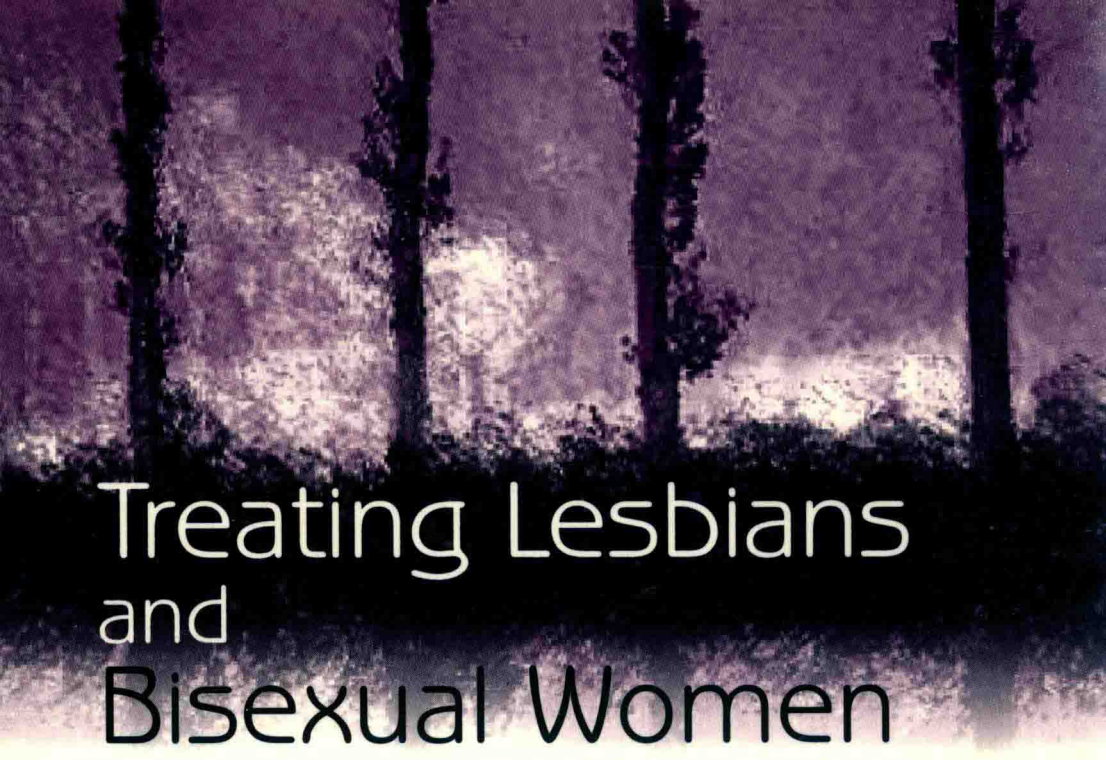

Treating Lesbians and Bisexual Women

Challenges and Strategies for Health Professionals

Elisabeth Paige Gruskin

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Treating Lesbians and Bisexual Women

Preface

This book was conceived in the office of Bill Vega, my graduate school advisor. We were discussing the need for a reference to supplement the course on lesbian, gay, bisexual, and transgender health and culture that I developed and teach at the University of California at Berkeley. In his typically proactive fashion, my advisor suggested I put together a proposal, find a publisher, and write a book. Three years later, with the help of countless people, here it is.

This book is an integrated analysis of lesbian and bisexual women's health written for health professionals, including, but not limited to, physicians, nurses, therapists, counselors, and educators. The focus of the book is women who identify as lesbian or bisexual or women who are in sexual and intimate relationships with women. You will find, however, that much of the information is applicable to gay and bisexual men as well. For the most part, the concerns of bisexual women in relationships exclusively with men, although important, are beyond the scope of this book.

This book is based on experiences of both patients and health professionals directly communicated to me by my students, the speakers in my class, colleagues, friends, Internet acquaintances, and research subjects, as well as indirectly communicated through biographies, scientific articles, poems, anecdotes, documentaries, visual art, and presentations at conferences. Represented are a wide variety of people—from transsexual and young women who have spent portions of their lives living on the streets to the most financially secure elderly couples, most of their relationships having been secreted.

After you have read the book, you will, at the minimum, better understand how the lesbian and bisexual woman lives her life as it relates to her health and her health care. I sincerely hope you then will be able to contribute to the improvement of the health care system.

Acknowledgments

First and foremost, I would like to thank the many women whose experiences this book is based on; the students and speakers in my class, the women who I interviewed, and the many women who shared their experiences through literature, art, and film.

To the people who spent countless hours developing, reading, and rereading my work, the book would not be the same without you: Sheryl Fullerton, Sharon Ponder, and Carol Somkin.

Special thanks to my mother, who with every revision not only improved the book, but became more sensitive to and supportive of lesbians and bisexual women.

Bill Vega, your belief in me pushed my bounds beyond what I thought possible.

Carol Somkin, everyone should have someone like you in their life.

Carol Cohen, Margaret Schadler, and Magdelena, you helped keep me sane.

To my friends and colleagues at Kaiser Permanente for listening to me as I rambled on about the book and for supporting me in my quest to learn more about the health of lesbians and bisexual women.

Lynn Winters, Terry Taylor, Margaret Rosario, and Joyce Hunter for accepting me into their community.

C. Terry Hendrix and Dale Grenfell for giving me this chance to express my ideas and for facilitating the editing and peer review of the manuscript.

Thank you for the time and energy of those who peer reviewed the manuscript.

My family—
everyone should be so lucky. . .

Introduction:
A Special Population With Special Needs

What is lesbian and bisexual women's health? Are not the health concerns of lesbians the same as those of all women? Bodies are bodies—why do lesbians and bisexual women need special consideration? I have heard health professionals and even lesbians ask these questions over and over. There are no easy answers because they involve more than just physiology, symptoms, and medical procedures. For health professionals to work with lesbian and bisexual women, they must understand the general hostility this population encounters in the general public and the medical establishment. They must appreciate the variety of life experiences of each individual woman and how they relate to their health and health care.

Althea and Nancy

When Althea and Nancy met at a teacher's conference, both had had relationships with women, but Althea had not lived as a lesbian until she became involved with Nancy. Not only was she reluctant to tell her family about her relationships with women, but she also worried about the parents of the children she taught. They were uncomfortable enough

with her being African American; if they found out about her relationships with women, she feared she would be forced to resign.

As their relationship progressed, Nancy became frustrated with what she felt was Althea's duplicity in her lifestyle and pressured Althea to tell her family about their relationship and to attend with her events in the lesbian and bisexual women's community. As tensions mounted over their differences, Nancy suggested they try couple's counseling.

Their first therapist, an "out" lesbian, in Althea's view, did not understand that her fear of coming out stemmed, in part, from the prejudice and racial discrimination she had experienced throughout her life. She felt much more comfortable, however, with their second therapist, an African American woman who helped both Nancy and Althea understand the complexity of coping simultaneously with racism and with the pervasive prejudices of a heterosexual world. As Althea became more secure in her relationship with Nancy, she came out to one of her sisters, and agreed to attend events in the lesbian community. Even so, it was still difficult for Althea, as she was one of the few women of color at most the events she attended.

Eventually, their therapist suggested they attend a conference for lesbian and bisexual women of color and read writings on the subject. At the conference, Althea had her first opportunity to talk with women she felt really understood her. Nancy, one of the few white women at the conference, began to understand how difficult it was to be in the minority. After she had listened to the presentations at the conference and read about the experiences of lesbians and bisexual women of color, she better understood the complexities of living with multiple identities. As Nancy became more supportive of Althea, Althea was able to acknowledge her fears and understand Nancy's frustrations.

Morgan

When Morgan had her first relationship with a woman in 1968 at the age of 22, she knew nothing about lesbianism, except that having sexual feelings for women was a sin and that she must not tell anyone. Coming out to her family a few years later supported her original fears. When she told them that she was a lesbian, they pleaded with her to pray for redemption and look to the church to help her stop her "sinful" behavior. When she refused and would not check herself into a psychiatric hospital to be "cured," they willed her out of their lives and insisted that

her brothers and sisters sever their ties to her. She felt so guilty and isolated that she considered ending her life.

Eventually, Morgan found a supportive group of friends who socialized at the local lesbian bar, one of the only places where they felt comfortable being themselves. Morgan became a bartender. Her life at the bar revolved around drinking and socializing. She, like most of her friends, smoked heavily.

When the bar eventually closed, Morgan, then in her late 30s, went on unemployment and began looking for a new job. Assuming she was a lesbian, potential employers seemed uncomfortable with her "butch" demeanor. Behavior that had served her well in her former world somehow seemed wrong as she searched for new work. Although she did find another job within a few months, Morgan had lost her old sense of security. She became depressed and tried to cope; her drinking increased.

Not long after she found her new job, Morgan was attacked and beaten by a group of teenagers because they thought she was a "bull-dyke." While the police and medical personnel in the hospital emergency room responded indifferently to this hate crime, she turned for support to her lesbian and bisexual friends and to counseling at a gay and lesbian community agency. Not only did Morgan feel more vulnerable after the beating, but it left her with chronic back pain that she sought to self-medicate with even more drinking.

When she finally realized she had "hit bottom," Morgan checked herself into an alcohol treatment center. However, as the only lesbian, she felt uncomfortable when talking about her female partners and stigmatized by the other clients and staff.

As she was ready to leave the treatment center in despair, one of the nurses suggested that she attend a gay and lesbian Alcoholics Anonymous group. Her participation in the gay and lesbian program not only helped her stop drinking and change her life, but also enabled her to find a new network of "clean and sober" friends who understood and accepted her relationships with women. With this support system, she maintained her sobriety and found new balance in her life.

Janis and Marybeth

Janis, mother of 7-year-old Benjamin from her heterosexual marriage, and Marybeth, her partner of 4 years, decided they wanted to have a baby together and that Marybeth would give birth. Marybeth's health

care plan covered artificial insemination only for women who were married to men. They saved enough money to go ahead with the process only to find that the sperm donor clinic in their town would not provide sperm to female couples or single women. Aware of the lack of legal protection for the nonbirth mother, especially when the father is known, they looked for and discovered a sperm bank in another nearby town that would provide sperm from an anonymous donor.

Although Marybeth's first Ob-Gyn provider said that she accepted lesbian relationships, her actions told another story. She never directly answered any of Janis's questions and she maintained eye contact only with Marybeth. They switched doctors three times before they found a doctor with whom they felt comfortable and who would treat them as coparents of their unborn child.

The couple had already looked into second-parent adoptions so that Marybeth could adopt Benjamin, but found that it was not legal in their state. They worked with a lawyer to protect their relationship with both of their children by legally changing all their last names to the same name, signing contracts that demonstrated Janis's commitment to raising the new baby and Marybeth's commitment to Benjamin, and signing agreements of joint custody in the case of a breakup. Both women granted each other durable powers of attorney for both health care and finances and they wrote new wills. They also had the members of their biological families sign an agreement prohibiting them from trying to gain custody of the children, if anything were to happen to either Marybeth or Janis. All of this legal maneuvering not only led to substantial attorney's fees but was stressful and difficult for them as a family.

Marybeth and Janis explained their situation and presented all their documents to each of their health care providers so that they would understand what to do in the case of an emergency. Even with these precautions, however, both Marybeth and Janis knew that there was a chance that either of them could lose custody of the children in the case of a breakup, or if the birth mother became incapacitated.

Laura

Laura, a transsexual lesbian, arrived at a shelter for battered women after surviving a particularly violent episode with her physically and emotionally abusive female partner. Two days after arriving at the shelter, a staff member, in a private counseling session, learned that Laura had

not yet undergone genital surgery; she still had a penis. The staff decided that she posed a risk to other clients, even though there had not been any complaints, and forced her to leave. Laura's decision to make the transition to being a woman had already cost her all family support and was making it difficult for her to find a job and support herself. With nowhere else to go, she returned to her abusive partner.

The health concerns of the women you just met can only be understood by first considering the negative attitudes that lesbians and bisexual women confront at all levels: societal, institutional, and individual. Althea's relationship with Nancy was complicated by their differing perceptions of the risks of discrimination they faced as a result of disclosing their sexual orientation. The success of their therapy was dependent upon a therapist helping them work together to understand these differences. Morgan, from the beginning of her relationships with women, internalized society's negative attitudes to such an extent that she considered suicide and struggled with a lifelong drinking problem. The most direct manifestation of these negative attitudes, a hate crime, resulted in emotional trauma and physical injury. She also had difficulty finding employment and appropriate substance abuse treatment because of the way others perceived her gender and her sexual orientation. To treat her effectively, Morgan's health care providers had to understand the role that her own and her family's negative feelings about homosexuality played in increasing her health risks.

Janis and Marybeth had to overcome tremendous obstacles to conceive a baby and to protect their relationships with their children. Their health care providers needed to understand the legal and emotional ramifications of the process they were undergoing, as well as general discrimination against alternative family structures.

The decision not to allow Laura, the battered transsexual woman, to remain in a shelter stemmed from society's biases about the requirements for being a "real woman" or a "real man." Laura's injuries were much deeper than the physical symptoms of the battering she had received.

The health effects of these negative social and cultural attitudes were in turn influenced by who they were as people—including the identities they had constructed for themselves, the cultural norms of

their social networks, their relationships with their biological families, their age, and their financial resources. As their life situations changed, so did the effects of discrimination on their health care and health. Similarly, each woman's financial security and family support contributed to the effect that discrimination had on them. Janis and Marybeth were fortunate to have the financial resources and family support that made it possible for them to minimize the effects of negative societal attitudes. On the other hand, because Morgan had little financial stability and no family support, she had difficulty coping with the discrimination she faced. Laura, who had been alienated from her birth family and had no financial resources, felt compelled to return to an abusive relationship. As with all patients, health care providers' understanding of their lesbian and bisexual patients' social support enhances their ability to assess their patients' risks, devise appropriate treatments, encourage clear and honest communication, and incorporate appropriate nonmedical supports in treatment plans.

In the pages that follow, you will meet women whose experiences will help you appreciate the complexity of lesbian and bisexual women's health. Their health can only be understood in the context of their lives, their experiences framed by the discrimination and bias they face, and the decisions they make based on all the other personal and societal factors. It is my hope that this book will help you better to understand your lesbian and bisexual patients and enhance your ability to provide them with the best care possible.

Contents

1

A Population at Risk

The following are some of the health risks that lesbian and bisexual women face. The statistics are drawn from national and local studies. However, there are methodological considerations, including the problems of sampling, the relevance of older studies to a changing community, and the lack of universal categories and definitions. (See Appendix D for more information about lesbian and bisexual women's health research.) The implications of these statistics will be explored in more detail in subsequent chapters.

HEALTH RISKS

Hate Violence

During their lives, most lesbians and bisexual women experience hate violence such as verbal harassment, threats, vandalism, physical assault with or without weapons, and sometimes even murder. This puts them at risk for physical injury, symptoms of post-traumatic stress syndrome, and death. The stress from hate violence can also contribute to substance abuses or psychiatric symptoms (Herek & Berrill, 1992).