when lesbian, gay, and bisexual individuals are compared with heterosexual respondents. Using data from a longitudinal cohort study of New Zealanders followed since birth, Fergusson et al. (1999) observed that lesbian and gay male youths, identi-

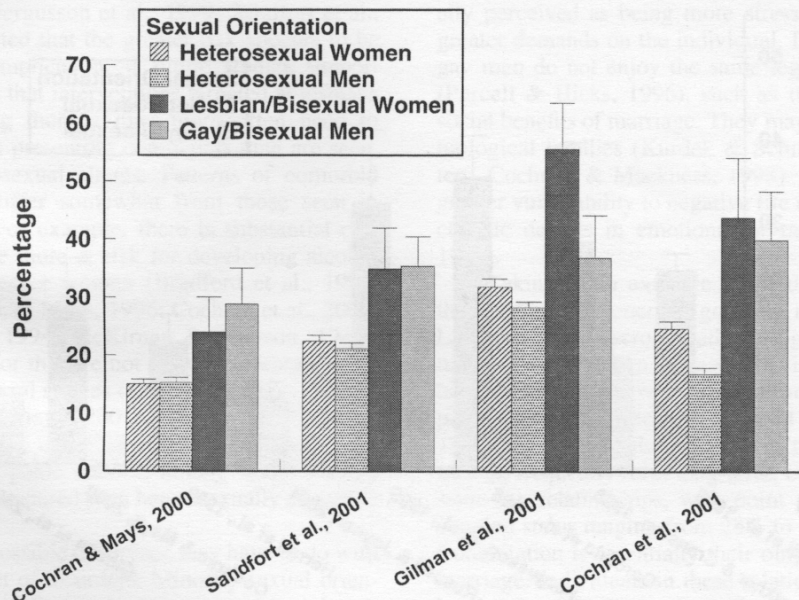
fied by self-reported sexual orientation at the age of 21 years, experienced greater prevalence than heterosexual youth of major depression, generalized anxiety disorder, and substance abuse or dependence between the ages of 14 and 21 years.

Four studies capitalized on the fact that some large, complex, multistage household surveys of the general population, designed to measure psychiatric disorders, also asked questions about the gender of respondents' sexual partners. By using individuals' reports of female and male sexual partners, researchers could classify respondents as probably lesbian, gay, bisexual, or heterosexual. In one study, my colleague and I (Cochran & Mays, 2000a) mined information available in the third National Health and Nutrition Examination Survey (U.S. Department of Health and Human Services, 1996) to examine lifetime histories of depression among men, age 17 to 39 years, who reported a lifetime history of same-gender sexual partners. We found evidence of possibly greater lifetime susceptibility to recurrent major depressions. In two additional studies, we used data from the 1996 National Household Survey on Drug Abuse (NHSDA; Cochran & Mays, 2000b) and collaborated with researchers from the National Comorbidity Survey (NCS; Gilman et al., 2001) to compare the psychiatric histories of respondents who reported any same-gender sexual partners or only opposite-gender sexual partners in either the prior year (NHSDA) or the past five years (NCS). In both, we again found evidence for greater morbidity risk for some disorders in homosexually active individuals as compared with exclusively heterosexually active respondents. Using a similar approach, Sandfort and colleagues (Sandfort et al., 2001) analyzed information available in a large multistage household survey of the adult Dutch population to find higher one-year and lifetime prevalence of several types of disorders among those who reported any same-gender sexual partners in the 12 months prior to interview as compared with those who indicated only opposite-gender sexual partners. Although each of these studies measured somewhat different clusters of affective, anxiety, and substance use disorders and were within sometimes different time frames, across studies a picture emerged of moderately greater risk for individuals who had a history of involvement with same-gender sexual partners (see Figure 1). In particular, the evidence for greater lifetime risk for major depression seemed fairly consistent across surveys.

Finally, we (Cochran, Sullivan, & Mays, 2001) also examined evidence for differential rates of psychiatric morbidity in the National Survey of Midlife Development in the United States (MIDUS; Brim et al., 1996), a survey of individuals between 25 and 75 years of age that assessed both the occurrence of several major mental health disorders and self-reported sexual orientation. As before, we found increased risk for some mental health disorders

**Figure 1**

*Population-Based Estimates of One-Year Prevalence of Mental Health Disorders by Gender and Sexual Orientation*



*Note.* Sexual orientation was estimated from reports of sexual partners' gender in the past year (Cochran & Mays, 2000b; Sandfort et al., 2001) or five years (Gilman et al., 2001) or from self-identification (Cochran, Sullivan, & Mays, 2001). Error bars depict standard errors of the estimates.

among lesbian, gay, and bisexual respondents as compared with heterosexual women and men (see Figure 1).

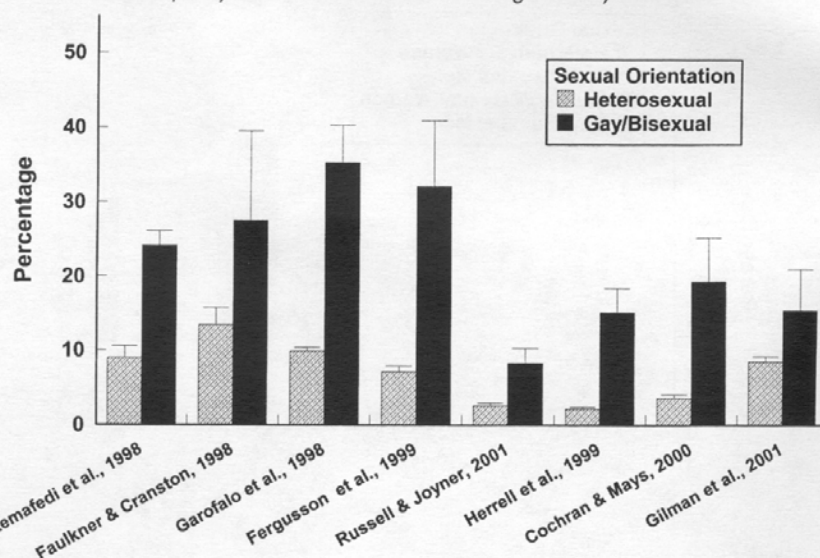
All of this recent work examining mental health correlates of sexual orientation has in common the use of samples drawn with well-designed sampling frames that avoid the sampling biases permeating most previous work in the area. In addition, all six studies measured evidence for psychiatric disorders in both homosexual or bisexual and heterosexual respondents using standard, well-tested instruments that generate information of diagnostic value within defined time frames. These strengths suggest that lesbians and gay men, in comparison with heterosexual women and men, probably do have some increased risk for some disorders. However, it is important to underscore that in the majority of studies, the majority of homosexual or bisexual respondents did not evidence any of the measured mental health disorders.

There is still quite a bit of uncertainty about the new findings, as well there should be. All of these studies had low precision in estimating point prevalences because of the small sample size of individuals classified as probably lesbian, gay, or bisexual. In addition, four of the studies relied on respondents' reports of the gender of sexual partners to identify those likely to be lesbian or gay. The pitfalls of this approach are well-known (Cochran et al., 2000), and generally one would expect that results would be biased toward finding no

differences. However, other possible hidden biases also exist in this type of research methodology that are less well understood. For example, it is not known how important nonresponse or response bias is in producing the results obtained. It may be that those who are willing to participate in intrusive health surveys and to disclose potentially stigmatizing information about their sexual histories or sexual orientation to interviewers are also more likely to admit to individual psychiatric symptoms. Further, it is possible that these surveys sample from a restricted range of the lesbian and gay population that is confounded in some unknown way with psychiatric morbidity. Finally, even though it appears that lesbians and gay men experience somewhat greater risk for mental health disorders, the reasons for this are not known. Although the observed differences are often attributed to the effects of social stigma, only one population-based study (Mays & Cochran, in press) has actually examined evidence for this. In that study, my colleague and I controlled for differences in discrimination experiences between lesbian, gay, and bisexual adults and heterosexual adults and, in doing so, greatly attenuated differences in mental health morbidity indicators between the two groups. Nevertheless, only further studies can answer the host of questions that remain, including what factors generate this possible excess risk.



**Figure 2**  
Positive Histories of Suicide Attempts by Sexual Orientation Across Eight Surveys



Note. These numbers are estimated for lifetime (Cochran & Mays, 2000a; Gilman et al., 2001; Herrell et al., 1999; Remafedi et al., 1998), seven-year (Fergusson et al., 1999), and one-year (Faulkner & Cranston, 1998; Garofalo et al., 1998; Russell & Joyner, 2001) periods. Error bars depict standard errors of the estimates.

### Is There Greater Risk for Suicidal Behaviors Among Lesbians and Gay Men?

Although the field lacks data regarding successful suicides, the risk for suicide attempts among lesbians and gay men has been a public health concern for several years (Muehrer, 1995). Much of the early research documenting higher rates of suicide attempts drew from convenience-based samples of volunteers (Remafedi, 1999). But studies from the past few years, relying on research designs less susceptible to sampling bias, also found higher risk for suicide attempts among lesbian-, gay-, and bisexual-identified youth (Fergusson et al., 1999; Garofalo et al., 1999; Remafedi et al., 1998); homosexually experienced youth (Faulkner & Cranston, 1998; Russell & Joyner, 2001); and homosexually active adults (Cochran & Mays, 2000a; Gilman et al., 2001), as compared with heterosexually classified counterparts (see Figure 2).

Although Figure 2 shows prevalence estimates for different time periods using varying definitions of sexual orientation status, across studies those classified as lesbian, gay, or bisexual consistently evidence higher rates of prior suicide attempts as compared with those classified as heterosexual. It appears that risk may be greatest during adolescence and young adulthood, with declines as individuals age (Cochran & Mays, 2000a; Sorensen & Roberts, 1997). Specifically, observed rates were highest in four of the five

studies of adolescents, all of which included both genders, as shown on the left side of the figure. In contrast, the three studies on the right side of the figure used adult samples and found apparently lower rates. But only one (Gilman et al., 2001) of these studies included women, which may have biased findings downward to some extent because of well-known gender differences in the prevalence of suicide attempts (Kessler, Borges, & Walters, 1999).

By now, there seems to be little doubt that the risk for suicide attempts among lesbians and gay men. Particularly in adolescence, should be of concern to psychologists. Although adolescence, in general, is a high-risk period for suicide attempts, sexual minority youth appear to be a vulnerable population (U.S. Department of Health and Human Services, 2001).

### Are There Differences in Symptom Clusters, Age at Onset, or Precipitants?

There may be differences, as yet largely unexamined in the research literature, in the ways that mental health morbidity manifests in lesbians and gay men. These differences, if they do exist, could have important implications for treatment.

One area of possible difference between lesbians and gay men on the one hand and heterosexual women and men on the other is in the frequency of comorbidity, the occurrence of which is generally a predictor of poor outcome, a more chronic course of disorder, and higher rates of treat-



ment utilization (Kessler et al., 1994). The greater risk for comorbidity among lesbians and gay men has rarely been addressed directly, but three recent surveys (Cochran, Sullivan, & Mays, 2001; Fergusson et al., 1999; Sandfort et al., 2001) have now reported that the greater risk appears to be real. The important implication, if future studies support these early findings, is that interventions targeted at lesbians and gay men entering therapy may more often need to address more complex presenting complaints than are seen, on average, in heterosexual clients. Patterns of comorbid disorders may also differ somewhat from those seen in heterosexual clients. For example, there is substantial evidence that lesbians are more at risk for developing alcohol dependency than are other women (Bradford et al., 1994; Cochran, Bybee, Gage, & Mays, 1996; Cochran et al., 2000; Hughes & Wilsnack, 1994; McKirnan & Peterson, 1989), although the reasons for this are not known (Cochran et al., 2000). In contrast, several studies (Cochran & Mays, 2000b; Cochran, Sullivan, & Mays, 2001; Sandfort et al., 2001) have found higher rates of some anxiety disorders, most often in the realm of panic attacks, among homosexually classified men when compared with heterosexually classified men.

Another area of possible difference may have to do with the timing of the onset of disorders. Minority sexual orientation and gender atypicality are early magnets for maltreatment. Lesbian and gay adolescents commonly report experiencing familial abuse and harassment on disclosing their sexual orientation (D'Augelli, 1998; Savin-Williams, 1994) and may be more likely to experience parental maltreatment (Corliss, Cochran, & Mays, 2001; Tjaden, Thoennes, & Allison, 1999). Studies have also documented that experiences with peer- and stranger-based victimization, verbal harassment, and the threat of or actual physical violence are frequently reported by lesbian and gay youth, particularly by those in the younger age groups (Garofalo et al., 1998; Herek, Gillis, Cogan, & Glunt, 1997; Hershberger, Pilkington, & D'Augelli, 1997; Otis & Skinner, 1996). An implication is that lesbians and gay men may be more vulnerable than heterosexual women and men to the onset of psychiatric disorders at an early age because of early psychologically stressful experiences arising from stigmatization. However, Gilman et al. (2001), in one of the few studies examining this issue, failed to detect statistically significant evidence in support of this hypothesis.

Finally, a third factor that may lead to different patterns of morbidity expression is the simple fact that lesbians and gay men lead lives that are somewhat different from those of their heterosexual counterparts. For example, lesbians, in comparison with other women, are more likely to participate in the labor market and have less expectation of not doing so (Alm, Badgett, & Whittington, 2000). The family structures of lesbians and gay men are also different (Matthews & Lease, 2000); for example, their families have a lower likelihood of including children (Cochran, Mays, et al., 2001; Patterson & Chan, 1997). Lesbians' and gay men's lives involve traversing unexpected life paths that may lead to the occurrence of fewer, in the words of Pearlin (Pearlin, 1999, p. 163), "scheduled" life events (e.g., marriage, birth of a

child), and the life events that do occur may be atypical (e.g., loss of custody of a nonbiological child). In particular, the atypical nature of unscheduled life events, which are generally perceived as being more stressful, may generate even greater demands on the individual. In addition, lesbians and gay men do not enjoy the same legal protections as others (Purcell & Hicks, 1996), such as the many economic and social benefits of marriage. They may have less support from biological families (Kurdek & Schmitt, 1987; Mays, Chatters, Cochran, & Mackness, 1998). All of this may lead to greater vulnerability to negative life events, through possibly chronic deficits in emotional or tangible support (Thoits, 1995).

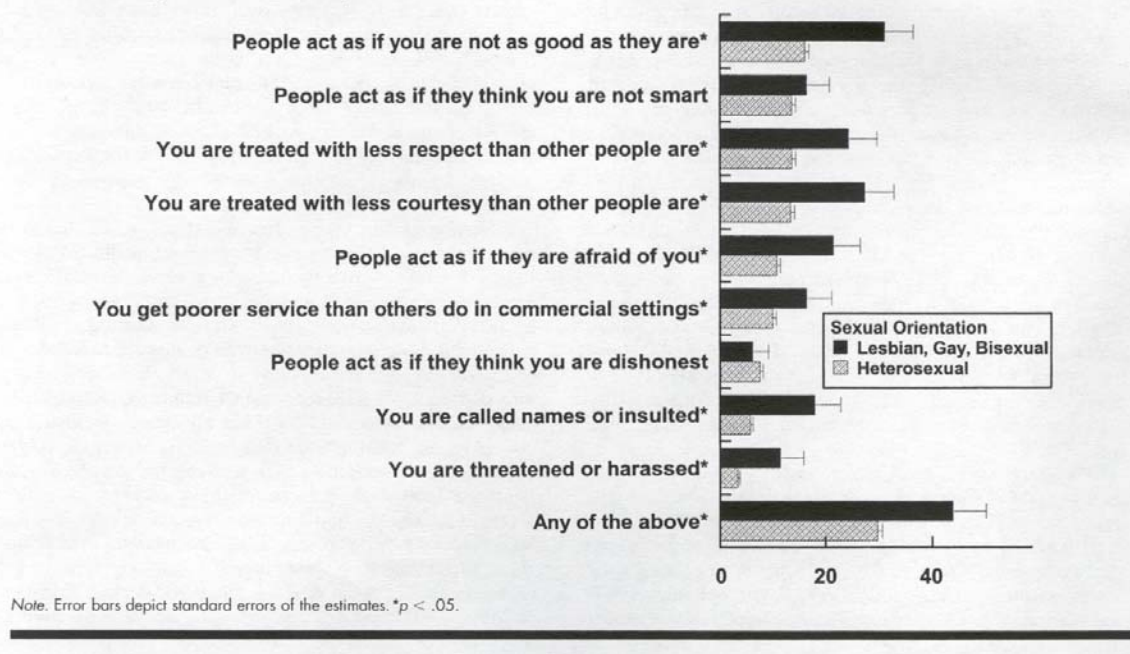
Taking as an example married status, research shows that marriage is generally good for mental health (Marks & Lambert, 1998). Across epidemiologic surveys, married status is a well-known, robust positive correlate of mental health, particularly when those who are married are compared with those who are widowed or divorced (Kessler et al., 1994). Despite the inability to marry, lesbians and gay men do frequently form long-term, committed, marriage-like same-sex relationships, with point prevalence estimates of coupled status ranging from 28% to 75% (Alm et al., 2000). Cohabitation is essentially their only means to approximate marriage. Individuals in these relationships experience high levels of satisfaction and emotional closeness, similar to the levels reported by heterosexuals in various types of relationships, such as those involving dating, cohabiting, or marriage (Kurdek, 1997; Peplau & Cochran, 1990; Peplau, Cochran, & Mays, 1997). Indeed, research indicates a close equivalence between marriage and committed gay relationships (Peplau & Cochran, 1990). But it is unknown if these relationships confer on lesbians and gay men a similar "marriage" mental health benefit.

Another major difference in the lives of lesbians and gay men, as compared with heterosexual women and men, is the need to cope with the ways in which minority sexual orientation has implications for an individual's life. One aspect, commonly referred to in the psychological literature as lesbian or gay identity development or "coming out" (Reynolds & Hanjorgiris, 2000), is often seen as a major issue that is dealt with in psychotherapy. There are three distinct components to the process: becoming aware of difference, "exiting from heterosexual identity" (D'Augelli, 1998, p. 192), and creating a gay or lesbian identity that is publicly acknowledged (D'Augelli, 1998). In theoretical writings, successful resolution of these issues is often seen as an essential developmental step for achieving optimal mental health (Dworkin, 2000). However, direct empirical evidence related to this hypothesis is sparse (D'Augelli & Hershberger, 1993; Zea, Reisen, & Poppen, 1999).

A second aspect of the implications of minority sexual orientation is discrimination. Lesbian, gay, and bisexual individuals, in comparison with heterosexual men and women, report more frequent experiences with discrimination, in terms of both discrete events and everyday affronts (Mays & Cochran, in press). As can be seen in Figure 3, in the MIDUS survey, sexual minorities, as compared with heterosexual respondents, reported more frequent experi-

**Figure 3**

*Age- and Race/Ethnicity-Adjusted Prevalences of Perceived Day-to-Day Discrimination by Sexual Orientation in the National Survey of Midlife Development*



ences with discrimination, which occurred either sometimes or often on a day-to-day basis. Further, my colleague and I showed elsewhere that these perceptions were positively associated with psychological distress (Mays & Cochran, in press).

In sum, these differences in lifestyle patterns, social stressors, and social resources may influence in unknown ways the onset and course of mental disorders among lesbians and gay men. In addition, lesbians and gay men, like other Americans, may also have to cope with additional social inequalities arising from gender, ethnic or racial status, or social class, to mention but a few known risk indicators. Research on mental health morbidity issues among ethnic or racial minority lesbians and gay men is exceedingly sparse (Alquijay, 1997; Cochran & Mays, 1988, 1994; Comas-Diaz & Greene, 1994; Greene, 1997; Nakajima, Chan, & Lee, 1996). Whether the effects of multiple stigmatized statuses are additive or synergistic (Miettinen, 1985) is not known at this point.

#### **Does Sexual Orientation Influence Entry Into Treatment?**

For lesbians and gay men, access to competent mental health services is complicated by the sometimes held negative stereotypes of homosexuality among service providers that unpredictably results in inappropriate or inadequate

care (Garnets et al., 1991). Further, although many lesbians and gay men report services are inadequately rendered by heterosexual providers (Garnets et al., 1991), a survey of providers who presumably were predominantly heterosexual found that most viewed the treatment needs of lesbians and gay men as being no different from those of other clients (Gambrell, Stein, & Brown, 1984). One strategy that lesbians and gay men use to avoid biased care is nondisclosure of their sexual orientation (MacEwan, 1994). For example, reticence in disclosing sexual orientation has been noted in alcohol treatment settings (MacEwan, 1994). But when therapeutic issues are woven together with sexual orientation, nondisclosure may result in less effective interventions (Cabaj, 1996). From the perspective of the behavioral model of health services utilization (Andersen, 1995), sexual orientation may be an important but unmeasured predisposing component.

Little is known about rates of mental health and substance use services utilization among lesbians and gay men, let alone factors that influence entry into treatment. There is evidence that lesbians and gay men may be more likely than others to access mental health care services. In population-based surveys, lesbians and gay men, as compared with heterosexual women and men, respectively,

more frequently reported using mental health services in the year prior to interview (Cochran, Sullivan, & Mays, 2001), and homosexually active women were more likely than exclusively heterosexually active women to indicate that they had recently used alcohol-related treatment services (Cochran et al., 2000). In two convenience-based national studies (Bradford et al., 1994; Sorensen & Roberts, 1997), the most common reasons mentioned by lesbians for seeking therapy services were depression and relationship difficulties. For gay men, coping with the HIV epidemic may be an important factor in seeking mental health services (Cochran, Sullivan, & Mays, 2001).

Positive community norms concerning use of psychotherapy are thought to exist for lesbians (Bradford et al., 1994) and perhaps for gay men as well. In addition, lesbians and gay men may enter therapy for reasons other than psychiatric morbidity, including seeking assistance in issues generated by sexual orientation (Hughes et al., 1997). One report (Liddle, 1997) suggested that lesbians and gay men may remain in therapy longer than heterosexual women and men do. There is also some evidence (Liddle, 1999) that lesbians' and gay men's satisfaction with psychotherapy services has increased in the past decade, perhaps as a consequence of changes in how homosexuality is viewed by mental health providers and the increasing numbers of openly lesbian or gay clinicians.

However, there are also reasons to believe that lesbians and gay men may experience somewhat different structural barriers than heterosexual women and men do when seeking psychotherapy services. For example, lesbians may be less likely than women of similar age, race, and educational background to have health insurance coverage (Cochran, Mays, et al., 2001), possibly because of the relative absence of spousal insurance benefits. Further, recent changes in health care delivery systems in the United States, such as managed care, may have had a negative impact on the ability of sexual minorities to access providers who possess preferred personal characteristics (Kaufman et al., 1997; Liddle, 1997), such as lesbian or gay sexual orientation or knowledge about sexual minority issues. Requesting a lesbian or gay male provider through managed care systems risks the loss of confidentiality for both the patient and the providers. In addition, managed care companies may be reluctant to create referral lists where the information would be available. Both of these barriers may greatly complicate help seeking by this population. Research specifically examining the effect on lesbians and gay men of changes in methods of entry into health care has yet to be done.

### **Do Efficacious Treatments for Depression and Anxiety in Lesbians and Gay Men Differ?**

Although there is no reason to believe that the efficacy of treatments for depression and anxiety varies with sexual

orientation, there may still be differential levels of effectiveness when interventions are actually delivered in health care settings. Two major questions need to be considered in how sexual orientation may influence treatment effectiveness. The first is whether lesbians and gay men actually do receive similar care when they seek treatment. The second question is whether standard care effectively treats the problems that lesbians and gay men may experience. An important difference between the types of psychotherapy services sexual minorities and heterosexuals may encounter in the health care marketplace is that lesbians and, more commonly, gay men may be offered or subjected to conversion or reparative therapy (Haldeman, 1994; Stein, 1996). Conversion therapy refers to interventions that seek to change a minority sexual orientation to heterosexual or to achieve heterosexual sexual and relationship functioning (Tozer & McClanahan, 1999). Although APA has passed a resolution condemning these practices (APA, 1997), conversion therapy advocates view efforts to change sexual orientation as an obvious intervention strategy to ameliorate causes of psychiatric morbidity in lesbians and gay men (Bieschke et al., 2000). At present, it is unknown how often lesbians and gay men undergo conversion therapy or how widespread the practice is.

Although conversion therapy as a distinct entity is generally discredited, therapists' behaviors during the course of treatment can still signal disapproval of homosexuality and conversely encourage clients to pursue heterosexual behaviors and preferences no matter what the psychological effects (S. L. Morrow, 2000). Some of this bias is unintentional, but there is continuing debate in the field as to whether it is appropriate for therapists to work toward a goal of a heterosexual lifestyle if the client desires this outcome (Garnets et al., 1991; Haldeman, 1994; Yarhouse, 1998). The fact that the debate exists suggests that providers vary in their handling of client-raised identity issues. What effect this may have on treatment effectiveness is unknown. For example, depressive symptoms are thought to be a common component of the coming out process (Hershberger & D'Augelli, 2000), and if some provider behaviors impair the therapeutic process, then treatment effectiveness for depression, in this instance, may be reduced.

Recent studies of mental health providers have documented that although the majority of providers do not view homosexuality as being pathological, they still frequently evidence both attitudinal and behavioral responses to sexual minority clients that may not be conducive to positive outcomes (Bieschke et al., 2000; Gelso, Fassinger, Gomez, & Latts, 1995; Hardman, 1997). These include having difficulties in recalling information the patient has provided (Gelso et al., 1995), avoiding topics that make the therapist uncomfortable (Hardman, 1997), and either over- or under-emphasizing the relevance of sexual orientation in a cli-

ent's problems (MacEwan, 1994). Provider behaviors thought by psychologists to be suboptimal in the care of lesbian and gay male patients (Garnets et al., 1991) have been shown to be associated with early therapy termination by this population and negative ratings of the therapists' helpfulness (Liddle, 1996). Even well-trained and motivated providers can fall prey to heterosexual bias (Brown, 1996).

One of the important practice and theoretical developments in the field of lesbian and gay psychology over the past two decades is the affirmative therapy model of intervention (Brown, 1992; Browning et al., 1991; Malyon, 1982). This model assumes that lesbians and gay men, like heterosexual women and men, incorporate learned negative attitudes and beliefs about homosexuality in the process of growing up. The effect of this, which is labeled *internalized homophobia*, is psychological problems with self-image and social functioning in adolescence and adulthood. Affirmative therapies consider internalized homophobia to be an important target for therapeutic intervention. From this perspective, depressive and anxiety episodes often covary with sexual orientation-related issues in those who have newly considered themselves to be a sexual minority. Therefore, effective treatment calls for targeting both areas of concern. Indeed, recent guidelines (Division 44/Committee on Lesbian, Gay, and Bisexual Concerns Joint Task Force, 2000) encouraged psychologists to consider the effects of antihomosexual prejudice on the presenting complaint and therapeutic process. However, outcome studies documenting the efficacy of affirmative therapies have not been done, nor has research explored the effectiveness of affirmative therapies in the broader practice community when delivered by a diverse set of providers in both gay-identified and traditional care environments. In fact, outcome studies reported in the indexed research literature are extremely rare (D. F. Morrow, 1996). It is possible that the combination of affirmative therapy methods and standard interventions for depressive and anxiety disorders may improve outcomes among lesbians and gay men, particularly for those episodes that are associated with coming out or identity concerns, but this has yet to be demonstrated empirically. This research would seem to be a necessary and important step in ensuring the most effective treatment practices for lesbians and gay men as psychology moves toward evidence-based treatment practices (Linden, 1999).

One of the great contradictions of the past two decades is that despite the fervor among practitioners that has led to the development of a new psychotherapy model and the emerging force of lesbian and gay professionals in psychology, psychiatry, medicine, and social work, very little empirical research has been conducted to evaluate the efficacy or effectiveness of these new models of care (Bieschke et al., 2000). In part, this may reflect the fact that outcome research demands more resources than most researchers

who are interested in these topics may be able to muster and that there is a lack of enthusiasm for health services research within traditional clinical training programs. Similarly, an insufficient amount of research documents the possible harmful effects of provider-based bias on therapy outcomes, although the results of the few studies that do exist indicate that problems in delivery of care may be relatively common.

### Where Does the Field Go From Here?

Any discussion of psychological morbidity, its occurrence or its effective treatment, in lesbians and gay men is fraught with the threat of polarized arguments. On the one hand, there is a long tradition in American culture and within the mental health disciplines, in particular, of pathologizing homosexual life. On the other hand, there is a newer history of "depathologizing" homosexuality (Haldeman, 1994). From either perspective, any evidence of greater morbidity risk among lesbians and gay men can be seen as support for contradictory theoretical positions. At the risk of displaying my own bias in this debate, it seems that one can draw at least four conclusions with a modicum of certainty from the existing research literature. First, there is fairly good evidence of elevated risk for depression and suicide attempts in lesbians and gay men, as well as evidence that this perhaps holds true for other disorders as well, such as for substance use disorders in lesbians. However, it is not known why this is so, and, clearly, the majority of lesbians and gay men represented in the recent studies did not evidence positive histories of psychological morbidity. Evidence linking stress arising from social stigma or victimization and psychiatric morbidity is still in an embryonic state, but recent findings (Mays & Cochran, in press; Meyer, 1995) are consistent with the social causation of greater risk.

Second, substantial differences between the life experiences of those of differing sexual orientations support hypotheses that lesbians and gay men may evidence somewhat different patterns of onset, causation, and course of mental health disorders than are seen in heterosexual women and men. Future studies could profitably explore the timing and precipitants of psychological morbidity among sexual minorities, as well as those factors that are protective and enhance resiliency (DiPlacido, 1998). Research on the latter is particularly essential, given findings from opinion polls conducted over the past 25 years that suggest that stress arising from the stigmatization of homosexuality is not likely to abate any time soon. Since 1977, American's perceptions of the rights of lesbians and gay men to enjoy job opportunities equal to those of other individuals has increased from 56% to 83% of those surveyed, with 74% as of February 1999 indicating that a lesbian or gay man should conceivably be hired as a member of the president's cabinet, up from 54% in 1992 (Newport, 1999).

However, there has also been almost no change in the percentage of Americans who believe that homosexual relations should be illegal. In both 1977 and 1999, it was estimated that 43% of Americans held this view (Newport, 1999).

Third, there are strong hints that although lesbians and gay men are higher consumers of treatment services than are heterosexual women and men, their therapeutic interventions may be especially vulnerable to factors that reduce effectiveness. Research is especially needed to determine if affirmative therapies enhance treatment outcomes (Bieschke et al., 2000) and to develop evidence-based treatment approaches. The guidelines for psychotherapy with lesbian, gay, and bisexual clients recently adopted by APA (Division 44/Committee on Lesbian, Gay, and Bisexual Concerns Task Force, 2000) may serve to sensitize practitioners to the issues that can arise during therapy with this population. But there are a host of other issues about which little is known, including the effects of recent changes in mental health care access and delivery and whether these changes have unduly burdened lesbians and gay men seeking help.

Finally, it would be unconscionable for psychology as a profession to ignore the possibility of differences associated with sexual orientation in both mental health morbidity and treatment experiences. Although for years research has been hampered by methodological limitations and other barriers, the recent availability of information from large-scale studies of the general population confirms fears that lesbian, gay, and bisexual individuals face a psychologically challenging world and that some may, in fact, be harmed by this. Clearly, what lies ahead for the field is the task of determining the answers to the many questions raised in this address. In doing so, it is important to pursue these research questions objectively and with sensitivity to the ways in which problems of bias may subtly permeate the work. Psychologists and others in helping professions are ethically compelled to examine whether treatment strategies for lesbians and gay men are optimally efficacious. Equally as important is that clinicians are trained to engage in culturally appropriate, evidence-based care when providing services for lesbians and gay men.

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