

LESBIAN HEALTH CARE  
PROJECT FOR GYNAECOLOGY NURSING  
ENB COURSE

Introduction R JONES APRIL 1987.

This project is an examination of lesbian health needs and health care in the field of gynaecology. A lesbian is a woman who chooses to give her emotional, social, psychological, sexual and sometimes political commitment to other women. Lesbianism is a perfectly normal, natural and healthy aspect of female relationships. There is no particular type of woman who is a lesbian. Lesbians are of all races, classes, nationalities and creeds. In our particular society lesbians and gay men have been oppressed through the centuries. Millions of women were burned as witches during the Middle Ages; many of them were women without men, and gay men were burned alongside them. Thousands of lesbians and gay men were put in concentration camps by the Nazis. Today, lesbians are frequently the victims of physical abuse and assault, and in some countries are still being imprisoned or executed.

However, the Feminist and Gay Liberation movements which have developed over the last twenty years are challenging this. Now, those who choose to be lesbian or gay are 'coming out' and demanding equal rights and equal opportunities. It is up to the institutions of society to meet this challenge, and health care professionals are no exception. Gynaecologically, lesbians have specific needs. The first of these is acceptance of their choice as a valid alternative to the heterosexual. Once this takes place other needs can be met. Without this, adequate health caring cannot take place, and health professionals will be failing a section of our community.

This project is based on medical research and on as many articles as I could find on the subject which were not blatantly anti-lesbian.

Chapter One is an assessment of the health status of lesbian women.

Chapter Two moves on to look at lesbians as patients and, on the basis of studies done, finds they are often 'invisible' to health professionals. This is because a) assumptions are made by health professionals that everyone is heterosexual and b) a reluctance by lesbians to 'come out'. The question is posed: Does this affect the standard of health care received?

I found it necessary, therefore, to examine the reasons why lesbians do not feel safe to make themselves known, and in Chapter Three I look at lesbians in society and the common myths existing among doctors and nurses about lesbians.

Chapters Four and Five then look at both the medical and nursing professions and their sometimes homophobic attitudes to lesbian patients. Some suggestions are made to help us overcome our negative attitudes in order to provide first rate health care.

I am able finally to discuss health issues as they affect lesbians in Chapter Six.

One last point I would like to make is the difficulty I had in finding relevant information. In 1976 the gynaecologist R. G. Good M.D. did a review of the medical literature on lesbianism, and discovered that his medical library contained only 11 out of 38,000 books on homosexuality, and that only 25% of these were devoted to women. He found no information in the obstetric and gynaecological journals. Looking for information in the 1980s I found the situation only slightly improved. British nursing journals had only four articles since 1980 on homosexuality, and not one related to lesbian patients. Most of the literature I found relevant was from the United States and therefore the studies I used have the drawback of not being related to the British population. This lack of information and interest in itself reflects a rather negative attitude, but one which is gradually changing.

In all the medical and nursing literature I looked at I could find only two articles which assessed the gynaecological health status of lesbians. Needless to say, both studies took place in the States.

In one study, by Johnson, 117 lesbians, 100 of whom were exclusively homosexual, were assessed.<sup>1</sup> The women were recruited in cooperation with a lesbian organisation. In the other study the information was gathered from a voluntary clinic run by and for lesbian women and doctors.<sup>2</sup> No research on this subject has been carried out in this country.

### Sexually Transmitted Diseases

At the health clinic women reported that doctors elsewhere had been ignorant about sexually transmitted diseases in lesbians.

'I went to the doctor because of a discharge and when I told him I was a lesbian he said it must be VD'<sup>3</sup> - was frequently heard. This misunderstanding arises from articles about STD referring to homosexuals when in reality they mean homosexual men.

In fact there have been no epidemics of STD reported in lesbians. The incidence of syphilis and gonorrhoea are observed to be lower in lesbians than in any other sexually active group, including heterosexual women.

In the clinic, no positive cervical gonorrhoea cultures were found out of 120 taken from exclusively lesbian women. One patient had had a positive cervical culture previously. She had been married years ago. Her lover proved to be negative.

Of 140 serologic tests for syphilis, one was reactive. This patient's only woman lover for years was found to be negative.

Enteric infections (eg hepatitis A, shigellosis, amoebiasis, giardiasis, helminthic disease and viral gastroenteritis) have been reported as epidemic among homosexual men. At the clinic, however, of the entire

patient population less than 12 cases of these have been found, and only one in a partner. The doctors there felt that the reason for this was that lesbians have far fewer sexual contacts than homosexual men.

There was no increased incidence of Hepatitis B found and no transmission between lesbian partners at the clinic. The incidence of genital herpes was low, and non-existent in a group of 148 lesbian patients studied in San Fransisco.<sup>4</sup> No transmission of venereal warts between partners was observed. The results found by Johnson corroborated the evidence found at the clinic. No cases of herpes, gonorrhoea or syphilis were found with lesbian sexual activity.

Vaginal Infections

As for non-sexually acquired infections, lesbian patients at the clinic had a higher incidence of non-specific vaginitis. This corresponds with its incidence among women with no sexual experience. There was a lower incidence of monilia among lesbians than among heterosexual women. In a review of records of 229 lesbian patients the following infections were found.

non-specific vaginitis	38%
candidosis	24%
trichomoniasis	14%

The San Fransisco study showed no chlamydia out of the 148 cultures performed.

Again, Johnson had similar findings. Only 14 cases of monilia out of 100 women occurred with lesbian sexual activity, compared with estimates of 85% occurring in the heterosexual population. Three women reported trichomoniasis at a time of only homosexual contact and it is recognised that this infection is not always transmitted by coitus.

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Table showing the incidence of vaginitis and sexually transmitted diseases in Johnson's survey occurring with lesbian sexual activity.

Vaginitis	%
Yeast	14
Trichomonas	3
Nonspecific	3
S.T.D.	
Herpes	0
Gonorrhoea	0
Syphilis	0

AIDS

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There have been no documented cases so far of sexual transmission of AIDS from woman to woman.<sup>5</sup> This does not mean lesbians are not affected. So far the biggest risk for lesbians is I.V. drug use although the number of drug users is not really known. The most serious consequence for lesbians of the AIDS scare is the homophobic reaction by the general public.

Other gynaecological problems

Problems	History of problem %	Saw a physician for a problem %
Dysmenorrhoea	54	23
Irregular menses	41	22
Cystitis	26	24
Endometriosis	3	2
Pelvic pain	28	17
Breast disease	20	17
Depression	30	15
Weight	23	12
Sexual dysfunction	23	3

This table shows the instance of other gynaecological problems found in Johnson's sample. Dysmenorrhea was found at the same percentage as in the heterosexual population. Johnson was surprised at the lower incidence of endometriosis.

### Mental Health

Depression was found to be a problem for 30% of Johnson's sample. This corresponds with findings in an earlier study by Bell and Weinberg where it was found to be lower than in the heterosexual control group.<sup>6</sup>

### Sexual Dysfunction

Johnson found the figure for this problem to be 25%. Kinsey had found the problem in 10% of his lesbian sample.<sup>7</sup> Johnson points to the contrast of a study of white, middle-class, heterosexual married women, who reported sexual dysfunction at 65%.<sup>8</sup> One of the few studies done on sexual problems in lesbians showed that the most frequent problem was finding a suitable partner.<sup>9</sup> Anorgasmia was an infrequent complaint.

### Cervical Dysplasia

In Johnson's survey, out of 11 women who had an abnormal smear, only four required biopsy and one needed treatment (cryotherapy). This woman was bisexual. Given the known connection between penile intercourse and cervical dysplasia, Johnson's estimate of cervical dysplasia among lesbians being less than 1% is not surprising.

We are therefore presented with a picture of a lesbian who is mentally and physically healthier than her heterosexual sister. However, this is a statistic, and individually lesbians do have health problems which cause them to seek medical and nursing help. When they do seek help, not only do they have to cope with the illness or problem itself, but they are also confronted with attitudes of fear and ignorance from the health professionals which often become a barrier to adequate health care being given. This will be explored more fully in this project.

# 2

## "Invisible" Lesbian Patients

### Who are the lesbians?

How many lesbians are we as health professionals aware of dealing with every week? Although this project does not define a lesbian only in terms of her having sexual contact with other women, it is interesting to note the information gathered by the modern sexologists.

Masters and Johnson in 1954 made breakthrough revelations when they found in their huge survey of sexual behaviour that 10% of the population were homosexual.<sup>1</sup>

Kinsey, thirty years ago, indicated that 12-13% of women had 'sexual relations to the point of orgasm' with another woman at some time during their adult lives, and that 11-20% of single women and 8-10% of married women on the sample 'were making at least incidental ... or more specific homosexual contacts between the ages of 20-35 years.'<sup>2</sup>

Dr. R. Green more recently commented that there may be an increase in bisexuality and/or lesbianism among women 'partly for political reasons - as one of the ways women can disassociate themselves from the extraordinary dependancy they have had on men all these years.'<sup>3</sup>

Among women interviewed for the Hite Report, a nationwide study of female sexuality, 8% said they preferred sex with women.<sup>4</sup>

It is impossible to know the real number of lesbians in our society as, due to prejudice and persecution, lesbians often remain 'closeted'. In this very heterosexually ordered society many women may perceive themselves as strictly heterosexual, who in a less regimented society might feel freer to pursue their relationships with other women.

It would certainly seem that, statistically speaking, at least 10% of the women patients doctors and nurses see must be lesbians. But how often do they remain invisible? The answer must be, frequently, if we as health workers think about how many we are aware of in our day to day contact with patients.

In Johnson's survey only 18% of the women had ever told a doctor that they were lesbian, but 64% said that they would like to. 40% thought that their health care would be adversely affected if the doctor knew of their sexual orientation, because of the doctor's negative attitude.<sup>5</sup>

In another survey, conducted in 1980 by Dardick and Grady, only 23% of lesbians with vaginitis had been open with their health professionals. While 15% assumed the health professional to know about their sexuality, the remaining 62% had not shared the information.<sup>6</sup>

In 'The Gynaecologist and the Lesbian' Good M.D. was interested in how many lesbians gynaecologists are aware of treating.<sup>7</sup> 43% of the gynaecologists he surveyed said they saw no patients they suspected of being lesbian. Another 43% saw between one and three they suspected of being lesbian. Only 14% thought four or more of their patients might be lesbian. Also 25 out of the 72 doctors who had a lesbian patient made their identification on the basis of clinical judgement and observation - which implies that the gynaecologist presumes to have the ability to recognise a lesbian at first sight. Nine of the gynaecologists asked their patient directly.

Does invisibility create a barrier to health care?

Does it really matter whether health professionals are aware of a patient's sexual orientation? Can the lack of knowledge adversely affect the medical and nursing care that is offered?

In terms of our modern nursing theory, this knowledge would be essential in order to give the care the whole person needs, with every possible problem identified and sensitively dealt with. Lack of knowledge about the role of the lesbian's lover or friend in hospital can lead to a situation of the lover being dismissed, or not recognised by staff, leaving the patient isolated and unsupported in an alien environment.



What about medical care? Would the knowledge that a patient is a lesbian affect the care that a gynaecologist would give? Good says, 'In order for the physician to consider the patient holistically and render comprehensive care, the more he or she knows about the patient, the better will be the care.'

Gynaecologists frequently make diagnoses on the basis of assumptions that a woman has intercourse; therefore iliac fossa pain is suspected of being an ectopic pregnancy or P.I.D. A lesbian who has a sexual relationship but not in the form of sexual intercourse with a man will not know how to answer the question 'When did you last have sex?' If she is brave, or if the attitude of the doctor seems supportive and/or sympathetic, then she may be able to 'come out', thus saving the time and psychological trauma of being investigated for pregnancy.

In Johnson's survey many of the subjects stated that the assumption by the doctor that every patient is heterosexual was a major hindrance to effective communication. For example, talk about contraception becomes irrelevant when a woman is exclusively lesbian, but many lesbians reported being 'virtually harrassed' about contraception when it was refused by them.<sup>8</sup>

Other lesbians may simply want information regarding, for example, infections or S.T.D., and whether she should refrain from certain sexual activities. If a doctor is unaware, this communication cannot take place, thus making the doctor's care useless for the patient.

It is clear from the evidence that lesbians frequently do not feel able to disclose to the health professionals the fact that they are lesbians, but many would like to be able to and feel that they would benefit if doctors had a supportive attitude.<sup>9</sup>

# 3

## Why dont Lesbian Patients "Come Out"?

There is no doubt that lesbianism in this society does not have the social, political or legal sanction that heterosexuality has. If you have chosen a member of your own sex as your loved one or life partner, you are unable to get that love vow recognised by society in marriage. Further, you are surrounded by images of so-called 'normality', the heterosexual, and there are very few positive images of lesbians anywhere. Women who have chosen women are discriminated against in employment and in other spheres of life. A lesbian is not considered by the courts as a 'fit mother', and many a heart has been broken by children being taken away from women for this reason. Far from being celebrated like heterosexual relationships, lesbianism is scorned and women who declare their sexuality can be rejected by their families as well as by society as a whole. The alternative is to live a secret life, putting extra distance and strain on relationships with friends and family. All these factors are undoubtedly the cause for lesbians 'passing for' heterosexuals when seeking health care. This is reinforced by something known as 'heterosexism'. 'It is a heterosexist society, heterosexuality is assumed to be normal, and everyone is assumed to be heterosexual unless there is "evidence" to the contrary.' (G.L.C. Womens Committee booklet 'Tackling Heterosexism').

Most health workers do make the assumption that everyone is heterosexual; like the society we live in we tend to believe many of the myths and legends that make life so hard for lesbians.

I wish to explore some of these myths in order to dispel some of the fear and ignorance which creates such a barrier when we are caring for lesbians in the health field.

Myth One - Lesbianism is abnormal and unnatural

The fact that people believe this is a product of the society we live in. Historically and in other cultures lesbianism and male homosexuality have been regarded as perfectly normal and even celebrated.

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The word lesbian originates from the island of Lesbos where in ancient Greece the great poet Sappho lived. In this culture homosexual relationships were revered, as is made clear in Sappho's poetry.

Charlotte Wolf writes of Sappho:

'She was married, apparently happily, and she had a daughter, but her homosexual tendencies dominated her life. Her poetry reflects her bisexual nature, but it is her poems to women that give touching expression to her feelings and reveal the power of her art. Even the fragments that have survived are overwhelming in their suggestive force. They reveal great depths of feeling, ranging from nostalgia to ecstasy.'<sup>2</sup>

Why the acceptability of same sex relationships became lost is a subject of debate. Some writers have linked this loss with the rise of more patriarchal cultures for example Christianity in the West.

The social scientist Susan Cavin, in 'Lesbian Origins' uses material drawn from Western anthropological data and discovers that lesbianism is geographically widespread across human society.<sup>3</sup> She found lesbianism in pre-industrial societies, hunter-gatherer societies and in societies of all major types of marriage and family organisation. She also notes the existence of 'woman marriage' in many African and Native American societies, which, as the name suggests, is the marriage of two women. 'Herskovits reports that the phenomenon of woman marriage is a social institution among not only the Fon in Dahomey, but the Yoruba in South West Nigeria, the Ibo of South East Nigeria, the Dinka and Nuer in the Sudan and the Bavenda of the Transvaal, and in various other parts of the African continent. Herskovits thinks that these female matings in Africa may represent a pattern having far wider distribution.'<sup>4</sup>

Anthropologist Caroline Niethammer reports cases of Native American women marrying other women among the Mohave, Navago, Eskimo, Yuma and Cocopa.<sup>5</sup>

In 1914 McMurtrie's study 'A legend of Lesbian Love' among the North American Indians states: 'Lesbian love is bound to exist among all peoples regarding whom complete and accurate data concerning vita  
available.'<sup>6</sup>

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Again, another anthropologist, Margaret Mead, shows some interest in findings on female sexual experiences in 'Coming of age in Samoa'. She found that out of 25 female adolescents she studied on Samoa, 17 of them had homosexual experiences while 8 did not. In contrast, only 12 out of 25 girls had heterosexual experiences; 13 did not. 68% of Mead's sample had homosexual experiences while 48% had heterosexual experiences. This finding upsets the assumption that heterosexuality is the sexual norm and homosexuality is the deviant case.<sup>7</sup>

In 'Keep the river on your right', Schneebaum reports that with the Amarahaeri of Eastern Peru, lovemaking is almost exclusively homosexual among women and men - except for heterosexual acts performed two to three times a year at ceremonial rites.<sup>8</sup>

From these cross-cultural studies it can be seen that lesbian relationships, far from being unnatural or abnormal, are universal. It is our particular culture that describes these relationships as abnormal, perhaps because they are a threat to the status quo of heterosexuality. However, more and more people are coming to realise that lesbianism and gayness are natural parts of the broad spectrum of human sexuality.

Sometimes animal behaviour is cited to support human theories. However, the heterosexual coupling which is considered so normal in our society is actually quite rare in the animal kingdom. More normal in animals is for reproduction to take place at certain times of the year, and for the remaining time the sexes keep apart. Kinsey, who was originally a biologist, says that mammals and other animals routinely have homosexual relationships.<sup>9</sup>

#### Myth Two - Lesbians are masculine

Any woman can be a lesbian. Lesbians are identical physically and mentally to those women who choose to be heterosexual, with the exception of the sex of their partners. However, the male and female roles in this society are fairly rigidly prescribed in the heterosexual community, and masculinity and femininity are character traits which

are learnt. This becomes clear when looking at masculinity and femininity in other cultures where the meanings are different. It is possible that one reason that lesbians choose women is because of the freedom from the restrictive and powerless role of passive femininity it gives. Maybe the refusal to fit themselves into the feminine stereotype gave rise to the idea that lesbians are masculine. That so many lesbians are invisible and not distinguishable from heterosexual women makes it clear that they are not visibly masculine.

Some people believe lesbians are women who want to be men. This is not the case, and transsexualism should not be confused with lesbianism. A lesbian is a lesbian because she is a woman who wishes to relate to other women.

#### Myth Three - Lesbians are sick

This notion owes its origin mainly to psychiatry. Psychiatrists, by looking for causes for homosexuality and then finding 'cures', have reinforced the myth that homosexuals are 'sick' and 'deviant'. For example, when a homosexual has needed psychiatric help, the psychiatrist has assumed that their homosexuality is the problem.

'When one of us expressed emotional or physical pain, not even related to her sexuality, the medical doctor or psychiatrist told her "It's all because you're a lesbian." The road to health is always seen as becoming heterosexual.'<sup>10</sup>

The 'cures' have been painful in themselves, for example, electric shock treatment, drugs, behaviour and aversion therapy and, as stated in 1973 in a British Medical Association pamphlet on homosexuality, 'In extreme cases, brain surgery, to turn them into heterosexuals'. Clitoridectomy has been used to 'cure' lesbianism in the past.

In 1955 Frank Caprio M.D. wrote 'Today psychiatrists know that sexual inversion is an emotional aberration - a disorder of psychological rather than genetic origin, and therefore should be treated by psychological methods. Psychoanalysis and psychotherapy are specific methods of treating lesbians. Attempts to cure homosexuals through

endocrine therapy have proven futile.'<sup>11</sup> (Underlinings mine.)

Doctors have also believed that lesbianism is caused by hormonal imbalance such as testosterone levels in the womb (Derner) or endocrine disorders. In 1972 a letter appeared in 'Nature' about research done to find physiological causes for lesbianism. Not surprisingly, 'This study failed to reveal any organic difference between lesbians and heterosexual women.'<sup>12</sup>

Charlotte Wolf M.D. was one of the few doctors to <sup>do</sup> extensive research into lesbianism (rather than tagging it on to studies of male homosexuality), in the 1950s and 1960s. Her work was interesting in that it incorporated the old psychological theories whilst also acknowledging more recent theories of sexuality. She partially accepts Simone de Beauvoir's existentialist theory that 'Lesbianism is no more perversion deliberately indulged in than it is a curse of fate. It is an attitude chosen in a certain situation'<sup>13</sup> - and gives a valuable insight into the actual situation of women in our society.

'The male commits emotional violence on the female by reducing her to the status of an object. This crime of trespassing on another person's right to be herself also damages him, since it must, at some time or other, lead to alienation between the sexes. So far man has been victorious in implanting a feeling of inferiority into most women. The female psyche has for centuries absorbed the idea that woman is reactive and placid and her emotional responses are tuned accordingly.'<sup>14</sup>

Here one facet of Wolf's theory of lesbianism is explained. 'The lesbian was and is unquestionably in the avant-garde of the fight for equality of the sexes, and for the psychical liberation of women.'

'Whatever their type .... all homosexual women are one in their rejection of bondage to the male. They refuse to be the second sex.'<sup>15</sup>

'My survey showed that a number of them (married lesbians) only discovered their homosexuality after years of marriage, but when that happened they changed in their attitude to their husband and, far more importantly, to themselves. They discovered their selves, and with it

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their absolute rejection of being an object. They realised then that they had never felt their position as wives as genuine, but had played a part which education and convention had prescribed for them. The unease they had always felt was only brought home to them when they experienced the spontaneity of homosexual society.<sup>16</sup>

As hard as they have tried, no researcher or doctor has been able to find a physical cause for lesbianism.

The American Psychiatric Association included homosexuality on the list of mental disorders until as recently as 1973. In the same year, in this country, the Gay Liberation Front disrupted the B.M.A. National Congress on psychosexual problems with homosexuality as a topic.<sup>17</sup> The Congress underlined the medical attitude that homosexuality is a disease or behavioural disorder. Nor is this completely changed today after twenty years of Gay Liberation. The London Medical Group in October 1986 debated 'Homosexuality - a personal preference or medical problem.'

In the library at Chelsea Hospital is a book called 'Psychosexual Counselling' which includes homosexuality in a list of perversions such as animism, nepholism and the like.<sup>18</sup>

It is small wonder that lesbians remain distrustful of the medical profession. It is time we as health professionals realised that individuals have a right to a self-defined sexuality.

Myth Four - Lesbian sex is impossible or an inferior version of the heterosexual act.

Because female sexuality is so strongly associated with heterosexual intercourse (penile penetration of the vagina), sex between women is often believed to be impossible or definitely inferior.

In Victorian society it was strongly believed that women had no sexuality at all with the exception of the 'evil' or 'sinful' few. Now it is widely acknowledged that women have sexual responses, but this is often seen as dependant on the male.

It was the sex researchers Masters and Johnson, and later Kinsey, who were partly responsible for this liberation of female sexuality. It was they who identified the clitoris as the organ of sexual response and orgasm in women, thereby implying that vaginal stimulation by a penis (or substitute) is not necessary for a woman's sexual gratification.

In 'Sexual Behaviour of the Human Female' 1953, Kinsey says, 'Most heterosexuals, both men and women, do not realise that sex between two women may be as effective as or even more effective than techniques used in heterosexual coitus.'<sup>19</sup>

'What do lesbians do sexually? Very much the same thing a man and a woman can do, with the exception that there is no penis present. There are a number of ways that two women can seek and find sexual gratification together, ways limited only by the imaginations of the persons involved.'<sup>20</sup>

As Masters and Johnson showed in their research, sex in itself is nothing mysterious or magical. It consists of particular physiological changes during the sexual cycle. The mystery and the magic come from the person with whom you are making love.

'Everything that women do together can also be done by a man and a woman, but for a lesbian that would change everything. It isn't the actions or the act. It is the woman involved who makes it more than just "physiological changes."<sup>21</sup>

'There is always a great deal of touching and affection, fingers run over each others' bodies, legs intertwined and a great deal of kissing all over our bodies.'<sup>22</sup>

Sex is slow with long preliminaries and explorations, conversation, gentle mutual stroking and then clitoral stimulation in unison. Great. It's great to do and feel the same done to you.'<sup>23</sup>

'Love-making with a woman is always more variable than with a man, and the physical actions are more mutual. While the same places are kissed and touched with a man, the whole feeling is heightened for me when the



lover is a woman, and it is so different because of all the psychological and emotional factors involved. The touches become different, the kisses different - the whole aura is different.'<sup>24</sup>

'Men were mostly concerned with their own pleasure rather than mine. I found no emotional love, just physical love. I find women better lovers. They know what a woman wants and most of all there is an emotional closeness that can never be matched by a man. More tenderness, more consideration and understanding of feelings, etc.'<sup>25</sup>

'What makes loving a woman so superior to being with a man is the equality we feel. Men so often want to be in control and to have all the power.'<sup>26</sup>

Masters and Johnson's discovery that sex between women involved more sensitivity and better communication seems to agree with the views of the women themselves.

Some psychoanalysts (Freud in particular) have claimed that lesbian sex is immature and inferior to heterosexual coitus. It would seem more relevant to listen to what women themselves say about their sexual activity, and not one lesbian felt this.

On the other hand, more knowledgeable sexologists and marriage counsellors point out the various erogenous zones of the human body and encourage variation in sexual technique to back up a problematic heterosexual relationship.

Myth Five - Women have to use a dildo or penis substitute when having sex with another woman.

It must be clear from the previous section that this is not the case. Women prefer women because they are women. In all studies about lesbian sexual practices one unanimous finding has been that the use of a penis substitute is relatively rare.

'As one lesbian declared, "If I wanted a penis for sex I'd go and find a live one, not a fake."<sup>27</sup>

Myth Six - Lesbians are sinful.

The Christian church has in the past persecuted lesbians and gay men, narrowly defining human sexuality as being for the sole purpose of procreation within marriage. There is still a strong sense today that same sex love is 'sinful', and religion, a traditional source of comfort and support in our culture, has thus been denied to homosexual men and women.

However, Gay Liberation has had its impact on the church, and same sex love is becoming more and more accepted in some spheres of the church. The Bishop of Southwark said in 1979, 'We must recognise the fact that love, whether it be between a man and a woman, a man and a man, or a woman and a woman, can achieve a pure and glorious relationship if it is expressed with restraint and discipline.'

In the United States, Churchmen have performed marriage ceremonies for gay people, even though the marriages were not legally recognised.

There are more and more groups of lesbians who wish to celebrate both their religion and their sexuality, for example the Catholic Lesbian Sisterhood, and gay synagogues.

# 4 Homophobia & Nurses

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Homophobia is the term used to describe fear and ignorance of homosexuality. It has been defined as 'the constellation of affective responses, including fear, disgust, anger, discomfort and aversion, that individuals may experience in contact with homosexuals.'<sup>1</sup> As any nurse will know, these responses abound in hospitals and among nurses. As J. C. Lawrence says, 'Although the nursing techniques used in the care of a homosexual patient with a physical illness will not differ from those prescribed for heterosexual patients, prejudicial attitudes negatively affect the manner in which their care is given. Moreover, the psychological considerations that play such a large part in the care of heterosexual patients may be absent. Nurses' failure to recognise the depth, variety and meaning of homosexual lifestyles can be a constant source of distress to homosexual patients.'<sup>2</sup>

It is well recognised that hospitalization is a frightening and distressing experience for any patient. These feelings are then intensified for the lesbian, who must either hide her life style, or be subject to gossip, curiosity, neglect, open hostility or abuse.

One nurse, on arriving at work, was met with this reaction about a patient.

'She's yours, Andrew. I'm not going in that room today.'<sup>3</sup>

The night nurse had reported that a patient's history stated she was a lesbian. The news of the patient's homosexuality was met with expressions of disgust.

Another nurse describes his first encounter with a patient labelled homosexual.

'At a ward handover report we were quietly but assuredly told that "a fruit" had been admitted. I knew what this oppressive colloquialism meant, otherwise I may have been confused. . . .'

He describes his nursing care:

'We talked to him in a monosyllabic way, and only if we had to. We only served to reinforce his feelings about himself and therefore his depression. He was discharged sometime after I left the ward. By all accounts he had improved little.'<sup>4</sup>

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Yet another nurse describes a patient's treatment:

'Nurses ignored her call light, and did not pay any attention to her except for giving prescribed medications. Help with turning, and back-rubs, were given only grudgingly. Sharon was aware of and deeply hurt by the snickers and glances exchanged by members of the staff. Pat was harrassed constantly about the visiting hours she kept; she was denied information about the patient's progress, and was treated with coldness and contempt.<sup>5</sup>

'"And all because I'm different in the way I live my life!" said Sharon. I knew she was right.'<sup>6</sup>

'We had gossiped and communicated confidential information about the patient among ourselves. We had compromised her privacy and prejudiced each other against her. No doubt our mood of conspiracy had affected the other patients' attitudes towards Sharon too.

'We had denied her basic comfort measures, and treated her in a mechanical, business-like way when we did offer physical care. We'd stereotyped her and kept her at a distance emotionally. We had, in fact, promoted instability in a patient, and paved the way for the drama of Sharon signing herself out.'<sup>7</sup>

Not only is the lesbian often isolated and deprived of caring attention in hospital, she is often also deprived of the support of her partner/friend/lover. This is because either they are made to feel uncomfortable when holding hands, expressing affection and concern, or the lover is not accorded the respect a partner of a heterosexual relationship would be given. The loved one may find herself unable to obtain information about the patient or to participate in decisions which relate to her care.

J. C. Lawrence again:

'Many homosexuals express horror at the thought of having a loved one hospitalized. They fear losing control, and experience a deep sense of anger at being dismissed as a 'queer friend'. One lesbian, who was chronically ill with multiple sclerosis, described hospitalisation as "a fragile experience that can destroy a relationship." The situation can become intolerable if extended, and hospital visits can

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become torturous. One cannot fight an entire hospital staff while indefinitely bottling up feelings of fear, loss and concern for the loved one.'<sup>8</sup>

Another myth that is often believed by nurses is that lesbians are sex maniacs and will try to make a pass at any opportunity.

'One nurse said she felt awkward touching the patient in potentially intimate situations. "I'm afraid she might say something suggestive and I wouldn't know how to handle it." Others voiced similar feelings. "I don't like being alone behind the curtain with her." "What if she made a pass?"'<sup>9</sup>

'Making a pass' or touching someone in a suggestive way is behaviour more associated with the male heterosexual, and is also known as sexual harrassment or assault. Nurses would do well to look at <sup>who</sup> the perpetrators of rape and sexual assault are; they would find that they are male and not female. Statistics show that nurses are in more danger from the male heterosexual than from the lesbian.

A better understanding of the lesbian life style would enable the nurse to see that sex is not an obsession for lesbians and is probably thought about as much or as little as the heterosexual would think about it. She also has to live her life, go to work, cook, clean, eat, laugh - and cope with being in hospital.

The lesbian in hospital is vulnerable and, in relation to the nurse, in the less powerful position. Far from being about to make sexual suggestions, she needs support, care and love to help her through the distress of her illness and the trauma of being in hospital, just like any other patient.

How can nurses overcome their homophobia and deliver the care?

'It was incredible. What, I asked the group, could have caused a team of skilled and compassionate nurses to behave in such an unprofessional

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way? There was a long silence. Then another nurse said she thought she felt threatened by someone who led a life so different from her own. "It makes me think about things I don't want to think about." Several nurses agreed, adding that they'd feel even more threatened by a woman who was homosexual than a man who was, because they'd be afraid of what others might suspect if they appeared to be accepting her. Being around a female homosexual might raise questions they didn't want to consider. As a defence they rejected the patient responsible for evoking the questions.<sup>10</sup>

Obviously, hostile ridiculing or cold behaviour is a result of defensiveness in nurses. Myths about lesbians being masculine or being sexmaniacs or being abnormal all enable the nurse to dismiss the issue and prevent her from confronting the real situation, that a woman has chosen for herself an alternative to heterosexual relationships and is happy with that choice - although not necessarily happy with the anti-lesbian society she lives in.

Here are some suggestions about how nurses can overcome their negative attitudes.

#### Checklist for nursing lesbian patients

1. Examine your own attitudes.

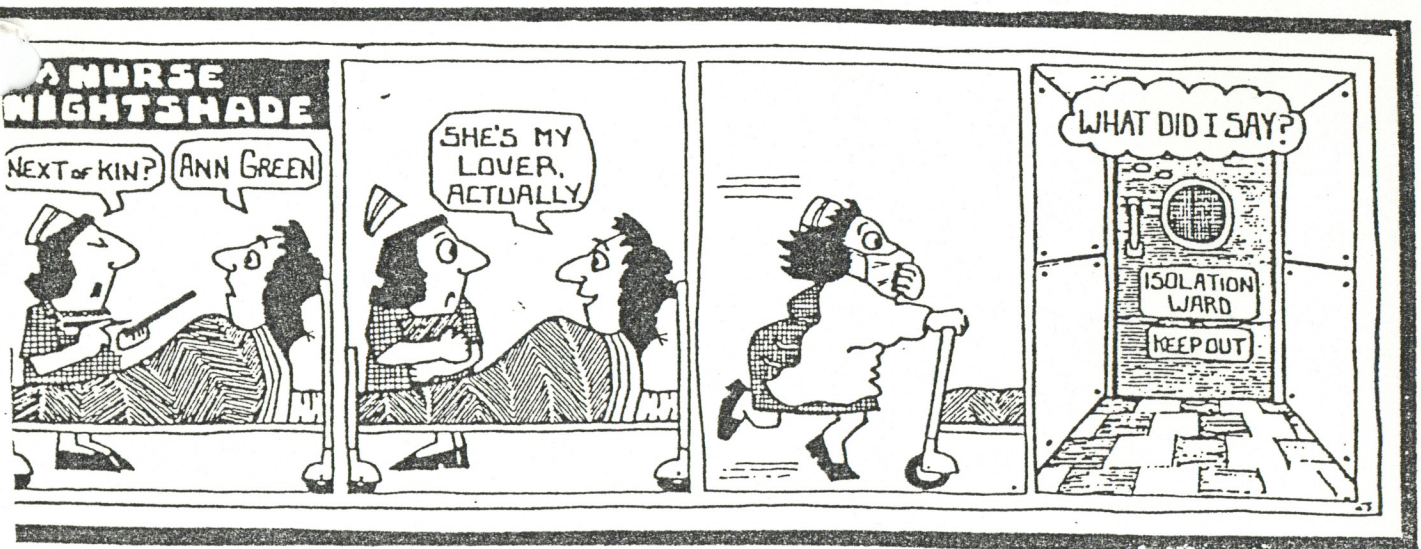
(i) Are you being homophobic?

Do you believe any of the myths about lesbians? - eg. lesbians will attack you, lesbians are men in womens' bodies, etc. - and if so, think about them and discard them. Remember, there are as many different 'types' of lesbians as there are 'types' of heterosexuals. Any woman can be a lesbian.

(ii) Educate yourself if you are ignorant.

Read books about gay and lesbian liberation (avoid old-fashioned medical literature as that too suffers from homophobia. Talk to lesbians and listen to their experiences of homophobia.

- (iii) Do not make the assumption that everyone is heterosexual.
2. Once you have rid yourself of negative feelings you can relate to the patient as you would to any other. However, you may be surrounded by nurses who hold homophobic attitudes and who will need to be challenged.
  3. Be open and receptive to health questions asked by lesbian patients.
  4. Be sensitive to the needs of the lover/friend of the lesbian patient, eg. for information, visiting time etc. She should be accorded respect and consideration equal to that of any partner and should be named as next of kin if the couple wish this.
  5. Provide positive information on notice boards etc. on lesbian issues.
  6. Education. Thought and discussion allow nurses to confront their feelings about issues, and lesbian health care could be brought into the training syllabus. Speakers could be invited from the lesbian and gay communities to open up the subject. Books on the subject could be included in the library.



# 5

## Homophobia & Doctors

Two studies about homophobia in the medical profession have been done in the United States. Although both studies imply homosexuals to be gay men, in the absence of research relating to lesbians they have to be taken as an indication of the attitudes towards lesbians also.

The first study, 'Physicians' Attitudes Towards Homosexuality', was carried out in 1982 before publicity linking AIDS with male homosexuality became widespread.<sup>1</sup> 2,304 members of the Californian Medical Association were sent questionnaires, and 1,009 responded. Questions were asked and the answers were given scores which corresponded with a scale of homophobia. Among the obstetricians and gynaecologists questioned, only 35.7% were found to have favourable attitudes towards homosexuals. When the medical specialities were ranked in order of the most homophobic, obstetricians and gynaecologists came second after orthopaedic surgeons.

The second study was called 'Homophobia Among Physicians and Nurses', and was conducted in 1985.<sup>2</sup> This was done in response to the AIDS epidemic and the feeling among gay men that homophobia had adversely affected their medical care. The responses of the doctors and nurses of a large teaching hospital were again rated on a 'homophobia scale'. The average score fell into the low grade homophobia range, and about 31% admitted they felt more negative about homosexuality since the emergence of AIDS. 9% agreed with the statement that homosexuals who contract AIDS are 'getting what they deserve'.

Although lesbians are at the lowest risk of sexually active people of catching AIDS, the backlash of anti-gay feeling generated by it undoubtedly affects lesbians in a negative way.

In December 1985 the British Medical Journal received angry letters to the editor about a small advertisement for the Gay Medical Association. For example, 'Am I to construe that the B.M.A. and the editorial committee support the activities of such a band of homosexual perverts?'<sup>3</sup> As the replying letter says, the author was entitled to his view, but for doctors to become moralists rather than medical experts, and to



reject compassion and to ostracise a patient would be 'to give less than adequate care.'<sup>4</sup>

Doctors as well as nurses would obviously benefit from homosexual issues being discussed on their educational curriculum. In Arizona a course on the medical school curriculum was developed to promote more positive attitudes among doctors-in-training towards homosexual patients.

'The format was primarily small group discussion between students and articulate homosexual people around societal biases towards homosexuals and issues of health care delivery. Students from this seminar and a control group from another course completed an attitudinal questionnaire before and after the course. The study group became more accepting towards homosexual life styles significantly in 12 of 15 measures, while no difference was found in the control group.

Students' reaction to this learning experience was highly positive: they appreciated the opportunity to learn about same-sex life styles in a personal and non-threatening way, thus enabling them to accept and better care for homosexual people.'<sup>5</sup>

Returning to the gynaecologist and lesbian patients, we have already noted that poor communication between the doctor and lesbian patients affects all aspects of lesbians' health care. One lesbian, who had had repeated admissions to hospital for lazer treatment for vulval dysplasia, knowing its association with the wart virus was frantically worried about the possibility of its sexual transmission, but she never felt able to ask the doctors this specific question.

The women in Johnson's survey felt that the single most important quality in a doctor was an open and supportive attitude. Included in this was to not make assumptions about a woman being heterosexual and to make it clear he/she is aware of homosexuality.

The issue of confidentiality is crucial for lesbians. It is important for the patient to know that her sexual preference is not being recorded in medical notes.<sup>6</sup> As the project has already shown, lesbianism is not

a physiological problem. Even if one doctor is supportive, to record the information would make the patient vulnerable to negative attitudes from other doctors and medical personnel in the future. All the women felt that the disclosure of the information should be a decision made by themselves as seemed relevant at any particular moment, rather than for it to follow them around in medical notes.

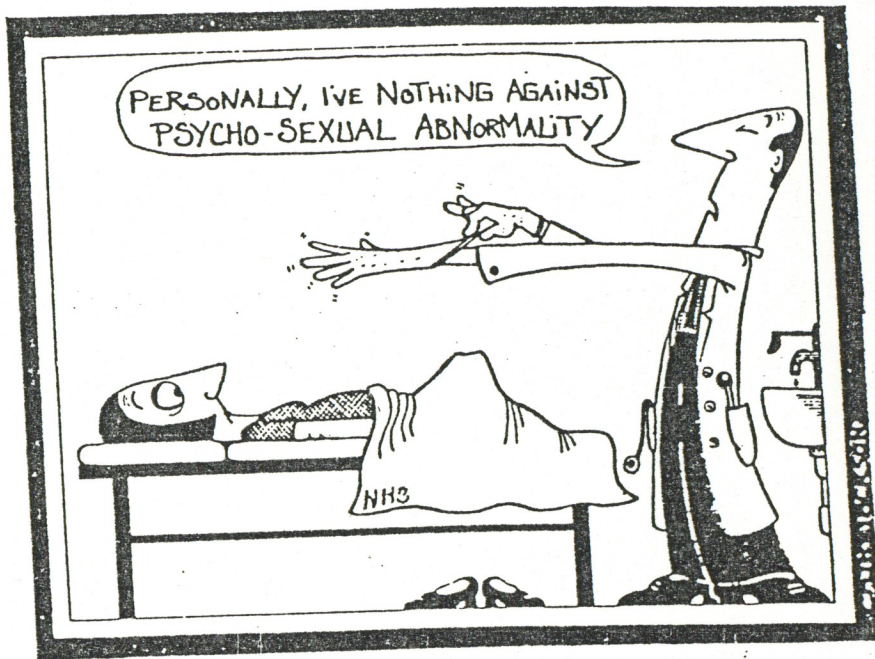
Degan and Waitkevicz, the doctors from the clinic, make some suggestions as to how better communication between lesbians and doctors can be established. Obvious barriers to avoid were aversive reactions, questions about the patient's sexual practices not warranted by the condition for which she is under treatment, and pressuring the patient to have her lesbianism 'treated' psychiatrically.

'Physicians who wish to give good health care to lesbians should assume every new female patient may be a lesbian until she declares otherwise. . . . It is equally important to avoid heterosexually biased questions. For example, in a gynaecological visit the question "What kind of birth control do you use?" is distressing to most lesbians since it forces a declaration of sexual preference. By asking: "Do you use birth control? - No? Why not?" the interviewer allows the lesbian, the celibate and the recently widowed or separated heterosexual woman to reveal as much or as little about her life style as she chooses. All may answer simply that they are not having intercourse. If birth control is the issue in question, that answer is sufficient.

'If the patient has a sexually transmissible disease it is inappropriate to ask: "Are you married or do you have a boyfriend?" More information will be gained by saying: "This illness can sometimes be spread by sexual contact. Have you been having sexual relations of any kind?" The ways in which the disease can be sexually transmitted should then be reviewed by the physician and questions invited.'

'The physician who makes these initial efforts at communication with

lesbian patients will be able to give care at a much higher level, and ultimately add to the fund of information on lesbian health.<sup>7</sup>



### Sexually Transmitted Diseases

Although investigation shows lesbians to have far fewer incidences of STD, the fact remains that if an infection is present then there is a possibility of its transmission.

Many doctors and nurses may be unable to advise a lesbian and her partner whether they should take any precautions during sex. One of the few sources of advice and information was the lesbian health clinic.

In spite of the low incidence of STD among lesbians it should be remembered that many lesbians have a heterosexual history. This was so for 80% of Johnson's sample. All types of contraception had been used in the past (oral contraception 48%, I.U.C.D. 14%).<sup>1</sup> Hence the women at the clinic who had a previous positive gonorrhoea culture. It was felt that transmission of gonorrhoea may be possible between women who are lovers or who live together in crowded conditions. This was based on paediatric literature involving cases of children acquiring the disease from sharing a bed with an infected partner or from 'freshly contaminated hands'.<sup>2</sup>

Syphilis transmission, not requiring anaerobic conditions, is also theoretically possible between women. The clinic's recommendation was for fit lesbian patients to have syphilis and gonorrhoea testing after any heterosexual contact, at intervals depending on number of partners; prior to and during pregnancy; and if occupational contact with syphilis is likely. Prophylactic treatment was given to the contacts of infected women and to rape victims.

### Enteric Infections

These infections can be spread by oral genital contact and health professionals should ensure that any homosexual or heterosexual who may practice this is informed about its mode of transmission, ie, not to

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be the recipient partner in oral sex.<sup>3</sup>

### Hepatitis B

This is found in the saliva, blood and vaginal secretions. It is not known whether vaginal secretions can transmit the infection, but blood taken orally is known to infect. Therefore in theory a woman can catch it by having oral sex with a woman who is menstruating, and possibly at other times too. In view of the other possible mode of transmission, of saliva entering through a break in mucosa, the clinic advises women with Hepatitis B not to be the recipient or the active partner in oral sex.<sup>4</sup>

### AIDS

Transmission of AIDS is via blood and semen. The virus is also found in other body fluids. Therefore if a lesbian is HIV positive she should be advised never to allow blood or vaginal secretions to enter another person's body. Similarly, lesbians should be advised to know their partner's sexual and drug history and to practice 'safe sex' unless she knows that person is not infected with the virus.<sup>5</sup>

Another way in which AIDS has affected lesbians is self insemination. Until recently, many lesbians (and heterosexual women) used gay men as sperm donors. It is now no longer always safe to do this.

### Genital Herpes and Venereal Warts

Women are warned to avoid spreading vaginal secretions to any part of their partner's body when lesions are present. Lesions should not be touched and towels not shared. It is also pointed out that women with oral lesions should not allow any contact with the lesions while there. Similar precautions would be advised if venereal warts were found.<sup>6</sup>

## Other Vaginal Infections

While not acquired sexually, all vaginal infections can be transmitted through heterosexual intercourse, and some research has found that women inoculated with infected discharge of another woman acquired the infection. Therefore the clinic advises any woman with vaginal infection to avoid transferring discharge to her partner's vagina.

Thrush can be transferred to the throat by active oral sex, and it was felt that this is a significant problem for immune suppressed patients. Therefore women taking antimetabolics and steroids were advised against oral sex.

Trichomoniasis was actively screened for in contacts of women with it and was found in less than half of them. Sharing towels and such things was advised against as well as avoiding transfer of discharge.

## Cervical Dysplasia

While the incidence of this is low in lesbians, it is still possible given the frequency of a heterosexual history or bisexuality. Smears were certainly advised - to be done yearly - while Johnson suggests the frequency should be individualised.<sup>7</sup> Women whose mothers took DES for preventing miscarriage are also susceptible to a rare form of vaginal cancer.

## Breast and Endometrial Cancer

'Never pregnant' women are thought to be at a higher risk for breast and endometrial cancer, and although some lesbians are mothers, many are childless. Therefore an important health issue for lesbians is awareness and breast examination.

Lesbian mothers

Like other women, many lesbians want to have children. To some people this is a contradiction, but again the idea that all lesbians are childless is a myth. In the United States, the National Gay Task Force estimates that between 1,430,000 - 2,200,000 lesbians are mothers. The distinction between loving human relationships and procreation has been made. Sexuality has a function for its own sake and is not always connected to making babies as witnessed by contraception and abortion.

Lesbians want to be able to develop all sides of their personality, including the desire for a loving relationship and their desire for children. The issue is controversial because lesbian families present an alternative and therefore a threat to the heterosexual nuclear family. Lesbians are accused of being 'unfit mothers' who will bring up disturbed children through lack of a male role model. Research that has been done shows that the opposite is true.

Professor Robert Gould, clinical psychiatrist at New York Medical College writes: 'Recent studies have shown that children raised by a homosexual parent are as sexually and emotionally well adjusted as children raised by a heterosexual parent.'<sup>8</sup> Similarly, Evelyn Hooker, a clinical psychologist from the Neuropsychiatric Institute of the University of California, notes: 'A large number of research studies have clearly demonstrated that sexual orientation in and of itself indicates nothing about attributes of personality or character, such as integrity, reliability, responsibility, or devotion to and the ability to care for children.'<sup>9</sup> Two research studies (Green and Kirkpatrick) have demonstrated that children in the custody of their lesbian mothers when compared to children in the custody of a divorced heterosexual mother, show no differences in the degree of psychologically healthy functioning and development.<sup>10</sup> And Betty Kalis, Clinical Professor of Medical Psychology at the University of California, states: 'There is, to my knowledge, no evidence that sexual orientation or sexual preference as such is in any way predictive of an individual's parenting ability.'<sup>11</sup>

Pepper Schwartz, a sociologist at the University of Washington, writes: 'I see no evidence of differences between homosexual and heterosexual parents. There seems to be no greater trauma for the children of gay parents, nor do these children feel unduly stigmatized or unworthy. Further, the lesbians and homosexuals I have interviewed or interacted with are functioning in society; there does not seem to be evidence of traits that might indicate unsuitability for parenthood. Indeed, I might argue the opposite. We have noticed that in a lesbian relationship both women tend to take a more equal interest in the children than in other "reconstituted" families. If, as has been hypothesized, children do best under conditions of attention, warmth and support from a number of adults, then lesbian parents might be considered superior care givers and parental figures.'<sup>12</sup>

The book 'Rocking the Cradle: Lesbian Mothers' investigates, through talking to lesbian mothers and lesbian families all over the country, the different ways in which lesbian mothers conceive and bring up their children in a hostile society.

'They bear a heavier burden of nastiness from the rest of society than do most other people, and need, therefore, more courage to live their lives. But normal, yes. They're as normal as anyone else is, having their fair share of domestic squabbling, pressures of work and money, anxieties about their children, and sometimes the pain of broken relationships. Lesbian mothers in particular are very concerned about the welfare of their children.'<sup>13</sup>

The will to have children is often very strong in lesbians. The book describes a visit made by a gynaecologist to a meeting of lesbians on this topic. He had been asked by two women, who had been living together for some time, for artificial insemination and he describes his reaction to the meeting:

'There must have been about 80 people there - all women. I was the only male. Interestingly enough I didn't feel out of place. It wasn't as though I was a single man among women. It was a meeting of ordinary people. Nobody stared at me. I didn't feel that I was in a place that



was strange. That impressed me immediately. It was just a normal gathering of people. They divided into three groups. One dealt with A.I.D., and there was discussion afterwards. What I learnt that day was that they were perfectly normal people, except in respect of their relationship with their partner; that was the only difference I could detect. . . .

. . . . Another thing that impressed me was that someone said they had gone into a married situation just because they wanted children. A number of marriages had ended in divorce and they had taken their children and had gone to live with another woman after a lot of difficulty; a number said they had gone to street corners, pubs, that sort of thing, to try and get pregnant; they found that very distasteful and very unpleasant; they got annoyed that they had to depend on men at all. What came out of all this, to my mind, was that they very much wanted children and adoption was completely closed to them. I had never before had an opportunity to get a first-hand idea of what was behind this particular couple and other lesbians who wanted A.I.D. I was very impressed. I suggested at the meeting that they didn't really need a doctor - a doctor was only required to vet the donor.'<sup>14</sup>

With AIDS more lesbians are giving up self insemination and want to have the reassurance of laboratory tested sperm. This is another area where the health service is badly lacking. NHS A.I.D. centres are blatantly discriminatory against lesbians and single women. A survey was conducted by London Womens' Reproductive Rights Information Centre and it was found that of the 14 National Health Service clinics which provide the service only one clinic would consider a lesbian. A NHS hospital consultant in Kent said: 'Under no circumstances whatsoever would the service be available to single women or lesbians if I have anything to do with it.'<sup>15</sup>

## Conclusion

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To conclude, then, in this project I have examined various issues of health and health care as they affect lesbian women. I looked at the health status of lesbians and found it generally good. Studies I looked at showed problems occurring when lesbians became patients, due to ignorance or hostility from health care professionals. I suggested some of the ways in which the health care of lesbians could be improved. I also looked at specific health problems and health issues associated with lesbians.

The difficulty I had in obtaining material for this project indicates a need for much more research, particularly in this country, on this topic. Lesbians I have talked to personally have experienced high levels of distress when coming into contact with the health service. This presents a challenge to health care professionals if their aim is to provide first rate health care for all sections of the community.

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