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Addressing Healthcare Disparities among Sexual Minorities

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Synopsis

Despite the paucity of population-based research on the health status and health needs of lesbian, gay, bisexual and transgender (LGBT) individuals, there is evidence of health disparities between sexual minority and heterosexual populations. Although the focus of LGBT health research has been HIV/AIDS and sexually transmitted infection among men who have sex with men, there is some documentation of health disparities among sexual minority women, with sexual minority women reporting poorer mental and physical health, in addition to less access to and less health care utilization. Using the minority stress framework, these disparities may be due in part to individual prejudice, social stigma and discrimination. To ensure equitable health for all, there is urgent need for targeted culturally sensitive health promotion, cultural sensitivity training for healthcare providers and intervention focused research.

Keywords

Sexual minority; health disparity; intervention

Introduction

In the past decade, there has been significant emphasis on reducing disparities in health, resulting in substantial attention on race/ethnic, socio-economic and gender disparities, but very little on sexual orientation disparities. The lesbian, gay, bisexual and transgender [LGBT] community is becoming more visible in society and there has been substantial progress in the social acknowledgement of the LGBT community. Common terms used in LGBT health are shown in Box 1. A recent report by the United States Center for Health Statistics [NCHS] using 2013 National Health Interview Survey (NHIS) data stated that

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1.6% of US adults 18 and older self-identify as gay or lesbian and 0.7% self-identify as bisexual.¹ This was similar among men and women, except that a slightly higher proportion of women self-identified as bisexual (0.9% vs. 0.7%) when compared to men. Unfortunately, very little is known about the health status and health care needs of members of the LGBT community. Moreover, most of the research on LGBT health has focused on HIV/AIDS and other sexually transmitted infections [STIs] among sexual minority men i.e. men who have sex with men [MSM].² Research on the health of sexual minority women (lesbians, bisexual and women who have sex with women) and transgender populations is limited.

Box 1

Common terms used in LGBT health

Term	Definition
Sexual minority	Lesbian, gay, bisexual, transgender, questioning, queer
Sexual orientation	An individual's pattern of emotional attractions to others (same sex, different sex or multiple)
Lesbian	Female who identifies her primary sexual and loving attachments as being predominantly female
Bisexual	Female or male who identifies her or his primary sexual and loving attachments as being with both sexes
Queer	Originally derogatory, now reclaimed to describe individual who reject mainstream cultural norms of sexuality and gender
WSW	A female who has sexual contact with other females whether or not she identifies as lesbian or has sexual contact with males

In 1999, the Institute of Medicine [IOM] issued a report on Lesbian Health indicating the importance of identifying and understanding factors unique to lesbians and their impact on health.³ Following this report a goal was added to the Healthy People 2020 initiative to improve the health, safety and well-being of lesbian, gay, bisexual and transgender (LGBT) persons. Later in 2011, the IOM acknowledged that members of the LGBT community have unique health experiences and needs.² This report also revealed disparities in several health indicators such as perceived health status, obesity, smoking, alcohol abuse and health care access.

This article focuses on health disparities among sexual minority women, i.e. lesbians, bisexual, women who have sex with women [WSW] and examines community initiatives to address these disparities. Several studies⁴ including combined data from the 2013 and 2014 NHIS, show that lesbian women were more likely to report moderate psychological distress, poor or fair health, multiple chronic conditions, heavy drinking and heavy smoking compared to heterosexual women. Similarly, bisexual women were more likely to report multiple chronic conditions, severe psychological distress, heavy drinking and moderate smoking.⁵

These disparities in health among sexual minority women may be influenced by the stressful social environment caused by societal stigma, prejudice and discrimination which have been described in terms of minority stress or chronic stress associated with being a member of a marginalized minority group.⁶ The minority stress theory has been used frequently to study mental health issues among sexual minority groups⁷ and is defined as the excess stress to

which individuals from stigmatized social categories are exposed, due to their minority position in society.⁸ Although the minority stress model is focused on mental health, there is some evidence to support the extension of the minority stress model to physical health. Meyer⁸ describes minority stress processes along a continuum from distal to proximal. Distal stressors are defined as objective events and conditions whereas proximal events are subjective personal processes since these rely on individual perception. Sources of minority stress may include discrimination, victimization and negative feelings regarding one's own sexual orientation commonly referred to as internalized homophobia. Studies have shown that these sources of stress are associated with poorer mental health outcomes.^{9–11} Minority groups often respond to “minority stress” with coping and resilience. However, mechanisms and sources of coping and resilience may have serious implications for overall health and well-being.

Unfortunately data for measuring and monitoring the health of LGBT populations in the US have been limited. Most of the research has been conducted using non-random convenience samples from clinic settings or community organizations. Due to small sample sizes, data have been pooled over several years and all LGBT adults have been collapsed into a single category resulting in challenges for making generalizations or appreciating the diversity within the LGBT community and the unique needs of subpopulations within the LGBT community.

Mental Health

There is overwhelming evidence that members of the LGBT community experience poorer mental health than their heterosexual counterparts. Studies consistently show elevated rates of mental disorders, substance use, violence, self-harm and suicidality.^{12–14} Using the minority stress theory, these elevated rates in poor mental health may be as a result of chronic adverse distal and proximal stressors. Not unlike what is observed in the heterosexual population, mental health disorders such as depression and mood/anxiety disorders tend to co-occur with heavy drinking and substance abuse. An understudied aspect of minority stress prevalent among sexual minority women is sexual identity mobility. Sexual identity mobility is defined as changes in self-reported sexual orientation and is a major contributor to depressive symptoms¹⁵. These changes in sexual identity appear to be more common among women compared to men.^{16–18} In addition, women are more likely to report changes in their sexual identity later in life.¹⁹

Postpartum depression [PPD]

Research on postpartum depression among sexual minority women is quite small since most studies do not report on participant sexual orientation. Data from the National Survey of Family Growth indicate that 34.9% of lesbian women and 44.8% of bisexual women have given birth.²⁰ About 13–19.2% of women experience PPD.²¹ Given the minority stress and the confluence of factors during pregnancy, it is possible that a large number of sexual minority women may experience PPD and in fact, several studies report that sexual minority women may be at higher risk for PPD.^{22–24} Moreover, Ross et al.²² found that known risk factors among heterosexual women such as lack of social support and relationship

satisfaction did not explain the elevated risk in sexual minority women. Researchers have suggested other factors like social exclusion, minority stress, and internalized homophobia as possible contributors to the excess risk. The few studies that have addressed this topic have not explored different subgroups of sexual minority women (lesbians, bisexuals, women who have sex with women) although there is some evidence that there are significant differences in mental health outcomes between bisexual and lesbian women with bisexual women reporting poorer mental health.²⁵ Given that a history of poor mental health is predictive of PPD, it is important to refrain from assuming homogeneity within the sexual minority group. In one study, women who had sex with individuals of more than one gender in the past 5 years, but were currently partnered with men (referred to as invisible sexual minority women) had higher Edinburgh Postnatal Depression Scale [EPDS] scores compared to women consistently partnered with men. This effect was not found in women who were currently partnered with women or were unpartnered.²⁰ These results support the added mental health burden due to sexual identity mobility among women.

Sexual Health

Sexual minority women, especially lesbians, frequently underestimate their risk of acquiring or being capable of transmitting sexual disease, since they consider this most likely to occur in sexual relationships with male partners or heterosexual relationships.²⁶ Due in large part to the AIDS epidemic, much of the lens of sexual health in the LGBT community has been traditionally focused on sexually transmitted infections [STI].²⁷ However, lesbian women have historically faced barriers to STI testing and treatment due to the perception that they are inherently a low risk group.^{28–30} This perception has been explicitly furthered by some medical professionals^{28,29,31} and self-perpetuated within the lesbian community.^{30,32} Additionally, lesbian and bisexual women have also reported a cognitive distance from safer sex health promotion messages that are often perceived to apply primarily to women who have sex with men rather than women universally.³⁰ The perception that lesbians or WSW are a low risk group for STIs is inherently problematic since woman to woman transmission of several sexually transmitted infections including HIV, HPV, Herpes, Treponema Pallidum (Syphilis), Chlamydia, Trichomonas Vaginalis, Bacterial vaginosis and Candida have been documented.^{28,29,31,33–35}

Sexual transmitted infection risk for lesbian women and other categories of WSW is also complicated by sexual orientation identifications' failure to consistently align with sexual behavior. Women who self- identify as lesbian or WSW may have had or continue to have sexual contact with male partners.^{29,36–39} This is especially true for ethnic minority lesbian women who reported more sexual contacts with men.³⁶ Further, ethnic minority women who identify as lesbian or bisexual may not report their sexual orientation and behaviors to healthcare providers as frequently as white lesbian women.³⁶ Therein lies a vulnerable trajectory of risk for minority lesbian and minority WSW; lower perceptions of risk of STI, higher number of sexual contacts with male partners, non-disclosure of sexual risk behaviors to health care providers, and less access to minority community based support networks. Bridges et. al⁴⁰ noted that African American women may lose community social and economic support if they identify as lesbian. There is a theoretical connection between social support and preventive health screenings.⁴¹ Despite the potential importance of community

support structures to health behavior, there is a paucity of community based STI prevention initiatives for lesbian, bisexual, and WSW women.⁴² To address this, Logie et. al. designed and piloted the Queer Women Conversations (QWC) study.⁴³ QWC specifically tailored group-based educational components to a diverse range of WSW (lesbians, bisexual, queer, other WSW). At the 6- week mark post intervention, sexual risk practices, barrier use self-efficacy, STI knowledge, and sexual stigma were significantly impacted. While long term results⁴³ were not sustained in the pilot for all outcomes, the pilot does provide an exploratory framework for further investigation about the role of community support and community connectedness⁴⁴ in addressing disparities in STI infection for this vulnerable population of women.

Disparities in unmet medical needs by sexual orientation

Health care access

There are both multiple barriers to care at the structural and individual level for sexual minority women.⁴⁵ Lack of health insurance coverage in addition to non-recognition of same-sex partnerships was a major barrier which prevented many from obtaining employer-sponsored health insurance coverage through their partners.⁴⁶ In addition, sexual minority women are more likely to lack health insurance.^{47–49} Another structural barrier is the lack of culturally competent providers trained in the health care needs of the LGBT community.^{45,50–52} As a result, encounters with the health care environment are often negative due to perceived or internalized stigma. As such, several studies show that sexual minority women are more likely to delay health care and less likely to have a usual place of care.^{47,48,53}

Preventive health care services

Data show that lesbians are at increased risk for not receiving important preventive health services such as Pap smears and mammograms.^{54–58} Extant literature demonstrates that sexual minority women underutilize cervical cancer screening services. Screening rates are estimated to be between 43 – 71% compared to 73% in the general female population.^{25,59–62} In addition to the risk factors identified among heterosexual women that contribute to non-receipt of preventive health services such as age, income, education, health insurance, having a regular health care provider or site of care, sexual minority women may have additional risk factors. Sexual minority women may be hesitant to disclose their sexual orientation to a health care provider, for fear of discrimination⁶³, physician ignorance regarding lesbian health issues due to heteronormative health care services and providers, and lack of insurance coverage or access to partner benefits.^{62,64} Bjorkman and Materud⁶⁵ highlight the unique challenges sexual minority women face in seeking healthcare even though they experience some health problems more frequently than their heterosexual peers, due to marginalization. This marginalization, which occurs when a person exists between two cultures but does not entirely feel connected to either, may result in feelings of isolation, low self-esteem and predisposition to emotional stress. Discrimination experiences include heterosexual assumption, inappropriate questioning, and refusal of services.

Although there has been some work to identify factors that influence screening behaviors, more knowledge on factors unique to sexual minority women may assist with the development of tailored strategies to increase screening rates. As with heterosexual women, there seems to be age differences in gynecological screening rates among sexual minority women. One study⁶² found that the highest rates of gynecological cancer screening among lesbians occurred in those aged fifty and above. The factors associated with the increased rates among older lesbians are unknown but may be due to more consistent messaging. This non-participation in preventive health screenings is detrimental to the health of sexual minority women. Lack of screening may result in later detection and treatment of gynecologic cancers. Breast cancer risk assessment is particularly important since sexual minority women seem to have a higher risk for developing breast cancer compared to heterosexual women due to higher prevalence of nulliparity, older age at first live birth⁶⁶ and obesity⁶⁷.

Interventions

There is very little in the literature regarding interventions to address LGBT health disparities since this work is still in the infant stages of development. However, sexual minority women report using certain strategies such as screening and crusading to address heterosexism and homophobia (defined in Box 2).^{68,69}

Box 2

Heterosexism & Homophobia

Term	Definition
Heterosexism	denotes the belief that heterosexuality is a superior orientation and fails to value alternative sexual identities
Homophobia	an irrational fear, prejudice, and hatred of gay individuals

Data from Chesir-Teran D, Hughes D. Heterosexism in high school and victimization among lesbian, gay, bisexual, and questioning students. *J Youth Adolesc.* Aug 2009;38(7):963–975; and Weinberg G. *Society and the healthy homosexual.* New York: St. Martens Press; 1972.

Screening involves direct contact with a service provider usually by phone and asking questions about service philosophy. The provider is screened for their attitude to the sexual orientation of the potential clients. Any intimation of homophobia would render the service/provider homophobic. However this may work in urban setting where there are lots of service provider options are available.⁷⁰ This method may simply contribute to lack of engagement with health care providers, if there are few options and they are all found to be homophobic by the potential client. In addition, some sexual minorities report using a method called crusading. Crusading involves the potential client taking on the responsibility to educate and normalize their sexual orientation. They accept that some health care providers may not have had exposure to sexual minority women.

Although sexual minorities have an increased risk for substance abuse, intervention research with this particular sub-population is sparse and even more so among sexual minority

women.⁷¹ However, there is some evidence that sexual minorities, specifically men, prefer alternative treatments instead of mainstream forms of treatment.⁷² At this point, it is not clear whether sexual minority women share this preference.

There is an obvious need for diversity training for health center staff and health care providers. The Gay and Lesbian Medical Association produced Guidelines for Care of Lesbian, Gay, Bisexual and Transgender Patients, which should be utilized by primary care health care providers⁷³. The publication includes recommendations for staff sensitivity training and questions to include on LGBT-sensitive forms.

Conclusion

Evolving shifts in policy resulting in greater inclusion of the LGBT community may have an impact of the health of sexual minority women. The inclusion of measures of sexual orientation, identity and sexual behavior in population surveys has provided some insight into the health needs and health status of sexual minority women. However it is imperative that we understand the health needs of subgroups of sexual minority women, since there may be significant differences. Individual and community-based strategies that promote resilience and positive coping of minority stress among sexual minority women are areas in need of further investigation. In addition, additional efforts should be made to improve the disparities in health care access and utilization by targeting the health care providers and increasing cultural competency training.

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Key Points

- Sexual minority women, lesbians, bisexual, women who have sex with women [WSW], experience health disparities and few interventions have focused on this underserved group of women.
- There is limited research on the health status and health needs of the lesbian, gay, bisexual and transgender (LGBT) population and this research has primarily focused on sexually transmitted infection among men who have sex with men with very little focus on sexual minority women (lesbians, bisexual women and women who have sex with women).
- Compared to their heterosexual counterparts, sexual minority women are more likely to report poorer mental and physical health and less access to and utilization of health care services.
- There is a need for cultural sensitivity training for health care providers and health care facility staff to reduce homophobia and heterosexism which may be harmful/ non-inclusive of sexual minority women.