

## **LESBIAN SERVICEWOMEN AND HEALTH**

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One of the fundamental tenets of good health care is obtaining an accurate history, and this is crucial when taking a sexual history. Issues related to sexuality may be difficult at the best of times. However what is the impact on patient care when the health practitioner assumes heterosexuality?

Arguably the most marginalised group within the ADF is lesbian servicewomen. To further understand and explore the health issues for lesbian servicewomen an extensive literature review was undertaken. What emerged was evidence suggesting that lesbians have unique health concerns that are not addressed in traditional health care models (Rankow, 1995).

It was hardly surprising to discover a paucity of information that connected both lesbian health and Australian servicewomen. There are possibly two reasons for this. Firstly there is a noticeable silence that surrounds military service and homosexuality. The ADF, as with most first world Military Forces, provides the ideal environment for men to affirm their masculinity. Within this dominant masculine culture women "are considered primarily by reference to their impact on the lives of heterosexual males" (Abrams, 1993,228).

Secondly, lesbian health issues have not been mainstreamed into women's health. This is demonstrated when research into women's health issues fails to identify lesbians. So while health practitioners fail to be sensitive to the needs of lesbians, quality health care is jeopardised. The result is that information collected may not be relevant to women who partner with women. This is evident when assessing attitudes about the need for Pap smears for lesbians. There has been little research into this area, causing confusion for both health provider and individual women.

While there is enormous diversity of individuals throughout lesbian communities, once lesbian sexual identity is disclosed, the common experience is one of marginalisation and stigmatisation (Denenberg, 1995; Rankow, 1995b). It is little wonder that in order to prevent such outcomes, lesbians often prefer to keep their sexuality invisible. The consequence is

that they may accept inappropriate treatment, such as oral contraception, and not have their health needs met.

### *Taking an Appropriate Sexual History*

Sexual history taking has invariably been approached from a heterosexual understanding (Roberts and Sorensen, 1995). Such exclusion has meant that not only are lesbians asked inappropriate questions, they reported feeling forced to "out" to their health practitioner (Stevens, 1995).

The Women's Health Nurse Association recommends a less clinically focused process that involves questions on other lifestyle factors (Horsely, 1995). Rankow (1995) who considered that a social rather than sexual history would improve communication between health practitioner and consumer supports this view. This approach acknowledges that lesbianism is not merely about sexual preference, but rather about how the whole of a woman's life is affected by her sexual preference (Perkins, 1995).

There is a need for health practitioners to reflect on personal barriers that will interfere with their ability to take a good sexual history that remains inclusive for all women. It is essential to explain to women why a sexual history is relevant. While it is inappropriate to ask voyeuristic questions about intimate sexual activity, it is essential to have a good knowledge of sexual practice in order to understand risky behaviour.

Inclusive language needs to be used with taking a sexual history. This means being sensitive to the information presented, and not asking about the type of contraception being used until sexuality has been established. Include in the language gender non-specific terms such as "partner" or "significant other" instead of "husband". The clinician may wish to include questions such as "Do you have sex with men, women or both?" This is particularly important, as some women who identify as lesbian have had heterosexual contact (Edwards & Thin, 1990).

## *Specific Health Issues*

Horsely and Tremellen (1995) felt that the important health issues for lesbians included breast cancer, cervical cancer, mental health and STDs and HIV/AIDS. While they were wary of specific "lesbian categories" they consider that homophobia in traditional organisations means that marginalised groups do not receive the health care and information to which they are entitled. Lesbians may in fact avoid health visits in order to protect themselves from this homophobia.

### **Breast Cancer**

Research conducted by the US National Cancer Institute in 1993 concluded that lesbians had a greater risk of breast cancer than heterosexual women (Horsely and Tremellen, 1995). Rather than collected empirical data, the researchers extrapolated from those lifestyle factors thought to increase individual risk, ie. nulliparity, delayed childbearing and increased alcohol and body fat (Rankow, 1995). Lesbians may be at greater risk of breast cancer because they avoid health care, and do not practice regular breast self-examination.

### **Cervical Cancer**

This is perhaps the single and most misunderstood issue in lesbian health. The Pap smear is a screening test and should be considered in terms of lifestyle rather than sexual practice. For health practitioners, the Pap smear should never be just about a woman's cervix. It does not, for example, detect ovarian or uterine cancers. Good health care means that women present for cervical screening should also have a pelvic examination. The risk factors for cervical cancer include early age of first coitus, multiple sexual partners/or a partner who has had multiple sexual partners, a history of STDs or infection with certain strains of human papillomavirus (HPV). Rankow (1995) discovered that many lesbians reported heterosexual activity. This, once again reinforces the importance of sexual/social history taking.

## **Mental Health**

Mental health has been described as the single most important issue for many lesbians (Horsley and Tremellen,1995). It is reasonable to argue that being secretive about virtually all aspects of ones life creates stress. Heterosexual health practitioners have little insight into the intense struggle of "coming out". There is no similar life event for heterosexuals, as "you cannot 'come out' as the assumed norm (Perkins,1995,21). Zeidenstein (1990) found that coming out to a health practitioner was rarely a positive experience, especially when lesbians attempt to reduce the negative feelings toward them.

Relationship difficulties for lesbians may have as much to do with the ups and downs of intimacy rather than lesbianism (Boston Women's Health Collective, 1984). However appropriate assistance is denied when traditional counselling services are accustomed only to dealing with heterosexual couples.

## **STDs and HIV/AIDS**

There is very little research into the transmission rates for various sexually transmissible diseases in lesbians. The lack of substantial research means that information regarding safe sex for lesbians may not be accurate. The occurrence of HIV/AIDS in lesbians is understood to be via drug injectors or heterosexual activity (Rankow,1995). There is documented evidence that women to women transmission of vaginal candida, gardnerella, trichomonas, HPV, HSV, chlamydia and hepatitis A occurs (Rankow,1995).

## ***Conclusion***

Letting incorrect assumptions, beliefs or prejudices cloud the manner in which health care is offered to lesbian servicewomen has obvious detrimental outcomes for their health. It is essential that nurses examine their beliefs and raise individual awareness to improve health outcomes. It is the responsibility of individual practitioners to open communication with women they encounter. The challenge for health providers in the ADF is to adopt an approach that does not assume heterosexuality, and look beyond the understood "norms" of the military environment.

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