FACTORS INFLUENCING DISCLOSURE OF LESBIAN IDENTITY IN THE WOMEN'S HEALTH CARE SETTING

by

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CHAPTER I

Kinsey (1965) most recently estimated that lesbian women represent seven percent of the female population, and the true figure is probably much higher. Many more women could be identified as other than exclusively heterosexual (Friend, 1987). Therefore, the nurse specialist providing women's health care may expect that a substantial number of her clients will be lesbian women or will need information related to lesbian health care.

There has been a historical lack of concern within the medical establishment about lesbian health care, mirroring society's reaction in general to minority groups (Glascock, 1986). However, the nearly twenty-year-old women's health movement has served as an impetus for re-examination of the provision of health care from a feminist perspective, and for the redefinition of the responsibilities of health care providers to include advocacy for the needs of all clients.

The purpose of this study was to investigate factors influencing lesbian women's identity management and subsequent satisfaction with women's health care,

in order to educate both women's health care providers and lesbian women about lesbian women's health care needs.

Statement of Problem

Since many lesbian women are physically and psychologically indistinguishable from heterosexual women, they frequently are not recognizable as such (Bell & Weinberg, 1978; Martin & Lyon, 1974). Interaction with the surrounding social system may not allow a lesbian woman to reveal her lesbian identity without fear of physical or emotional repercussion, so that she must hide an important part of who she is and how she lives.

In making the decision for or against disclosure, lesbian women must take into account the stigma inherent in the lesbian identity in the larger society, and the risks they will incur by revealing their identity outside the lesbian subculture (Ponse, 1978). The individual with an invisible stigma, especially if it is an integral part of her self-image, may divide the world into those from whom the stigma must be hidden, those who know about it but do not share it, and those who share the stigma. With those who are not aware of the stigma and from whom the lesbian woman anticipates negative reactions or sanctions, she must

pass, or appear to be someone different from whom she really is (Moses, 1978). Maintaining social fabrications that veil her sociosexual orientation exacts a psychic cost (Brooks, 1981), bringing safety at the price of potential social and emotional isolation (Loewenstein, 1980).

The lesbian woman, and every woman, is assumed de facto to be heterosexual. This assumption pervades our culture and places the burden of correcting or conforming to the assumption on those who have been negated or discriminated against. In every interaction in which she is presumed to be heterosexual, a lesbian woman weighs the possible costs of revealing her lesbian identity against the benefits that may be gained from either conforming to the assumption that she is heterosexual or revealing her lesbian identity. Lesbian women constantly experience stress as they confront such disclosure decisions (Brooks, 1981).

Homophobia is defined by Masters and Johnson (1979) as an irrational fear of homosexuals representing a not uncommon extreme of the range of attitudes held in our culture toward homosexuals. O'Donnell, Leoffler, Pollock and Saunders (1979) state that homophobia can express itself in the health field in many ways, and may manifest as verbal and non-verbal

language which alienates gay people and can interfere with their giving complete histories, cooperating fully in treatment plans, and accepting preventive services.

Until recently, homosexuality has been viewed within the helping professions and by society at large as distinctly negative. Medical, psychiatric, sociological and popular literary treatments of lesbianism still reflect widely diversified opinions of homosexuality (Ponse, 1978). When a lesbian woman approaches the medical community seeking women's health care, she enters a system that she knows has, until recently, considered her sexual identity to be deviant and a mental illness, and has not otherwise addressed her specific health needs. Moreover, she is in a position of powerlessness relative to the medical community, both by virtue of her gender in the face of the male-dominated medical establishment, and, in most cases, her relative lack of medical knowledge. Unsurprisingly, many lesbian women perceive the medical context as a particularly dangerous place to reveal their lesbian identity (Glascock, 1986).

Lesbians are also especially vulnerable to having their problems "sexualized", or attributed to their sexual identity, with the result that the lesbian risks having treatment focus on her "unhealthy" sexual

identity rather than on her presenting concern. Clients are not as inclined to report their symptoms fully if they expect to have them regarded as psychogenic (Ruzek, 1979).

The literature that addresses lesbian health care concurs in the opinion that health care provider knowledge of a lesbian woman's sexual identity is frequently essential to the provision of adequate women's health care (Dardick & Grady, 1980; Darty & Potter, 1984; Degan & Waitkevicz, 1982; Edelman, 1986; Glascock, 1986; Hepburn & Gutierrez, 1988; Johnson & Palermo, 1984; Johnson, Guenther, Laube, & Keettel, 1981; O'Donnell et al., 1979; Ruzek, 1979; Smith, Johnson, & Guenther, 1985). If the lesbian woman does not disclose her lesbian identity, she may be unable to ask questions or offer information relevant to her health care. As a result, she may risk misdiagnosis or incomplete treatment. She may be denied social support if the health care system does not recognize her partner or her friends as her chosen family (Darty & Potter, 1984). Health care providers must be aware of the importance of their ability to provide an atmosphere conducive to disclosure, as the lesbian woman herself may not realize that the information she can provide may be essential to her care.

Moreover, since lesbian women do not use the health care system to obtain contraceptives, it may be easier for them than heterosexually active women to postpone annual gynecologic examinations, especially if they anticipate an emotionally or physically unpleasant interaction. These examinations routinely include screening for breast and cervical cancer, as well as provide a valuable forum for health education (Edelman, 1986).

Nurses working in any aspect of the health care field that includes women will almost inevitably encounter lesbian women in their practice, and may frequently be unaware of it (Williamson, 1986). Thus, the nurse specializing in maternity and/or women's health, who works with an exclusively female population, is ignoring the needs of a significant number of her clients if she denies the possibility that any are lesbian women, or, knowing their sexual identity, refuses to incorporate this information into their care.

The American Nurses' Association (1980), in its social policy statement, says that nurses are committed to respecting human beings regardless of specific attributes of the human beings receiving care. Williamson (1986) concurs, alleging that nursing

promotion of the health of lesbian women is not a choice but a professional and social responsibility. Given this mandate, and the dearth of theory and research in existence that is applicable to nursing practice with lesbian women, nurses who give health care to women must educate themselves about lesbian women's lifestyles. Recognizing the lesbian woman's emotional and physical health needs is essential for nurses to provide adequate health care, impart accurate information and empower lesbian women within the health care system.

The focus of this study will be on a limited segment of lesbian women's health care experiences, and will seek to determine if a lesbian woman's general degree of openness about her lesbian identity, her perceptions of her previous women's health care experiences and her perception of the sensitivity of her health care provider are related to her decision to disclose her lesbian identity in a women's health care setting. It will also explore whether a lesbian woman's decision to disclose or not to disclose her lesbian identity in a women's health care setting is related to the satisfaction she feels with the health care she received.

Review of the Literature

The interaction of a lesbian woman with the health care environment is an exceedingly complex and multi-faceted phenomenon. The proposed study acknowledges the interconnectedness and interdependence of the biopsychosocial aspects of health, especially in regard to individuals who live with either an apparent or invisible stigma. The researcher has chosen to focus mainly on the biological consequences of women's health care interactions for lesbian women, as they occur in a psychosocial context.

This section will provide an overview of the literature that considers perspectives of lesbian women from related fields, followed by a review of nursing and medical literature that considers the lesbian woman as client in the health care setting. The latter section of the review will be subdivided into the interrelated categories of the lesbian woman's identity in the context of health care, the dynamics of disclosure, specific health concerns of lesbian women, lesbian women's health care experiences, and the lesbian woman as client in a women's health care setting.

Perspectives of Lesbian Women

Until recently, little attention has been paid to the lesbian population's interaction with the health care system (Good, 1976; Hepburn & Gutierrez, 1988; O'Donnell et al., 1979). In the past few years lesbians and feminists working in the women's health movement have compiled health information for the use of lesbian women, fully expecting their work to be referenced by health professionals as the most comprehensive available (O'Donnell, et al., 1979). Apuzzo (1985), Darty & Potter (1984), Hepburn & Gutierrez (1988), O'Donnell et al. (1979), and Ruzek (1979), writing as concerned feminists, cite the lack of research done on lesbian health issues, and call for studies that accurately reflect lesbians' own considerations of what is important to their health care.

In the past ten years, the fields of psychology and social work have produced literature intended to help providers working within these professions more adequately understand their lesbian clients, and thus provide them with more sensitive and appropriate care (Brooks, 1981; Gramick, 1983; Hall, 1978; Kaufman, Harrison & Hyde, 1984; Krestin & Bepko, 1980; Loewenstein, 1980; Roth, 1985; Smalley, 1987; Sophie,

1987). Sociologists have studied several facets of the lesbian experience in depth, including identity management and its consequences, and the dynamics of a lesbian woman's interaction with the surrounding social milieu (Bell & Weinberg, 1978; Fine & Kleinmen, 1979; Moses, 1978; Ponse, 1978). Lockard (1986) explored the lesbian subculture from an anthropological perspective. However, articles within the nursing and medical literature with the lesbian client as their focus are rare (Schwanberg, 1985), and still more rare are those that study the interaction of lesbian women with women's health care providers.

Lesbian Identity in the Health Care Context

Stevens and Hall (1988) interviewed twenty-five lesbian women, recruited through snowball sampling, about their perceived identifiability as lesbians, their cultural beliefs about wellness and illness, and their experiences in interaction with health care providers. They found that half the lesbian women interviewed thought they were recognizable to everyone as lesbians, and thus perceived that they entered health care settings in the vulnerable position of not having the option of passing, or concealing their lesbian identity. The women interviewed often did not feel comfortable seeking health care, had experienced

non-empathetic responses when they did, and even had occasionally felt at risk of harm in some health care situations. The authors conclude that there is a burden of responsibility for nursing as a profession and for nurses as individual clinicians, educators, and researchers to evaluate the adequacy of their knowledge base and reassess the quality of health care offered to lesbian women.

Friend (1987) used Shively and DeCecco's (1977) four-part model of sexual identity as a framework for his descriptions of the range of human sexuality. He noted that nurses may have biases relative to aspects of certain clients' sexual identity of which they may be unaware, until they find themselves confronted with such clients. The author believes that this is not surprising since our society can be described as "heterosexist", that is, one that assumes that everyone is or should be heterosexual. Recommendations for practice include prominently displaying information that is affirmative of lesbian, gay or bisexual lifestyles, excluding heterosexist assumptions, avoiding technical language and negative non-verbal cues, and supporting the lesbian, gay, or bisexual client's concept of family and support systems.

In an unpublished paper, Glascock (1986) explored the interactions with the medical system of 51 well-educated, white, professional women, as they were reported in interviews. Twenty-seven of the women in her sample were lesbians and twenty-four were religious sisters. For both groups identity management affected their perceptions of how well the health care system had met their needs. Both groups believed that revealing their identity frequently resulted in their being stereotyped by health care providers based upon the health care providers' ignorance of their lifestyle, with consequent inappropriate care. Concealing their identity almost inevitably led to heterosexist assumptions, provision of incomplete or inadequate information, or misdiagnosis and improper treatment. Provision of inadequate and inappropriate care caused apprehension and barriers to further care seeking, as well as reconsideration of identity management during subsequent health care interactions.

About half of the lesbian women interviewed had never revealed their identity in a medical context, but many added that they had never been given the opportunity to do so as they had been assumed to be heterosexual by their health care providers. Those who had decided not to disclose their lesbian identity

often cited fear of homophobic reactions on the part of their health care provider, fear of official stigmatization, and anticipation of physician ignorance of their special needs as reasons why they were not willing to take the risk.

Gillow and Davis (1987) surveyed 142 lesbian women regarding the stressors and coping behavior that they perceived to be associated with their sexual orientation and lifestyle choice. This study is relevant to the provision of health care to lesbian women, even though it is even broader in scope. Survey participants were lesbian women who responded to an advertisement placed in a national lesbian publication, and were mostly white, college-educated and employed full-time. Job-related problems, personal relationships and family acceptance of lifestyle choice were most frequently cited as stressors. Issues related to identity formation were also listed as stressors by twenty-four percent of the participants. The study found that larger social networks were positively associated with use of more varied coping techniques. The authors suggested that nurses must become more knowledgeable about issues associated with the choice of a lesbian lifestyle and view their lesbian clients in the context of their perceived

stressors, coping behaviors and social system in order to provide high quality services to lesbian women.

The Dynamics of Disclosure

Brooks (1981) described disclosure as a process by which a person allows him- or herself to become known by another person, emphasizing that disclosure is not a single act. The lesbian woman must evaluate whether the anxiety which may be perpetuated by non-disclosure of her lesbian identity is more or less costly than the potential negative consequences she may face from its disclosure. Limandri (1987), describing the help-seeking patterns of abused women, recognized that the most critical element in eliciting disclosure of these women's self-identification as abused may be the nurse's response to disclosure. The abused woman may leak out her story gradually and wait for her health care provider to elicit further details, or indirectly invite the health care provider to probe further. The woman may also openly discuss the abuse in her relationship, or directly deny abuse in her relationship when questioned.

Ponse (1978) acknowledged the gradual nature of the disclosure process for the lesbian woman. Some lesbian women report a time of "feeling others out" or laying the groundwork for disclosure prior to revealing

their lesbian identity. During this time attitudes towards gay people or minorities in general may be evaluated. Disclosure of a woman's lesbian identity may be attempted by her adoption of an identifiably gay style, classified by the author as non-verbal disclosure, or by the woman putting her lesbian identity into words. The author noted that non-verbal disclosure is open to multiple interpretations, while it is only through verbal assertion that the gay actor can be assured of having disclosed her/his identity. She stated that such direct disclosure is distinguished by many lesbian women from other forms of knowledge of their identity by others, such as strong suspicions, guessing, or hunches.

Specific Health Care Concerns of Lesbian Women

Kenyon (1980) acknowledged that relatively little attention has been paid to the lesbian client in the medical literature. He believes that gynecologists must have an adequate knowledge of female psychosexual development and the ability to elicit concerns related to sexual orientation in order to provide comprehensive gynecological service. The article began with a broad survey of etiological and psychological theories of lesbianism, concluding that there are significant methodological problems with much of the research about

lesbian women to date, so that no valid conclusions may yet be drawn. He then addressed the sexual experiences and practices of lesbians, and their health problems. No specific sexual practices of lesbians were identified in the literature that appeared to predispose to specific gynecological problems. He stated that the research is problematic, and called for further and unbiased research.

Kenyon concluded by stating that a thorough history, including a detailed sexual history, is essential to the enlightened care of the lesbian client, and that this may best be elicited when a physician conveys a tolerant and non-judgmental attitude. He emphasized the therapeutic value to a lesbian woman of being allowed, and even encouraged, to voice some of her most intimate worries in the "right atmosphere".

Whyte and Capaldini (1980) made clear the sense of "double jeopardy" that lesbian women and gay men experience when entering a health care system that has historically been indifferent or hostile toward their needs. If their sexual orientation is not disclosed, these patients may fail to convey information necessary for their health care. If they do disclose their sexual orientation, they risk the alienation of their

physicians and the receipt of insensitive care. The authors also believe that many minority patients prefer to be treated by someone openly sensitive to minority issues, and that the reality of a physician's attitudes may not be as important as the patient's perceptions of those attitudes. They recommended an "actively manifested sensitivity" as necessary to overcome the history of discrimination which many lesbian women and gay men have internalized. This might consist of a posted non-discrimination policy, gay-related health information in the waiting room, and open-ended interviewing techniques that do not pre-suppose heterosexuality. The importance of confidentiality and inclusion of support systems was also emphasized.

The authors continued with a discussion of specific areas of health care where they believe that a patient's sexual orientation is of particular concern, including gynecology and sexually transmitted disease. The point was made that a patient population of lesbian women or gay men may not experience different disease processes than a heterosexual patient population, but rather will have different health needs in that they may be reluctant to enter the health care system to begin with, will need interviewing techniques sensitive to their minority status, and may require different

education regarding their presenting condition related to precautions to be taken to ensure effective treatment and to prevent transmission to other individuals.

In the area of gynecology the authors acknowledged that much preventive health care and screening is put off by lesbian women who feel pressure to masquerade as heterosexual, and who have no need for the contraceptive devices that routinely bring heterosexual women in for screening exams. Informational needs may be neglected if gynecological treatments prohibit "sex" or "intercourse" for a stated period of time without any elaboration of what specific sexual activities are prohibited. And the need for sensitive counseling and health care related to the option of artificial insemination for lesbian women was addressed, with the authors emphasizing that lesbian women <u>will</u> have children; the physician's decision is only whether they will do so with or without adequate screening and pre-natal care.

The authors believe that few physicians are aware that sexually transmitted disease is virtually non-existent among women who are exclusively lesbian. The article concludes by recommending that physicians

examine their emotions, attitudes, and knowledge about homosexuality.

Robertson and Schacter (1981) screened 148 lesbian women for sexually transmitted disease and cervical cancer as a beginning effort to identify the prevalence of venereal disease and cervical cancer in the lesbian population. An evening clinic was especially designated for the study, and participants were those women who came to the clinic in response to publicity circulated through the women's media and community meeting places. No cases of sexually transmitted disease were discovered, but four abnormal Pap smears were noted, ranging from mild dysplasia to carcinoma in situ. The average time interval for the lesbian women in the study group since their last Pap smear was 21 months, as compared with eight months for the general population of age matched women using the same clinic. The authors concuded that, as a high-normal number of abnormal Pap smears was discovered for the age group in question, lesbians are still at risk for dysplasia and should be encouraged to have routine Pap smears. Routine screening for venereal disease, however, may not be necessry in a lesbian population.

In 1984 Johnson and Palermo outlined specific gynecological problems as experienced by lesbian women,

discussed lesbian patient-physician interaction, and pointed out gaps in the knowledge, based upon the earlier Johnson et al. (1981) survey data. Only vaginal infections and herpes were found to occur as frequently among lesbian as heterosexual women, while gonorrhea, syphilis, chlamydia, AIDS, cervical cancer and sexual dysfunction were stated to be more rare. Though only preliminary research has been done, the authors postulated that endometriosis, which is generally thought to be more common in nulliparous women, might be expected to occur at a higher rate among lesbian women. Lesbian women may also have pregnancy-related concerns, including the need for advice about artificial insemination. The authors emphasized that, though most gynecological problems occur at a similar or lesser rate in lesbian women than in heterosexual women, advice to lesbian clients concerning routes of transmission or precautions that must be taken may differ somewhat, thus necessitating a knowledge of the lesbian client's sexual identity in order that treatment may be effective.

Therefore, the skill of providing an atmosphere that allows patients to comfortably discuss sexual preference is particularly important for the gynecologist. Lesbians are put off by the assumption

that they are heterosexual, as well as by the realization that gynecologists are not well informed about lesbian health care issues. They may also be fearful of possible repercussions from a breach of confidentiality upon their personal life or medical care, and may fear homophobia on the part of their physician. The authors recommended that physicians reassess their attitudes, educate themselves about lesbian health concerns, respect the importance of an assurance of confidentiality to lesbian patients, and recognize the patient's significant others.

Degan and Waitkevicz (1982) described health problems of lesbians in five areas: sexually transmitted diseases, alcoholism, mental health, sexual dysfunction, and incest history, based upon their practices of psychiatric and internal medicine in a voluntary clinic run by and for lesbian women.

The authors stated that little is known about sexually transmitted diseases in lesbian women. No increased incidence of hepatitis B was discovered in lesbian women in their practice, and they knew of no such transmission between lesbian partners. The authors warned that herpes and venereal warts may be transmissible between women, and advise against oral-genital sex in such cases. Again, it was noted that

knowledge of a lesbian woman's sexual identity is necessary in order to properly counsel lesbian women with regard to routes of disease transmission or precautions that should be taken.

The authors speculated that breast cancer and endometriosis may appear more frequently in lesbian women, as they believe that more lesbian women remain childless throughout life, and these conditions are thought to occur more commonly in childless women. No research data was cited that would support these speculations, but careful and frequent screening was advised.

Figures that imply that lesbian women experience alcoholism at a higher rate than heterosexual women were questioned, as they are not based on research studies. It was acknowledged that studies on the prevalence of alcoholism in homosexuals have largely involved homosexual men, so that applying the results to lesbian women is not valid. There is no research available that shows that sexual problems or mental health problems are experienced at a different rate among lesbian than heterosexual women. And, the authors acknowledged that their opinion that many lesbian women have a history of incest was purely based on their practice experience.

The authors stated that physicians who wish to provide good health care to lesbian women should assume that every new female patient may be a lesbian, until she states otherwise. They suggested that questions related to the sexual history be posed in an open and easy manner, allowing all women to reveal as much or as little about their lifestyles as they choose. They advocated that all women should be able to bring a companion to their medical visits, and concluded by positing that an increased level of communication with lesbian patients will lead to a higher level of care for those patients, as well as ultimately add to the fund of information available on lesbian health.

Lesbian Women's Health Care Experiences

Dardick and Grady (1980) studied what factors gay men and lesbian women might identify as facilitating the decision to be open with health professionals about their sexual orientation, and how the ability to disclose their sexual orientation affects quality of care. A total of 622 men and women responded to a questionnaire distributed in a gay and lesbian publication originating in Boston, Massachusetts, with readership throughout the country. The researchers found that the more relatives, co-workers and fellow students that a homosexual person was open with, the

more likely they were to be open with their primary health professional. There was also a direct relationship discovered between what the client perceived their health care provider to feel about homosexuality and how open they were. And, respondents gave a dramatically higher satisfaction rating to those health professionals who were perceived to be supportive or very supportive. The authors recommended avoidance of actions that prematurely foreclose the possibility of patients' disclosure of sexual orientation to health professionals, such as using sex-typed pronouns when asking about sexual activity, assuming that all sexually active women are heterosexual, and assuming that all women who are not having sexual intercourse are celibate.

Johnson, Guenther, Laube and Keettel (1981) surveyed 117 lesbian women to determine the patterns of their utilization of health care, their gynecologic problems, and their attitudes toward physicians. Participants were recruited by distribution of questionnaires from person to person with the cooperation of a local lesbian organization, and by distribution at a local women's center and women's health clinics in both a university community and nearby urban area. The researchers acknowledged the

impossibility of obtaining a random sample of the lesbian population, and stated their awareness of the resulting inherent bias in sampling technique. The researchers discovered that the lesbians surveyed actively utilized the health care system, though many sought out less traditional sources of care. No gynecologic problems were reported that differed from those experienced by heterosexual women. Seventy-three percent of the total group received a Pap smear at least every two years. Forty percent of the lesbians surveyed thought that their health care would be negatively affected if their health care provider knew of their sexual orientation. Only eighteen percent had ever disclosed their sexual orientation to a physician, though forty-nine percent stated that they would have liked to have done so. Sixty-three percent of the lesbian women said that they would be more likely to discuss their sexual orientation if they were assured it would not become a part of their medical record.

Though a lesbian gynecologist was preferred by an overwhelming number of the respondents, many women said that both the gender and sexual orientation of the physician were less important than an open, supportive attitude. The researchers recommended providing an atmosphere of openness and tolerance, which can be

greatly facilitated by the physician not assuming that every patient is heterosexual.

Smith, Johnson, and Guenther (1985) surveyed 1,921 lesbians, contacted at an annual cultural event for women, regarding their sources of women's health care, utilization patterns, degree of openness with physicians, and assessment of quality of care provided. About forty percent believed that their health care would be adversely affected if physicians were aware of their clients' sexual preference, while the same number believed it would have no effect. One-third of the women had not disclosed their sexual orientation, though they would have preferred to do so . Physicians had asked only nine percent of the women about their sexual orientation. A lesbian physician was overwhelmingly preferred for women's health care.

The authors proposed that some health problems may be related to specific sexual practices, such as oral-genital sex, and that inadequate care may result if the patient does not feel free to disclose her sexual identity. They suggested assurances of confidentiality that extend to the medical record, allowing a friend or partner to be present during medical visits, including this friend or partner in treatment decisions if the lesbian woman indicates that this is what she wishes,

learning about health problems as they affect lesbian women, and not presuming that all female patients are heterosexual.

The Lesbian Woman as Client in the Women's Health Care Setting

Good (1976) surveyed 144 gynecologists in Florida, seeking to discover whether an identified lack of published material in the medical literature was an indication of lack of interest in the lesbian client by physicians in general, and by gynecologists in particular. He mailed questionnaires to 144 physicians, without mentioning how his sample was chosen, asking them to identify how many women they had treated in the "past few months" whom they knew to be lesbians, and how they knew that these patients were lesbians. The questionnaire also asked how many women they had treated in the same period of time whom they suspected to be lesbians. Two questions were stated to have been asked to imply that the purpose of the survey was gynecologically oriented, so as to increase the response rate. One hundred and ten responses were received.

Over half the gynecologists surveyed reported that they had not knowingly treated a lesbian woman in the past several months, and ninety percent had knowingly

treated three or less. This suggests that the gynecologists were unaware of many of their clients' sexual identities. The author concluded by stating that a knowledge of the lesbian client's sexual orientation is necessary for a physician to render comprehensive health care.

In a nursing text on women's health care, Williamson (1986) noted that a holistic awareness of the lesbian experience will assist nurse advocates to address the special needs of lesbian women. To this end she discussed theories of causation of lesbianism, myths and realities about the lesbian lifestyle, common physical health concerns of lesbian women, emotional and mental conflicts that lesbian women experience, and the nurse advocate's role in relation to the lesbian woman. She advised that the nurse advocate identify and examine her personal values relative to lesbianism, use open-ended and non-judgemental questions with all clients, including lesbian clients, and ensure that a lesbian woman's support system is available to her in her health care interactions.

Owen (1980), counseled that a complete history, including sexual history, is necessary in any patient in order to identify risk factors for disease. This may be especially necessary with homosexual patients,

given the lack of recognizable homosexual stereotypes. He pointed out that this history may be more difficult to obtain in the homosexual person, and advised that a lack of sensitivity on the part of the provider may result in barriers between physician and patient. This may alienate homosexual men and women, thereby interfering with development of a therapeutic physician-patient relationship. He suggested avoidance of offensive words, awareness of one's non-verbal communication, assessing the homosexual patient's social milieu, indicating a non-judgmental attitude and sense of acceptance, providing information, offering confidentiality, and reassessment by physicians of their own basic attitudes and prejudices.

Edelman (1986) identified five problems, derived from lay and medical literature, which were used as the basis for a lesbian health workshop with the goal of increasing lesbian use of the university health services for preventive health care. Lesbians seeking treatment are confronted with the assumption that they are heterosexual. Treatment that is not sensitive to physical and emotional health issues faced by lesbians may act as a deterrent for lesbians seeking routine medical examinations. Lesbians do not seek medical care for contraceptives, therefore it is easier for

them to avoid scheduling routine women's health examinations that can detect such serious illnesses as breast and cervical cancer. The health system, by limiting the recognition of family to blood relatives and spouses invalidates the lesbian couple. And lastly, because a lesbian will not usually discuss her sexual orientation with her health care provider, there is necessary information that does not get communicated during her women's health examination. Recommendations from the conference included the need for consciousness raising regarding the inappropriateness of assuming that all clients are heterosexual, the importance of an understanding of lesbians' lifestyles, and the importance of discretion in interviewing.

Dillon (1986) stated that, if the widely quoted estimate that ten percent of the American population is gay is accepted, then there must be many faculty, students and staff on every college campus who would benefit from gay-sensitive health services. The author believes that the reason that such services may not currently exist is that many college health providers from all disciplines may have been deterred from vigorously educating themselves concerning the gay lifestyle and identity issues by their own homophobia. She stressed that gay clients also bring stereotypes to

their health care interactions, and that it may be up to the health care provider to give the cues that the health care encounter is a safe place. With this in mind, Dillon recommended readiness to be informed by the client's story rather than by stereotypes and pathology-oriented assumptions, asking open-ended questions, exploring the unique aspects of each person's experience instead of 'treating gays', and sharpening awareness of one's own relationship to homosexuality. She was also the only author to address the gay health care provider, noting that, in some cases, gay caregivers may plan with administration to be open in their practice about their gay identity for the purpose of offering healthy models for identification and assurance of a safe place for gay people on campus to reflect confidentially with someone familiar with their lifestyle.

Analysis and Critique of the Literature

The literature regarding women's health care in relation to lesbian women is severely limited in quantity and, as is evident from the review of the literature, is largely anecdotal. Its scope is narrow, as few research questions have as yet been asked, and few interviews or surveys that have been done have been replicated to validate preliminary results. The

research available is also plagued by methodological problems, such as self-selected samples that tend to over-represent white and well-educated lesbian women, and researchers who approach lesbian women from the context of a male-dominated medical model, attempting to interpret lesbian women's responses in the light of pre-existing theory not developed by women nor with women in mind. The scarcity and erratic quality of existing research means that those who care for lesbian women must continue to largely rely on common sense and intuition (Stevens & Hall, 1988).

However, beginning attempts have been made to elicit from lesbian women themselves what their experiences with women's health care have been, and what recommendations they might have that would facilitate future, more therapeutic health care interactions. This is in accordance with the guidelines for feminist research as outlined by Duffy (1985), and with grounded theory methodology in general (Edgerton & Langness, 1974, Glaser & Straus, 1967).

Despite the stated limitations of the current research, major themes have emerged. The literature reviewed consistently suggests that lesbian women may be denied adequate health care in many cases when their sexual identity is not known to their health care

providers. Lesbian women are shown to have cited many factors as influencing their decision as to whether or not to disclose their sexual identity in their women's health care interactions, including their perceptions of previous women's health or gynecological health care experiences, the general degree of openness with which they live their lesbian identity, and a constellation of perceived provider attributes, such as knowledge, behavior and attitude, among others. Similarly, they have reiterated that the result of this decision affects the satisfaction they feel with the health care they have received.

Conceptual Framework

A complex interrelationship exists between the lesbian woman and her women's health care provider, largely mediated by the lesbian woman's perception of the sensitivity of that provider to her special needs and minority status. Based upon the literature reviewed, it appears that a lesbian woman is more likely to disclose her sexual identity if she perceives that her health care provider is sensitive to her needs and experiences as a lesbian woman. In addition, the general degree of openness with which she lives her lesbian identity and her perception of previous women's health care experiences also influence her decision.

Her ability to disclose her lesbian identity appears to be correlated with the degree of satisfaction she experiences with her care. Therefore, the lesbian woman's perception of the sensitivity of her health care provider is a pivotal factor in any women's health care interaction between a health care provider and a lesbian client.

This study proposes a conceptual framework wherein the degree of openness with which a lesbian woman lives her lesbian identity, her perceptions of her previous women's health care experiences, and the perceived sensitivity of her health care provider will be treated as the independent variables. The decision for or against disclosure of lesbian identity in the women's health care encounter will be considered an intervening variable. And, the satisfaction which the lesbian woman experiences with the health care provided, as a result of the health care encounter, will be treated as the dependent variable. For the purpose of the study, perceived sensitivity of the health care provider will be defined subjectively by lesbian women's reports of perceived provider knowledge, attitude, behaviors and attributes (see Appendix A).

This study assumes that women's health care providers have an interest in providing adequate health

care to their lesbian clients, and are willing to examine the values and the stereotypes they hold concerning the lifestyle of lesbian women.

A lesbian woman will be defined as any woman who answers the survey question "Do you consider yourself a lesbian?" with an affirmative response.

Research Questions

This study asks the following research questions:

1) Is a lesbian woman's general degree of openness about her lesbian identity related to her decision to disclose her lesbian identity in a women's health care setting?

2) Are a lesbian woman's perceptions of her previous women's health care experiences related to her decision to disclose her lesbian identity in a women's health care setting?

3) Is a lesbian woman's perception of the sensitivity of her health care provider related to her decision to disclose her lesbian identity in a women's health care setting?

4) Is a lesbian woman's decision to disclose or not to disclose her lesbian identity in a women's health care setting related to the satisfaction she feels with the health care she received?

CHAPTER II

Methods

The methods used in the study will be discussed in this section, and the philosophical perspective from which the study originated will be described. Survey participants will be identified. The instrument that was used for data collection from lesbian women will be detailed. Data collection procedures and setting will be discussed, and data analysis will be elaborated.

Design

The study aimed to describe the relationships among variables rather than to infer direct cause-and-effect relationships. Thus, the design chosen for the study was descriptive correlational.

Philosophical Foundation

Feminist researchers insist that women's lived experiences be taken as the starting point for all research in women's health care, as it is not possible that women's experiences can be understood by extrapolation from research conducted by men with male subjects (Dobash & Dobash, 1979; Duffy, 1985; MacPherson, 1983; McBride & McBride, 1981). As a sharing of experience occurs between the woman researcher and the participants in her study, the researcher's own lived experiences become an integral

part of the research she conducts (Duffy, 1985). The feminist researcher acknowledges that no research can ever be value-free or removed from its social, cultural and gender-based context; therefore the researcher takes responsibility for identification of personal values and assumptions, and is aware that she herself influences her research findings. The study was conceptualized with this philosophy in mind.

In-depth interviews with women would be the method of data collection most consistent with the philosophy of feminist research. However, time restrictions required that a survey form be used. A combination of pre-determined closed and open-ended questions were composed. Every attempt was made to conduct the research in accordance with a feminist philosophy, including allowing researcher interaction with survey participants. The researcher acknowledged to the survey participants that they were co-participants with her in the research process, and that they provided expertise in the knowledge they brought of their own lived experiences. Questions were worded in a non-sexist manner. The researcher made her own feminist bias known to the survey participants during interactions with them at the time of data collection.

Sample and Setting

The study used a purposive sampling technique at an annual, five-day long women's cultural event that traditionally attracts thousands of lesbian women. The diversity and number of women present gave access to large numbers of lesbian women from a variety of geographic areas and cultural backgrounds.

Protection of Research Participants

Lesbian women must be considered a vulnerable population with regard to participation in research studies, as public knowledge of their lesbian identity may constitute a perceived, potential, or actual threat to their physical or emotional well-being. In lieu of a signed consent form, the cover letter for the survey form stated that participation in the survey signified the participant's consent. Participants were also asked not to write their name or any identifying information on the survey form.

Measurement of Variables

A survey form was designed for administration to the survey participants. A cover letter was attached to each survey form introducing the researcher, the purposes of the research, the philosophical foundations of the research, and the information that participation

in the survey was taken as an indication of consent in lieu of a signed consent form (see Appendix B).

The survey form consisted of 54 questions, mostly quantifiable. Several open-ended questions were asked, and additional comments were encouraged in order to allow the survey participants to more accurately portray their women's health care experiences. The survey was pilot tested on a group of 20 volunteer self-identified lesbian women before administration at the cultural event. The survey was also reviewed for content validity by three lesbian health care providers. Revisions were minor editorial changes.

Demographic and Provider Characteristics

Participants were asked to report the region of the country where they live, their age, ethnic background, household income, education, designation of self as lesbian, and relationship status. They were also asked the type, gender and perceived sexual orientation of their most recent women's health care provider, and whether provider gender or sexual orientation is important to them.

Openness Scale

Question 15 was a five-item Openness Scale used to measure the general degree of openness with which participants live their lesbian identity. Participants

were asked to rank their degree of openness with family, friends, co-workers, school peers, and health professionals on a scale of 1-3 (see Appendix B). A score of one indicated not open, two indicated somewhat open, and three indicated completely open.

Perceptions of Previous Women's Health Care Scale (PPWHC Scale)

The PPWHC Scale was constructed to measure participants' perceptions of the women's health care experience they recalled as preceding their most recent one. The scale was composed of questions 41-44, asking participants to rank perceptions of their previous women's health care provider's attitude toward women and lesbians, on a scale of 1-5 (see Appendix B). Possible scores ranged from one, indicating the most negative perception of their previous women's health care provider's attitude, to five, indicating the most positive perception.

Perceived Sensitivity of Most Recent Women's Health Care Provider Scale (PS Scale)

The PS Scale was composed of questions 19-32, and was designed to measure participants' perceptions of their most recent women's health care provider's attitudes, behaviors and knowledge; termed the perceived sensitivity of the provider (see Appendix B).

Possible scores ranged from one, indicating the most negative perception of that trait in the previous women's health care provider, to five, indicating the most positive perception.

Satisfaction and Disclosure

Satisfaction with health care received was evaluated by question 38: "Overall, were you satisfied with the health care experience?" Possible responses were yes, no and unsure. Question 16, "Does your most recent women's health care provider know that you are a lesbian?" was used to elicit whether the participant felt that she had disclosed to her health care provider, either directly or indirectly. Possible responses were yes, no and unsure, and an explanation was requested.

Procedure

The survey was distributed at a table available at the event for the purpose of survey and questionnaire distribution. Surveys were available as women walked by, and the researcher posted times during which she would be present at the table to answer questions.

Participants were asked to return their completed forms to the table, where they were picked up by the researcher at the end of each day. Many women requested that they be allowed to return their surveys

in the mail. Five hundred surveys were distributed. Of these, 71 were completed at the festival, and 165 were returned by mail, resulting in a 47.2% return rate.

Limitations of the Study

A descriptive correlational design contains inherent limitations from the standpoint of the scientific method. Since the independent variables cannot be manipulated, and investigation is done retrospectively, cause-and-effect conclusions become difficult to infer. Interpretations of results must be considered tentative. The complexity of the reality of human interaction further complicates the interpretation of study results.

However, ex-post-facto research is acknowledged to be rich in realism, and is an efficient means of collecting a large amount of data about a problem area (Polit & Hungler, 1987). It appears ideally suited to the practice problem as a method of investigating complex human relationships retrospectively, with an ultimate goal of a more accurate understanding of these relationships as they manifest in the practice setting, from the perspective of the survey participants themselves.

Another limitation of the study is that there is no way to accurately identify the entire population of lesbian women, therefore a truely random sample of lesbian women is not possible. This sample was a volunteer group of lesbian women, and was already self-selected in that the women who comprised the sample were those that were at least somewhat comfortable with disclosing their sexual identity. In addition to being volunteer, survey participants were highly self-selected in that they could afford to attend the event, and took the time to participate in the study. Thus, generalization from the sample to the entire target population is not possible.

Analysis

Using the CRUNCH statistical package, analysis of variance (ANOVA) was calculated to determine the relationships between variables. Chi squares were used to determine if differences existed between variables. A level of significance of $p<.05$ was accepted. Cronbach's alpha was calculated for each scale to determine internal consistency reliability.

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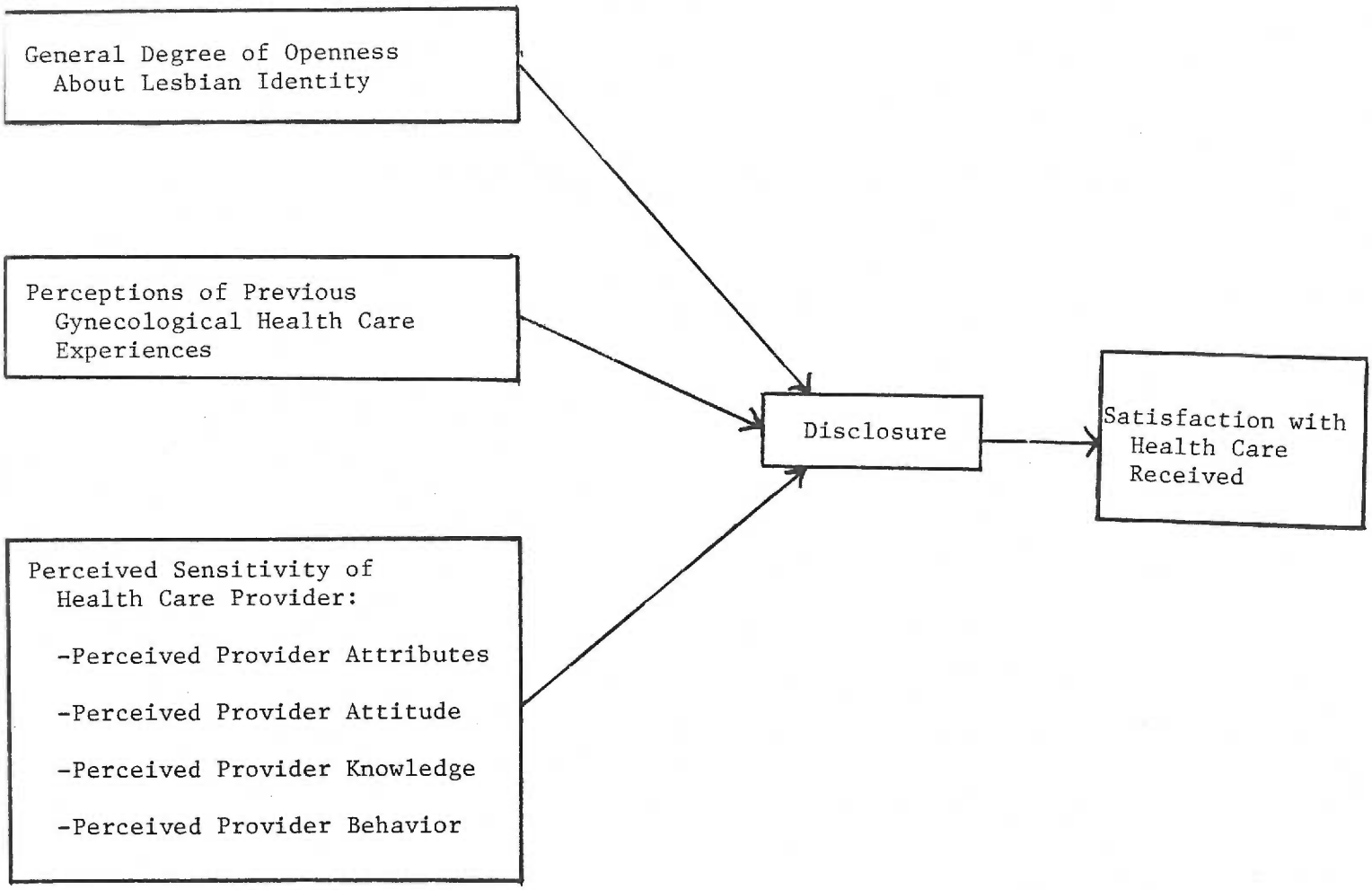
APPENDIX A

Conceptual Framework

CONCEPTUAL FRAMEWORK



APPENDIX B

Survey Form

THE OREGON
HEALTH SCIENCES UNIVERSITY
3181 S.W. Sam Jackson Park Road, EJSN, Portland, Oregon 97201 (503) 279-8382

School of Nursing
Department of Family Nursing

SURVEY OF LESBIAN WOMEN'S EXPERIENCES WITH

WOMEN'S HEALTH CARE

As a lesbian and a feminist, I am concerned about the general lack of recognition of lesbian women's emotional and physical health care needs. In addition, I do not believe that it is possible to understand lesbian women's experiences fully when they are viewed through the lens of the existing patriarchal culture. We, as lesbians and as women, must make our experiences known in our own words and through our own eyes so that they can be better understood. Only then may many of our needs be fully met, including those for sensitive and comprehensive health care.

I am studying to be a nurse practitioner in the master's program at the Oregon Health Sciences University, and am specializing in women's health care. I am especially interested in lesbian women's health care, and am doing a study about our experiences when we consult with the medical system. Very few surveys have been done which have asked lesbian women directly about such experiences. This survey is an attempt to obtain information concerning lesbian women's experiences with women's health care providers from lesbian women themselves. The goal of the study is to raise the consciousness of nurse practitioners who provide such care, and to further empower lesbian women within the health care system. To this end, when the study is completed, the findings will be reported to both professional and lay audiences.

Please make no identifying marks on the survey form. Your completion of the survey form will indicate your consent to participate in the study. Thus, all responses will be anonymous. The site where you fill out the survey form will also remain confidential, and will be reported only in general terms.

I am asking lesbian women to contribute their voices to this project. Your participation is greatly appreciated, and will help women's health care providers better serve our community. I'll be at the survey table often to answer questions, clarify my purpose, or just talk, and will make the times when I'll be there known in advance.

Please return completed surveys to the box at the survey table marked "Survey of Lesbian Women's Experiences with Women's Health Care". I'll collect them several times each day.

Thank you for your help with the study.

SURVEY FORM

PLEASE ANSWER THESE GENERAL QUESTIONS ABOUT YOURSELF.

1. What city and state do you live in? _____ City _____ State

2. How old are you? _____

3. What is your ethnic background/race?

_____Asian
_____Black
_____Latin/Hispanic
_____Native American
_____White/Anglo
_____Other (Please specify)

4. What is the best estimate of your annual household income?

_____Less than $9,999
_____$10,000 to $14,999
_____$15,000 to $19,999
_____$20,000 to $24,999
_____$25,000 to $29,999
_____$30,000 to $34,999
_____$35,000 to $39,999
_____$40,000 to $44,999
_____$45,000 to $49,999
_____More than $50,000

How many wage earners does this represent? _____

5. What is the highest grade of schooling that you have completed?

_____0-8 years
_____Some high school
_____High school graduate
_____Vocational training
_____Some college
_____College degree
_____Master's or professional degree (e.g., M.D., etc.)
_____Doctoral degree (Ph.D.)
_____Other (Please specify) _____

6. Do you consider yourself a lesbian? _____Yes _____No
(If not, please note that this survey is intended to evaluate lesbian women's experiences)

7. Are you currently in a relationship? _____Yes _____No

8. If so, how long have you been in this relationship? _____

9. Do you consider it a committed relationship? _____Yes _____No _____Unsure _____Not Applicable

PLEASE ANSWER THE QUESTIONS THAT FOLLOW WITH YOUR MOST RECENT WOMEN'S HEALTH CARE EXPERIENCE IN MIND (such as a well-woman check-up or visit with specific women's health questions as the focus).

10. What type of health care provider did you choose? (Please check only one)

_____Nurse practitioner or Nurse Midwife (N.P. or C.N.M.)
_____Physician's Assistant (P.A.)
_____Family Practice Physician (M.D.)
_____Gynecologist (M.D.) or Obstetrician (M.D.)
_____Internist (M.D.)
_____Osteopathic Physician (D.O.)
_____Naturopath (N.D.)
_____Other (Please specify) _____

11. What gender was your most recent health care provider?

_____Female _____Male

CONTINUED ON OTHER SIDE →

12. Does the gender of your health care provider matter to you? (Please check only one)

_____Yes, I will only consider female health care providers
_____Yes, I prefer female health care providers, but will consider male health care providers if necessary
_____It doesn't matter
_____Yes, I prefer male health care providers, but will consider female health care providers if necessary
_____Yes, I will consider only male health care providers

13. Is your most recent health care provider a lesbian woman or a gay man?

_____Yes _____Lesbian woman _____No _____Unsure
_____Gay man

14. Does it make a difference to you if your health care provider is a lesbian woman or gay man, as opposed to a heterosexual health care provider?

_____Yes _____No _____Somewhat

Please briefly explain your answer:

15. Please indicate how open/out you are with the following people concerning your lesbian identity:

	Completely Open	Somewhat Open	Not Open	Not Applicable
Family				
Friends				
Co-workers				
School peers				
Health professionals				

16. Does your most recent women's health care provider know that you are a lesbian?

_____Yes _____No _____Unsure (Please explain briefly)

17. If yes, how does she/he know? (Please explain briefly)

18. If no, please briefly explain why not:

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CHECKING THE BOX MOST APPROPRIATE TO YOUR MOST RECENT WOMEN'S HEALTH CARE EXPERIENCE. If you believe that the responses provided do not allow you to adequately describe your experience, I would be very interested in hearing what you have to say. There is space for additional comments at the end of the survey.

	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree	Not Applicable
19. I think that my most recent women's health care provider's attitude is non-judgemental toward women in general.						
20. I think that my most recent women's health care provider's attitude is non-judgemental toward lesbian women.						
21. My most recent women's health care provider asked me questions which made the assumption that I was heterosexual (straight).						

(PLEASE CONTINUE TO ANSWER THE FOLLOWING QUESTIONS BY CHECKING THE BOX MOST APPROPRIATE TO YOUR MOST RECENT WOMEN'S HEALTH CARE EXPERIENCE)

	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree	Not Applicable
22. I think that my most recent women's health care provider is knowledgeable about women's health in general.						
23. I think that my most recent women's health care provider is supportive toward women in general.						
24. I think that my most recent women's health care provider is knowledgeable about the specific physical health needs of lesbian women.						
25. I think that my most recent women's health care provider is knowledgeable about the specific emotional health needs of lesbian women.						
26. I think that my most recent women's health care provider is supportive toward lesbian women.						
27. My most recent women's health care provider assured me that nothing would be noted in my medical record regarding my lesbian identity.						
28. I feel secure that my most recent women's health care provider would not inappropriately reveal my lesbian identity.						
29. My most recent women's health care provider suggested that my partner or a friend might be present during my exam.						
30. My most recent women's health care provider was supportive when I suggested the presence of my partner or a friend during my exam.						
31. Lesbian-oriented information or resource literature was conspicuously posted or available in the waiting area or exam room.						
32. My most recent women's health care provider was able to provide lesbian-oriented resource literature or appropriate references when asked, though they were not offered or conspicuously displayed.						

Please answer questions 33 and 34 only if you did tell your most recent women's health care provider about your lesbian identity.

33. Do you feel that the health care you received was negatively affected by your most recent women's health care provider knowing that you were a lesbian?						
34. Do you feel that the health care you received was positively affected by your most recent women's health care provider knowing that you were a lesbian?						

CONTINUED ON OTHER SIDE →

Please answer questions 35, 36 and 37 only if you did not tell your most recent women's health care provider about your lesbian identity.

	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree	Not Applicable
35. Since you did not disclose your lesbian identity, do you think that information relevant to your health care was not conveyed to your most recent women's health care provider?						
36. Were there things you would have liked to have discussed with your most recent women's health care provider, but were not able to since they involved revealing your lesbian identity?						

37. Would you have liked to have revealed your lesbian identity?

_____Yes _____No _____Unsure

38. Overall, were you satisfied with the health care experience?

_____Yes _____No _____Unsure

39. Do you think that your health care provider was attentive to your emotional needs?

_____Yes _____No _____Unsure

40. Looking back on your most recent women's health care experience, can you identify whether it had any effect on your feelings about your lesbian identity? Please check the answer which most adequately represents your response.

_____It made me feel more positive about my lesbian identity
_____I felt that it validated my lesbian identity
_____It didn't affect the way I feel about my lesbian identity
_____Unsure
_____It made me feel less positive about my lesbian identity
_____I felt that it invalidated my lesbian identity

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CHECKING THE BOX MOST APPROPRIATE TO THE WOMEN'S HEALTH CARE EXPERIENCE WHICH YOU REMEMBER AS PRECEDING (OR COMING BEFORE) YOUR MOST RECENT WOMEN'S HEALTH CARE EXPERIENCE. If you believe that the responses provided do not allow you to adequately describe your experience, I would be very interested in hearing what you have to say. There is space for additional comments at the end of the survey.

	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree	Not Applicable
41. My previous women's health care provider's attitude seemed non-judgemental toward women in general.						
42. My previous women's health care provider's attitude seemed non-judgemental toward lesbian women.						
43. My previous women's health care provider's attitude seemed supportive toward women in general.						
44. My previous women's health care provider's attitude seemed supportive toward lesbian women.						

45. What was your degree of satisfaction with your previous women's health care provider?

Greatly dissatisfied	Moderately dissatisfied	Dissatisfied	Satisfied	Moderately satisfied	Greatly satisfied

46. Does your previous women's health care provider know that you are a lesbian?

_____Yes _____No _____Unsure (Please explain briefly why you think she/he is unsure)

47. If yes, how does she/he know?

48. If no, please briefly explain why not.

49. Have you had a problem related to women's health care in the last year which alarmed or frightened you? (such as a breast lump, irregular menstrual bleeding or unusually painful menstrual periods)

_____Yes _____No

50. If so, did you seek care? _____Yes _____No _____Not applicable

51. If you had such a problem and did not seek care, please briefly explain why not.

52. In your experience, what have women's health care providers/gynecologists done or not done which has positively or negatively influenced your experiences with them?

53. What could women's health care providers do to make you more likely to disclose your lesbian identity to them?

54. Do you have any suggestions for women's health care providers which would allow them to help you feel safer, more respected or more validated as a lesbian woman, and more adequately cared for in the future?

PLEASE ADD ANY ADDITIONAL COMMENTS ON THE BACK -- ALL ARE WELCOMED!

Thank you for sharing your experiences related to this very personal subject. Your time and energy are greatly appreciated.

MANUSCRIPT

TO BE SUBMITTED FOR PUBLICATION

Lesbian women represent, at minimum, seven percent of the female population (Kinsey, 1965), and many more women are other than exclusively heterosexual (Friend, 1987; Gramick, 1983; Kinsey, Pomeroy, & Gebhard, 1953). Therefore, women's health care providers may expect that a substantial number of their clients will be lesbian women or will have questions related to lesbian health care. However, historically there has been a lack of concern about lesbian health care within the medical establishment, and thus a scarcity of knowledge about the health care needs of lesbian women exists (Apuzzo, 1985; Darty & Potter, 1984; Glascock, 1986; Good, 1976; Hepburn & Gutierrez, 1988; Kenyon, 1980; O'Donnell, Leoffler, Pollock, & Saunders, 1979; Ruzek, 1979).

The purpose of this study was to investigate factors influencing lesbian women's identity management and subsequent satisfaction with women's health care, in order to educate both women's health care providers and lesbian women about lesbian women's health care needs.

Background

Since many lesbian women are physically and psychologically indistinguishable from heterosexual

women, they frequently are not recognizable as such (Bell & Weinberg, 1978; Friend, 1987; Martin & Lyon, 1974; Owen, 1980). Interaction with the surrounding social system may not allow a lesbian woman to reveal her lesbian identity without fear of physical or emotional repercussion, so she may feel that she must hide an important part of who she is and how she lives.

The lesbian woman, and every woman who does not indicate otherwise, is assumed to be heterosexual (Dardick & Grady, 1980; Degan & Waitkevicz, 1982; Edelman, 1986; Glascock, 1986; Johnson & Palermo, 1984; Smith, Johnson & Guenther, 1985; Stevens & Hall, 1988). This assumption pervades our culture and places the burden of correcting or conforming to the assumption on those who have been negated or discriminated against. In every interaction in which she is presumed to be heterosexual, a lesbian woman weighs the possible costs of revealing her lesbian identity against the benefits that may be gained from either conforming to the assumption that she is heterosexual or revealing her lesbian identity (Brooks, 1981; Ponse, 1978). When a lesbian woman approaches the medical community seeking women's health care, she enters a system that she knows has, until recently, considered her identity to be deviant and a mental illness, and has not otherwise

addressed her health needs. In addition homophobia, the irrational fear of and loathing for the quality of homosexuality in oneself and others, is more evident among health care professionals as a result of the AIDS epidemic (Friend, 1987), and has been expressed in the health field in many ways (O'Donnell, Leoffler, Pollock & Saunders, 1979). Moreover, the lesbian woman is in a position of powerlessness relative to the medical community, both by virtue of her gender in the face of the male-dominated medical establishment, and, in most cases, her relative lack of medical knowledge. Unsurprisingly, many lesbian women perceive the medical context as a particularly dangerous place to reveal their lesbian identity (Glascock, 1986).

However, the literature that addresses lesbian health care emphasizes that health care provider knowledge of a lesbian woman's identity is frequently essential to the provision of adequate women's health care (Dardick & Grady, 1980; Darty & Potter, 1984; Degan & Waitkevicz, 1982; Edelman, 1986; Glascock, 1986; Hepburn & Gutierrez, 1988; Johnson & Palermo, 1984; Johnson, Guenther, Laube, & Keettel, 1981; O'Donnell et al., 1979; Ruzek, 1979; Smith et al., 1985). As long as lesbian women remain fearful of the

medical system, it is clear that many of their health care needs are likely to remain unaddressed.

Review of the Literature

Lesbians have reported that disclosure is perceived as both cause and effect of practitioner responses in the health care context (Glascock, 1986). Disclosure is an interactive process (Limandri, 1987), involving both the lesbian woman and the health care provider (Brooks, 1981; Ponse, 1978).

Whyte and Capaldini (1980) make clear the sense of "double jeopardy" lesbian women experience when they enter a health care system that has historically been indifferent or hostile to their needs. If their lesbian identity is not disclosed, these clients may fail to convey information necessary for their health care. If they do disclose their lesbian identity, they risk the alienation of their health care provider or the receipt of insensitive care.

Many lesbian women report that they have received non-empathetic responses when they have disclosed in the health care context, or have anticipated that their health care would be negatively affected if their provider knew their lesbian identity (Glascock, 1986; Johnson, et al., 1981; Smith et al., 1985; Stevens & Hall, 1988). Almost three-quarters (72%) of the

lesbian women interviewed by Stevens and Hall (1988) recounted negative responses from their health care provider after their identity was known. However, lesbian women who do not disclose their identity risk possible misdiagnosis, provision of inadequate information, or improper treatment (Edelman, 1986; Glascock, 1986; Good, 1976; Johnson, et al., 1981; Johnson & Palermo, 1984; Owen, 1980; Smith et al., 1985; Stevens & Hall, 1988; Whyte & Capaldini, 1980).

The reasons lesbian women give for not disclosing their identity to their health care providers include expectation of stereotyping based on health care provider ignorance of their lifestyle, anticipation of negative responses, concern about confidentiality and about job security, fear of isolation from loved ones, fear that health care will be adversely affected, and even fear that they may risk actual danger from inadequate health care due to withdrawal of provider concern for their welfare (Darty & Potter, 1984; Glascock, 1986; Johnson et al., 1981; Johnson & Palermo, 1984; Stevens & Hall, 1988).

Lesbian women are more likely to disclose their identity if they live it openly, and if they perceive their health care provider to have a favorable attitude toward lesbians (Dardick & Grady, 1980). Their

decision to disclose is also affected by their previous health care experiences (Glascock, 1986). Further, disclosure in the health care setting has an effect on the ultimate satisfaction that lesbian women report with the health care they received (Dardick & Grady, 1980; Glascock, 1986; Johnson et al., 1981).

An "actively manifested sensitivity", as recommended by Whyte and Capaldini (1980), helps the lesbian client perceive the health care setting as one in which it is safe to reveal her lesbian identity if she wishes to do so. The literature contains concrete suggestions from both lesbian women and providers for creating an environment which is perceived as safe. These include avoidance of the heterosexual assumption, conveyance of a tolerant and non-judgmental attitude, provider self-education about the lesbian lifestyle and reassessment of attitudes about lesbianism, prominent display of information that is affirmative of the lesbian lifestyle, and support for the lesbian woman's concept of family (Dardick & Grady, 1980; Degan & Waitkevicz, 1982; Dillon, 1986; Edelman, 1986; Friend, 1987; Gillow & Davis, 1987; Johnson et al., 1981; Johnson & Palermo, 1984; Kenyon, 1980; Owen, 1980; Smith, et al., 1985; Stevens & Hall, 1988; Whyte & Capaldini, 1980; Williamson, 1986).

Since it has been demonstrated that less than optimal health care may result if a lesbian woman's identity is not known, there is a burden of responsibility for women's health care providers to be aware of the existence of their lesbian clients, and to provide an atmosphere that allows lesbian women to discuss their lesbian identity. As the reality of a provider's attitudes may not be as important as the lesbian client's perception of those attitudes (Whyte & Capaldini, 1980), demonstration of an open, supportive attitude may be one of the most important contributions the health care provider makes toward facilitation of a safe environment for disclosure (Dillon, 1986; Johnson, et al., 1981).

Summary and Critique of the Literature

The literature regarding lesbian women's experiences with women's health care is limited and largely anecdotal. However, major themes exist. Disclosure of lesbian identity is an interactive process, involving both the lesbian woman and the health care provider. Since lesbian women may be denied adequate health care when their identity is not known to their women's health care provider, and since the lesbian woman puts herself in a vulnerable position by revealing her identity, it is the responsibility of

the health care provider to give the cues which indicate that the context is a safe place for the lesbian woman to disclose.

Conceptual Framework

A complex interrelationship exists between the lesbian woman and her women's health care provider, mediated by the lesbian woman's perception of the sensitivity of that provider to her special needs and minority status. This study further explored the relationship between disclosure of lesbian identity and the degree of openness with which a woman lives her lesbian identity, her perceptions of previous women's health care experiences, and the perceived sensitivity of her health care provider. In addition, the relationship between the satisfaction which the lesbian woman experienced with the health care provided and the result of her decision as to disclosure was examined.

Research Questions

1) Is a lesbian woman's general degree of openness about her lesbian identity related to her decision to disclose her lesbian identity in a women's health care setting?

2) Are a lesbian woman's perceptions of her previous women's health care experiences related to her decision

to disclose her lesbian identity in a women's health care setting?

3) Is a lesbian woman's perception of the sensitivity of her health care provider related to her decision to disclose her lesbian identity in a women's health care setting?

4) Is a lesbian woman's decision to disclose or not to disclose her lesbian identity in a women's health care setting related to the satisfaction she feels with the health care she received?

Methods

A descriptive correlational design was chosen to describe the relationships among the variables of the conceptual framework.

Philosophical Foundation

Feminist researchers insist that women's lived experiences be taken as the starting point for all research that will be generalized to women (Dobash & Dobash, 1979; Duffy, 1985; MacPherson, 1983; McBride & McBride, 1981). The researcher's experiences become an integral part of the research she conducts (Duffy, 1985), and the feminist researcher acknowledges that no research can ever be value-free or removed from its social, cultural and gender-based context. Therefore,

the researcher takes responsibility for identification of personal values and assumptions, and is aware that she herself influences her research findings. This study was conceptualized with this philosophy in mind.

In-depth interviews with women would be the method of data collection most consistent with the philosophy of feminist research. However, time restrictions required that a survey format be used. Questions were worded in a non-sexist manner. The researcher made her own feminist bias known to the survey participants during interactions with them at the time of data collection.

Sample and Setting

The study used a purposive sampling technique at an annual, five-day woman's cultural event that traditionally attracts thousands of lesbian women. The diversity and number of women present gave access to large numbers of lesbian women from a variety of geographic areas and cultural backgrounds.

Protection of Research Participants

Lesbian women must be considered a vulnerable population when they participate in research studies, as public knowledge of their lesbian identity may constitute a perceived, potential, or actual threat to their physical or emotional well-being. Therefore, a

cover letter for the survey stating that participation in the survey signified the participant's consent was used instead of a signed consent form. Participants were also asked not to write their name or any identifying information on the survey form.

Measurement of Variables

The researcher designed a 54 question survey for this study. The majority of the questions were quantifiable measures of the study variables. Several open-ended questions were included to allow the participants to more completely portray their women's health care experiences. The survey was pilot tested on a group of 20 volunteer self-identified lesbian women before administration at the cultural event. The survey was also reviewed for content validity by three lesbian health care providers.

Demographic and Provider Characteristics

Participants were asked to report the region of the country where they live, their age, ethnic background, household income, education, designation of self as lesbian, and relationship status. They were also asked the type, gender and perceived sexual orientation of their most recent provider of women's health care (provider) and whether provider gender or sexual orientation is important to them. A lesbian

woman was defined as any woman who answered the question "Do you consider yourself a lesbian?" with an affirmative response.

Openness Scale

The researcher constructed a five-item Openness Scale to measure the general degree of openness with which participants lived their lesbian identity. The scale asked participants to rank their degree of openness with family, friends, co-workers, school peers, and health professionals on a scale of 1-3. A score of one indicated not open, two indicated somewhat open, and three indicated completely open. The means, range and internal consistency reliability coefficient for the scale are described in Table 1.

Perceptions of Previous Women's Health Care Scale

The Perceptions of Previous Women's Health Care Scale was constructed to measure participants' perceptions of the women's health care experience they recalled as preceding their most recent one. The scale was composed of four questions that asked participants to rank their perceptions of their previous provider's attitude toward women and lesbians, on a scale of 1-5. For example, participants were asked to what degree they agreed or disagreed with the statement: "My previous women's health care provider's attitude seemed

supportive toward lesbian women." Possible scores ranged from one, indicating the most negative perception of their previous provider's attitude, to five, indicating the most positive perception. The means, range and internal consistency reliability coefficient for the scale are described in Table 1.

Perceived Sensitivity of Most Recent Women's Health Care Provider Scale

The Perceived Sensitivity of Most Recent Women's Health Care Provider Scale was a 14 question scale designed to measure participants' perceptions of their most recent provider's attitudes, behaviors and knowledge; termed the perceived sensitivity of the provider. An example of an attitude question is: "I think that my most recent women's health care provider's attitude is non-judgmental toward lesbian women." An example of a behavior question is: "My most recent women's health care provider asked me questions which made the assumption that I was heterosexual (straight)." And, an example of a knowledge question is: "I think that my most recent women's health care provider is knowledgeable about the specific health needs of lesbian women." Possible scores ranged from one, indicating the most negative perception of that trait in the previous provider, to five, indicating the

most positive perception. The means, range and internal consistency reliability coefficient for the scale are described in Table 1.

Satisfaction and Disclosure

Satisfaction with health care received was evaluated by asking the question: "Overall, were you satisfied with the health care experience?" Possible responses were yes, no and unsure. The question: "Does your most recent women's health care provider know that you are a lesbian?" was used to elicit whether the participant felt that she had disclosed to her provider, either directly or indirectly. Possible responses were yes, no and unsure.

Procedure

The survey was distributed at a table available at the event for the purpose of survey and questionnaire distribution. Surveys were available as women walked by, and the researcher posted times during which she would be present at the table to answer questions.

The researcher asked participants to return their completed forms to the table, where the researcher picked them up at the end of each day. Many women requested that they be allowed to return their surveys in the mail. Of the five hundred surveys distributed,

71 were completed at the festival and 165 were returned by mail, resulting in a 47.2% return rate.

Analysis

Using the CRUNCH statistical package, analysis of variance (ANOVA) was calculated to determine the relationships between variables. Chi squares were used to determine if differences existed between variables. A level of significance of $p<.05$ was accepted. Cronbach's alpha was calculated for each scale to determine internal consistency reliability (see Table 1).

Results

Sample Characteristics

All participants identified themselves as lesbians. As seen in Table 2, participants were from each area of the country. The largest number was from the Midwest, where the event was held. Women's ages ranged from 16 to 65, with women 26 to 35 accounting for more than half the respondents. The sample was overwhelmingly composed of white women (91.5%). Almost 70% had earned a college or graduate degree. More than half reported household incomes of less than $30,000, even though almost 44% reported their household income as representing two wage earners. Sixty-four percent identified themselves as currently in a relationship.

Health Care Providers

As seen in Table 3, family practice physicians were the most commonly consulted type of provider, closely followed by nurse practitioner/nurse midwife and obstetrician/gynecologist providers. The majority of providers were women. Most respondents preferred a female provider but would consider a male if necessary, although almost twenty percent would consider only female providers. Several added that they would prefer a female or a lesbian/gay provider but had no choice, either as a result of the limited options available to them as low income women, or as a result of the limited options provided by their work-related health care coverage. However, a majority also responded that the gender or sexual orientation of their provider was not as important as the provider's willingness to affirm their lifestyle as a healthy option.

Some (18.6%) knew their provider was a lesbian woman or gay man, although almost 78% said it was at least somewhat important to them if their provider was a lesbian woman or gay man. Thus, some obstacle appears to exist for this sample of lesbian women in either the availability, accessibility, or visibility of lesbian/gay providers.

Disclosure

The reasons women gave for not disclosing their lesbian identity reflected anticipation of negative responses and/or the belief that it would not benefit them if their provider knew their lesbian identity, as they perceived their health concerns to be unrelated to their lifestyle. Several women living in small towns stated that they did not disclose because confidentiality was problematic for them. One woman, a nurse, said that she feared receiving inferior care if her male doctor knew her lesbian identity. Women who did disclose their lesbian identity either did so as a matter of course, as they thought their provider needed the information in order to deliver accurate health care, or did so in response to questions presuming heterosexuality.

Research Questions

The first question asked whether a lesbian woman's general degree of openness about her lesbian identity is related to her decision to disclose her lesbian identity in a women's health care setting. The ANOVA between the Openness Scale and Disclosure (Table 4) revealed a significant effect for the interaction. The more open women were about their lesbian identity in general, the more likely they were to disclose their lesbian identity in a women's health care setting.

The second question asked whether a lesbian woman's perceptions of her previous women's health care experiences are related to her decision to disclose her lesbian identity in a women's health care setting. The ANOVA between the Perceptions of Previous Women's Health Care Scale and Disclosure (Table 4) did not indicate that this sample of lesbian women were more likely to disclose their lesbian identity in a women's health care setting based upon their perceptions of previous women's health care experiences.

The third question asked whether a lesbian woman's perception of the sensitivity of her provider related to her decision to disclose her lesbian identity in a women's health care setting. The ANOVA between the Perceived Sensitivity of Most Recent Women's Health Care Provider Scale and Disclosure (Table 4) revealed a significant interaction effect between participants' perception of the sensitivity of their most recent provider, and whether or not they chose to reveal their lesbian identity in interactions with these providers. The more sensitive they perceived their providers to be, the more likely these women were to reveal their lesbian identity.

The fourth question asked whether a lesbian woman's decision to disclose or not to disclose her

lesbian identity in a woman's health care setting related to the satisfaction she felt with the health care she received. As seen in Table 4, there was no significant interaction effect between the two variables.

Almost two-thirds (61.5%) of the participants who did not disclose or who were unsure if their provider was aware of their lesbian identity (n=65) thought that information relevant to their health care had not been conveyed to their most recent provider. A similar number (62.7%) agreed that they had omitted discussing matters of personal importance with their most recent provider rather than reveal their lesbian identity. More than half of those who did not disclose their lesbian identity (52.4%) would have preferred to have done so.

Additional Findings

Chi square could be used to examine only three of nine relationships of interest, due to small cell sizes. There was a significant difference between disclosure and the survey participants' report of the gender of their most recent provider, X^2 (2, N = 229) = 9.6233, $p<0.0081$. Similarly, the Chi square between disclosure and whether the survey participants' most recent provider was lesbian or gay was significant (4,

N = 231) = 34.55 with $p<0.0000$. Of slightly lesser significance was the difference between disclosure and importance of provider's sexual preference, X^2 (4, N = 231) = 11.69, $p<0.0198$.

Discussion

The lesbian women who participated in this study appeared to be relatively open about their lesbian identity. As might be expected from this sample, a high percentage (61.47%) reported that their provider was aware of their lesbian identity. However, the self-selected nature of the sample must be taken into account.

The sample clearly demonstrated that both the openness with which they lived their lesbian identity, and the perceived sensitivity of their provider had a significant effect on whether or not they would decide to disclose their identity in the women's health care setting. Perceptions of previous women's health care experiences had no significant bearing upon this decision. Further, disclosure/non-disclosure had no significant effect upon the satisfaction reported with the health care they received.

The literature supported the complexity of the decision faced by lesbian women as to whether or not to disclose in the health care setting (Brooks, 1981;

Glascock, 1986; Johnson & Palermo, 1984; Ponse, 1978; Stevens & Hall, 1988). The potential for painful emotional consequences is perceived to be high by lesbian clients. In this study lesbian women apparently evaluated each provider and each health care environment independently. The possible risks and benefits of disclosure were thus assessed, and their decision was based upon the results of this assessment, as influenced by the openness with which they live their lesbian identity.

If a lesbian woman's perception of the attitudes, behavior and knowledge of her provider was such that she anticipated negative consequences from disclosure, she would remain closeted no matter how openly she usually lives her lesbian identity. And, if lesbian women did not believe that provider knowledge of their lesbian identity was relevant to their health care, they would weigh disclosure as a potential benefit during their risk/benefit analysis. Examples from women who did not disclose illustrate this:

> "It definitely did not feel safe. All workers at the clinic looked extremely heterosexual."
>
> "I'm sure she (provider) would disapprove. Perhaps even lecture me."
>
> "She (provider) does not appear to be open

enough to accept lesbianism, and I always worry about my job."

"It hasn't been necessary to be specific - my health problems are not related to my lifestyle."

However, as previously discussed, approximately two-thirds of women who did not disclose did believe that their non-disclosure precluded communication of information relevant to their health care. It appeared that the perceived risks of disclosure outweighed perceived benefits for these women.

Women who did disclose tended to be more brief in their explanations, simply stating that they chose providers with whom they felt safe in disclosing, that they always disclosed since they felt it was important to their health care, or that they disclosed in response to questions which presumed heterosexuality. Some examples are:

"I think it is important information for my gynecologist to know."

"I told her, reluctantly. She insisted and insisted that I use birth control."

"The profession of obstetrician/gynecologists deals with sexuality, not just medicine. If they're not comfortable with issues of sexuality, they should be in a different profession."

The lack of significant interaction between disclosure and satisfaction with health care received was intriguing, and suggestive of an intervening variable not included in the conceptual framework. For example, several women volunteered the information that they had little control over the selection of their provider. Since the participants were not asked how they had chosen their most recent provider, this information was not available for the sample as a whole. However, a provider chosen at random would most likely be less aware of the health needs of lesbian women than one chosen selectively.

Perceived sensitivity of support workers was another possible intervening variable which may have affected lesbian women's decision to disclose, and also their satisfaction with health care received. Several participants recommended that support workers be educated about the lesbian lifestyle as a healthy option, and about the health needs of lesbian women. One woman wrote:

> "When I came out to the nurse in response to her question about what kind of birth control I used, her manner changed completely. She became abrupt, and left the room quickly. After that there was

no way I would come out to anyone who worked with her."

Unsurprisingly, it was most likely that the participants had disclosed their lesbian identity if their provider was perceived to be lesbian or gay. They were also more likely to have disclosed if their provider was a woman, or if they stated that it was important to them that their provider was lesbian or gay. Both sexual orientation and gender were provider attributes which may have contributed to the lesbian client's perception of the women's health care environment as a safe space.

When the study participants were asked what their provider could have done to make it easier for them to disclose their lesbian identity, their suggestions were consistent with recommendations noted in the literature. They included various forms of permission giving ranging from use of neutral pronouns to advertising in lesbian publications, and the conveyance of a non-judgmental and knowledgeable attitude.

Summary and Conclusion

This study was a preliminary exploration of the dynamics of the interaction between a lesbian woman and her women's health care provider. The study indicated that many lesbian women were understandably hesitant to

reveal their identity in a women's health care context, even though the majority of those who did not disclose understood that they were foregoing optimal health care by remaining closeted. Barriers to effective communication between women's health care providers and lesbian women were clearly evident, and hinged upon the lesbian woman's perception of the sensitivity of her provider. Given the interactive nature of the disclosure process, and the consensus in the literature and among the majority of lesbian survey participants concerning the potential value of disclosure of lesbian identity, the responsibility for facilitation of an environment conducive to disclosure rests with women's health care providers.

It is important to note that some lesbian women may never disclose their identity to providers, nor ever wish to. However, a non-judgmental and knowledgeable attitude still serves as a tacit acknowledgement of provider affirmation of diversity, and is always an appropriate intervention with every client.

The proposed explanatory model shows promise, but further research is needed to continue to develop the dimensions of the interactive process between the lesbian woman and her women's health care provider. In

the interim, the researcher recommends that clinicians demonstrate an "actively manifested sensitivity" (Whyte & Capaldini, 1980) and convey a knowledgeable and non-judgmental attitude to facilitate the process of identity management for lesbian women, and all clients. In the words of one of the survey participants: "Let us know that family-centered care means us, too."

Table 1

Scale Means, Standard Deviations and Reliability Coefficients

Scale	Mean	SD (Range)	Internal Consistency Reliability (Cronbach α)
Openness	2.3	0.5 (1-3)	0.80
PWHCP[a]	3.3	1.1 (1-5)	0.94
PS[b]	3.4	0.9 (1-5)	0.91

[a] Perceptions of Previous Women's Health Care Scale

[b] Perceived Provider Sensitivity Scale

Table 2

Sample Characteristics

	Frequency	Percent	Mean
Region (n=236)			
Northeast	58	24.6	
Northwest	39	16.5	
Midwest	83	35.2	
Southwest	35	14.8	
South	21	8.9	
Age (n=233)			
16-25	28	12.0	
26-35	131	56.2	
36-45	49	21.0	
46-55	20	8.6	
56-65	5	2.2	
			33.2
Education (n=236)			
Some High School	8	3.4	
High School Graduate	11	4.7	
Vocational Training	2	0.9	
Some College	54	22.9	
College Degree	104	44.1	
Master's or Professional Degree	49	20.8	
Doctoral Degree	8	3.4	
Household Income (n=236)			
Less than $9,999	20	8.5	
$10,000 to $19,999	74	31.4	
$20,000 to $29,999	41	17.4	
$30,000 to $39,999	49	20.8	
$40,000 to $49,999	30	12.7	
More than $50,000	22	9.3	
			$29,466

Table 3

Health Care Provider Attributes

	Frequency	Percent
Type of Most Recent Women's		
Health Care Provider (n=233)		
Family Practice Physician	61	26.2
Nurse Practitioner/Nurse Midwife	51	21.9
Other	50	21.5
Gynecologist or Obstetrician	44	18.9
Internist	27	11.6

Table 4

Results of ANOVA of Disclosure with

Openness Scale, PPWHC Scale, PS Scale, and Satisfaction

	F	p
Openness Scale	75.47	0.0000
PPWHC Scale[a]	1.83	0.1620
PS Scale[b]	39.44	0.0000
Satisfaction	2.08	0.1261

[a] Perceptions of Previous Women's Health Care Scale

[b] Perceived Provider Sensitivity Scale

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AN ABSTRACT OF THE THESIS OF

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Title: FACTORS INFLUENCING DISCLOSURE OF LESBIAN IDENTITY IN THE WOMEN'S HEALTH CARE SETTING

Approved: [redacted]
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The purpose of this descriptive correlational study was to investigate factors influencing lesbian women's identity management and subsequent satisfaction with women's health care in order to educate both women's health care providers and lesbian women about lesbian women's health care needs.

The study is based on the belief that a complex relationship exists between the lesbian woman and her women's health care provider, mediated by the lesbian woman's perception of the sensitivity of that provider to her special needs and minority status. It explored the relationship between disclosure of lesbian identity and the degree of openness with which a woman lives her lesbian identity, her perceptions of previous women's health care experiences, and the perceived sensitivity of her health care provider. In addition, the relationship between the satisfaction which the lesbian woman experienced with the health care provided and the result of her decision as to disclosure was examined.

A survey form was designed for the study, largely composed of quantifiable measures of the study variables. A snowball sampling technique was used whereby 500 survey forms were distributed by the researcher at an annual cultural event which traditionally attracts thousands of lesbian women. Two hundred and thirty-six completed survey forms were obtained.

Significant effects were discovered for the interaction between the openness with which a lesbian woman lives her identity and disclosure, and between the woman's perception of the sensitivity of her health care provider and disclosure. In addition, the study indicated that many lesbian women were hesitant to reveal their identity in a women's health care context, even though the majority of those who did not disclose understood that they were foregoing optimal health care by remaining closeted.

Further research is needed to develop the dimensions of the interactive process between the lesbian woman and her health care provider, but in the interim the researcher recommends that clinicians actively demonstrate sensitivity and convey a knowledgeable and non-judgmental additude to facilitate the process of identity management for lesbian women, and all clients.