Topics in Primary Care Medicine

Lesbian Health Care
What a Primary Care Physician Needs to Know

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Many primary care physicians take care of lesbians and women sexually active with women without being aware of their patients' sexual orientation. These women have unique medical and psychosocial needs that each physician must consider. Lesbian identity or being sexually active exclusively with women influences care in areas such as sexually transmitted diseases, risk of human immunodeficiency virus infection, counseling, cancer risk, screening, parenting, depression, alcohol use, and violence. We review an approach to taking a history with all women that facilitates open, comfortable communication with lesbians. We also review specific medical and psychosocial areas of primary care in which caring for lesbians is different from caring for other women. Further research is needed on lesbian health issues to provide appropriate guidelines to clinicians.

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Busy primary care physicians may see more than 100 patients a week. If physicians estimate that fewer than five of these are lesbian, they may be underidentifying the lesbians in their practice. Knowing the sexual orientation of patients is important to providing high-quality primary care.

History Taking

The dictionary definition of a lesbian is "a female homosexual," meaning a woman who is sexually attracted to other women. For practical purposes, this definition is too narrow because lesbianism is not only a sexual orientation, but also an identity based on psychological responses, cultural values, societal expectations, and a woman's own choices in identity formation.[1-4] Some women call themselves lesbians, but are not sexually active exclusively with women; conversely, some are sexually active with women, but do not identify themselves as lesbian.

Lesbians are a diverse group of women from all racial, economic, geographic, religious, cultural, and age groups. Lesbians are also a diverse group in terms of sexual practices. They may be celibate or sexually active with women or men, or both.[5] Most lesbians are currently either sexually active with women exclusively or are celibate, although in one study, 77% of lesbians had at some point participated in heterosexual coitus.[6] The specific sexual practices of a patient determine her risks of particular diseases and are important in developing individual medical recommendations.

Surveys estimate that 2% to 10% of the population are women sexually active with women.[1,7] Being sexually active exclusively with women and identifying oneself as lesbian influences both the biomedical and the psychosocial aspects of medical care. Primary care physicians need to understand how women sexually active with women are unique with respect to sexually transmitted diseases, the human immunodeficiency virus (HIV), and cancer risk and screening. Women who identify themselves as lesbians also have unique needs with regard to psychosocial issues such as support systems, homophobia, parenting, adolescence, substance abuse, battery, and hate crimes.

Most lesbians defy stereotypes. It is important to realize that any female patient can be lesbian or bisexual. Until physicians know the sexual orientation of their patients, it is important to use language free of heterosexual assumptions. Questions like "What form of birth control do you use?" "Are you married?" and "When was the last time you had intercourse?" set up barriers for a lesbian patient because they assume she is heterosexual. After hearing questions like these, a lesbian may withhold or give false information to protect herself from her physician's possible negative attitudes.[8-18]

There are many nonjudgmental ways to ask about a patient's sexual orientation. We believe the most comfortable time to address the issue is during the social history. Questions such as "Are you in a committed relationship or partnership?" "Are you single, partnered, or married?" "Is your partner a man or a woman?" "Who is in your immediate family?" and "What is your relation-

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ship with your roommate?" can be asked during the social history and do not assume the patient is heterosexual. Questions should be phrased in ways that will assure the patient that her self-disclosure will not produce a negative reaction. Using the social history instead of the sexual history to address sexual orientation removes some of the discomfort associated with talking about sexual activity and provides opportunities to explore patients' social supports as they relate to various illnesses or conditions.

Similarly, during the sexual history taking, it is important not to convey heterosexual bias. The most commonly asked questions are, "When was the last time you had sexual contact?" and "Have you been sexually active with men, women, or both?" Again, because no one can identify every lesbian simply by appearances, it is helpful with all patients to use language free of heterosexual assumptions. Physicians who are unable to convey acceptance or a nonjudgmental attitude toward lesbians might be helped by talking to colleagues or should refer these patients to colleagues who are free of negative attitudes about lesbians.

Medical Issues

Sexually Transmitted Diseases

Sexually transmitted diseases are less common in lesbian patients than in either heterosexual women or gay men. No known gynecologic problems are unique to lesbians, and none occur more often in lesbians than in bisexual or heterosexual women. This may be due in part to the relative epidemiologic isolation of this group from men and the lack of penile-vaginal intercourse among lesbians. Lesbian sexual practices include kissing, breast stimulation, manual and oral stimulation of the genitals and anus, friction of the clitoris against the partner's body, and penetration of the vagina and anus with fingers and devices.[6,19]

Women sexually active with women appear to have a lower incidence of syphilis and gonorrhea than any other group except those who have never been sexually active.[19] Infections with chlamydia, herpesvirus, or human papillomavirus, and pelvic inflammatory disease appear to be uncommon in lesbians who have been sexually active exclusively with women, but all are theoretically transmissible.[6,19,20] Hepatitis A, amebiasis, shigellosis, and helminthism have a low prevalence in lesbians. Hepatitis B occurs only when other risk factors are present.[6,19,20] In contrast, bacterial vaginosis, candidiasis, and *Trichomonas vaginalis* infection do occur in lesbians and appear to be transmissible between women.[6,8,19,21] Based on current data, we do not recommend routinely screening for sexually transmitted diseases in women sexually active exclusively with women. Physicians should survey patients for the most recent heterosexual contact and manage these women and their partners according to the risk of exposure.[22]

Human Immunodeficiency Virus

More than 90% of lesbians with the acquired immunodeficiency syndrome are injection drug users. To date, HIV may have been transmitted between women as a result only of sexual contact in as many as nine cases, but this has not been proved (S. Y. Chu, PhD, MSPH, Centers for Disease Control and Prevention, Division of HIV/AIDS, oral communication, April 1993).[23-25] Exposure to menstrual and traumatic bleeding was probably the source of transmission. The human immunodeficiency virus has been cultured from cervical and vaginal secretions and cervical biopsy specimens taken throughout the menstrual cycle, however.[26] Therefore, it may theoretically be transmitted by infected women who are not bleeding.

Physicians should counsel lesbians to avoid contact with cervical and vaginal secretions, menstrual blood, and blood from vaginal and rectal trauma in all partners, including monogamous partners who have not tested negative for the virus twice within a six-month interval. Methods thought to protect against transmission for orogenital contact include latex squares, known as dental dams, and latex condoms or gloves cut open and laid flat. For vaginal penetration, latex gloves used on hands and condoms on sexual toys may be appropriate. Lesbians who are sexually active with men may become infected with HIV and should use all of the standard safer-sex precautions.

Lesbians who undergo artificial insemination with either fresh semen from donors in the community or frozen semen from sperm banks are also at risk for HIV infection.[27,28] Sperm banks routinely test donors for HIV infection at the time of donation and six months later before releasing the specimen for use. Because of delays in seroconversion, however, it is possible for lesbians to be exposed to HIV with frozen semen or fresh semen from a seronegative donor.[29] Lesbians should avoid fresh semen, especially from donors with an unknown HIV status.

Cancer Risks and Screening

No population-based studies of cancer risk in lesbians have been reported. As a result, screening decisions should be based on individual risk factors using standard screening guidelines for women.

Cervical cancer appears less common among lesbians than among bisexual or heterosexual women, as suggested by lower rates of dysplasia and abnormal Pap smears.[6,20,30] In the absence of specific data, we recommend screening these women every three years, similar to the American Cancer Society's maintenance screening interval.[31] Women with a history of frequent heterosexual contact or another known risk factor should be screened according to published guidelines.

No specific information on breast cancer, endometrial cancer, or ovarian cancer in lesbians is available. Epidemiologic studies suggest an increased risk of breast cancer among nulliparous women, women who are older with their first birth, and women who have never breast-fed.[32,33] Ovarian cancer has been reported to occur more frequently in women who have not used oral contraception and those who have not given birth.[34,35]

Endometrial cancer is also more common in nulliparous women. Many lesbians fall into these categories and may have an increased risk for breast, endometrial, and ovarian cancers. Physicians should follow current guidelines on screening for these cancers where available.

Lesbians older than 40 years report smoking and drinking alcohol more often than their heterosexual counterparts.[36] No data have been reported on lung or head and neck cancers in lesbians. Physicians should emphasize the health risks of smoking and alcohol use in lesbians and strongly encourage smoking cessation.

Psychosocial Issues

A lesbian patient's support network should be elicited to determine her ability to cope with homophobia, illness, and other stressful life events.[37] Societal attitudes toward lesbians may be compounded by a lesbian's own internal homophobia developed from years of living in an intolerant society. Lesbians most often derive support from partners, friends, and lesbian and gay community organizations.[38-40] The quality of the relationship with a partner can be particularly important to a lesbian's psychological well-being.[41] Discord in a lesbian couple can be even more stressful than for a married heterosexual couple because of a lack of traditional social supports.

The process of discovering one's homosexual orientation and revealing it to others, known as "coming out," may begin at any age and may be associated with notable emotional distress.[42] This process has been well described.[43-46] It involves a shift in core identity that takes place in four stages: awareness of homosexual feelings, testing and exploration, identity acceptance, and identity integration and disclosure to others.[47] Prevailing social attitudes influence the experience of coming out.[42,47,48] Internalized and societal homophobia cause a lesbian to perform a sophisticated and fatiguing "cost-benefit" analysis for each situation in which she considers self-disclosure.

Lesbian adolescents are particularly vulnerable to the emotional distress of coming out, and this distress often confounds their developmental tasks.[43] Parental acceptance during this process, especially maternal, may be the primary determinant of the development of healthy self-esteem in adolescent lesbians.[49,50] Signs of confusion about sexual orientation in adolescents may include depression, diminished school performance, alcohol and substance abuse, acting out, and suicidal ideation.[51] In fact, gay and lesbian youth are two to three times more likely to attempt suicide and may account for 30% of completed youth suicides.[52] It is important for primary care professionals to screen adolescents for these signs and to consider confusion about sexual orientation in the differential diagnosis of depression and substance use.

Alcohol use may be as much as three times more common in lesbians than in heterosexual women, although a random sample study found no difference.[19,53-58] As in heterosexual relationships, violence is an issue in lesbians. More than a third of lesbians 22 to 52 years of age have experienced battery by a partner, and alcohol or drug use was involved in most of these incidents.[59] As part of a comprehensive clinical evaluation, primary care professionals should screen all women, including their lesbian patients, for alcohol abuse, depression, and violence.

According to a study for the US Department of Justice, lesbians and gay men may be the most victimized group in the nation.[60] The number of hate or bias crimes against lesbians, including verbal abuse, threats of violence, property damage, physical violence, and murder, is increasing each year.[61-64] Lesbians at universities report being victims of sexual assault twice as frequently as heterosexual women.[65] Perpetrators of hate crimes often include family members and community authorities.[64] Many gay and lesbian adolescents may leave home because of abuse related to their sexual orientation. Primary care professionals should be aware of the possibility that a patient has been a victim of violence, particularly when patients present with symptoms of depression or anxiety.

Parenting plays a role in the lives of many lesbians. Lesbians may have children from previous heterosexual relationships, from adoption, artificial insemination, or heterosexual intercourse, or they may be a foster parent.[9,66,67] Studies have shown no differences between children raised by lesbians and those raised by heterosexual persons.[68-72] Open communication with children about their parents' lesbianism appears important in family function.[70] Some physicians feel uncomfortable performing artificial insemination for lesbians. A physician who feels unable to comply with a patient's wishes should refer the patient to another physician for the service. Primary care physicians can support the pregnant lesbian by demonstrating nonjudgmental attitudes and encouraging acceptance of lesbian motherhood among members of the obstetric team; childbearing classes; and by including partners in the process of conception, prenatal care, and delivery.[66,72]

This article is one of a series on topics in primary care in which common diagnostic or therapeutic problems encountered in primary care practice are presented. Physicians interested in contributing to the series are encouraged to contact the series' editors.

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REFERENCES

1. Kinsey AC, Pomeroy W, Martin CE, Gebhard PE: Sexual Behavior in the Human Female. Philadelphia, Pa, WB Saunders, 1953

2. Lockard D: The lesbian community—An anthropological approach. J Homosex 1986; 11:83-95

3. Blumstein PW, Schwartz P: Lesbianism and bisexuality, *In* Goode E, Troiden RR (Eds): Sexual Deviance and Sexual Deviants. New York, NY, William Morrow, 1974, pp 278-295

4. Ponse B: The Social Construction of Self. Westport, Conn, Greenwood Press, 1978

5. Ryan C, Bradford J: The National Lesbian Health Care Survey—An overview, *In* Shernoff M, Scott WA (Eds): The Sourcebook on Lesbian/Gay Health Care, 2nd edition. Washington, DC, National Lesbian/Gay Health Foundation, 1988, pp 30-40

6. Johnson SR, Smith EM, Guenther SM: Comparison of gynecologic health care problems between lesbians and bisexual women. J Reprod Med 1987; 32:805-811

7. Diamond M: Homosexuality and bisexuality in different populations. Arch Sex Behav 1993; 22:291-310

8. Johnson SR, Palermo JL: Gynecologic care for the lesbian. Clin Obstet Gynecol 1984; 27:724-730

9. Zeidenstein L: Gynecological and childbearing needs of lesbians. J Nurse Midwifery 1990; 35:10-18

10. Owen WF: Medical problems of the homosexual adolescent. J Adolesc Health Care 1985; 6:278-285

11. Smith EM, Johnson SR, Guenther SM: Health care attitudes and experiences during gynecologic care among lesbians and bisexuals. Am J Public Health 1985; 75:1085-1087

12. Johnson SR, Guenther SM, Laube DW, Keettel WC: Factors influencing lesbian gynecologic care—A preliminary study. Am J Obstet Gynecol 1981; 140:20-28

13. Paroski PA: Health care delivery and the concerns of gay and lesbian adolescents. J Adolesc Health Care 1987; 8:188-192

14. Harvey SM, Carr C, Bernheine S: Lesbian mothers—Health care experiences. J Nurse Midwifery 1989; 34:115-119

15. Cochran SD, Mays VM: Disclosure of sexual preference to physicians by black lesbian and bisexual women. West J Med 1988; 149:616-619

16. Dardick L, Grady KE: Openness between gay persons and health professionals. Ann Intern Med 1980; 93:115-119

17. Raymond CA: Lesbians call for greater physician awareness, sensitivity to improve patient care. JAMA 1988; 259:18

18. Olesker E, Walsh LV: Childbearing among lesbians—Are we meeting their needs? J Nurse Midwifery 1984; 29:322-329

19. Degen K, Waitkevicz HJ: Lesbian health issues. Br J Sex Med 1982 May, pp 40-47

20. Robertson P, Schachter J: Failure to identify venereal disease in a lesbian population. Sex Transm Dis 1981; 8:75-76

21. Sivakumar K, De Silva AH, Roy RB: *Trichomonas vaginalis* infection in a lesbian (Letter). Genitourin Med 1989; 65:399-400

22. Ernst RS, Houts PS: Characteristics of gay persons with sexually transmitted disease. Sex Transm Dis 1985; 12:59-63

23. Chu SY, Buehler JW, Fleming PL, Berkleman RL: Epidemiology of reported cases of AIDS in lesbians, United States 1980-89. Am J Public Health 1990; 80:1380-1381

24. Sabatini MT, Patel K, Hirschman R: Kaposi's sarcoma and T-cell lymphoma in an immunodeficient woman—A case report. AIDS Res 1984; 1:135-137

25. Marmor M, Weiss LR, Lyden M: Possible female-to-female transmission of human immunodeficiency virus (Letter). Ann Intern Med 1986; 105:969

26. Poole L: HIV infection in women, *In* Cohen PT, Sande MA, Volberding PA (Eds): The AIDS Knowledge Base, 4th edition. Waltham, Mass, Medical Publishing Group, 1990, pp 1-10

27. Chiasson MA, Stoneburner RL, Joseph SC: Human immunodeficiency virus transmission through artificial insemination. J Acquir Immune Defic Syndr 1990; 3:69-72

28. Eskenazi B, Pies C, Newstetter A, Shepard C, Pearson K: HIV serology in artificially inseminated lesbians. J Acquir Immune Defic Syndr 1989; 2:187-193

29. Imagawa DT, Lee MH, Wolinsky SM: Human immunodeficiency virus type 1 infection in homosexual men who remain seronegative for prolonged periods of time. N Engl J Med 1989; 320:1458-1462

30. Sadeghi SB, Sadeghi A, Cosby M, Olincy A, Robboy SJ: Human papillomavirus infection: Frequency and association with cervical neoplasia in a young population. Acta Cytol 1989; 33:319-323

31. Hayward RSA, Steinberg EP, Ford DE, Roizen MF, Roach KW: Preventive care guidelines: 1991. Ann Intern Med 1991; 114:758-783

32. Kelsey JL: A review of the epidemiology of human breast cancer. Epidemiol Rev 1979; 1:74-109

33. Byers T, Graham S, Rzepka T, Marshall J: Lactation and breast cancer—Evidence for a negative association in premenopausal women. Am J Epidemiol 1985; 121:664-674

34. Cancer and Steroid Hormone Study of the Centers for Disease Control and the National Institute of Child Health and Human Development: The reduction in risk of ovarian cancer associated with oral-contraceptive use. N Engl J Med 1987; 316:650-655

35. Cramer DW, Hutchison GB, Welch WR, Scully RE, Ryan KJ: Determinants of ovarian cancer risk: I. Reproductive experiences and family history. J Natl Cancer Inst 1983; 71:711-716

36. Whyte J, Capaldini L: Treating the lesbian or gay patient. Del Med J 1980; 52:271-280

37. Gillow KE, Davis LL: Lesbian stress and coping methods. J Psychosoc Nurs 1987; 25:28-32

38. Kurdek LA: Perceived social support in gays and lesbians in cohabiting relationships. J Pers Soc Psychol 1988; 54:504-509

39. Albro JC, Tully C: A study of lesbian lifestyles in the homosexual microculture and the heterosexual macro-culture. J Homosex 1979; 4:331-344

40. Kurdek LA, Schmitt JP: Perceived emotional support from family and friends in members of homosexual, married, and heterosexual cohabiting couples. J Homosex 1987; 14:57-68

41. Gonsiorek JC: Mental health issues of gay and lesbian adolescents. J Adolesc Health Care 1988; 9:114-122

42. Schneider M: Sappho was a right-on adolescent: Growing up lesbian. J Homosex 1989; 17:111-130

43. Raphael SM: 'Coming Out': The Emergence of the Movement Lesbian. (5536A, University Microfilms No. 75-5084.) Dissertation Abstr Int 1974; 35:5536A

44. Minton HC, McDonald GJ: Homosexual identity formation as a developmental process. J Homosex 1984; 9:91-104

45. Spaulding EC: The Formation of Lesbian Identity During the 'Coming Out' Process. (University Microfilms No. 82-26834.) Dissertation Abstr Int 1982; 43:2106A

46. Sophie J: A critical examination of stage theories of lesbian identity development. J Homosex 1986; 12:39-51

47. Faderman L: The 'new gay' lesbians. J Homosex 1985; 10:85-95

48. Savin-Williams RC: Coming out to parents and self-esteem among gay and lesbian youths. J Homosex 1989; 18:1-35

49. Savin-Williams RC: Parental influences on the self-esteem of gay and lesbian youths: A reflected appraisals model. J Homosex 1989; 18:93-109

50. Anstett R, Kiernan M, Brown R: The gay-lesbian patient and the family physician. J Fam Pract 1987; 25:339-344

51. Feinleib MR: Report of the Secretary's Task Force on Youth Suicide. Rockville, Md, US Department of Health and Human Services, 1989

52. Nardi PM: Alcoholism and homosexuality: A theoretical perspective. J Homosex 1982; 7:9-25

53. Fifield L: On My Way to Nowhere, Alienated, Isolated, Drunk—An Analysis of Gay Alcohol Abuse and an Evaluation of Alcoholism Rehabilitation Services for the Los Angeles Gay Community, Los Angeles, Calif, Gay Community Service Center, 1975

54. Saghir MT, Robins E, Walbran B, et al: Homosexuality—IV. Psychiatric disorders and disability in the female homosexual. Am J Psychiatry 1970; 127:147-154

55. Hall JM: Alcoholism in lesbians: Developmental, symbolic interactionist, and critical perspectives. Health Care Women Int 1990; 11:89-107

56. Lewis CE, Saghir MT, Robins E: Drinking patterns in homosexual and heterosexual women. J Clin Psychiatry 1982; 43:277-279

57. Bloomfield K: A comparison of alcohol consumption between lesbians and heterosexual women in an urban population. Drug Alcohol Dependence [Elsevier Scientific Publishers Ireland Ltr] 1993; 33:257-269

58. Schilit R, Lie GY, Montagne M: Substance use as a correlate of violence in intimate lesbian relationships. J Homosex 1990; 19:151-165

59. Anti-Gay Violence: Causes, Consequences, Responses. Washington, DC, National Gay and Lesbian Task Force, 1986

60. National Lesbian Health Care Survey: Mental Health Implications. Atlanta, Ga, National Lesbian and Gay Health Foundation, 1987

61. Gross L, Aurand SK, Addessa R: Violence and Discrimination Against Lesbian and Gay People in Philadelphia and the Commonwealth of Pennsylvania. Philadelphia, Pa, Philadelphia Lesbian and Gay Task Force, 1988

62. D'Augelli AR: Lesbians' and gay men's experiences of discrimination and harassment in a university community. Am J Community Psychol 1989; 17:317-321

63. Herek GM: Hate crimes against lesbians and gay men—Issues for research and policy. Am Psychol 1989; 44:948-955

64. Duncan DF: Prevalence of sexual assault victimization among heterosexual and gay/lesbian university students. Psychol Rep 1990; 66:65-66

65. Kirkpatrick M: Clinical implications of lesbian mother studies. J Homosex 1987; 14:201-211

66. Wismount JM, Reame NE: The lesbian childbearing experience—Assessing development tasks. Image: J Nurs Schol 1989; 21:137-141

67. Strong C, Schinfeld JS: The single woman and artificial insemination by donor. J Reprod Med 1984; 29:293-299

68. Green R: The best interests of the child with a lesbian mother. Bull Am Acad Psychiatry Law 1982; 10:7-15

69. Brewaeys A, Olbrechts H, Devroey P, Van Steirteghem AC: Counselling and selection of homosexual couples in fertility treatment. Hum Reprod 1989; 4:850-853

70. Hanscombe G: The right to lesbian parenthood. J Med Ethics 1983; 9:133-135

71. Golombok S, Rust J: The Warnock Report and single women—What about the children? J Med Ethics 1986; 12:182-186

72. Stevens PE, Hall JM: Stigma, health beliefs and experiences with health care in lesbian women. Image: J Nurs School 1988; 20:69-73