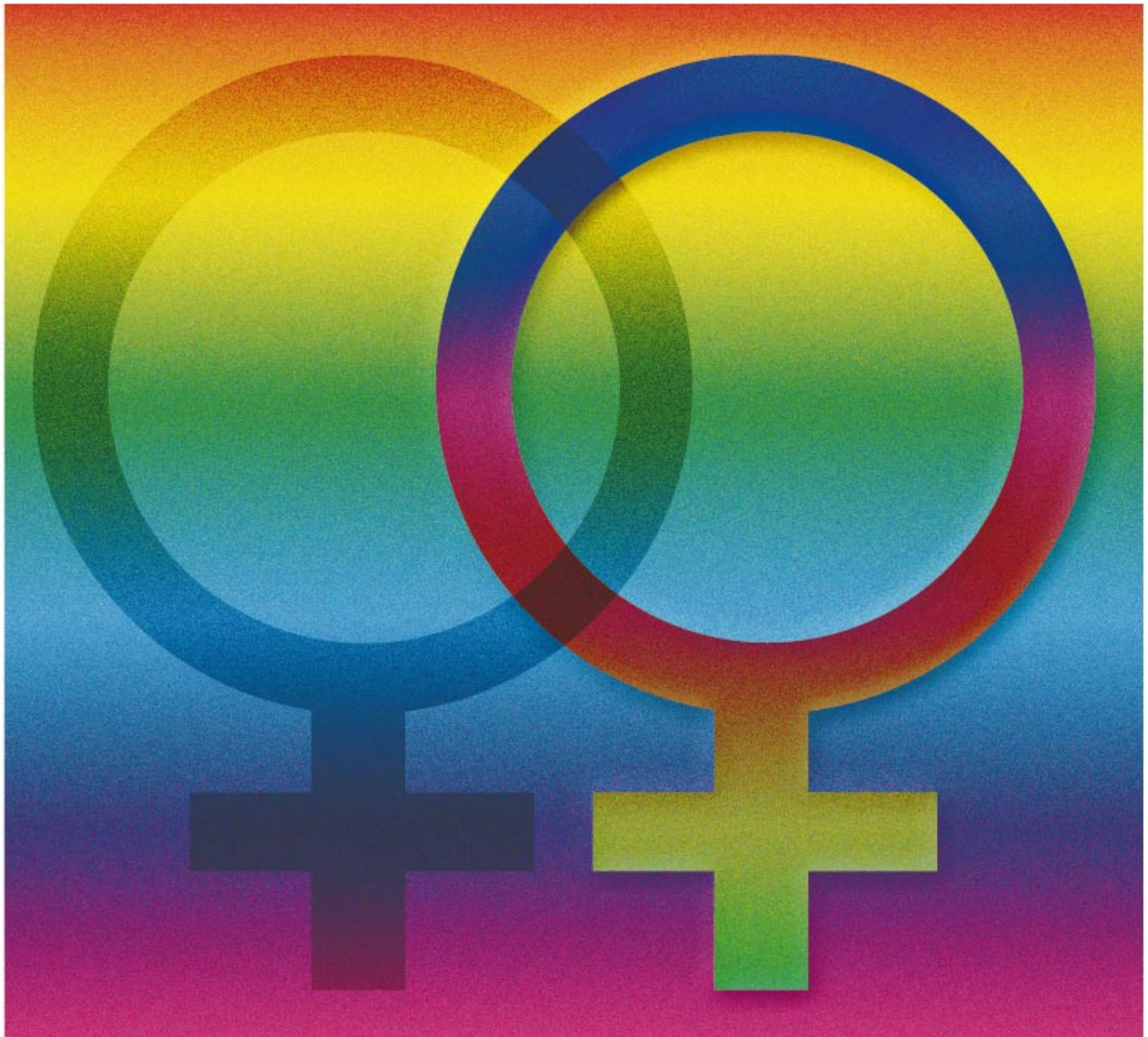


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# Lesbians and Midlife Health

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It is not known whether lesbians are at higher risk for certain chronic diseases that affect midlife women, but a higher incidence of some risk factors suggests that this might be the case. Regardless of their precise risk for disease, some lesbians are reluctant to seek medical care; this can jeopardize their health and well-being, especially as they age. Whether or not these women receive optimal care—or, in some cases, any care at all—is largely dependent upon the quality of the patient-clinician relationship.

Data on midlife lesbian health issues are limited. There is, however, evidence suggesting that lesbians might have a higher prevalence of several risk factors for chronic diseases, including some cancers and cardiovascular disease (CVD). There also is evidence to suggest that some lesbians seek medical care less frequently than do their heterosexual counterparts. Reasons for this behavior range from fear of interactions with healthcare professionals to misperceptions about disease risk to lack of medical insurance.

This article presents a brief overview of what is known about the health risks of midlife lesbians, and addresses the importance of the patient-clinician relationship in providing high-quality care and achieving optimal outcomes for this group of women.

### Health Risks

There are, as yet, no definitive data to indicate whether midlife lesbians have a higher incidence of chronic diseases than do their heterosexual peers. It is, however, becoming increasingly apparent that, as a group, lesbians appear to have a higher prevalence of several risk factors that might impact the development of such diseases. These risk factors include nulliparity/fewer pregnancies, limited use of hormonal contraceptives, higher dietary fat intake and a higher prevalence of obesity, and higher rates of alcohol consumption and cigarette smoking.

The two studies that are, arguably, the most interesting in this regard are the ongoing Women's Health Initiative (WHI)<sup>1</sup> and a smaller study by Dibble and colleagues.<sup>2</sup>

The WHI, funded by the National Institutes of Health, was designed to randomly examine the effects of three common interventions for disease prevention in postmenopausal women; specifically, hormone replacement therapy (HRT), calcium/vitamin D supplementation and low-fat diet.

A few years into the study, a case was made for returning to the participants

and asking questions that would allow the investigators to put the women into groups according to sexual preference. This was done, and we now have data on 500 women who identified themselves as having partnerships/sex exclusively with women during adulthood, constituting the largest number of women over age 50 to identify themselves in this way in the literature. This enabled the investigators to select a comparison group from among the other women in the study and to look at risk factors such as alcohol consumption, smoking and overweight; the incidence of all these risk factors was shown to be higher in the lesbian women.

In the study by Dibble and colleagues,<sup>2</sup> lesbians recruited from the community were asked to identify a heterosexual friend within a certain age range and a sister of any age; data were collected on all three groups. The investigators found a higher incidence of risk factors (overweight, alcohol consumption, cigarette smoking) in the lesbian women than in their sisters; the lesbians' risk factor profiles were actually more similar to those of their heterosexual friends, although on average, the lesbians smoked more, drank more alcohol and were more overweight. What is interesting about these findings is that they seem to point less toward heredity and more toward lifestyle with respect to these risk factors. This type of information is especially important—both to clinicians and patients—as midlife approaches and these risk factors become more problematic in terms of development of chronic diseases.

**Cancers.** It is believed that some lesbians underestimate their risk of developing cancer, particularly reproductive cancers<sup>3</sup>; a false sense of security might arise from the infrequency of heterosexual intercourse in lesbians' sexual histories. This is suggested by one large survey in which the rate of Pap smear screening was lower in lesbians and bisexuals than in heterosexual women.<sup>4</sup> While most lesbians have had heterosexual intercourse at some point in their lives, it is true that the overall frequency of such encounters is consider-

ably lower than in heterosexual women, perhaps reducing lesbians' risk for certain sexually transmitted diseases (STDs), including cervical neoplasia. In theory, this might translate into a reduced risk for cervical cancer.

This "no risk" perception can, however, be a dangerous one, in terms of both STD and cancer screening. Human papilloma virus (HPV) has been identified<sup>5</sup> and abnormal Pap smears found<sup>6</sup> in studies of screening in lesbian women. Lesbians can acquire HPV by virtue of a history that includes heterosexual intercourse, or by having sexual relationships with women who have had male sexual partners. Pap smear screening and cancer screening, in general, are important in this group of women; such screening may be personalized if the clinician is aware of the patient's sexual history. In addition, there is some evidence that lesbians who *are* at high risk for cervical neoplasia do not recognize this risk, and do not seek appropriate screening.<sup>7,8</sup> Finally, data from the WHI<sup>1</sup> showed a higher rate of reported cervical cancer among the women in the study who identified themselves as lifelong lesbians, compared to the heterosexual women. At the very least, lesbians need to be made aware of their actual risks, and misconceptions about such risks need to be allayed.

Although data on actual cancer incidence in lesbians are scarce, evidence for higher rates of the risk factors cited above suggest that this population might be at increased risk for certain cancers. A possible increased risk of breast cancer, by virtue of higher rates of nulliparity,<sup>4</sup> obesity,<sup>1,4</sup> alcohol consumption<sup>1,4,9</sup> and smoking,<sup>1,4,9</sup> is the focus of increasing attention. Although many lesbians have been pregnant, they do, as a group, experience far fewer pregnancies overall than do heterosexual women. In addition, some fairly convincing data suggest that lesbians tend to have a higher incidence of obesity/overweight than do heterosexual women.<sup>1,4</sup> Although the reason for this possible difference in weight is not known, one common, albeit unproven, specula-

tion in the lesbian community is that lesbians, as a group, might be less concerned with their weight than are heterosexual women, and are therefore less susceptible to cultural pressures to be thin. This could result in “skewed” weight distribution because of a lower rate of abnormally thin lesbians. Furthermore, while older data pointing to high rates of alcohol abuse among lesbians have not been confirmed, data from recent studies do suggest that, on balance, lesbians consume more alcohol than do their heterosexual counterparts, although the rates of heavy, abusive drinking might be no different.<sup>10,11</sup>

Considered together, these risk factors suggest that lesbians might, indeed, be at increased risk for breast cancer. The only study that has looked at the actual rate of breast cancer in a group of lesbians, the WHI,<sup>1</sup> found a nonsignificant trend toward higher rates of breast cancer among the lesbian and bisexual participants, as compared to the heterosexual women. The most sensible clinical approach is to screen lesbians for breast cancer using the same approach as that used for heterosexual women; this approach should include encouraging self-breast exams, and performing clinical exams and mammography screening at regular intervals.

The risk factors discussed above might also be placing lesbians at higher risk for other reproductive cancers. Nulliparity and overweight both are well-established risk factors for endometrial cancer, and the risk of ovarian cancer has been shown to be slightly higher in nulliparous women and in those who have never used hormonal contraceptives (thought to be protective in this regard).

As stated above, there is evidence that, in general, lesbians tend to have a higher incidence of tobacco use than do their heterosexual counterparts<sup>1,4,9</sup>; this could lead to an increased lung cancer risk.

**CVD.** Cigarette smoking, a high-fat diet and obesity are, of course, risk factors for diseases other than cancer, including CVD, diabetes and lung diseases. Again,

it is not known if the rates of these diseases are actually higher among lesbians. Screening should be carried out according to each woman’s unique risk profile and history.

**STDs.** Does screening need to be conducted differently, based on a woman’s sexual orientation? Based on what is known about the heterogeneity of lesbians’ sexual practice histories, it is clear that decisions about screening should be based on the individual woman’s history and not on her “membership” in a specific sexual-orientation group.

There are “no new diseases” when dealing with lesbians. The viral STDs (e.g., herpes, HPV) can be transmitted from woman to woman<sup>5,12</sup>; the same types of precautions used with heterosexual partners need to be used in lesbian relationships. Some uncertainty in this regard exists about transmission of human immunodeficiency virus (HIV); the Centers for Disease Control and Prevention has a risk factor scheme category called Women who have Sex with Women (WSW). These WSW data suggest that lesbians who are HIV-positive almost always have a history of either intravenous (IV) drug abuse or sex with men who are IV drug abusers<sup>13,14</sup>; the risk of woman-to-woman transmission is likely very low or even nonexistent.<sup>15,16</sup> The general rule with respect to HIV is that there are lesbians who are at high risk, but it is because of their IV drug abuse and their sexual (heterosexual/bisexual) practices.<sup>5,12</sup> HIV risk should be discussed and safer sex practices encouraged; the latter is particularly important, since there is evidence that lesbians who engage in high-risk behaviors are *less* likely than heterosexual women to use safer sex practices.<sup>16</sup>

Neither gonorrhea nor chlamydia infections have ever been reported in a woman who has only had sex with women; thus, the risk of transmission between women must be exceedingly low. Studies of lesbian versus heterosexual clients in both routine-care and STD-clinic settings have revealed that the rate of bacterial vaginosis is consistently higher among

the lesbians.<sup>12,17</sup> *Trichomonas* can be transmitted between female sexual partners, and affected women should be advised not to have intimate contact until the condition has resolved.

### Patient-Clinician Relationship

A good patient-clinician relationship forms the foundation for high-quality medical care. A patient needs to feel comfortable telling her healthcare practitioner anything and everything about herself that might have an impact on her health status and any proposed treatment regimens. She also should feel comfortable taking her clinician’s advice, and returning to the office for needed follow-up. While this is, of course, true regardless of a patient’s sexual orientation, the prospect of sharing information about sexual orientation with a medical professional actually keeps some lesbians from seeking medical care<sup>18</sup>; this can set up a situation that can become increasingly dangerous during midlife and beyond.

In a survey conducted in the early 1980s, 1,921 lesbians were asked about their experiences with medical practitioners.<sup>19</sup> Among the responses were some alarming accounts of insensitivity, at best, and homophobia, at worst, on the part of medical professionals. One of the more blatant examples is that of a woman whose male physician responded to being told she was a lesbian by abruptly leaving the room and sending in a nurse to complete the examination. A survey of California physicians during the same time period revealed that almost half of the respondents were sometimes or often uncomfortable providing care to gay or lesbian patients.<sup>20</sup>

Fortunately, tolerance for diversity in sexual orientation appears to have improved over the past 20 years and, even 2 decades ago, it is likely that most expressions of homophobia on the part of medical practitioners were less overt than the one described above. Problems do, however, remain. In a recent, large survey of men and women, half of the gay men and lesbians reported having experienced dis-

crimatory behavior from healthcare professionals.<sup>21</sup> It is, therefore, not difficult to understand why some lesbians might be reluctant to seek medical care. Going to a doctor can be a frightening prospect when past personal experiences, or those of friends, are marred by insensitivity or even hostility.

*A need to know?* The above discussion notwithstanding, do we, as clinicians, really need to know whether a patient is a lesbian? With respect to the clinician's awareness of the patient's risk factors, the answer is probably no; overweight, smoking, alcohol consumption and pregnancy history will be apparent even if the patient's sexual orientation is not. On the other hand, if it's true that lesbians tend to underestimate or deny their risks for certain diseases, such as reproductive cancers, doesn't knowing the patient's sexual orientation alert the clinician to the need to counsel the patient accordingly, in order to allay potentially dangerous misconceptions? Furthermore, if a patient has had a bad experience with a medical professional because of her sexual orientation, wouldn't knowing this enable the clinician to take extra steps to reassure her, and perhaps even "mend some fences"? Returning to the fundamental premise that optimal care depends upon a patient's willingness to share needed information with her clinician, can a woman who is not comfortable doing so truly receive the high-quality care that comes from such relationships?

*A nonjudgmental approach.* Although tolerance has improved, and continues to improve, in the medical community and the public at large, midlife lesbians still have realistic concerns about encounters with healthcare practitioners. In a small community, or when one is a new member of a community, those concerns can be especially poignant.

How can we, as clinicians, ensure that we come across as caring, nonjudgmental professionals, especially when doing so can make the difference between patients seeking and not seeking needed medical care? While there aren't any "rules of

thumb" in this regard, there are some simple steps that can, and should, be taken. All of these "steps" should be taken in the context of respecting patient confidentiality; patients should be assured that what is discussed in the office stays in the office. Furthermore, when dealing with a new patient, or a patient who hasn't talked about her personal relationships, questions should be phrased in a way that essentially "leaves the door open" and lets the woman decide whether or not to reveal her sexual orientation. When asked in the context of a routine history or interview, a question such as, "Do you have sex with men, women or both?" demonstrates that you, as the clinician, are open to hearing any of the possible answers, and have heard those answers before.

The issue of birth control provides another example. Simply asking a woman what type of birth control she uses implies an assumption of need for birth control. The same information can be obtained by first asking whether the patient has sex with men, women or both; more specific queries can then be used to follow up accordingly.

Other ways to help put lesbian patients at ease, thereby nurturing the patient-clinician relationship, include the following:

- Include brochures about lesbian health issues in the display area in the office waiting room and make them clearly visible. This is a simple way to convey that you and your associates are knowledgeable about and accustomed to dealing with lesbian patients and their health concerns. Informational brochures are available through the American College of Obstetricians and Gynecologists ([www.acog.org](http://www.acog.org)) and The Mautner Project for Lesbians with Cancer ([www.mautnerproject.org/](http://www.mautnerproject.org/)).

- Have new patients complete a "self-history" at the beginning of the office visit. If the questionnaire includes queries about personal relationships, patients can be asked with whom they live and, again, whether they have sex with men, women

or both. This is a strategy that we, and many other clinicians, have found useful in our practices. People are more likely to be honest when filling out a paper-and-pencil questionnaire than when being put on the spot with direct questioning. In addition, simply seeing these types of questions on a patient form tells patients that this is a medical practice in which hearing (and revealing) information about sexual orientation is acceptable.

- Respect the role of the lesbian's partner in her life, care and health-related decisions, as you would that of a spouse. This can become especially important during midlife, as the risk for chronic illness increases. Questions such as, "Whom would you like to be involved in the discussion of your treatment/surgery?" or "With whom do you want me to talk after your surgery?" gives the woman the option to reveal or not reveal a relationship, and assures her that the relationship will be respected, regardless of her decision.

It is critical for the patient to know that a loved one may be involved in her medical care. If a patient needs to be hospitalized, the clinician can do an enormous service by paving the way with hospital staff and ensuring that the woman's partner has complete access. When needed, the clinician also can provide some tangible advice, such as that related to obtaining durable power of attorney for a patient's partner, to provide legal protection when important health-related decisions need to be made. Clinicians also should be aware of potential insurance problems faced by lesbian partners, when only one woman is working and the employer doesn't recognize the partner as family.

## Summary and Conclusions

We are, at this time, unable to say whether lesbians are at greater risk for chronic diseases during midlife. We do, however, know that lesbians, as a group, have a higher incidence of certain risk factors that can affect the development of those diseases. The message for patients is not to

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assume that they have no risks for serious diseases that can occur during midlife and beyond. The cautionary note about assumptions holds true for clinicians, as well. It would, for example, be a mistake to assume that a patient cannot have been exposed to HPV and does not need Pap smear screening, simply because she is a lesbian. Most lesbians have had heterosexual sex at some point in their lives, and screening decisions should be based on a patient's history and unique risk profile.

Further research is needed to determine if an apparent prevalence of certain risk factors actually translates into greater risk for disease as lesbians enter midlife. It also is interesting to ponder whether lesbians have a different perception of menopause than do heterosexual women. Are there differences related to feelings about loss of fertility, changes in physical appearance and so on?

Regardless of the true nature of disease risk in this group of women, the character of the patient-clinician relationship is often the pivotal factor in determining the health and well-being of these women. Will the lesbian patient feel sufficiently comfortable to share important information, to follow recommendations, to return for follow-up? Will she feel sufficiently comfortable to seek medical care at all? The answers to these questions lie, in large part, in the hands of clinicians. ■

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