


Gynecologic Care for the Lesbian

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This article has three purposes: 1) We provide information about reproductive system problems as experienced by lesbian women and make recommendations for management. Research in this area is limited; so we also point out the gaps in our knowledge. 2) Alcohol abuse is the one health problem that may be more common among lesbians than among heterosexual women. Because the obstetrician-gynecologist may see patients who are concerned about alcohol dependency, we include a section outlining current thinking about alcoholism as it occurs among lesbians. 3) The physician will not know a patient is lesbian unless she chooses to reveal this information. A variety of concerns make the decision to disclose such information difficult. We will review some of these concerns and suggest ways the interested physician can provide an atmosphere that allows patients to comfortably discuss sexual preference. Because information about sexual activity is important in the assessment of many gynecologic complaints, this skill seems particularly important for the obstetrician-gynecologist.

Gynecologic Health

In this section we will review specific gynecologic problems and suggest how management may differ for lesbians. We have relied primarily on our study at the University of Iowa in which 117 lesbians were surveyed. Other relevant studies are cited where appropriate. The reader should recognize the limited generalizability of all these studies due to the (unavoidable) use of volunteer subjects.

Vaginal Infections

Vaginal infections of all types occur even in women who are exclusively homosexual. In our study half of the women had experienced a monilial infection, a figure similar to the expected rate in heterosexuals and consistent with the epidemiology of Candida albicans, which does not require venereal transmission. While Trichomonas

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vaginalis vaginitis is frequently thought of as a heterosexually transmitted disease, this is not the case. Several women in our study who were exclusively homosexual experienced *Trichomonas* vaginitis. It is not known whether a woman can transmit trichomonads to a female sexual partner; we suggest discussing this uncertainty with the individual lesbian patient, recommending examination of any partners in whom symptoms develop. The epidemiology of nonspecific vaginitis (*Gardnerella vaginalis* vaginitis) is largely unknown. While transmission by heterosexual coitus is probable, it does not appear to be necessary. Lesbians in our study had been given a diagnosis of nonspecific vaginitis, and we have seen exclusive lesbians in our own clinic who have this problem. Again, it is not known whether a lesbian can transmit this infection to her partner.

The lesbian patient will want to know whether she needs to alter her sexual practices while she is being treated for a specific vaginal infection. It seems prudent to recommend that activities which are uncomfortable should be stopped until the infection is treated. Specific advice about the risks of transmission cannot be given because scientific information is lacking. There is, for example, the theoretic possibility that a partner could contract oral pharyngeal monilial infection after oral genital contact, but this must be rare. Treatment of each of these infections in lesbians is identical to that in heterosexual women.

**Sexually Transmitted Diseases**

As suggested by several studies, the traditional sexually transmitted diseases, gonorrhea and syphilis, are rarely contracted by lesbians. Further, *Chlamydia*, now considered an etiologic agent in pelvic inflammatory disease, was not found in routine cultures of a group of lesbians. We conclude that the diagnosis of pelvic inflammatory disease in an exclusively homosexual woman is unlikely.

Genital herpes, on the other hand, while not identified as a specific problem in any reported studies, can occur in lesbians as a result of oral-genital transmission of the virus. Lesbians need to be aware of this potential problem, and if they do suffer from either oral or genital herpes, need to take the usual precautions in order not to expose sexual partners directly to virus-shedding lesions.

**Acquired Immunodeficiency Syndrome**

There are no reported cases of lesbians contracting acquired immunodeficiency syndrome (AIDS) on the basis of their sexual activity. The susceptibility to this illness of homosexual men seems to be based on the increased rate of drug abuse, sexually transmitted disease, and exposure to penile-anal intercourse. Because neither of the latter risk factors affect lesbians, nondrug abusing exclusively homosexual women are not likely to be at risk for contracting this disease.

**Cervical Intraepithelial Neoplasia**

The prevalence of cervical intraepithelial neoplasia among women who have been exclusively homosexual would be expected to be similar to the rate found in celibate women. In our study the only woman who had significant dysplasia defined herself as bisexual, and thus her risk was presumably more similar to that of a heterosexual woman. One study performed screening Papanicolaou smears on 148 consecutive lesbians and found a dysplasia rate of 2.7%, suggesting that dysplasia does occur. As many as 80% of women who identify themselves as lesbian have had heterosexual intercourse in the past, thus placing them at some risk. We agree with Robertson and Schachter that Pap smear screening should be offered to lesbians, the interval between screenings determined by the patient's individual history.

**Menstrual Cycle Disorders**

There do not appear to be differences in reproductive hormones between lesbians and
heterosexual women. There is thus no
theoretic reason to suspect that lesbians
would have any increased risk for menstrual
cycle abnormalities. In our study, only 15%
of women surveyed had ever seen a gynecol-
ogist for irregular menses, a rate which does
not seem unusual for a reproductive age
population. Kenyon's work found that
lesbians reported fewer menstrual cycle
irregularities, dysmenorrhea, and premen-
strual symptoms than heterosexual control
subjects. 

Endometriosis

Because endometriosis is thought to be more
common in nulliparous women, nullipar-
ous lesbians should be at increased risk.
This problem has not been examined
differently, but in our study only one
woman reported this disease. While the
diagnosis of endometriosis in lesbians
would be made in the usual way, manage-
ment might differ. For many lesbians
fertility is not a major concern and earlier
consideration of definitive surgical therapy
might be considered.

Pregnancy-Related Concerns

A substantial number of lesbians, 25-50% in
reported studies, have been pregnant and are
raising children. While these preg
ancies may have occurred during a prior
heterosexual relationship, some lesbians are
choosing to have children on their own or
with a female partner. We found evidence
that the desire to have a child is quite
common, but that the number of women
who are actually successful in doing so is
small. Several options for obtaining a child
are theoretically available: 1) adoption, 2)
artificial insemination, 3) intercourse with a
cooperating male, or 4) intercourse with an
unsuspecting male. In our study, all four
options had been considered by at least some
women, with adoption and artificial in-
semination the most commonly considered
courses.

Many adopting agencies will not consider
single persons, and the option of coitus is
not acceptable to many lesbians. Thus, the
gynecologist may be approached about
arranging artificial insemination. There is
no information available about how many
physicians are willing to do this, but
apparently many are not. In response to this
perceived lack of availability, several inde-
pendent women's clinics have set up
artificial insemination programs.

Unless a woman is exclusively homo-
sexual, she may still need information about
birth control methods.

Sexual Function and Dysfunction

Lesbians have available the same repertoire
of sexual techniques as heterosexual men
and women, with the obvious exception of
the absence of a penis. Manual stimula-
tion of the clitoris and clitoral glands are
reported to be the two principal methods of
achieving orgasm. While use of dildos seems
to be relatively uncommon, vibrators are
probably used to the same extent as among
heterosexual women. There is no difference
in the sexual response cycle when female
homosexuals and heterosexuals are com-
pared.

The prevalence of sexual dysfunction
among lesbians is not known, but there is
some evidence to suggest that it is no higher
and may even be lower than the incidence
among married heterosexual individu-
als. When these problems occur, the
approach to treatment would in general be
the same as with heterosexuals. The
physician who is trained in office sexual
counseling and is comfortable with lesbian
patients should feel confident that he or she
can undertake the management of sexually
dysfunctional lesbian women. Physicians
without this training or comfort level
should refer the patient to an appropriate
source. While this latter advice seems
obvious, it has not always been followed.
Masters and Johnson reported that of 151
gay men and women who came to them for
treatment, 81 had sought help first from
another physician; of these 81, 57 had been
refused treatment, and only one had been referred elsewhere. Some physicians may believe that caring for lesbian patients will require counseling skills beyond their training. This belief is perhaps derived from the stereotypic notion that homosexual persons are all unhappy and would like to change their sexual orientation. In fact, this problem will rarely be encountered by the practicing physician. Recent studies on samples of the general population suggest that most gay people are satisfied with their sexual preference. Bell and Weinberg suggest that those who do seek help for problems related to sexual preference usually see psychiatrists, counselors, or other mental health care professionals rather than gynecologists or general practitioners. In our view it is not appropriate for the physician to suggest therapy to a patient who has not expressed dissatisfaction.

Alcohol Abuse

The incidence of alcoholism among lesbians is estimated to be from 25% to 35%, or 5-7 times that of heterosexual women. The three most commonly cited reasons explaining this high incidence are 1) the importance of the gay bar as a social/community center, 2) the alienation and isolation lesbians experience as a result of society's rejection and oppression, and 3) the lack of responsiveness alcoholism treatment agencies have shown for the needs of lesbian alcoholics.

Background

Before discussing each of these hypotheses, we will point out three assumptions researchers often make—incorrectly, we think—about characteristics of lesbian alcoholics.

First, lesbians are assumed to be the same as gay men, and the results of studies focusing on male homosexuals are generalized to lesbians. While lesbians experience many of the same effects of homophobia, as women they experience additional stresses and expectations that gay men do not—they earn significantly less, are usually the single parent when there are children from a heterosexual marriage, and they are under greater social pressure to marry.

Second, all alcoholics are often assumed to be the same regardless of sexual orientation; the real differences that exist between heterosexual and homosexual lifestyles and experience are ignored. Treatment programs that ignore or deny the special needs of homosexual clients have had very little success.

Third, some writers have assumed that men and women alcoholics are alike. Recent studies suggest that women's drinking patterns differ from men's in several significant ways. Women abuse alcohol in response to situational crises such as battering, rape, divorce, death in the family, menopause, etc. Woods found that factors contributing to lesbian alcohol abuse include many of these same stresses, and she suggests that differences between lesbian and heterosexual female alcoholics may not be so much a difference in kind as of degree.

To return to the reasons for the high relative incidence of lesbian alcoholism, we begin with the importance of the gay bar as a social center. Fified found that a significant proportion of Los Angeles homosexuals spent up to 80% of their social time in gay bars or at parties where alcohol was served (grant proposal submitted to the NIAAA, Los Angeles, 1975). This finding is probably more descriptive of the limited social options available to gays rather than an indication of deviance, and while a lack of alternatives for socializing may encourage greater attendance in bars, alcoholism is not an inevitable result. For example, Woods found that nonalcoholic lesbians went to bars as often as abusers did, but they drank less and did not stay as long.

Woods discredits the second hypothesis that lesbian alcoholism is the sole result of societal oppression. "The available litera-
ture is preoccupied with the view that alcohol abuse among lesbians is mainly symptomatic of the oppressed minority status of lesbians. There seems to be a definite unwillingness on the part of such writers to consider other possible factors. . . . Perhaps a reason for this unwillingness to look at other factors is the inability to separate the subject of lesbianism from that of alcohol abuse.”

While it is important not to ignore the effects of the minority status of lesbians, oppression does not cause lesbian alcoholism. Lesbian alcoholics are sick not because they are lesbians but because they are alcoholics.

A lack of responsiveness of treatment programs does appear to be an important factor. Three major types of negative interaction have characterized the lesbian alcoholic’s experience with alcoholism agencies: 1) refusal of services if the woman’s lesbianism was known or suspected; 2) provision of services on a limited basis, or with attitudes not conducive to support, self disclosure, or sobriety; and 3) isolation of lesbianism as the primary problem, with little or no attention directed to the alcoholism.

While a lack of responsiveness in an agency cannot be considered causal in lesbian alcoholism, neither is it curative. Those few agencies that do attempt to address the specific needs of gays have found that they will come for treatment. Underhill suggests that in order for treatment programs to serve lesbians effectively, they must 1) provide lesbian staff counselors, 2) do outreach to lesbian alcoholics in the local community, and 3) integrate an awareness of the damaging effects of homophobia and sexism into the traditional treatment goals of maintaining sobriety (personal communication, February 1983).

In summary, it is important to understand both the unique factors contributing to alcohol abuse among lesbians as well as the factors they share in common with alcoholic heterosexual women and with alcoholics in general.

**Recommendations**

Physicians should keep the following recommendations in mind when interacting with lesbian patients who abuse alcohol: 1) Do not assume that alcohol abuse is causally related to sexual preference. 2) Respect the patient’s reluctance to enter into a traditional treatment program. While this cannot be used as an excuse to avoid treatment, every effort should be made to make a referral based on verification of the agency’s ability to work effectively with lesbians. 3) Be familiar with gay resources, including books, organizations, lesbian or gay support groups, Alcoholics Anonymous, and Al-Anon. 4) Be willing to involve the lesbian alcoholic’s significant others in her treatment. They are profoundly affected by the problem and can be critical in the success of her treatment. 5) Above all, examine your own prejudices and make an honest assessment of your strengths and weaknesses in intervening with lesbian women with alcohol problems.

**Patient-Physician Interaction**

There is little doubt that many lesbian patients have serious concerns about physicians. Only 18% of the women in our study had ever revealed their sexual preference to a physician providing them with gynecologic care. Forty percent thought their health care would be adversely affected if their physician were aware of their sexual preference. Finally, 35% of the women in our sample sought out nontraditional alternative clinics for their gynecologic care.

Despite these figures, the majority of the women in our study reported that under ideal circumstances they would prefer to be open with their physicians. Why? Lesbians who feel they cannot be open may unwillingly give inaccurate or incomplete information related to their medical problems. Many lesbians would like to be open so they can obtain accurate information, especially when a problem may relate to sexual activity. The desirability of openness is supported by Dardick and Grady, who
found a strong positive correlation between openness with the physician and overall satisfaction with health care.\textsuperscript{16}

What are some of the reasons for concern? Many lesbians are put off by the assumption of heterosexuality reflected in the language of questions concerning "marital status," birth control, and sexual activity. The lesbian hearing these questions may assume the doctor is not willing to listen to her answers. In addition, each time the doctor asks a question related to sexual activity, she must decide whether to be honest or whether to withhold information.

Many of the women in our survey believed gynecologists are not well informed about lesbian health care issues. This is likely to be the case, because little has been written and most residency programs do not include specific information about this topic.

Lesbians are aware of the potential repercussions a breach of confidentiality may have on their employment, family, and even treatment by the remainder of the health care team. Our survey suggests that lesbians would be more likely to discuss their sexual preference if they were assured the information would not be recorded in the medical record. The patient's need for confidentiality may be particularly acute if the community is small, if the patient is a minor, or if she has not been open about her sexual preference with other people in her life.

Homophobia is defined as an irrational fear of homosexuals, and represents a not uncommon extreme of the range of attitudes held in our culture toward homosexuals.\textsuperscript{3} The lesbian has no way of knowing in advance what attitude a physician may hold, and she may be concerned that her care will be compromised if the attitude is a negative one. Dardick and Grady reported that 27% of a sample of 622 gay men and lesbians had dealt with at least one primary care physician whom they thought was prejudiced against homosexuals.\textsuperscript{16}

While the women in our study indicated that, given a choice, they would prefer to see a lesbian gynecologist, many wrote that they would prefer a caring, knowledgeable, nonjudgmental physician regardless of sex or sexual preference; we conclude that any interested physician can successfully care for lesbian patients.

**Recommendations**

We believe there are several steps the obstetrician-gynecologist can take that will improve his or her ability to care for lesbian patients.

1. The physician should reassess his or her own attitudes and beliefs about persons with a homosexual preference. Stereotypic images are reinforced by the media, and because many people have never known an openly gay person, they have no real basis on which to test their thinking. Recent research confirms that homosexuals are no different in appearance, job choice, pattern of friendships, or family relationships than heterosexuals. There are no physical or historical characteristics that allow homosexual men and women to be easily identified. As Bell and Weinberg point out, there is "no unique gay lifestyle, and homosexual men and women are similar in every way to heterosexual persons except in the choice of their sexual partners."\textsuperscript{14}

2. The physician should learn about health problems and concerns of lesbians. While much is unknown, particularly in the area of the transmission of vaginal infections and in the incidence of long-term health problems, information included in the first section of this chapter will provide a beginning point for this education. It should be noted that we and others have been unable to identify any medical disorders that are unique to or appear to be more common in lesbian patients.

3. The physician should recognize the importance of confidentiality and let the patient know that information about sexual preference need not be written in the medical record.

4. The physician should recognize and utilize the lesbian patient's support system, particularly if she develops either a chronic or serious illness. This system may include
either a single "significant other" or a group of friends. While there are legal constraints on the physician in certain matters like informed consent, other areas are within the physician's control. The physician should ask the patient whom she would like to be involved in her care, and then the physician can communicate with those persons just as he would with the family or friends of a heterosexual patient. Hospital visiting regulations can be modified to allow a significant other of the same sex to spend the same time with the patient that a heterosexual's spouse would spend. This is especially important in intensive care units, where regulations are often quite restrictive.

5. Physicians need to think carefully about what they say to patients and how they say it. Recognize that questions about sexual preference are not necessary in every situation. This information is pertinent if an illness may affect sexual functioning or sexual activity may have caused the problem. If the physician asks directly about sexual orientation, the reason for the question should be made clear. All questions should be open-ended and nonjudgmental and should not imply that the patient is heterosexual. They should allow the patient to respond without embarrassment or the need to hide information. For example, instead of asking, "What kind of birth control do you use?" one should ask, "Are you using or in need of a birth control method?" The lesbian patient who senses that the physician is nonjudgmental is more likely to volunteer the information about her sexual preference if she feels that it is important.

6. The physician should find indirect ways to let patients know you accept their lifestyle choices. For example, information about lesbian health issues or organizations could be included among the brochures in the waiting area. If the physician is uncertain about whether to ask a patient about her sexual activity, information relevant to both the heterosexual and homosexual situations can be provided. For example, if the patient has genital herpes, she can be told that she is at risk of transmitting the disease to a male partner via coitus or to either a male or a female partner via oral-genital sex. The patient is provided with the information she needs without needing to disclose information and also has received a positive message about the physician's attitudes.

Summary

Lesbians constitute a significant minority in the practice of many gynecologists. No special skills are needed for physicians to care for lesbian patients—he or she need only use the skills needed for the expert care of any patient: knowledge, acceptance, and empathy.

References

10. Woods C. Alcohol abuse among lesbians: an investigation of possible contributing