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Barriers to Lesbian Health Care

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BARRIERS TO LESBIAN HEALTH CARE

A Thesis
Presented to the
Faculty of the Department of Sociology
Western Kentucky University
Bowling Green, Kentucky

In Partial Fulfillment
of the Requirement for the Degree
Master of Arts

by
Paula S. Bowles
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BARRIERS TO LESBIAN HEALTH CARE

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The primary purpose of this research was to examine a sample of sixteen lesbian women regarding the barriers to lesbian health-care. From this information several interpretive findings regarding lesbian health-care are made. Data were gathered via in-depth interviews with each individual lesbian. The data suggest that most lesbian women do not reveal their sexual orientation to their primary-care physician for fear of reprisal. Most of the women interviewed do feel they receive adequate health-care from their physician.

The women who participated in this project did so confidentially and were assigned pseudonyms. They were asked questions on a variety of topics, which included demographics, physical health-care, mental health-care, general health, dental care, social and political issues, and homophobia. It was assumed that participants from smaller, more rural areas would face more barriers to health-care than participants from larger cities. The data gathered indicate that only three of the participants had, in fact, informed their primary-care physicians of their sexual orientation.

Erving Goffman’s stigma and social identity theory, feminist standpoint theory, lesbian feminist theory, and feminist theory provided the theoretical framework utilized in the analysis of barriers to lesbian health care. Combining these three theories allows
a discussion of how stigma and homophobia combine to make lesbians invisible in the medical community. Health-care systems, like other major institutions, are structured to support traditional society.
CHAPTER I

INTRODUCTION

Looking at the historical development of research on lesbians and their communities, we learn how new categories of persons and experiences get incorporated into social science and health care.

First they are seen: then they are found deviant (and viewed as exotic); then they are defended, and finally when perceived as sufficiently ordinary, they are included with the rest of what is partly understood (Krieger 1983, p. 284).

A positive acknowledgement of gay and lesbian patients would reduce the fear those individuals have when seeking competent medical care. A general lack of interest in research about lesbian health, coupled with inadequate support for researchers, results in a lack of scientific knowledge about their health-care needs.

Lesbians seeking medical care continue to face discrimination and prejudice (O’Hanlan 1999). Homophobia in society persists, with the result being that lesbians seek medical care only when and if it is absolutely necessary (O’Hanlan 1999). Lesbians are found throughout all areas of the world, among all subgroups of the population, in all racial and ethnic groups, all occupations and professions, all ages, and all socioeconomic statuses (O’Hanlan 1999).

Health-care providers’ assumption that all women are heterosexual leads to not only a failure to appreciate the diversity of humankind but also to a loss of confidence on the part of the homosexual patient (Evans 2000). Many health-care professionals are prejudiced or uninformed about lesbian life, and lesbian women
to share personal information. Doctors must, therefore, ask questions in a
nonjudgmental and nonaggressive way. Further, they must provide a safe environment in
which the patients can share important information about their sexual and general health.
This study, unlike most other research on this topic, will focus on the unique experiences
of lesbians with health-care professionals and their perceptions as to the barriers to
competent health-care. Lesbians lack a reason many heterosexual women have for
routine doctor’s visits. Women in general, and lesbians in particular, make less money
than do men (Norman 1994). This situation may prevent some heterosexual women and
lesbians from seeking medical care for anything other than an emergency. Lack of health
insurance for partners of lesbians is another factor that prevents some lesbians from
seeking routine health care (Norman 1994).

This study may help to ensure that health care for lesbians can be more comfortable
and respectful. Also, better informed health-care providers can render better diagnoses
and recommendations for appropriate treatment. In addition, this work may help health-
care providers feel more comfortable while dealing with issues that are perhaps new to
them. These findings may also be useful to colleges and universities to integrate
information into their curricula so that health-care providers are taught how to deal with
issues of sexual orientation in a nondiscriminatory way. This study will look at lesbians
as whole beings with a variety of needs/concerns, and not as segmented individuals.

Lesbians have been an integral part of evolving health movements, but not one of
those movements has “definitively addressed their health-care concerns” (White and
Martinez 1997, pp. 12-13). For the most part, lesbians are an invisible group in the
health-care system. When lesbians have unique problems or needs, the medical system generally cannot or will not meet those needs. Substantial informal research exists regarding lesbian health issues; however, this knowledge has not been successfully incorporated into the body of knowledge on women’s health (White and Martinez 1997).

The unique health-care needs of lesbians can be met only by increasing access to important health-care services without regard to sexual orientation. This research will utilize in-depth interviewing to assess how self-esteem, social identity, previous health-care experience, and coming out impact lesbians seeking routine medical care. Studying lesbian health should result in knowledge that will be useful for improving the health status and health care of lesbians. Identification of health risks faced by lesbians and how their risks may differ from those of other women will assist lesbians and health-care providers in their efforts to promote healthy lives for this underserved population.

Fundamentally the health care system needs to be responsive to and inclusive of everyone. There are health problems that may be more prevalent among lesbians or for which risk factors and interventions may be different. Many lesbian health issues could be remedied by improving access to care and by reducing discriminatory behaviors.

The sheer lack of research about lesbian health is a form of discrimination (O’Hanlan 1999). Ignorance of a population’s problems can be extremely damaging to a group because there is not adequate information about them. The lack of adequate research is particularly true in the case of lesbians. The degree of invisibility and isolation that lesbians confront in the racial, ethnic, and religious communities from which they come also puts them at risk (O’Hanlan 1999). These patients often feel rejected by the very people charged with safeguarding not only their health but their lives.
The current research was framed in an interactionist perspective. Relying on the work of Erving Goffman (1963) as a starting point, this research built on the concepts of stigma and deviance. Goffman’s writings described how stigmatized individuals are discreditable and alienated from mainstream society. This study also builds on previous studies completed on lesbian health care to evaluate what changes or progress has been made.

Data for the current research were gathered via in-depth, semi-structured interviews with 16 lesbians. The lesbians were selected through the process of chain referral. A detailed description of the data gathering methods used in this study is found in Chapter Four.
CHAPTER II
THEORETICAL PERSPECTIVE

Perhaps for some of you here today, I am the face of one of your fears. Because I am a woman, because I am black, because I am lesbian, because I am a cancer survivor, because I am myself, a black woman warrior doing my work, come to ask you, are you doing yours? (Lorde 1980, p. 21)

The women with whom Audre Lorde spoke in 1980 were gathered to hear her speak about her struggle with breast cancer. Lorde underwent a mastectomy and the doctors automatically assumed that she would want a prosthesis to look like a “normal” woman. Lesbians who are seeking competent medical care face a difficult challenge.

Studies indicate that discrimination against homosexuals leads to higher death rates from cancers and heart attacks when compared to heterosexuals (O’Hanlan 1999). Because lesbians appear to seek health care less often, they are less likely to receive routine testing procedures that heterosexual women receive, further compounding their problem. Lesbians are acutely sensitive to language and behaviors that signal danger or safety on issues of sexual orientation. Lesbians say that

the most serious health issue for lesbians is that too often we don’t feel comfortable or safe seeking care when we need it because of the ignorance, anti-woman, and anti-lesbian attitudes we encounter in most of the medical system. (Sanford 1998, p. 190)

A study of nurse educators in the United States found that twenty-five percent of participants saw lesbianism as immoral or wrong, and fifty-two percent believed that lesbians should undergo treatment to become heterosexual (Rankow 1995). These
attitudes affect the quality of care that lesbians receive. Discrimination impacts every aspect of health-care interactions, from a woman’s decision to access care to the health-care provider’s diagnosis and treatment. A survey of the American Association of Physicians for Human Rights found that sixty-seven percent reported knowing of instances in which lesbian, bisexual, or gay patients had been refused care or had received substandard care because of their sexual orientation (Rankow 1995).

There are three theories that provide the basis to examine the barriers to lesbian health-care. They are stigma and labeling theory, standpoint theory, and lesbian feminist theory. The basics of these three perspectives must be understood to reveal their compatibility and relevance.

**Stigma and Labeling Theory**

The theoretical framework that is most relevant to this study appears to be Goffman’s (1963) work on stigma and Becker’s analysis of labeling. Erving Goffman has defined stigma as “an attribute that is deeply discrediting” (Goffman 1963, pp. 25-6). Goffman describes several kinds of stigma; for example, abominations of the body, blemishes of individual characters, and tribal stigma, which is transmitted through lineages. Homosexuality is defined by at least a segment of the public to be a blemish of individual character. According to Becker (1963) homosexuality is a form of deviance. Deviance is not a quality or an act a person commits, however, but rather a consequence of the infraction of the rules that social groups create (Becker 1963). Deviant behavior is, therefore, behavior that has been so labeled by society. This labeling has the potential to result in a radical change of a person’s self-concept and social identity (Macionis 1997). Negative labeling has another effect as well. Goffman (1963) points out that if an
individual possesses a stigma, his/her interactions with others are affected. Results may include inappropriate treatment or negative consequences.

There are basically two types of stigmatized people, the discredited and the discreditable. The discredited are individuals who visibly vary from ideal human beings. The discreditable secretly vary from ideal human beings, and if their secrets were known would be rejected by other people (Goffman 1963). Each type of stigma has a distinct effect upon a stigmatized individual’s behavior. Discredited people may try to hide or worry about their secret becoming known by critical people. A stigmatized person, at least in respect to his or her stigma, is often not considered to be a human being at all. Stigmatized individuals are frequently denied respect and regard from others.

Society's institutions view and label deviation from the statistical or power norm in different pathological ways according to their own focus and structure. To be a woman in a male-dominated society or to be gay or lesbian in a heterosexual society is considered not altogether healthy by medical institutions and is stigmatized as such (Hacker 1971). In addition, the physicians who pin the sick role on such deviants then tend to blame the victims for their differences (Armitage, Schneiderman, and Bass 1979).

Labeling theory focuses on the process linking behavior and context, seeing deviance as a natural (not necessarily negative) consequence of laws and expectations (Becker 1963; Goffman 1963). From this interactionist perspective, deviance is no longer seen as simply individual deviant behavior but as social interaction, depending on the characteristics of all of the actors as well as the time, place, and cultural context of the situation. Once a person is defined as deviant, new relationships occur among the audience, the labeler, and the labeled individual. Thus, it may be important to the self-
identified deviant to withhold information from others, causing bad consequences in the process of avoiding other consequences that are perceived as being even worse. Because of the critical relevance of sex to personal identity, management of a sex-related stigma becomes extremely important (Schur 1965).

While at times it may be useful for lesbians to remain invisible as far as the larger culture is concerned, it becomes important for them to identify each other in certain contexts. Special cues must be developed that remain unidentifiable by outsiders in most circumstances but that are readily picked up by ingroup members. The coming out process specifically alters the relationship of an individual to society and its traditional institutions through declining secrecy, expected rejection, actual hostility, and consequent isolation from dominant group members (Ponse 1976). Because members of stigmatized groups are usually socialized in the dominant culture, they frequently have internalized or at least have become cognizant of societal judgment. Their socialization may become more apparent when stigma is invisible because dominant group members will probably make no attempt to disguise negative responses within the hearing of the invisible deviant (Ponse 1976). For lesbians, whose stigma is invisible, the major internal crisis is often whether to pass or to come out in traditional health care settings as well as in other situations (Humphreys 1972). Fear of judgment and official stigmatization as well as anticipation of physician ignorance about special needs have been suggested as motivations for lesbians who try to pass as heterosexuals in the physician's office (Albro and Tully 1979).

The medical system is not just a service industry. It is a powerful instrument of social control, replacing organized religion as a prime source of sexist ideology and an enforcer of sex roles...It has the
unique authority to judge who is sick and who is well, who is fit and who is unfit...Our social roles, and not our innate biology, determine the state of health. Medicine does not invent our social roles, it merely interprets them to us as biological testing. (Ehrenreich and English 1973, pp. 67-68)

The concepts of stigma and deviance and their management apply to the health care system in two ways (1) persons defined as sick (deviant in regards to health or mental health) by the health care system are, by that definition, stigmatized in their interactions with the rest of society, and (2) persons stigmatized by society (regardless of the origin of the stigma) may interact with the health care system in ways dissimilar to members of the majority (Kaplan, Boyd, and Bloom 1962). Thus, the health-care system itself plays a dual role, first defining stigma, then reacting to stigmatized individuals. Stigma, then, may be intensified through stress by the traditional health care system.

Furthermore, lesbians illustrate the concept of double stigma: they are seen first as women and then as nonheterosexually active in a culture dominated by men and heterosexually active adults (Hacker 1971). The impact of this status can be seen in their perception of health needs, in their internal psychosocial inhibitions to seeking health care, and in their perceptions of the responses to them by the traditional medical system. Moreover, the interaction of these factors may intensify the effect of nontraditional status on access to the health care delivery system.

Stigma and social identity play an important role in the lives of lesbians. As discreditable individuals, who must hide their true social identity, lesbians receive less than adequate or competent medical care. Goffman’s (1959) dramaturgical analysis, *Presentation of Self in Everyday Life*, explains the situation that lesbians face daily. Their lives have much in common with Goffman’s theatrical performances. Lesbians,
like most individuals, have a variety of reasons for attempting to control the impression others receive of their actions in social situations. The smooth flow of social life depends upon others accepting the impressions lesbians attempt to convey concerning their identities and the meaning of their actions. Lesbians give the appearance of “normal” when they are in the general population and then revert to their true selves when they are at home or in another environment that they consider to be safe.

Goffman defined interaction as the “reciprocal influence of individuals upon one another’s actions when in one another’s immediate physical presence” (Goffman 1959, p. 23). He defined performance as “all the activity of a given participant on a given occasion which serves to influence in any way any of the other participants” (Goffman 1959, p. 23). Lesbians must seriously consider their social actions prior to taking action to hide their true identity for the benefit of heterosexual people. Otherwise, they fear further discrimination, stigma, and possibly violence.

People who engage in role behaviors associated with the opposite sex are not viewed in a positive manner. Lesbians who are viewed as having cross-sex traits and assuming cross-sex roles are disliked by those with traditional gender-role attitudes (Kite and Whitley 1998). Lesbians are typically aware of the risks of disclosing their sexual orientation. Heterosexuals’ negative attitudes toward lesbians and gay men may stem from a denial of sexual impulses in general or, more specifically, the denial of attraction of same-sex others (Kite and Whitley 1998). These negative attitudes may partially account for homophobia.

Internalized homophobia manifests itself in many ways — isolation, fear of discovery and deception, self-hatred, shame, and moral and religious condemnation (Gartrell 1984;
Internalized homophobia is important because it is a major cause of psychological distress in lesbians and gay men, and to varying degrees all lesbians and gay men experience it as a result of living in an antigay and heterosexual society (Shidlo 1994).

Many lesbians attempt to pass as heterosexual in order to hide their true identity. One strategy involves assuming “heterosexual behavior and dress” in order to be socially acceptable (Shidlo 1994, p. 178). It is obvious that this approach is fear based, causing lesbians not to reveal the places, events, or people with whom they normally associate. Charles Horton Cooley’s (1904) looking-glass self suggests that it is very important to lesbians for others to see them as “normal” and as adhering to society’s unspoken rule of compulsory heterosexuality. The looking-glass self has three principle elements: the imagination of our appearance to other people; the imagination of their judgment of that appearance; and some sort of self-feeling, such as pride or mortification. People reveal or hide certain things in order to manipulate the reactions of others.

**Feminist Standpoint Theory**

A standpoint is a position in society involving a level of awareness about an individual's social location, from which certain features of reality come into prominence and from which others are obscured. Standpoint theory begins with the idea that the less powerful members of society experience a different reality as a consequence of their oppression. To survive, subordinate people must be attentive to the perspective for the dominant group as well as their own. As a result they have the potential for double vision or double consciousness—a knowledge of, awareness of, and sensitivity to both the dominant worldview of society and their own perspective. Members of subordinate
groups have the potential for a more complete view of social reality. Members of oppressed groups must develop this more complete view as a survival skill to cope with oppression. Standpoint theory offers an explanation of how research directed by social values and political agendas can produce empirically and theoretically preferable results (Harding 1991; Hartsock 1983).

Life experience structures one's understanding of life. Research must begin from concrete experience, rather than abstract concepts. The life experiences of members of marginalized groups have been devalued. Marginalized populations have fewer interests in maintaining ignorance about how the social order actually works and fewer reasons to invest in maintaining or justifying the status quo than do dominant groups. Because they have less to lose, their perspective can more easily generate fresh, critical analyses and questions (Swigonski 1994). Adrienne Rich's (1990) analysis of the exercise of male power to ensure compulsory heterosexuality emerged because of the viewpoint available to her as a lesbian, a viewpoint that is more comprehensive than that of the dominant heterosexual group. Knowledge emerges for the oppressed through the struggles they wage against their oppressors. Examining the everyday lives of marginalized groups reveals the ways in which the public world structures the private, everyday lives of marginalized groups in ways that are not immediately visible as those lives are lived. Such a perspective can reveal the caring and valuing of group members for each other, the prioritizing of their welfare, and the possibility of experiencing real intimacy that are invisible to traditional approaches to research.

Standpoint theory makes it possible to ask new questions and to see new things about social relations, not from the lives of those who control the ruling apparatus but from the
lives of those at the margin (Hartstock 1997). Centering the lives of marginalized groups in research provides a way to identify and control both individual and sociocultural assumptions and biases while strengthening objectivity. Standpoint theory does not rule out the insights of any group of persons. Each group contributes the distinctive knowledge emerging from its particular social situations and social structures.

Karl Marx and Frederick Engles influenced early feminist standpoint theory, as did symbolic interactionism, from the perspective that gender is socially constructed. People with subordinate status, such as lesbians, have greater motivation to understand the perspective of powerful groups than vice versa (Harding and Wood 1997). As a result of cultural inequities, society is not experienced identically by all members. Economic condition, race, and sexual orientation also contribute to a woman's position in society.

Karl Marx and Frederick Engles' philosophy represents a protest against man's alienation, his loss of self, and his subsequent transformation into a thing; it is a "movement against the dehumanization and automatization of man inherent in the development of Western industrialism" (Fromm 1961, p. 5). Alienation or estrangement when applied to lesbians means they do not experience life fully. They are passive and alienated from life. Lesbians experience alienation from love through having to withhold their true feelings. Alienation has been implicated in depression. As a socially oppressed class, lesbians cannot communicate their true social identity without being stigmatized and discriminated against.

Economic conditions, race, and sexuality contribute to a person’s position in society, and lesbians are at a disadvantage. As members of what is considered to be an invisible group, lesbians’ special health needs are not adequately met because of a lack of funding.
due to political influences from heterosexual men. Failure by the medical community to recognize or to acknowledge diversity among their patients is unacceptable and is a primary cause of lesbians seeking medical care only when it is absolutely necessary (Saulnier and Wheeler 2000).

Standpoint theorists see important differences between men and women that affect their communication. These differences are a result of cultural expectations and the treatment that each group receives from the other because of inequities. Culture is not experienced identically by all members of society. Women are underadvantaged and men are overadvantaged (Harding and Wood 1997). When groups are further broken down, one can see the distinct disadvantage that lesbians, gay men, and bisexuals endure.

Standpoint feminist theory provides a broader perspective than most micro theories. The marginalized people with whom it deals have more motivation to understand the perspective of the powerful, and they have little reason to defend the status quo (Harding and Wood 1997). Because standpoint theory is based upon inquiry and is research grounded in the standpoints of women and other marginalized groups, it may be more objective and complete.

**Lesbian Feminist Theory and Feminist Theory**

Lesbian feminist theory, as defined by Ettore, is a:

contemporary political theory which extends the traditional feminist analysis of sexual politics to an analysis of sexuality itself, and it is structured into our society (Ettore 1985, p. 423).

Lesbian feminist theory focuses on compulsory heterosexuality. Heterosexuality is viewed as a political institution that is maintained through forces through which women have been convinced that marriage and sexual orientation toward men are inevitable
Feminist theory is woman-centered, with its focus on the situations and experiences of
women in society. It treats women as the central subjects and seeks to see the world from
the vantage point of women. Feminist theory is critical and activist on behalf of all
women, seeking to produce a better world for women and all humankind. Feminist
theory asks the following questions:

1. And what about the women (lesbians)?
2. Why then is all this as it is?
3. How can we change and improve the social world so as to
   make it a more just place for women and all people?
   (Lengerman 1998, p. 444)

Feminism’s qualifying question is “and what about the differences among women”
(Lengerman 1998, p. 445). It leads to a general conclusion that the invisibility,
inequality, and role differences in relation to men that characterize women’s lives are
affected by a woman’s social location, by her class, race, age, affectional preference,
marital status, religion, ethnicity, and global location. The basic questions of feminist
theory produce a theory of social life that is universal in its applicability. Karl Marx
helped us to discover that the knowledge people had of society, what they assumed to be
an absolute and universal statement about reality, reflected the experience of those who
economically and politically ruled the social world. Marx demonstrated that one could
also view the world from the vantage point of those who were economically and
politically subordinated and indispensable producers of our world.

Lesbian feminism emerged in the United States in 1970 as a radical political project
by antiwar-student and civil-rights movements (Hatch, Hamalian, and Blum 1970). The
early lesbian feminists were mainly white and from a range of class and cultural
backgrounds. They pointed out that compulsory heterosexuality is the key to a male-dominated society or patriarchy. Their strategy was to escape heterosexuality and embrace lesbianism in order to free themselves, overthrow the social order, and create a more just society (Hatch, Hamalian, and Blum 1970).

Synthesis of Theories

Stigma and labeling theory, standpoint theory, lesbian feminist theory and feminist theory each offer perspectives from which this research will be analyzed. These theories offer valuable information to describe the barriers to lesbian health care. Stigma and labeling theory provide the background to understand the barriers that women, in particular lesbians, face when seeking competent medical care. In addition, the stigma and the label of lesbianism erect a barrier between the lesbians and homophobic practitioners, who, then, cannot see past the lesbianism to look at the medical problems of the women. Standpoint theory, lesbian feminist theory and feminist theory lay the foundation to analyze why lesbians face discrimination when they seek medical care. From the humanistic standpoint of the lesbian the heterosexual attitudes of the powerful protect the interests of a male-dominated society and further promote patriarchy. By using the key concepts of stigma and deviance to focus this research, a greater degree of knowledge may be obtained about the health care experiences of lesbians.
CHAPTER III

LITERATURE REVIEW

The health of a nation, physically and emotionally, can only be as good as the health of its most vulnerable and stigmatized citizens (Peterkin and Risdon 2003). Developing a relationship with a medical doctor or a mental-health provider who truly addresses the entire well being of the person requires the provider not only to be tolerant but also to be knowledgeable about sexual orientation and its impact on psychological and physical health. Being open about one’s sexuality is especially difficult if the patient perceives that sexuality, in general, and same-sex orientation, in particular, appears to make the provider uncomfortable. Even well meaning providers can create an atmosphere of discomfort for lesbian and gay people by assuming the patient is heterosexual and thereby forgoing the opportunity to ask the patient in a nonjudgmental way about his or her sexual orientation (Peterkin and Risdon 2003).

Open dialogue about a lesbian patient’s health is often stifled by doctors' attitudes. Doctors frequently tell lesbians that they do not approve of homosexuality, offer them little assistance in finding lesbian-specific items such as dental dams, and ignore sexual and drug-use factors (Cole and Cooper 1990). Outright homophobia in medicine also drives lesbians away from doctors’ offices. The presence of this discrimination is evidenced by a study cited in the New York Times that indicated that “72 percent of lesbians surveyed said doctors either ostracized them or made degrading remarks to
them” (Gilbert 1995, c 15). As a result, “84 percent hesitated to return to the doctor” (Gilbert 1995, c 15). The presence of this discrimination is corroborated by the medical community, in which “54 percent of 710 gay and lesbian doctors” polled had seen their colleagues either deny care or give substandard care to lesbian or gay patients Gilbert 1995, c 15).

Coming out as gay or lesbian over and over again in health-care settings can be anxiety provoking and difficult even for those people who have negotiated this process in other aspects of their lives. For young people, in particular, health-care providers can provide much needed support for integrating sexual orientation into a positive self-image (Peterkin and Risdon 2003). Adolescence is a difficult time for lesbian and gay people, and finding a health-care environment in which information and nonjudgmental care are offered can help in avoiding dangerous and self-destructive behaviors.

All of the presently recognized inadequacies of scientific inquiry into the health concerns of women affect lesbians (Denenberg 1995). In addition, lesbians are an invisible minority to the health care system and its providers. Providers, along with the general public, assume heterosexuality as the norm. As is true for all value judgments presented to patients by health-care providers (such as “you don’t smoke, do you?”), the assumption of heterosexuality initiates a complex series of problems for the relationship between patients and providers (Denenberg 1995). First, there is the conflict for the client who must consider whether or not to correct the assumption and come out. Even if the client prefers to be out to her medical provider, if the assumption of heterosexuality is asserted first, the disclosure becomes more complex. Contradicting an authority is no easy matter and may set up a conflict that need not have existed. In addition, the patient
must consider the possibility that the provider will not provide optimum health care to lesbian patients. In the final analysis, the provider cannot provide optimum health care unless the patient’s situation (in terms of family, support system, sexual behavior, health habits, substance use, etc.) is uncovered and known (Denenberg 1995). A paradox is encountered by the patient, whose burden it becomes to negotiate the murky, unknown territory in order to bid for the best health-care possible.

The patient also may experience the dilemma of not feeling trust in the provider’s judgment if she has not been truthful or complete in her presentation of the situation. This complex feeling actually implicates the patient as the cause of communication problems between her and the health-care provider. As trust and truthfulness are the cornerstones of provider-patient relationship, the relationship may falter or fail. Lesbian responses to inherent problems in the provider-patient relationship include distrust of all providers, distrust of male providers or nongay providers, opting out of the health-care system with failure to obtain preventive or screening services, skepticism toward all health-care strategies, denial of risk, perception of lesbians as being at increased risk, and increased use of alternative health practitioners (chiropractors, naturopaths, acupuncturists) (Denenberg 1995).

For many reasons lesbians are found to underuse health-care services that target populations of women. Systemic problems that affect access for all women also serve to reinforce this finding in lesbians. In the present system of care in the United States, general primary-care services often exclude reproductive and sexual services (Denenberg 1995). Conversely reproductive service providers are inadequately prepared to provide comprehensive primary health care for their female patients. Thus, the majority of
women are well-served only if they see a primary-care medical provider as well an
ob/gyn or other women’s health specialist. Difficulties facing all women in a fragmented,
depersonalized system are simply exaggerated for lesbians, who may have fewer dollars
to spend on their health care and less access to public benefits or to private insurance
(Denenberg 1995). Lesbians are singularly excepted from public-health messages that
urge women to seek health-care services such as cancer screening, family planning
services, and treatment for sexually transmitted diseases.

It is difficult to compare disease morbidity and mortality rates of lesbians with those
of heterosexual women because of the sexual heterogeneity of the lesbian population, the
lack of representative samples of lesbians, and the inevitable inclusion of all sexual
orientations in any sample (Howey 2003). In a national survey of lesbians, 21 percent
reported sexual abuse in childhood, 15 percent in adulthood, and 4 percent in both
(Howey 2003, p. 22). Sexual abuse of lesbians may lead to alcohol abuse and the use of
cocaine and other drugs. Numerous factors suggest that lesbians may be at a higher risk
for smoking. Like other economically and socially marginalized communities, lesbians
may face a disproportionate amount of daily stress due to homophobia and
discrimination.

Sexual orientation as a way to categorize people is both misunderstood and
controversial (Bernstein 1994). Our culture is obsessed with sex and as a result is phobic
about it. It is difficult to talk calmly about any sexual topic, and sexual orientation is no
exception (Bernstein 1994). In general, there is a lack of interest in research about
lesbian health and a lack of support for researchers who would like to pursue study in this
area.
Schwanberg (1996) reviewed 51 different studies completed in the early 1970s to the early 1990s to determine health-care providers’ attitudes toward lesbians. She found that attitudes of health-care providers did influence type and quality of health care provided. Education, adherence to conformity, unfamiliarity with homosexuality, and religiosity were found to affect how health-care providers viewed lesbians (Schwanberg 1996). While a variety of attitudes were found to exist, education and interaction with lesbians were found to modify negative attitudes in some instances.

One study by Stevens (1995) examined the issue of heterosexual assumptions imposed on lesbian health-care clients at both the macro and micro levels. Examination at the macro level showed that health care is set up in a heterosexist social structure with women’s health-care focusing on reproductive concerns, which result in lesbians’ believing they did not have full access to knowledge and skills to promote better health (Stevens 1995). Another result was that lesbians’ partners were not recognized as having the same rights as heterosexual spouses and not given the same access to their partner’s medical insurance. At the micro level health-care providers’ abilities to diagnose, treat, and provide supportive interactions were negatively affected by their heterosexist assumptions (Stevens 1995).

Some research found that lesbians would sometimes not seek medical attention due to the fear of discrimination. According to Trippet and Bain’s (1992, p. 149) research 24.7 percent of the lesbians in their study failed to seek traditional health care for the underlying reason of fear of discrimination. Many turned to low-cost, natural, and/or alternative care. One author explained that fear of homophobia is still the main consideration in lesbians’ decisions regarding health care (Trippet and Bain 1992).
Menstrual problems were found to be the biggest health concern in the Trippet and Bain study, yet twice as many women did not seek treatment for it as those who did, due to the fear of homophobia by health-care providers.

Other researchers explored lesbians’ experiences once their health-care providers knew of their sexual orientation. Stevens and Hall (1990) found that 72 percent of their respondents experienced negative reactions when their health care providers knew of their sexual orientation. Experiences were reported to range from embarrassment to fear, to breaches in confidentiality, to doctors’ ceasing to talk with them, to rough handling, to misdiagnosis, and even to refusal of care (Stevens and Hall 1990). Another study by Stevens (1994, p. 645) found that lesbians rated 77 percent of health-care interactions negatively when their sexual orientation was known. Lesbians reported experiencing no eye contact, abrupt commands, rejection, being made to feel ashamed, snap judgments based on prejudicial stereotypes, being silenced, judgments based on appearance, not being given adequate information, and rough handling (Stevens 1994). Outright sexual abuse in the course of health-care encounters was reported by 16 percent of the respondents in yet another study conducted by Stevens (1996).

While some lesbians did let their fears and/or negative experiences deter them from seeking traditional health care, others sought alternative, more protective strategies instead (Stevens, 1994). For example, some lesbians shared health information and gave diagnostic suggestions or actual care to others. Some lesbians sought recommendations regarding treatment providers or actually screened the providers and/or the treatment facility. Health-care providers with similar characteristics to themselves such as sex or race were frequently sought by lesbians. Disclosure of sexual orientation depending on
its relevance to current health-care needs was also a protective strategy. Some lesbians brought witnesses to their appointments, and some challenged mistreatment (Stevens 1994). As a last resort some lesbians removed themselves from the situation if they did not feel safe.

Another study examined the differences between health lifestyle activities and health histories of lesbian and heterosexual women (Buenting 1992). Lesbians were found to be less likely to seek routine gynecological care. They showed a higher use of recreational drugs and a lower use of prescribed medications than heterosexual women (Buenting 1992). Lesbians also showed a higher use of alternative diets and meditation/relaxation techniques. Last, they utilized therapy or counseling more often than did heterosexual women. These differences between lesbians and heterosexual women help to exemplify why it is important for health-care providers to be more knowledgeable about lesbian health and lifestyles as the differences may result in lesbians having different needs, which could, in turn, result in different treatment or interventions (Buenting 1992). For example, lesbians have a slightly higher risk for the delayed detection of cervical cancer than heterosexual women, and they may have an increased risk for breast and endometrial cancer due to their low incidence of child bearing (Lucas 1992). As lesbians are known to skip gynecological checkups for a myriad of reasons, they often receive no preventative health-care services such as blood pressure checks or cholesterol screenings (Denenberg 1995).

Failure to separate lesbian health means that health issues defined from lesbian experience have not been explored. The absence of this focus implies that research on health issues important to lesbian women, and that may be increasingly important for elderly, widowed, or celibate heterosexual women for whom it is no longer appropriate
to define health around procreation and heterosexual activity has not been undertaken. (Rosser 1993, p. 199)

**Homophobia and Heterosexism**

A primary obstacle to lesbian health-care is homophobia. Homophobia is the antipathy or disdain for gay men and lesbians (Gilbert 1995). Lesbian health advocates indicate that homophobia can cripple a lesbian’s ability to receive quality health care (O’Hanlan 2001). Many gay, lesbian, and bisexual people are subjected to discrimination and violence, and this increases stress and harms mental health (O’Hanlan 2001). Lesbians often have less access to health insurance, and most workplace policies do not cover unmarried partners (Margolies, Becker, and Jackson-Brewer 2001).

Homophobia operates in a different manner to keep lesbians in their place of minority status, and the results of this oppression strike in many ways. Systematic erasure of lesbians in history perpetuates the lack of role models and increases the need to make the unfamiliar familiar. Building a strong lesbian community is hampered by closeted living due to fear. This fear can lead to stress-related illnesses. Homophobia reinforces the isolation lesbians can sometimes experience. One consequence of isolation is that abuse in lesbian relationships often goes unseen, unheard, and, therefore, unaided because of the fear of airing dirty laundry and perpetuating societal and health-care providers’ homophobia. It is clear, therefore, that homophobia is one aspect of life over which a lesbian has little control yet one that influences how a lesbian makes her way in the world and the degree to which she lives her life (Morse and Field 1995).

The term "homophobia" was first used by Weinberg to "describe an irrational fear, hatred, and intolerance of homosexuality" (Weinberg 1972, p. 76). Manifestations of
homophobia range from casual jokes about "queers" or "dykes" to feelings of revulsion toward homosexuals (Gramick 1983, p. 183). Internalized homophobia represents the internalization of negative attitudes and assumptions regarding homosexuality by lesbians and gay men themselves (Shidlo 1994; Sophie 1987). These feelings and attitudes may be conscious or unconscious (Falco 1991; Loulan 1984).

Internalized homophobia in lesbians manifests itself in several ways— Isolation, fear of discovery, deception, self-hatred, shame, and moral and religious condemnation of homosexuality (Shidlo 1994). Other manifestations include short-term relationships and restricting attractions to women who are unavailable, such as a woman who is currently married (Shidlo 1994). Lesbians, as members of a minority community, suffer disproportionately from systemic and direct discrimination.

The problem of individual internalized homophobia in gays and lesbians can be seen in their dealings with medical authorities. The shame and guilt that some feel stops them from fighting for their legitimate place with their partners in hospitals, courtrooms, and against parents (Freidman 1997). They cannot demand that doctors, nurses, and dentists treat them with the same courtesy, respect, and attention that is given to heterosexuals and as a result may settle for second-class medical care. Adolescents, in particular, have a difficult time demanding that their personal physician give them advice about the health risks in same-sex dating (Freidman 1997).

The health-care system is criticized for its insensitivity to the needs and difficulties that gays and lesbians face (Freidman 1997). The assumption of heterosexuality by health care workers is frequently left uncorrected by patients. The fear of discrimination, rejection, and expressions of revulsion by health-care providers effectively silence gays
and lesbians.

The term heterosexism was added to the vocabulary to refer to the "overt and covert mistreatment of lesbians and gay males" (Van Wormer, Wells, and Boes 2000, p. 29). Heterosexism as defined by the dictionary is "prejudiced attitudes or discriminatory practices against homosexuals by heterosexuals" (Random House Webster's ...1997, p. 61). Heterosexism refers to the negative treatment of the gay, lesbian, and bisexual minorities. Heterosexism is more inclusive than homophobia as it deals with external behaviors rather than motivating factors (Van Wormer et al. 2000). The revulsion toward homosexuals can lead to punishment being inflicted upon them by heterosexuals.

Homophobia is widespread in America and the discrimination it inspires touches the lives of many Americans, not just the gay and lesbian communities. America pays a dear price because of homophobia (Bidstrup 1997). There are murders inspired by hatred, and there are suicides as a result of maltreatment. Homosexuals find it difficult to maintain their perspective and to realize that the problem is others' perceptions, not one's own beliefs of traits (Bidstrup 1997).

Homophobic fears skew how our culture deals with sex, sexuality, relations with strangers, co-workers, and others, and with public issues. The military expels homosexuals from its ranks in open defiance of the "don't ask, don't tell" law even though its own studies have shown that homosexuals do not represent a threat to unit cohesion (Bidstrup 1997). Straight men see gay men as a threat, and they instinctively fear that threat. It is a fear of loss of control, of dominance, and of status.

Suzanne Pharr, founder of the Women's Project in Little Rock, Arkansas, has defined homophobia as "the irrational fear and hatred of those who love and sexually desire those
of the same sex" (Pharr 1993, p. 3). Pharr has experienced the effects of homophobia first hand through rejection by friends, threats of loss of employment, and threats upon her life (Pharr 1993). In addition to losing their children lesbians have been subjected to beatings, rapes, and death.

Homophobia works effectively as a weapon of sexism because it is joined with a powerful arm, heterosexism (Pharr 1993). Heterosexism creates the climate for homophobia with its assumption that the world is and must be heterosexual and its display of power and privilege as the norm (Pharr 1993). To be named as a lesbian threatens all women, not just lesbians, with great loss. Women who step out of the traditional roles risk being called lesbian.

**Physical Health**

Lesbians have reported that they delay seeking health care because they fear the negative consequences of disclosing their sexual orientation (Hart 1995). Numerous studies report that lesbians have experienced hostility, demeaning jokes, anxiety, and curiosity from their health-care providers (Randall 1989; Stevens 1992; Turner and Kessler 1986). Lesbians have been subjected to a breach of confidence, stereotyped comments, and mental-health referrals from their physicians (Hart 1995).

Lesbians' nondisclosure of their sexual orientation can lead to misdiagnosis and inaccurate health teaching by their physicians (Hart 1995). It has been reported that the risk for lesbians to develop breast cancer is one in three. These numbers contrast sharply with the one in eight risk for heterosexual women in developing breast cancer in their lifetime (Hart 1995). Not bearing children, as a general rule, places lesbians at a greater
risk for breast cancer, higher rates of alcohol abuse, smoking, and being less likely to do routine breast exams and to seek gynecologic health-care (Haynes 1992).

With the exception of their sexual orientation, lesbians demonstrate as much variety with regard to race, class, occupation, and age as their heterosexual counterparts. Many lesbians also share a history of heterosexual experiences. Many married, either before they recognized their sexual orientation or as an attempt to conform to the pressures for compulsory heterosexuality in this society (Rosser 1993). Many lesbians are biological parents, their children having been conceived while in a heterosexual relationship or through artificial insemination. These diverse factors and their implications are important for health care studies because they can lead to appropriate diagnoses and treatments for lesbians (Rosser 1993).

Studies indicate that lesbians are not at a higher risk for any particular health problem because of their sexual orientation but that some risk factors for certain diseases may be more common among lesbians because they do not seek routine medical care (Tierney 1999). Fear of discrimination keeps lesbians from seeking routine medical care, and the stress experienced due to homophobia negatively impacts lesbian health (Tierney 1999). However, studies do indicate that lesbians have a variety of health concerns.

A recent study found that the incidence of cancer and infectious diseases increased proportionally to the degree to which participants hid their sexual identity (Cherin 1999). Physical illness can result from the increased demands on the cardiovascular system and the chronic unhealthy feelings that result from lesbians hiding their sexual identity (Cherin 1999). Because lesbians seek routine examinations less frequently than heterosexual women, their risks for certain illnesses such as breast cancer and heart
attacks are greater.

Doctors tell lesbians "that they do not approve of homosexuality, offer them little assistance upon learning their sexual orientation, and ignore both sexual and drug use factors" (McGrath 1996, p. 83). A study cited in the *New York Times*, Bias in Doctors' Offices May Harm Gay Women's Health, Study Finds," indicated that 72 percent of lesbians surveyed (578) said doctors "ostracized them or made degrading remarks to them" (Gilbert 1995, p. C15). This study also polled 710 gay and lesbian physicians, and 54 percent of them reported they "had seen colleagues either deny care to gay and lesbian patients or give them substandard care" (Gilbert 1995, p. C15). These data indicate that physicians are alienating homosexual patients, making them reluctant to seek mainstream health-care.

Studies on substance use demonstrate a correlation between societal marginalization and substance misuse (Bushway 1991). Some studies have shown higher use of alcohol, cigarettes, and other drugs among a subpopulation of lesbians (Bradford 1994; Hall 1992). These studies found that lesbians tended to use psychoactive substances to cope with isolation and societal and internalized homophobia. Two general types of risk factors appear to play a role in the development of alcohol problems among lesbians. One of the risk factors is related to sexual orientation, while the other applies to all women but may affect lesbians differently from heterosexual women. It includes life roles such as employment status, characteristics of intimate relationships, interpersonal violence and sexual abuse, a family history of substance abuse problems, and gender role socialization and identification (Hughes 1994).

Abuse is an issue of power and control, and it impacts lesbians. Although there is
increasing awareness of this issue in lesbian communities, there is still a pervasive silence about lesbian battering and abuse. Lesbians who experience abuse are less likely to seek help in the medical system and are less likely to turn to shelters (Saunders 1999). When lesbians do reach out for help, the violence is often minimized and framed by care providers as mutual aggression (Scherzer 1998). This silencing is particularly evident in cases of sexual assault (Orzek 1998). Societal homophobia and sexism exacerbate the fear and shame that lesbian survivors of abuse and lesbian perpetrators experience.

A difference exists between homosexual and heterosexual women when it comes to seeking health care (Fisher 1998). The majority of younger women who receive regular health examinations, including mammograms and Pap smears are heterosexual with either birth control or childbirth-related conditions. The National Institute of Health and the Centers for Disease Control and prevention are aware of the possibility of a distinct difference in the medical care given to lesbians; however, no complete study exists (Fisher 1998). Lesbians will admit that they often do not seek health care because they feel uncomfortable doing so.

“Lesbian-sensitive health-care providers” are providers who acknowledge their lesbian clients and who treat them without homophobic fears (Neisen 1997). A high quality, lesbian-sensitive provider has been described this way:

a competent practitioner who is comfortable treating lesbians and is aware of common concerns among lesbians; includes women’s partners in care as necessary; discusses with clients whether sexual orientation should be noted in their charts. (Saulnier and Wheeler 2000, p. 429)

A 1997 Ontario, Canada study reported that 51 percent of lesbian patients had not come out to their health-care providers, even though 91 percent of the lesbian patients
believed that this knowledge was important for their providers to have (Davis 2000).
Another recent study looked at the impact of antilesbian/antigay social climate on
lesbians and found that this negativity had permeated health care services (Davis 2000).
As a result significant changes are needed in services to encourage lesbians’ access to
health care.

**Mental Health**

One of the most common mental health problems in the United States is depression
(Oetjen and Rothblum 2000). Women, and lesbians in particular, are highly susceptible
to depression. There are a number of factors that lead to a high rate of depression among
lesbians. These include relationship status, relationship satisfaction, social support from
family, social support from friends, and disclosure of sexual orientation. It is troubling to
recognize the personal costs to lesbians of societal attitudes and legal restrictions that
severely limit their personal growth and expression of sexual identity.

Many mental-health-care workers assume heterosexuality, and this assumption renders
lesbians invisible (Oetjen and Rothblum 2000). This assumption sends the message that
nontraditional relationships are not important to the mental-health-care practice. As a
result lesbians must either translate the advice they receive to fit their circumstances or
“come out” before they are ready to do so.

Mental health is defined as a “relative state of emotional well-being, freedom from
incapacitating conflicts, and the consistent ability to make and carry out our rational
decisions and cope with environmental stresses and internal pressures” (Clarke 1995,
p. 23). The societal taboos and stigmas associated with homosexuality are deterrents to
revealing sexual identity. Mental-health agencies, like medical doctors, assume universal
heterosexuality, placing lesbians and gay men at a distinct disadvantage (Clarke 1995).

Research suggests that medical practice with lesbians and gay men is biased, inadequate, or inappropriate (Saulnier and Wheeler 2000). Many mental-health professionals believe homosexuality to be a psychological disorder. Common issues lesbians discuss with mental-health-care providers include “rape, incest, domestic violence, and difficulties with relationships” (Saulnier and Wheeler 2000, p. 412).

The bodies of lesbians and heterosexual women are the same, but their lives are not. Lesbians need mental-health care that is sensitive to their particular needs. They also need providers with whom they can be open and honest about their lifestyle.

Lesbians experience stress because of a double minority status as both women and lesbians (DiPlacido 1998). As a result, they experience more negative life-events from living in a sexist, homophobic, and heterosexist society:

> The initial cause of minority stress is the cultural ascription of interior status to particular groups. This ascription of defectiveness to various categories of people, particularly categories based on sex, race, and sociosexual preference, often precipitates negative life events for the minority member over which the individual has little control. (Brooks 1970, p. 8)

Minority stress can lead to negative health outcomes among members of sexual minorities. Little research has been conducted on the stresses that lesbians experience. However, the National Lesbian Health Care Survey concluded that “lesbians engage in a number of negative health behaviors that put them at risk of developing certain illnesses, including cancer and heart disease” (Larson and Chastain 1990, p. 440). Lesbians with low self-esteem appear to experience more psychosomatic and psychological problems than do lesbians with high self-esteem and social support (DiPlacido 1998).
Cultural stereotypes, when internalized, can be a source of stress (DiPlacido 1998). When lesbians do not meet the idealized values of society, internal conflict occurs. Negative feelings are incorporated through self-image as homophobia and can emerge as self-hatred (Gonsiorek 1993). These negative attitudes are related to depression, alcoholism, eating disorders, and suicide (Finnegan and Cook 1984; Glaus 1989; and Meyer 1995).

Social situations can be a constant challenge and struggle for those who feel the need to hide their true feelings. Heterosexuals do not have to deal with the stress of self-concealment and emotional inhibition as homosexuals do (Gartrell 1984). Lesbians must keep their distance, and as a result they feel misunderstood, isolated, and dishonest. This self-concealment and emotional inhibition suggests that internal stress levels for lesbians are high.

Lesbians are sometimes overwhelmed by their experiences (Smith 1999). They are often socially isolated and have extreme emotional problems as a result. Low self-esteem has been identified as a prominent issue for lesbians (Hart 1995). A 1986 study conducted by the U. S. Department of Justice found that lesbians and gay men may be the most victimized groups in the nation.

Lesbians want health-care providers who look at them as whole people. They want the health-care system to be focused on health and wellness. Lesbians want their physical, emotional, and spiritual well-beings to be addressed (Haynes 1992). Health-care providers should be more flexible and responsive to the needs of lesbians. Many lesbians emphasize the need for mental-health services to be a more integral part of the overall health-care system (Clarke 1995).
Stigmatization

Stigmatization can be defined as the condition of being denied full social acceptance (Katz 1981). Members of certain social groups or those who possess certain characteristics are devalued, denigrated, and avoided by society (Katz 1981). Stigmatization can also occur toward family members or associates of homosexuals. Goffman called this “courtesy stigma” (Goffman 1963, p. 31). Society may treat discredited individuals, their families, and associates with contempt. Goffman asserted that stigmatization spreads in waves to family members, friends, and associates but diminishes in intensity as it does so (Goffman 1963).

One group singled out for stigmatization is individuals with same-gender sexual orientations (Herek 1998). Researchers agree that negative attitudes toward homosexuals are widespread (Herek 1998; Kite and Whitley 1998). Forty percent of physicians in one study declared they were often uncomfortable providing care to lesbian or gay patients (Matthews, Booth, and Turner 1986). Many lesbians report that their doctors are not sensitive to or knowledgeable about their particular health risks and needs so they do not disclose information that may be pertinent to their care (Smith, Johnson, and Guenther 1985; Trippet and Bain 1992).

Lesbians experience invisibility by physicians who make incorrect assumptions about them (Simkin 1998). Other types of invisibility faced by lesbians come from physicians’ denial that the patient is a lesbian and the inability of a lesbian to self-identify. Invisibility is a form of stigma that lesbians must cope with in their everyday lives.

Despite a steady increase in the acceptance of homosexuality over the past two decades, there is still a great amount of stigma surrounding homosexuality in the United
States (Herek 1999). A recent poll found that the majority of Americans view homosexuality as morally wrong, in the same category as adultery (Ungvarsni and Grossman 1999). Throughout the health-care system there exists an institutionalized assumption of heterosexuality.

Too often the presumption that all women partner with men guides the policies and practices of health care and renders lesbians invisible (Luce 2000; Simkin 1998). This invisibility directly affects the health of lesbians and the care they receive. To ensure that adequate care is provided, lesbians must often make a declaration of sexual identity or sexual practices. This disclosure may be met with disgust, fear, hostility, or misunderstanding, and the anticipation of such a reaction may discourage a woman from being out (Simkin 1998).
CHAPTER IV

RESEARCH METHODS

The purpose of this chapter is to outline the methodological approach that was taken. In the examination of this population, a qualitative methodological approach was both viable and beneficial. Qualitative analysis allows a degree of understanding that is greater than a more traditional quantitative approach. Qualitative research allows the researcher more opportunity to gain trust and to reassure the participant that his/her insights will contribute to the wealth of knowledge on the particular topic.

Although the ability to generalize the findings of qualitative research is limited when compared to quantitative research, the depth of information a researcher can gather is an asset for the current research. Further, qualitative research allows the researcher to select a small sample of people and to study them in depth. Qualitative research is more purposive than quantitative research in that the researcher can focus on an understudied and/or underserved group in a population to better understand that group. A sensitive researcher can often gain considerable insight into people’s natural behavior when using qualitative research techniques (Huberman 1996). Gaining insider status is important when conducting research about sensitive topics such as lesbian health-care. It is for this reason that I chose a qualitative method, in-depth interviews. Interviews allowed the participants the opportunity to explain their experiences more fully. Some advantages associated with qualitative research are that it (1) studies real-world situations, (2)
observes the whole phenomenon rather than its separate parts, (3) includes detailed, in-depth interviews and direct quotations, (4) emphasizes personal contact, (5) assumes that each individual is special and unique, (6) expresses empathic neutrality, and (7) avoids a rigid design permitting the researcher to adapt when situations change (Huberman 1996).

This research asks the question, “What are the barriers to adequate health-care for lesbians”? The information gathered from this study will help us to understand the dynamics that are involved when lesbians seek medical care. Studying lesbian health should result in knowledge that will be useful for improving the health status and health care of and for lesbians. It will provide insights into how the health of lesbians differs from that of heterosexual women and could help to improve the health of all women.

Sexual orientation as a way to categorize people is both misunderstood and controversial (Bernstein 1994). Our culture is obsessed with sex, and as a result, is phobic about it. It is difficult to talk calmly about any sexual topic, and sexual orientation is no exception (Bernstein 1994). There are no universally accepted definitions for sexual orientation, bisexual, gay, or lesbian. For this reason each researcher must define each term in accordance with his or her research.

Definitions

Lesbian: An adult female whose fantasies, attachments, and longings are predominantly for women, who may or may not express those longings in overt behavior (Reiter 1989, p. 58).

Gay: An adult male whose fantasies, attachments, and longings are predominantly for men, who may or may not express those longings in overt behavior (Reiter 1989, p. 58).

Heterosexism: “The overt and covert mistreatment of lesbians and gay males” (Van Wormer et al. 2000, p. 29).

Lesbian-sensitive health-care providers: Providers who acknowledge their lesbian clients
and who treat them without homophobic fears (Neisen 1997, p. 30).

Homophobia: Antipathy or disdain for gay men and lesbians (Neisen 1997, p. 30).

Bisexual: Adult females or males whose attachments are for both the same sex and the opposite sex (Reiter 1989, p. 58).

**Sample and Data Collection**

The sampling frame of the current research were lesbians who were selected through snowball sampling. Snowball sampling uses a process of chain referral: “when members of the target population are located, they are asked to provide names and addresses of other members of the target population, who are then contacted and asked to name others, and so on” (Singleton and Straits 1999, p. 163). Snowball sampling is applicable to studies of deviant behavior, where “moral, legal, or social sensitivities surrounding the behavior in question...pose some serious problems for locating and contacting potential respondents” (Biernacki and Waldorf 1981, p. 144). Lesbians may be socially invisible by virtue of their sexual orientation. This technique does introduce bias because it reduces the likelihood that the sample will represent a good cross section from the population. Measures must also take into account racial, ethnic, and age differences among the participants, which may further affect the validity and reliability of the sample (Singleton and Straits 1999).

The participants for this research were contacted through friendship associations. Participants came from Kentucky and Indiana. Participants from Kentucky came from both rural areas and mid-size cities. Participants from Indiana came from a large city. The lesbians interviewed for this research ranged in age from 21 to 63 years of age. All of the participants were White with a middle-class background. This study is not
statistically representative but expands upon the limited descriptive and theoretical work mentioned in the review of the literature. To guide this inquiry it seemed useful to use a series of questions to structure the collection of the data. The questions were built around factors that were expected to affect both the woman's care-seeking behavior and the care she received. Care-seeking behavior was expected to be influenced by perceived health status and needs, psychosocial factors, and perceived experience with the health-care system. The care received was expected to be related to the practitioner's experience, knowledge, and attitudes as well as elements of the specific experiences of an individual woman:

   a. Whether the lesbian has special health problems
   b. Whether the lesbian tries to pass in her daily life
   c. Whether the lesbian perceives her health needs to be addressed or understood by the traditional health-care system
   d. Whether the lesbian anticipates, perceives, or has experienced homophobia or other negative responses from the health-care system
   e. Whether the lesbian has health problems that she cannot ignore
   f. Whether the lesbian is relatively comfortable with her sexual identity (is out)
   g. Whether the lesbian is active in feminist or gay organizations
   h. Whether the lesbian has perceived or experienced positive interactions with the health-care system
   i. Whether the lesbian has been referred to a known sympathetic practitioner through the grapevine

(See Appendix B for the complete interview schedule).

Participants were asked a variety of physical-health questions such as the status of their health and whether they see a medical doctor routinely. Further, participants were asked about their mental-health and dental-care experiences. The questions posed were open ended so the participants could freely and openly describe their experiences.

**Informed Consent**

In order to assure the interviewee of confidentiality and her right to refuse to answer
any question(s) she felt were too personal, an informed consent was presented for signature immediately following introductions. See Appendix B. All of the women willingly signed. In addition, written notes were made by the researcher on the questionnaire for all short answers and for key phrases on longer open-ended questions. Some written notes were also kept about the researcher’s observations of nonverbal responses during the interview.

**Interview Process**

In order to encourage a relaxed atmosphere, I conducted face-to-face, in-depth interviews at the participants convenience and in locations where they felt most comfortable. The initial interviews with 16 lesbians lasted approximately two and one-half to three hours. All of the interviews were audiotaped using a portable tape recorder, and field notes were recorded upon completion of each interview. All tapes were typed verbatim and rechecked for accuracy. Identifying information such as names were omitted from the transcripts to ensure confidentiality. Each interview included information on demographics, on physical- and mental-health issues, and lifestyle habits. Questions regarding the interviewee’s current state of health, lesbian-sensitive physicians, experience with the medical community, and experience with homophobia were also included in the interview (Appendix A).

It is believed that understanding occurs when the participants describe their world in their own manner, without imposing the world of the research on them (Rubin and Rubin 1995). Moreover, designing qualitative research is a gradual flexible process as the researcher begins to understand the meaning of the data (Rubin and Rubin 1995). Therefore, with each repetition of interviewing a lesbian, the phenomenon became clearer
and the questions were modified. Due to the fact that the interviews were flexible but structured, sometimes there would be interruptions (i.e., one interview was conducted at her work place, and the individual had to stop to answer the telephone and assist patrons); however, these situations allowed the researcher to see each one in her own environment and pay attention to her actions and interactions as well as her words.

In general lesbians were willing to participate and eager to refer me on to other potential respondents. Although some initially expressed nervousness at being interviewed, at no time did this seem to interfere with their cooperation in sharing intimate aspects of their lives. At the conclusion of many of the interviews, several participants expressed further interest in my suppositions and plans for publication of the study. Those who asked were offered a written abstract of the findings to be sent upon the completion of the study.

**Ethical Considerations**

Many factors were involved in ensuring the rights of the participants in an ethical manner. After I explained the study to each participant individually, I reviewed a copy of the consent form with her and asked her to sign it. Explanation of the research process was given as well as what the participants could expect from me and what was expected of them. After obtaining written consent from the participants the interview process began.

Measures were taken to protect the women’s confidentiality. I assured the participants that their anonymity would be respected throughout and any identifying information would be kept in the strictest of confidence. As confidentiality was especially important, pseudonyms were used throughout the data analysis, and only I have been aware of their
true identities. My thesis chairperson and myself were the only people with access to the interview tapes.

Various factors needed to be considered when managing the data. After interviewing the participants, I recorded field notes to enhance understanding of the taped interview. Included in the field notes was a description of the physical setting and non-verbal communication. I also kept a diary of my reflexive impressions. In part, the function of the field notes and diary were to create a research decision trail where it could be ascertained whether there is sufficient dependability of the research process. Handling of the data was conducted manually. As soon as possible after the interview, I listened carefully to the tape, made additional notes, and transcribed it. The complexities of lesbians’ everyday experiences required a research method that was both respectful and sensitive to their needs. The methods and ethical considerations employed attended to the participants’ needs first and foremost to avoid further marginalizing and stigmatizing these women.

The use of the snowball technique does not deliver a representative sample of the population under study. It was expected that biases would appear in the sample in terms of age, education, and other variables. Biases were minimized as much as possible. The technique did allow a broader spectrum of respondents than a survey of any one community or group would have, as well as a more extensive investigation of health needs and system responses to lesbians than previously encountered. The taped answers to these questions often ranged over a variety of topics, including subjects that more closely answered other questions in the interview. Categorizing these long answers to open-ended questions posed a significant difficulty that would have been eliminated by
precoding the instrument for computer analysis.
CHAPTER V

FINDINGS

The findings were obtained from in-depth interviews with sixteen lesbians. All participants were assured confidentiality and assigned pseudonyms. The interviews were conducted and analyzed according to the procedure suggested by Lofland and Lofland (1984). Rather than utilizing the statistical analyses of quantitative methods, the interview data were examined for emergent patterns of responses and descriptions.

Self Perception

Most of the women interviewed believed that their lesbian identity was readily apparent to all. Susan indicated that “my short hair and the way I walk gives me away.” Barb indicated “it is obvious in everything that I say and do.” Stacey said “my short hair and the fact that I was in the army are good indications that I am gay.” It has been assumed in the literature that the task for lesbians in managing stigma is to conceal information so that others do not become aware of the attribute. However, the present findings suggest that at least some women perceive themselves to be readily recognized as lesbians so that their task becomes minimizing the negative impact of the stigma. Consequently, a lesbian’s perceived social vulnerability is related to her beliefs about her own identifiability.

Participants thought themselves to be androgynous in appearance. They believed themselves to be differentiated from other women by a more purposeful carriage; a more
natural walk; a stronger, more athletic body; open, definite body gestures; and a more casual mode of dress and hairstyle. They believed their degree of independence, self-reliance, assertiveness, persistence and strength of will distinguished them, making them more recognizable as lesbians. Barb and Susan both said “we want everybody to know that we are lesbians.” Jan indicated that “I carry myself so nobody will even think about trying to walk on me.” Kate indicated:

I have to hide it [sexual orientation] because of my practice. Although there are probably those that suspect I am a lesbian, I don’t come right out and say it to my clients.

The participants believed that lesbians are marked by their interactional style and patterns of association. They believed it was noticeable that they do not defer to men, do not form intimate relationships with men, and generally pay very little attention to men. Heather said “I deal with men every day and I have told them straight out I don’t want anything to do with them.” The women felt lesbians establish more eye contact with other women, stand and sit closer to women, and are more likely to touch women with whom they socialize and associate. Participants believed it was a combination of physical, psychological, and social factors that combined to distinguish them. Leslie said:

My whole attitude is different around women. They are just so much easier to talk to. Men just don’t understand women the way they deserve to be understood. Women just understand what another woman goes through in different stages of her life.

Profile of the Women Interviewed

In profile the survey population was White, mostly well-educated, professional women. Ages ranged from 21 to mid 60s. The lesbians had different marital and sexual
histories as well as a range of experiences in self-identification and socialization into the lesbian or gay subculture. Some of the lesbians interviewed had children from previous marriages. With the exception of three of the lesbians interviewed, all were employed full-time. One of the women has recently been discharged from the Army, one was a recent high school graduate, and one was disabled. Five of the women had been previously married. All of the participants in this study were involved in a relationship with another woman. The majority (9) of the participants had completed at least a bachelor's degree, and the remainder had a high school diploma. One of the participants had completed her doctorate, one had two master's degrees, two had one master's degree, and five had completed a bachelor's degree so overall this group of lesbians was highly educated. A brief description of the women interviewed appears in Appendix C.

Care-seeking Behavior

In comparing their own health to that of other women, lesbians perceived themselves as healthier. Jan indicated that she “tried to eat healthy foods and get plenty of exercise.” Others indicated that they tried to exercise four or five times a week although most of the women interviewed did believe they needed to “lose a few pounds.” Moreover, lesbians related being concerned about health to a positive interest in self-care and responsibility. Lesbians tended to signal their status for social purposes but disguise it professionally when it might elicit sanctions. Jan has helped to produce a tape on AIDS awareness as well as other gay and lesbian issues; however, she is not out at her place of employment or to her physician. This fear of judgment appeared to be the principle psychosocial factor affecting the care-seeking behavior of lesbians.

Special problems and needs were identified. These special health concerns centered
around four primary issues: medical risks of the lifestyle, their own psychosocial inhibitions to seeking care, practitioner attitudes about women of their nontraditional status, and inadequate care based on provider lack of knowledge about the lifestyle or the woman’s status. The majority claimed to have regular sources of health care in the traditional health-care system, and three-fourths had received routine medical and dental checkups within the past twelve months. Care-seeking behaviors specifically related to gynecological services were low. In many cases psychosocial inhibitions to care seeking were reinforced or exacerbated by the policies and practices perceived in the system. The two major perceived practitioner responses with negative implications for the care of nontraditional women were stereotypical assumptions and ignorance of the lifestyle and its implications for health, disease, and treatment. These often resulted in inadequate or inappropriate care and contributed to psychosocial inhibitions in the women to future care-seeking.

Concealment of Identity

For lesbians the concealment of identity is common, with consequences including assumptions of heterosexuality and improper diagnosis and treatment. Recognizing inappropriate care, the lesbian may contemplate revealing her identity. If she overcomes her inhibitions, she may experience homophobic reactions of varying intensity, or she may encounter physician misinformation about her lifestyle and its implications for disease and treatment. Thus, for the lesbian, the major task in the health care interaction is identity management. In making this decision she weighs the perceived benefits and risks of each stance, the importance of identification to her particular perceived health need, and her anticipation of provider response, in particular sanctions. While these
considerations seemed to limit few lesbians in seeking care, they did cause the majority to conceal their sexual orientation in most contacts with the traditional health-care system. Of the sixteen lesbians interviewed, only three of these women were out to their physician. These three women were not concerned with appearance or saving face; they simply wanted “to be themselves in their interactions with their physicians.” Kate said, "you just never know what will be said and I can't risk the word getting out because I don't know how that would affect my practice."

Mediating between the individual and the delivery system are a set of individual psychosocial factors (real and perceived), that influence both the health status and the behavior of that individual. Verbal and nonverbal, alienating gestures on the part of health-care personnel or the system itself are perceived by the lesbian who fears rejection, labeling, or judgment by society’s traditional institutions. In this way actually experienced as well as anticipated homophobia and judgmental attitudes form a powerful inhibiting barrier between the woman and the traditional health-care delivery system. This barrier may reinforce other stressful lifestyle factors that adversely impact on the individual’s health status.

Participants were asked very specific questions about their health, what problems they had experienced in the past and were experiencing now, and how they were dealing with their needs for health care. When I asked whether she was out to her health-care provider, one participant stated:

I would not come out in a medical situation unless there were compelling reasons to do so because in the patient role I have so little power and I am vulnerable to harassment. I practice in advance how to maintain my privacy and still get the care I need. I refuse to answer offensive or unnecessary inquiries. I ask direct, specific questions about what I need to know (Julie
Another participant indicated that she was out to her medical provider (nurse practitioner). She indicated that she told the nurse practitioner at their first meeting; and the response was whatever you want, I will still treat you. According to Susan, this particular nurse practitioner is interested in Susan's total health and not just the presenting problem. Susan is employed by a large chain department store and currently is covered by a medical card. She will have health insurance provided by the company she works for after 90 days of successful employment.

We have the right to expect professionalism from our health-care providers, whether they are physicians, nurse practitioners, or physicians' assistants and from the other personnel in the health care setting. Some participants in this study felt they were given optimal health care regardless of their sexual orientation. Susan's companion, Barb, a 50 year-old woman, with multiple health problems, is retired from state employment (not Kentucky) and is attempting to get medical disability. She is also out to her health-care provider. Barb recently spent a week in the hospital (rural area, 4500 residents), and her companion was with her at all times. They were open with all hospital personnel about their relationship and both said they were treated well. Susan said “the nurse came in one time, and I was laying in the bed, with her and she did not say anything.”

Most (14) of the participants did have one person they think of as their primary care physician. All of the participants felt this was necessary for their emergency health care needs to be met. One of the participants in this study, a 63 year-old woman (Kate) with a Ph.D. in Psychology, has a primary care physician in the city of 30,000 where she resides and a neurosurgeon in a larger city some 75 miles away. She is not out to either
physician; however, she suspects that they both are aware of her sexual orientation. This woman has two grown children and presents her partner (Lucy) as her "daughter" because there is a 23 year age difference between them. Her "daughter" accompanies her on her doctor visits out-of-town and has stayed overnight in the hospital with her on several occasions. Her partner does have a medical power of attorney. Because this woman is in a professional practice, she does not feel comfortable coming out in her community although she is very comfortable with her sexual identity. Her children are also comfortable with her lesbian identity, and she has frequently kept her grandchildren for extended periods of time. Her elderly parents are not aware of her sexual orientation; however, her sister is aware, and they are on very good terms with one another. This individual has changed primary-care physicians (female to male) recently although it was not related to an issue about sexual orientation. The previous physician was lackadaisical in her care and was not providing adequate treatment for the patient.

A major issue in a lesbian's life is whether or not to disclose her sexual orientation. Revealing one's sexual orientation is called coming out of the closet (Sohier 1986). Coming out can be the defining moment when a lesbian realizes and accepts her sexual identity. However, coming out requires constant decision-making from a lesbian in all aspects of her life. Lesbians who live their lives in the closet may find there is an increased stress level associated with the secretiveness and level of vigilance needed to maintain their concealed lives (Depoy and Noble 1992; Green, Causby, and Miller 1999). In addition, being closeted provides a self-limiting ceiling and causes others to have a discomfort and mistrust because they are left wondering what the woman is holding back. For example, a woman may be overlooked for career advancement when she avoids
company events because she cannot bring her partner. Management could see this as an affront to their hospitality and retaliate by promoting others.

Lesbians' everyday lives include seeking means for maintaining their health. Lesbians believe their most common sources of support for maintaining their health are partners, friends, family, and co-workers:

When I have a problem, I first ask my girlfriend to see if she has had [the health problem] before or if she knows anyone that has. I don't have any insurance, and I cannot afford to run to the doctor unless it is an emergency. I don't trust doctors anyway. (Tina, age 21)

I just got out of the army a few months ago so I am pretty healthy. I usually ask my Mom if it is very bad, but I usually just go to Wal Mart and find something over the counter to use. I don't like doctors at all; they are crazy. The army will make you wary of just about everybody and everything. (Stacey 23)

Many lesbians appear to gather support and advice for maintaining their health through networking with their friends. Tina and Stacey are both out of the closet to their families and are accepted as such. They live in a city of approximately 50,000; but both said, if they had to see a medical provider, they would prefer to go to a larger city. Tina and Stacey consider themselves to be a couple although they have not known one another very long and they do not live together. Neither Tina nor Stacey has a job or any prospects at the present time. Both indicated that they might like to go to college, but neither could identify an area of study in which she was interested.

One of the participants who lived in a large city (over 100,000) was very open and direct in answering the interview questions. Jan, is a confident lady in her late 40s; however, she does not think that it is a physician’s business what her sexual orientation is. Jan stated:

I am in excellent health. I go to the doctor whenever I need to; that is not an
issue. I have very good health insurance. I lead a very active life, not only with my job but my social life as well. I like to bicycle, garden, go out with friends, visit my girlfriend (4-hour drive), and other things. I am active in the gay and lesbian movement in my area. We have made tapes and done other things to help increase community awareness about gay and lesbian issues.

For each of the lesbians interviewed for this research there was a moment in time when she realized or became aware of a same-sex attraction. Some of the women indicated that they knew early and had never been attracted to men (Stacey 23 and Tina 21). Others indicated that they were in their early twenties (Susan) and older. However, after probing, some did admit they were aware much earlier but felt they had to do the "prim and proper thing" (Kate, Barb, Jennifer, and Betty) and get married. Kate said, "I was miserable for the most part as a married woman, but I grew up in a time when this [lesbianism] just didn't happen." Jennifer indicated that she "had to ignore what I wanted and do the right thing. I wouldn't have been able to survive otherwise."

Criticism and hatred allowed in the media and homophobia within the educational system and in publicly distributed religious propaganda can inflict an overwhelming fear in some women. One participant said, “because I have had to hide who I am for such a long time, I’m finding I’m a lot more stressed” (Leslie 39). “There’s the fear of, the risk of, losing my job if I’m out.” Another woman recounted the fact that “I did not realize that I had not built a support system” (Heather 43). “The most detrimental thing to my overall well being is the isolation, the feeling of not belonging, of not being included” (Leslie 39). Both of these women assumed that neighbors, co-workers and even health-care providers probably knew they were lesbians; however, they relied on people’s good will to not say the words that might result in rejection, threat, or lack of care.

Formal health-care services are permeated by the homophobia and heterosexism of
society. A heterosexual woman is not afraid to see a health-care provider and say “this is my partner.” She does not have to think about whether or not this doctor in an emergency situation will hate her if she discloses that she is in this relationship or if he or she will treat her differently. Although some participants did describe positive encounters (Barb and Susan), most related that they did not feel safe coming out to any health-care provider regardless of the situation. One participant (Jennifer 46) who did come out to her health-care provider described her experience this way.

The doctor was very attentive and real talkative before I told her that I was a lesbian. And then the room became silent. Her whole attitude changed; you could tell. She just stared at me, like stared at me, you know. I had wanted my partner to come in to the examination room with me because I was having some problems, and I just wanted her to hear what the doctor said. Right then and there I told her to just forget it, that it would probably be best if I found another doctor to take care of me. She just turned and walked out of the room; she did not even make a comment one way or the other. She really did not care about me as a person. I had insurance and everything. It wasn’t like she wasn’t going to get paid for her services. I found out later that she is big on religion, and I don’t know if this had anything to do with it or not. She knew I was divorced. Maybe I just took her by surprise when I said I was a lesbian, but she had been my doctor for a good while, almost since she had come to town (Jennifer 46).

Lesbians are known to skip gynecological checkups for a variety of reasons, including lack of knowledge, lack of resources, fear of discrimination, and assumptions of health-care providers that patients are heterosexual. Lesbians also underuse health-care-screening services, such as Pap smears, breast exams, and mammograms. Susan, age 35, divorced with three children (two live with her ex-husband and one grown) has not had a gynecological checkup since her last child (10 years of age) was born, does not complete monthly breast exams, and has never had a mammogram. Her partner (Barb 50) indicated that she was going to rectify the problem and take Susan to see her gynecologist located in another city, where they are not known. Susan does not want to go through
with this exam but she appears to be enamored with Barb and will do whatever she is told she should do. When I asked Susan if she would tell the gynecologist that she is a lesbian, Susan replied, “I don’t hide it from anybody. Heck, I’m proud finally to be out. It’s a relief to not have to hide what I am or who I am.” Susan and Barb both said that lesbians should not "be ashamed of their sexual orientation."

**Substance Abuse**

One of the participants described her life (Vicky 26) quite differently from the other participants. Vicky is a shy, rather quiet individual who would rather be in the background. Vicky said:

I’ll be honest. There have been times in my life when I’ve hurt so badly, when I’ve been so ashamed of being gay, when I’ve felt so unloved and alone that I have just wanted to take a gun and blow myself away, but I can’t or couldn’t do it. I did turn the violence on myself and attempted suicide by other means (pills). They just seemed easier than putting a gun to my head, I’m such a big chicken. Finally, I found someone else like me and was able to kind of connect with them. We went to some 12-step meetings together and I stopped drinking and doing drugs and was able to get my life together. I am in a loving, healthy relationship now and even though I stay away from doctors unless it is an emergency, I think I would be treated okay as long as I didn’t say that I was a lesbian. People around here in this town don’t understand gay people. I probably shouldn’t say that, but it is small and everybody knows everybody else. I would probably have to leave here if people knew for sure. I might come out to a doctor in a big city where they probably wouldn’t care anyway.

Vicky also revealed that she had been sexually abused as a child, and that this was probably why she had tried to commit suicide. She has recently entered counseling to deal with the sexual abuse and other issues.

One 33 year-old lesbian (Judy) said she might have a problem with alcohol. She said that she "likes to party and when she drinks she can’t quit until she is out cold.” Judy also likes to smoke marijuana every night before she goes to bed. Judy and her partner
(Angie) party on average two to three nights per week. They are both in good health, have good jobs, and are buying a home. Judy did say:

sometimes I drink to cope with the fact that I have never been able to please my parents. They wanted grandchildren, and I don’t have any kids and don’t plan to have any. Even when I was dating men, I didn’t want kids. Stress in general sometimes makes me drink, or I drink to relieve the stress of the day, you know.

Judy does have a medical doctor; however, she sees him only in cases of emergency:

“like the other day I slid into second base playing softball and broke my ankle” (wearing a brace on her right ankle). Judy is not out to her physician.

Other participants indicated that they might have a problem with substance abuse as well. Betty (46) and Peggy (49) who live together both indicated they enjoyed the feelings they got from drinking because “they did not have to think about anything or anyone else.” Betty is a divorced mother of two grown children who has very little contact with them. When Betty revealed her lesbianism to her family she said it “was like I had died. Nobody has anything to do with me.” Peggy has never been married. She was raped and has a 30 year-old daughter with whom she has a very close relationship. Peggy said, “We drink and smoke (marijuana) to relieve the stress and tension of everyday life just like a lot of others we know.” Both of these women have health insurance and have a health-care provider. Neither of them is out to her physician although they both suspect the physician knows their sexual orientation because they are always together. Barb and Susan both said “we smoke marijuana everyday, it helps to us to relax and we really don’t hide it.”

Women’s Health-care

Health-care providers commonly ask their lesbian patients what type of contraception
they are using if they are of childbearing age. The patient frequently feels uncomfortable and put on the spot with this type of question. It means the patient must come out to the physician or accept a prescription for contraception. Pat, a 28 year-old lesbian with two master’s degrees was asked this question by her physician and responded “I am not sexually active at this particular time and do not want any form of contraception.” The physician found this answer difficult to accept. However, this study has shown that many physicians take care of lesbian patients without being aware of their patients’ sexual orientation.

Mammography screening is one important aspect of women’s health care. Women in general should have a mammogram by the age of 40. However, the literature reveals that lesbians underuse this service. One participant (Ellen 45) has never had a mammogram and gave multiple reasons:

I don’t have any health insurance (medical card) and they are pretty expensive. I don’t know if the card (medical) would cover it. My doctor has not mentioned it. He is so old that he should probably retire, but I keep seeing him because I’ve seen him for as long as I can remember. He’s okay really for colds and things like that. He doesn’t seem to be up on things though. It could be because of the card though.

The patient-physician relationship is a critical factor in a patient’s well being. Ellen wishes that she could be open with her physician but said “he probably wouldn’t understand what a lesbian is.”

Mental-health Care

Most of the participants (12) had previous experience with mental-health professionals. Their experiences varied widely; some were positive and others were negative. Kate, who is now a psychologist, had two dramatic experiences with
psychiatrists. Both psychiatrists “hit” on her when she took her son to see them. This was a traumatic time in her life as she and her husband had separated. Her son was having some problems that could probably be associated with the difficult adjustment he was having to make with his father not around. In Kate’s words:

my son was hitting me and misbehaving at school and just doing things that really were out of character for him. The first psychiatrist told me to leave [my son] at home the next time and come alone, and that is when he hit on me. I didn’t go back, but I did make an appointment with another one and we went off again. The same blame thing happened again, and I just gave up. There were a couple of times in my life that I wanted to give up and commit suicide, but I had my kids to think about. Things were really bad for awhile, but I made it through, and it made me a better person, a much stronger person really. And, I think because of it, I can relate to my own clients better; it helps me to be more empathic to them. You know experience really is a good teacher. Obviously, I don’t have any thoughts of suicide, and I am very satisfied with my mental health, if only, my physical health were as good.

Some of the other participants had negative experiences with mental-health-care providers as well. Another participant (Julie) said, when she told the social worker assigned to her that she was a lesbian, “the woman kept wanting me to give her intimate details about what it was like.” Apparently this is not uncommon when a client is seen at a mental health facility, as another participant (Betty) related a similar story about the social worker whom she saw at her local mental-health clinic.

I will never ever go to another one of those clinics again. Those people are not professional. They want the intimate details about what you are doing and how it is. It is disgusting. It completely turned me off to getting any kind of help for my depression. I actually saw a shrink for about 10 minutes first and he gave me a prescription for Zoloft; but after that time I never went back so when that 45 day supply of medicine ran out, I was out in the cold. I think it was beginning to work too, which is what makes it so bad.

Betty was afraid to go back to the psychiatrist because she did not keep her appointment with the social worker. She said, “I just don’t want that hassle anymore. I will make it
on my own just like before.”

Other participants have more positive experiences with psychologists and/or psychiatrists. Barb, who is currently seeing a psychologist, gave glowing recommendations for her psychologist.

I don’t think I could have asked for a better person. You know I have to drive about 40 to 45 minutes to see her but it is worth it. She is that great. She does not judge me for being a lesbian, for drinking or smoking, or for smoking marijuana either. I told her the truth. It helps to relieve the stress and the pain. I have applied for my social security disability and should hear from it in a few weeks. Getting it will help with the stress some but not the pain that I have all time. My depression is better ever since I started seeing _______. She is just a wonderful therapist. I took my girlfriend in to see her last week and she has her own appointment with her now.

Heather also sees both a psychiatrist and a psychologist, both of whom are in private practice. She takes medication for depression. Heather said:

I just got up one morning and realized that I didn’t like me and started looking in the telephone book and called this guy. He prescribed me something for the depression and said he thought I should see a psychologist. I went back home after getting my pills filled at the drug store and found somebody to call. I didn’t like him so I didn’t go back, but I asked some of my friends, and they put me onto somebody that is real good. That don’t mean that I tell them everything though. You know you have to keep some things quiet, but this person is there if I want to talk, which is good.

Vicky also sees a female psychologist and was quite pleased with the services that she had received thus far. She was referred by a medical doctor to this psychologist after he prescribed her an antidepressant.

I didn’t realize that it would make any difference, but I thought I would give it a try and see what happened. I was surprised because it does help to be able to talk and not be judged for what you say. The pills help too. Seeing her along with the 12-step meetings have really turned my life around. People say that I am a totally different person, but I don’t see it. I do like myself better now and I don’t want to die anymore. Life really is much better now but I can’t say when it happened. I just know it is better now.
Ellen indicated that she could probably use some counseling but “I don’t know whether they would take my medical card.” She has never contacted the local mental health clinic or asked her caseworker about mental health services that are available for her.

Peggy who spoke in some depth about being raped is in counseling at this time; however, according to her “I just shoot the breeze really; it’s not a big deal. I wouldn’t tell him anything that I didn’t want the whole world to know.” Peggy did not want to talk in-depth about her mental health experience other than to say “that ______ doesn’t know anything important about me and what I do or don’t do.”

**Holistic Health**

Overall the participants conceptualized health in a holistic fashion, discussing wellness as a composite of emotional, physical, and social elements. They focused on independence and self-reliance as the primary components of wellness. A positive self-concept, an affirming attitude toward life, purposeful work toward emotional health, and an ability to manage stress were frequently cited.

These women were distressed about aging. They feared being dependent on others as they grow older and isolated from social support. Most had contemplated being old and anticipated alienation, seeing no present social structures supportive of older lesbians. They also feared that the health-care system could not be trusted to care adequately and safely care for lesbians.

Questions asked by health-care providers assumed that their female clients were heterosexual, their partners were male, and their sexual activity involved intercourse. Overwhelmingly participants found that there was no comfortable way to let health-care providers know that heterosexual assumptions were not applicable to them as lesbians.
As a result, the majority of the participants did not reveal that they were lesbian, because as Kate said, “Society says it is not okay to be a lesbian. We face rejection based on that all the time.” These lesbians wanted to feel accepted, respected, and welcomed by health-care providers and not have to worry about being treated differently from anyone else.
CHAPTER VI

CONCLUSIONS

This study is limited in its generalizability because it is not representative of the lesbian population in general. The sampling procedure imposed limitations on the study. Subjects were obtained by snowball sampling. As the sample is not random, the findings cannot be generalized to the lesbian population as a whole. Thus, the findings can be suggestive but not conclusive.

Women’s health has recently become a major topic of interest for health- and medical-sciences research. Much of the researched information stems from white, heterosexual, middle-class participants without the realization of privilege given to heterosexuality, skin color, and socioeconomic status (Cassidy, Lord, and Mandell 1995; Phelan 1994; Range and Leach 1998). Although the information gained is significant for many women, there are still others whose lives are not addressed. Hidden within the general population of women lives an invisible minority, namely lesbians. Researchers often omit lesbian lives in the landscape of women’s everyday experiences. Rather than blend lesbian experiences into the background, research is required for women who self-identify as lesbian.

It is clear that women of all races, classes, and sexual identities are exposed to and internalize cultural messages concerning gender and the female body. In a similar manner, all women who live in our culture are overtly and subtly socialized to become
heterosexual. Adrienne Rich (1980) coined the term “compulsory heterosexuality” to describe the “cluster of forces [in our society] by which women have been convinced that marriage, and sexual orientation toward men, are inevitable, even if unsatisfying or are oppressive components of their lives” (Rich 1980, p. 12). All of our societal institutions -- including the family, church, government, schools, and mass media -- are constructed around the ideal of heterosexuality. Examples of how compulsory heterosexuality is enforced include family pressures to marry by a certain age, social events geared towards heterosexual couples, and the various economic benefits associated with heterosexual marriage.

As previously stated, the stigma associated with homosexuality represents a significant barrier to seeking health care and utilizing the health-care system (Sanford 1998). Power stigma associated with homosexuality may make it difficult for lesbians to seek medical assistance for health maintenance and treatment and to cooperate with their health-care providers in necessary treatments in any pathological conditions (Simon and Das 1984). Issues surrounding disclosure of lesbian identity figure prominently in the findings of research regarding lesbians health-care experiences. Under ideal conditions many lesbians would prefer to be open with their health-care providers about their lesbian identity. They believe that disclosure would facilitate higher quality relationships with their caregivers and more comprehensive and appropriate health care (Johnson and Guenther 1987; Stevens and Hall 1988). Because of negative reactions they or other lesbians have experienced, they often do not feel free to disclose their sexual identity in health-care interactions (Cochran and Mays 1988; Johnson and Guenther 1987). The consequences of remaining closeted include a sense of invisibility and an alienation from
the health-care system.

The management of undisclosed discrediting information about the self is influenced by the visibility of the stigma and the decoding capacity of the audience (Jones, Farina, Hastorf, Markus, Miller, Scott, and French 984). The literature generally suggests that lesbians possess a discreditable stigma (Goffman 1963). The heterosexual assumption that pervades much of society places the burden of correcting this assumption, or conforming to it, on individual lesbians. Lesbians must either communicate that they are not heterosexual or maintain behaviors that allow others to continue their heterosexual assumptions (Brooks 1981). As a result, lesbians face oppression in their daily lives and in the health-care system due to both their gender and sexual orientation. Heterosexual upbringing and societal influences render lesbian life invisible as the stories of these sixteen women have shown. They are strong and brave; however, they are basically voiceless in this heterosexual society in which we live. The lack of prior socialization and role modeling for a lesbian into everyday living leads the individual to fashion her own way in the world with few guidelines.

Heterosexism often leaves lesbians feeling invisible within the health-care system. When health-care providers are not sensitive to lesbian issues or fail to ask about sexual orientation, they cannot address the isolation, stress, and self-esteem problems that come with living in the closet. They may not be aware that lesbian patients are at higher risk for substance abuse or suicide. Lesbians may be less honest for fear of receiving insensitive care. They may not want to expose themselves by mentioning that birth control is not an issue for them. They may avoid routine gynecological care because of the system’s insensitivities. On the other hand, doctors who are poorly informed about
lesbian health may deny routine gynecological care, such as Pap tests and STD screening, operating from the misconception that lesbians do not get pregnant. Many health-care professionals may also assume that domestic violence does not occur in lesbian households, a misconception that adds to the health risks for many lesbians.

The purpose of this exploratory study was to determine what lesbians perceive as being the barriers to adequate health-care for them. This study focused on identifying the perceptions of lesbians concerning their health-care providers and how lesbians perceived that their sexual orientation affected the health care they received. The term health care encompassed physical, mental, and dental care.

Two ideas in Goffman’s work on stigma (1963) are particularly relevant here. The first is that individuals with a stigma are likely to experience discrimination. In this study the findings indicate that most of the respondents did not report experiencing discrimination with regard to health care. It is possible that more respondents might have reported experiencing negative treatment in their health care if they had revealed their sexual orientation to the health-care provider. According to Goffman (1963) this act is a form of stigma management. The low incidence of reported discrimination with regard to health care may also be due to homosexuality becoming less of a stigma as time progresses. The lessening of the impact could be construed to occur because as time goes on individuals become aware of the discrimination they are experiencing, and they begin to subtly pressure society to become more aware of them as a group and the dilemmas they are facing. In recent years, for example, groups, including homosexuals, have come together to fight to end discrimination, leading to a lessening of negative consequences due to the stigma of being homosexual. The second idea in Goffman’s work on stigma
that is relevant here is that individuals with stigmas will tend to expect to experience discrimination. The findings in this study indicate that fear of discrimination is still felt by lesbians. This observation is probably indicative of the fact that fears are hard to overcome even if what one fears may no longer exist.

The findings in this study suggest that while fear of negative treatment such as discrimination or past negative experiences does not affect lesbians’ decisions to seek health-care treatment, it does affect lesbians’ decisions about whether to come out to their health-care provider. Therefore, if health-care providers wish to know the sexual orientation of their patients, the providers should either ask their patients directly or add the question to their medical history intake forms. If lesbians know that their health-care providers are going to ask them their sexual orientation, then each time they meet a new health-care provider they will not have to worry about whether to advise them of their sexual orientation. It will also allow them to assess the health-care provider’s response to their sexual orientation from the start of their relationship; if they should be uncomfortable with the response of the provider, they could then start looking for another health-care provider. Because the findings of this study indicate that lesbians continue to have significant fears about experiencing negative treatment, it is important that health-care providers’ knowledge base concerning lesbian patients increases so that providers may become sensitized to the fears that the patients possess and, thus, treat them more effectively.

Lesbianism should be treated as a culture, not as a deviant behavior. Health-care professionals may need some form of continuing education designed to make them more aware that some of their patients are homosexual and that they may have special needs.
Health-care professionals must be trained to make a commitment to competent and nonjudgmental treatment regardless of sexual orientation.

**Recommendations for Future Research**

Future research should examine lesbians’ experiences with health care and health-care providers with regard to issues such as artificial insemination and in-vitro fertilization. As some individuals in society feel that homosexuals should not raise children, this topic could produce some useful information. This information may be used by policymakers to ensure equality of such health care for both heterosexual women and lesbians or by health-care providers to increase their knowledge base surrounding this issue and to sensitize them to the needs/issues of lesbian patients in this area. A study comparing lesbians’ experiences with artificial insemination and in-vitro fertilization against heterosexual women’s experiences in this area is also recommended. Determining if there is a difference in experiences or opinions with regard to artificial insemination and in-vitro fertilization between lesbians who are closeted and lesbians who are openly out is recommended as well. It is suggested that studies be conducted in larger cities or areas where there is a higher concentration of lesbians. Future researchers should also gather a larger, more representative, sample of lesbians to improve the generalizability of the findings. In addition, a more diverse sample in terms of race, education, and social class should also be used.
APPENDIX A

INFORMED CONSENT

Project Title: Barriers to Lesbian Health Care

Investigator: Paula Bowles, Sociology Department, 270-783-9274, 270-991-1695 under the direction of Dr. Ann Goetting, Professor of sociology, 270-745-2253 at Western Kentucky University.

This project is being conducted by Paula Bowles as partial fulfillment for a Master of Arts Degree in sociology at Western Kentucky University. The University requires you to give your signed consent to participate in this project.

The investigator (Paula Bowles) will explain to you in detail the purpose of this project, the procedures to be used, and the potential benefits and possible risks of participation. You may ask her any questions you have to help you to understand the project. A basic explanation of the project is written below. Please read this explanation and discuss with the researcher any questions you may have.

If you then decide to participate in the project, please sign on the last page of this form in the presence of the person (Paula Bowles) who explained the project to you. You will be given a copy of this form to keep.

1. Nature and Purpose of the Project: This research will focus on the unique experiences lesbians encounter in their interactions with the medical community. This research seeks to fill in some of the missing gaps in lesbian health research related to lesbians’ perceptions as to the barriers they face in receiving quality health care.

2. Explanation of Procedures: This research will utilize personal in-depth interviews and will be conducted by Paula Bowles, investigator. The interviews will be recorded on cassette tapes, which will then be transcribed by Paula Bowles. Interviews will last approximately three and one-half to four hours and will be conducted at a location of your choosing. Interviews may be completed in one sitting or, if necessary, may be broken down into time segments.

3. Discomfort and Risks: Sensitive topics may cause some discomfort to you; however, there are minimal risks involved as you may at anytime discontinue the
interview or refuse to answer any question(s). I understand that participation in this project may cause me some anxiety or discomfort. If participating in study does cause me problems, such as emotional discomfort from answering personal questions, the researcher has a list of professional counseling services available and will refer me to a counselor for support and counseling (see attachment). Many questions will be personal; however, answers will not affect your reputation as confidentiality is guaranteed by the researcher, Paula Bowles.

4. **Benefits:** The benefits to you for participating in this research project may include gaining the knowledge necessary to make better informed decisions regarding your personal, social, and mental health. You may also gain an enhanced ability to question your health-care provider regarding pertinent health issues.

5. **Confidentiality:** The data obtained from this research project will be locked in a secure place in Grise Hall on the campus of Western Kentucky University for a period of three years, after which time it will be destroyed. Your identity will be known only to the researcher, Paula Bowles. Your name will be replaced with a pseudonym at the completion of the data collection process.

6. **Refusal/Withdrawal:** You may refuse to answer any question(s) or withdraw from this project at any time. Refusal to participate in this study will have no effect on any future services you may be entitled to from the University. Anyone who agrees to participate in this study is free to withdraw from the study at any time with no penalty.

By participating in this project you give Paula Bowles, researcher, permission to use any information gathered in completion of her master’s thesis and for publication purposes.

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**Signature of Participant**  
Signature

**Date**

**Witness, Paula Bowles**

**Date**
APPENDIX B

INTERVIEW GUIDE

BARRIERS TO LESBIAN HEALTH-CARE

I assure you complete confidentiality. Your name will not be used, nor will any information that would identify you. You do not have to answer any question(s) that you do not want to. You may discontinue this interview at any time.

Demographics

1. What is your age?
2. Where did you grow up?
3. What is your educational level?
4. What is your occupation?
5. What is the population of the town that you reside in?
6. What is your household’s annual income from all sources?
7. What is the number of people currently living in your household?
8. Did you grow up in a religious family? If so, what religion/denomination?
9. Do you consider yourself religious now? Why?
10. If yes, what religion/denomination are you?

General Health

1. During the past 30 days, for about how many days did poor physical or mental health keep you from performing your usual activities, such as work or recreation?
2. When you are sick or need advice about your health, where do you go for care? Why?
3. Was there a time in the past 12 months when you needed medical care, but could not get it? If yes, why could you not get the care that you needed?
4. Do you have at least one person you think of as your personal doctor or health-care provider?
5. When was your last visit to your health-care provider?
6. How satisfied are you with your physical health? What would you like to change?
7. Are you limited in any way in any activities because of physical, mental, or emotional problems? How are you affected?
8. How satisfied are you with your mental health? What would you like to change?
9. How satisfied are you with your family relationships? What would you like to
change?
10. How satisfied are you with your social life? What would you like to change?
11. How satisfied are you with your community involvement? What would make it better?
12. How satisfied are you with your employment? What would make it better?
13. How satisfied are you with your spiritual life? What would make it better?
14. Is your personal doctor or health-care provider aware of your sexual orientation? Why? If yes, how did he or she find out?
15. Did you choose your personal doctor or health-care provider based on her or his lesbian sensitivity or status? Why?
16. Is there anything that you would like to add about your general health? How has this affected your life?

Physical Health

1. Now, let us think about your physical health, which includes physical illness and injury. For how many days during the last 30 days was your physical health not good?
2. Do you now have any health problem that requires you to use special equipment such as a cane, a wheel chair, or a special bed?
3. During the past month did you participate in any leisure-time activities or sports such as brisk walking, bicycling, gardening, tennis, weight training, or anything else that cause increases in breathing or heart rate? Describe that activity.
4. On average how many minutes a week do you spend doing these activities?
5. How do you perceive your nutritional health to be? How could you improve it?
6. Do you see a medical doctor routinely? Why?
7. Describe your experience with the medical community.
8. When was your last complete physical examination? Are annual physical examinations required for your work?
9. Is your physician concerned with your total health and not just the presenting problem? Give examples.
10. Do you complete monthly breast exams? Have you ever had a mammogram? What was that experience like?
11. Do you have an annual Pap smear? How do you feel about a Pap smear when you are in the midst of one? Why?
12. Do you take any prescription medications? What for? How often?
13. Do you currently have medical insurance? Is this insurance provided through your employer? Is it single coverage? If not, can you afford routine medical care?
14. Has your physician ever suggested that you use a dental dam? How was the subject approached? How did you react? Do you use a dental dam?
15. Have you ever asked your physician about dental dams? What was his or her reaction? How did this make you feel? Why?
16. Do you smoke? How often do you smoke? How much will you smoke in an average day?
17. During the past 30 days how many days per week did you have at least one drink of
any alcoholic beverage?
18. Considering all types of alcoholic beverages, how many times during the past 30 days did you have five or more drinks?
19. During the past 30 days how many times have you driven when you have had, perhaps, too much to drink?
20. Do you use any kind of illegal drugs or substances? What? How often?
21. Has any physician ever said anything to make you feel uncomfortable about your sexual orientation? What did he or she say? What was your reaction?
22. Has any nurse ever said anything to make you feel uncomfortable about your sexual orientation? What did he or she say? What was your reaction?
23. Does your physician take the time to answer any questions that you may have? How does this make you feel? Why?
24. Is your physician lesbian-sensitive? How do you know? How does this make you feel?
25. Has any medical provider offered to help you become straight? Describe that experience. How did you feel after you had thought about the incident? Did or do you still visit that medical provider? Why?
26. Overall how would you rate the quality of health care that you receive?
27. Do you consider your sexual orientation to be related to your health problems? Why?
28. In the last 30 days how often have you practiced safe sex? Unsafe sex?
29. Is there anything that you would like to add about your physical health? How has this affected your life?

Mental Health

1. Now, thinking about your mental health, which includes stress, depression and problems with emotions, for how many days during the past 30 days was your mental health not good? Why?
2. What causes the most stress in your life at the present time? Please explain.
3. Have you sought mental-health services? Describe that experience. Did you reveal your sexual orientation? Why or why not? Were you treated with respect? How did this make you feel?
4. In the last year have you had thoughts of suicide? Why? What prevented you from acting on your thoughts? Have you ever attempted suicide? Why?
5. Is there anything that you would like to add about your mental health? How has this affected your life?

Dental Care

1. Do you have regular dental check-ups? Is your dentist male or female?
2. How did you choose this particular dentist? Is the dentist aware of your sexual orientation? Why? Does he or she treat you with respect?
3. Has the dentist ever suggested that you need to use a dental dam? How did you react to this suggestion? Do you now use a dental dam?
4. Have you ever asked a dentist about using a dental dam? What was his or her
reaction? How did this make you feel?
5. Is there anything that you would like to add about dental care? How has this affected your life?

**Receptionists/Office Personnel**

1. Are the personnel in your physician’s office aware of your sexual orientation? Why? How do you know? Do they treat you with respect? How do they make you feel?
2. Are the personnel in your dentist’s office aware of your sexual orientation? Why? Do they treat you with respect? How do they make you feel?
3. Are you at ease when you talk to the personnel in your physician’s office? Why not?
4. Are you at ease when you talk to the personnel in your dentist’s office? Why not?
5. Would you like to add anything related to receptionists/office personnel? How has this affected your life?

**Knowledge of Service Providers**

1. Do you know of any lesbian friendly physicians in this area? Who? How did you find out about them?
2. Do you go outside of this county for any of your health care needs? Why? Where do you go? Why?
3. How important do you feel it is to have mental-health counseling designed to meet the specific needs of lesbians? Why?
4. How important is it to have lesbian-identified drug and alcohol counseling available? Why?
5. Is there anything you would like to add about service providers? How has this affected your life?

**Social and Political Issues**

1. Are you registered to vote? What political party is on your voter registration card? Why did you choose this party?
2. Do you vote? How often? How much is your choice of candidates based on their support of LGBT concerns?
3. Have you ever experienced anti-gay/lesbian violence, threats, or harassment or hate crimes that could have been reported to the police? What did you do?
4. How many of these incidents did you actually report to the police department? Why did you not report all of the incidents to the police?
5. How would you rate the overall performance of the police that you contacted?
6. Do you think you were treated any differently because you are a lesbian? Why?
7. Do you have a medical power of attorney? Why not?
8. Do you have a partnership agreement with your partner? Why or why not?
9. Do you take an active part in the lesbian and gay community and culture? Why or why not? How?
10. Do you have any other social concerns that you would like to address? How has this
affected your life?
11. Do you have any other political concerns that you would like to address? How has this affected your life?

**Sexual Orientation**

1. How out are you at your place of employment? Why? Are you accepted?
2. How out are you in your community/neighborhood? Why? How are you treated?
3. How out are you with your birth family? Do they accept you as you are?
4. How out is your partner/lover?
5. Who supported your coming out? Please explain the process.
6. Did you seek support services when you first came out? Please explain.
7. How old were you when you specifically concluded that you were a lesbian? Did you try to hide it? Why? Did anyone tell you that it was just a phase? What was your reaction?
8. Has your lesbian status affected your decision on whether or not to have children? How?
9. Has your lesbian status had any influence on your opportunity for career advancement? How? What did you do about it?
10. Are you comfortable with a lesbian identity? Why? How?
11. Is there anything that you would like to add about sexual orientation? How has this affected your life?

**Homophobia**

1. Do you believe homophobia leads to inadequate health care? Why? How?
2. Have you ever had a negative experience with a health-care provider due to sexism/homophobia? Describe that experience.
3. Have you changed health-care providers because of a homophobic experience? How long was it before you saw another physician, and did you tell him or her that you were a lesbian?
4. Is homophobia a part of your everyday life? Describe what you go through as a result of homophobia?
5. Are there other issues related to homophobia that you could tell me about? How has this affected your life?

**Other**

1. When you were growing up, did your parents take you to the doctor for regular medical check-ups? Were you comfortable visiting a doctor as a child? Why not?
2. Describe any other health-care setting that you have been in. Were you treated with respect? Is there anything about any of these situations that stands out? Please explain.
3. How often do you use alternative methods of health care? Why? What types of alternative health-care have you used? How satisfied with you been with alternative
health-care?

4. Do you have a partner or significant other with whom you share your life?

5. Do you have any other health care related issues that you would like to talk about? How has this affected your life?
APPENDIX C

PROFILE OF PARTICIPANTS

Julie is 34 years of age and resides in a city of approximately 30,000 residents. She works full-time and makes approximately $22,000 a year and has medical insurance provided by her employer. She has never been married and has no children.

Susan is 35 years of age and resides in a town of approximately 5,000 residents. She has just started working for a department store and will have medical insurance after 90 days of employment. She will make approximately $14,000 a year. She has been married and has three children. Susan is out to her health-care provider.

Barb is 50 years of age and retired from state employment (not Kentucky) and is attempting to get medical disability. Barb is out to her health-care provider. She has multiple health problems. She resides in a town of approximately 5,000 residents.

Kate is 63 years of age and resides in a city of approximately 30,000 residents. She is a licensed clinical psychologist. She has been married and has two grown sons and two grandchildren. Kate is not out to her health-care providers although she believes they are aware of her sexual orientation. Her annual income exceeds $100,000. Kate does have private insurance.

Tina is 21 years of age and resides in a city of approximately 50,000 residents. She does not have a health-care provider. Tina is not employed or in school. She is presently looking for a job and is also considering attending college.

Stacey is 23 years of age and resides in a city of approximately 50,000 residents. She has recently been discharged from the army. She does not have a health-care provider. Stacey is not employed or in school. She is presently seeking employment and considering attending college.

Jan is in her late 40s and resides in a large city of over 100,000 residents. She is employed with an annual income of $75,000. Jan is not out to her health-care provider. She does have medical insurance provided by her employer.

Leslie is 39 years of age and resides in a city of approximately 55,000 residents. She is employed full-time and has medical insurance through her employer. Leslie earns about $30,000 a year.
Heather is 43 years of age and resides in a city of approximately 55,000 residents. She is employed full-time and does have medical insurance through her employer. She earns about $24,000 a year.

Jennifer is 46 years of age and resides in a city of approximately 35,000 residents. She is employed full-time and has medical insurance provided through her employer. Jennifer earns about $18,000 a year. She has been married and has two children from that marriage. Her family is aware of her sexual orientation and are somewhat supportive of her.

Vicky is 26 years of age and resides in a city of approximately 15,000 residents. She is employed and has insurance through her employer. She earns approximately $23,000 a year.

Judy is 33 years of age and resides in a city of approximately 30,000 residents. She is employed full-time with an annual income of about $50,000. Judy has a medical doctor that she sees in emergency situations. She has not been married and does not have any children.

Betty is 46 years of age. She is a divorced mother with two grown children. She has very little contact with her family because they do not approve of her lifestyle. Betty resides in a city of approximately 30,000 residents. She has medical insurance provided through her employment.

Peggy is 49 years of age and resides in a city of approximately 30,000 residents. She has never been married but does have a 30 year old daughter with whom she has a very close relationship. She has medical insurance provided through her employment.

Pat is 28 years of age and resides in a city of approximately 50,000 residents. Her annual income is $40,000 a year. She has two master’s degrees and works three jobs, one of which is full time and does provide her with medical insurance. Pat is not out to her health-care provider.

Ellen is 45 years of age and resides in a city of approximately 15,000 residents. She is not employed but does have a medical card.
REFERENCES


