CREATING A SAFE AND CARING HEALTH CARE CONTEXT FOR WOMEN WHO HAVE SEX WITH WOMEN

A Master's project submitted in partial fulfillment of the requirements for the degree of

MASTER OF NURSING

By

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To the Faculty of Washington State University:

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Creating a Safe and Caring Health Care Context for Women Who Have Sex with Women

Abstract

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Purpose: The purposes of this paper are to identify common health disparities among women who have sex with women (WSW), identify discrimination/substandard care for WSW by many health care providers, and recommend ways to create a safe and caring patient-provider relationship.

Data Sources: Data for this article are from a search of several databases including the Cumulative Index to Nursing and Allied Health, PubMed, PsycInfo, sociology indexes, and Web of Science databases.

Conclusions: Much of the literature on WSW identifies the lack of a safe and caring health care context for this population. There are common health disparities identified including: cancer and screening, substance abuse, mental health issues, sexually transmitted diseases and reproductive health, and obesity and cardiovascular risk. Research on WSW has historically been difficult, inconclusive and underutilized so there remains a need for increased and improved research on WSW.

Implications for Practice: Providers are responsible for providing quality, ethical care for all populations, including the WSW population. There are several key elements to establishing a safe and caring patient-provider relationship. Elements discussed are: reflection, environment, language, and knowledge. While gaps in the research on the WSW population remain, integration of current knowledge is ethically required and is needed to address disparities within the population.
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Creating a Safe and Caring Health Care Context for Women Who Have Sex With Women

Women who have sex with women (WSW) are a population who have long been stigmatized and marginalized within our society. Commonly, WSW are referred to as ‘lesbian’ or ‘bisexual’. However, many WSW do not self-identify as lesbian or bisexual; therefore using the term WSW is more inclusive. However, this paper will use WSW and ‘lesbian’ interchangeably to be compatible with references and citations although the preferred and more accurate term is WSW. WSW are often grouped together along with people of other sexual minorities: Lesbian, Gay, Bisexual, and Transgender (LGBT). While this paper’s main points and literature review are focused on WSW, the LGBT “population” will be mentioned as well. There has been incremental improvement in the United States towards societal acceptance of the LGBT population, yet there is still stigma associated with living anything other than a heterosexual lifestyle (Dean et al, 2000; Neville & Henrickson, 2006). Neville and Henrickson (2006) posit that consequences of these attitudes lead to violence, homophobia and heterosexism that affect the mental and physical health of the LGBT population. “Although homosexuality has been removed from the list of diagnoses in the diagnostic manual of the American Psychiatric Association, the relationship between homosexuality and sickness has proved more enduring in the minds of many providers” (Dean, et al, 2000, p. 107).

There are many accounts of discrimination, abuse, assumptions, voyeurism, lack of knowledge and substandard care towards the WSW population in health care (Bjorkman & Malterud, 2009; Hutchinson, Thompson, & Cederbaum, 2006; Platzer & James, 2000; Spinks, Andrews & Boyle, 2000). Some WSW report that after coming out to their health care provider, they were treated with physical roughness during their exam. (Bjorkman & Malterud, 2009). Some women have been denied care after their providers found out about their sexual orientation
(Spinks, Andrews & Boyle, 2000). According to Bjorkman and Malterud (2009), since many health care providers assume that women are heterosexual, a woman who self-identifies as lesbian has to “choose to actively intervene and inform the professional about her lesbian orientation, or passively pass as heterosexual” (p. 240). They also point out that the pressure to disclose sexuality is particularly present during gynecologic exams, when the provider doesn’t understand when the patient reports being sexually active, not using contraception but having no possibility of pregnancy (Bjorkman & Malterud, 2009).

It is difficult to accurately estimate the size of the LGBT populations or the population of WSW due to poor research methodologies, non-standardization of terms, and the historical invisibility of the population. There are different estimates currently in the literature, all of which are relatively low. The Institute of Medicine (IOM) report on lesbian health from 1999 lists the estimated percentage of lesbians from 2% - 10% of the population. The range of 1%-10% is reflected in other references (Hutchinson, Thompson, & Cederbaum, 2006; Mravcak, 2006; O’Hanlan, Dibble, Hagan & Davids, 2004; Seaver, et al, 2008; Spinks, Andrews & Boyle, 2000).

“Lesbians are a diverse group of women from every ethnic, religious, economic, cultural and age group” (Dibble, Roberts, Robertson, & Paul, 2002, p. E2). Regardless of the exact percentage of WSW, it is highly likely that every health care professional who cares for women will, at some point, provide care for a WSW patient. Although there is still a lack of information on LGBT health-related issues (Harcourt, 2006), many agencies are addressing the issue of providing culturally safe care for the LGBT population. Some agencies have brought attention to the health-disparities and consequent need for culturally safe care and include: The Joint Commission (The Joint Commission, 2010), Healthy People 2010 (GLMA, 2001), as well as the Institute of Medicine’s 1999 report on lesbian health needs (IOM, 2009). The American Nurses
Association Code of Ethics (ANA, 2001) states that “the nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems” (Provision 1; McManus, 2008, p. 30).

Clinicians not only have a duty to “do no harm” but, according to the standards of care published by all of the major health professions organizations today, are obligated to educate themselves appropriately to be able to provide culturally competent health services to diverse patients, including LGBT patients (Potter, Goldhammer, & Makadon, 2008, p. 7).

While these agencies clarify the professional and ethical mandate of the nurse and have the potential to influence positive change for the WSW population, there are still many challenges to overcome in order to provide the holistic care that this population deserves. The purposes of this paper are to identify common “mistakes” or substandard elements of care of WSW by many health care providers, and recommend ways to create a safe and caring WSW patient-provider relationship.

**Literature Search Methods**

Using the Cumulative Index to Nursing and Allied Health (CINAHL) as a database, “MM GLBT Persons +” search was done. Over 2,000 results were yielded. Adding “healthcare” and published date of 1995 to 2010, and source types of academic journals and periodicals narrowed the search to 56 results. Several articles from this search were chosen for this literature review. An additional search of CINAHL using “lesbian” and “healthcare” as search terms was conducted. The literature review also includes articles selected from searches from PubMed, PsycInfo, sociology indexes, and Web of Science databases using search word “lesbian” or “lesbians” in combination with words/phrases such as: stigma, self-disclosure, quality of health care, attitude to sexuality, homophobia, discrimination, health services accessibility, nurse-
patient relations, professional-client relations, and professional-patient relations. A search of “WSW” and “lesbian” was done on the Center for Disease Control (CDC) website as well.

**Literature Review**

The literature review is organized by common health issues found among WSW. The issues discussed are: cancer and screening, substance abuse, mental health, obesity and cardiovascular risk, and sexually transmitted diseases and reproductive health.

**Cancer and Screening**

**Cervical cancer and dysplasia**

“All women, regardless of sexual preference, are at risk for cervical cancer” (Hutchinson, Thompson & Cederbaum, 2006, p. 395). Many providers are under the assumption that WSW do not need regular Papanicolaou (Pap) smears due to perceived low risk of cervical dysplasia and cancer (Mravcak, 2006; O’Hanlan, Dibble, Hagan & Davids, 2004). This belief may also be held by many WSW themselves (Roberts, 2006). However, Human Papilloma Virus (HPV), the believed cause for 90% of cervical dysplasia, can be transmitted between women (Spinks, Andrews & Boyle, 2000). In addition, most WSW report a history of male sexual partner/s (Spinks, Andrews, & Boyle, 2000; Mravcak, 2006; O’Hanlan, Dibble, Hagan & Davids, 2004; Hutchinson, Thompson & Cederbaum, 2006). There has been evidence that WSW have lower rates of cervical cancer screening than do heterosexual comparison groups (Roberts, 2006). One study of 7,000 lesbians cited by Hutchinson, Thompson and Cederbaum (2006) reported “lesbians had higher rates of abnormal Pap results than rates reported in the general U.S. population” (p. 395). Clearly, WSW should not be excluded from regular cervical cancer screening. Moreover, health care providers may need to educate WSW that they are in need of this screening.
Breast cancer

During the mid 1980’s, according to the National Lesbian Health Care Survey, WSW were thought to have individual risk factors for developing breast cancer with rates as high as one in three, as compared to the one in seven national comparison of all women (Hutchinson, Thompson & Cederbaum, 2006). This survey has been since considered “methodologically flawed” (p. 396) and this high level risk has not been subsequently replicated. However, there are several reasons identified in the literature why WSW may be at a higher risk to develop breast cancer than heterosexual women. It is believed that WSW do not seek preventative mammograms as often as heterosexual women citing reasons of: mistrust of health care providers, negative past experiences, and perceived homophobia in the health care setting (Hutchinson, Thompson & Cederbaum, 2006). However, the data suggesting that WSW do not receive screening mammography as much as heterosexual women is not consistent. Mravcak states “rates of mammogram screening in lesbians and bisexual women are similar to those in heterosexual women” (p. 284). Also discussed in the literature are lower rates of breast self exams (BSE) among the lesbian [WSW] population (Spinks, Andrews & Boyle, 2000). It is commonly believed that many WSW are at a higher risk for developing some cancers as a result of higher rates of nulliparity, smoking, alcohol use and obesity (Hutchinson, Thompson & Cederbaum, 2006; Roberts, 2006). O’Hanlan, Dibble, Hagan and Davids (2004) identify these risks as well as the use of menopausal hormone replacement therapy as a risk. This information is not well researched and needs further study. As Spinks, Andrews and Boyle (2000) point out, “current research has not accurately identified the incidence of breast cancer in lesbians; however, simply being female places lesbian clients at risk” (p.140). Health care providers need
to encourage WSW to perform monthly BSE, have regular screening visits with a health care provider, and screening mammograms by following the guidelines as suggested for all women.

**Ovarian cancer**

There is little research available about the occurrence of ovarian cancer in WSW as compared to the general population of women. Dibble, Roberts, Robertson and Paul (2002) performed a study on risk factors for ovarian cancer for lesbians and heterosexual women. The actual number of WSW diagnosed with ovarian cancer is unknown due to the lack of inclusion of sexual orientation in cancer statistics. Risk factors for developing ovarian cancer addressed in the study included: age, ethnicity, family history, parity, breastfeeding, exogenous hormones, tubal ligation and hysterectomy. Other factors that may increase ovarian cancer risk for women are addressed as well and include smoking, high body mass index (BMI), antidepressant use, high dairy galactose intake, and use of talc in the perineal region. This study of over 1,000 women found “as expected from previous reports, the lesbians had significantly fewer pregnancies, miscarriages and abortions, and lower use of birth control pills. These variables place lesbians at a higher risk for developing ovarian cancer” (Dibble, Roberts, Robertson & Paul, 2002, p. E6).

"Whether women are at increased risk for ovarian cancer secondary to exposure to HRT is not clear. The prevalence of HRT usage among lesbians is unknown" (Dibble, Roberts, Robertson & Paul, 2002, p. E3). In addition, the authors report an unexpected finding: more of the heterosexual women smoked than the self-identified lesbian group (Dibble, Roberts, Robertson & Paul, 2002). These authors suggest that more research needs to be done to evaluate the differences in risk factors for heterosexual women and lesbian women. They also suggest it would be helpful to include sexual orientation in tumor registry data (Dibble, Roberts, Robertson & Paul, 2002).
Substance Abuse

"Accurate estimates of the prevalence of substance abuse in lesbians are not available due to the marginalization and hidden nature of the population" (Spinks, Andrews & Boyle, 2000, p. 140). The rate of alcohol abuse in WSW is unclear and there are conflicting data. Dean, et al. (2000) identify that early studies on the gay and lesbian population recruited subjects in bars "which not surprisingly showed higher rates of heavy alcohol and drug use than the general population" (p. 121). Many reports discussed by Roberts (2006) indicate that there is more alcohol use in the lesbian [WSW] community. "Data from the Women's Health Initiative study and other, smaller studies indicate that tobacco use is higher among lesbians than among the general female population" (Mravcak, 2006, p. 284). This is in contrast with the Dibble study mentioned above. Roberts states "reviews have concluded that smoking rates for adolescent and adult lesbians are higher than their national comparison groups, with adolescents being highest for both groups" (2006, p. 585). It appears that there may be increased substance abuse among WSW in comparison to heterosexual women but this, too, needs further research. Many factors may put WSW at higher risk for substance abuse and/or mental health issues including: social stigma, societal pressures, internalized homophobia, the "coming out" process, and discrimination (Spinks, Andrews & Boyle, 2000; Mravcak, 2006; Roberts, 2006). With all patients, primary care providers need to provide referral resources and emphasize the health benefits of smoking cessation and ending substance abuse.

Mental Health

"Most lesbians and bisexual women are emotionally healthy and well-adjusted" (Mravcak, 2006, p. 284). However, mental illness, especially depression, occurs in the WSW population and may occur in higher rates than heterosexual women. The most common mental
illness reported in WSW is depression (Roberts, 2006). It is difficult to accurately capture the full effect of marginalization, discrimination and stigmatization on the mental health of an individual or minority group. The results can be devastating. LGBT persons “are subject to unique social stressors such as prejudice, stigmatization, and antigay violence that may precipitate mental distress, mental disorders, suicidal ideation, and self-harm” (Mravcak, 2006, p. 284). Suicide attempts may occur at a higher rate in WSW than in heterosexual women. Matthews, et al. (2002) performed a study of the role of sexual orientation in predicting depressive distress in a sample of women. Their study’s sample (n=829) showed “Fifty-one percent of lesbians and 38% of heterosexual women reported seriously considering suicide at some point in the past” (Matthews, et al., 2002, p. 1134). Also, “more than twice as many lesbians as heterosexual women in this age group [15-19] reported suicide attempts” (Matthews, 2002, p. 1134). Although research is limited, LGBT youth may also be at increased risk for suicide attempts compared to their heterosexual counterparts. Haas, et al. (2011) state “over the last two decades, an increasing body of empirical research in the United States and other countries has pointed to significantly elevated suicide risk among LGBT compared to heterosexual people” (p. 41).

Although there is limited research describing reasons for increased risk in the WSW population, it may be that many of the mental health issues are associated with the consequences of being a WSW living in a “heterosexual-oriented society” (O’Hanlan, Dibble, Hagan & Davids, 2004, p. 228). “Heteronormativity denotes how the social life of Western culture is constructed on the assumption that all people are heterosexual, assuming the heterosexual nuclear family norm to be natural and universal, and thereby making homosexuality socially invisible and second class” (Bjorkman & Malterud, 2009, p.239). It is important to understand
that marginality of any kind can be a risk factor for mental health issues. Lehavot and Simoni (2011) suggest screening (and referring as needed) for minority stress and the presence/absence of "coping resources" among sexual minority women. Regardless of the possible reasons for increased risk for mental health issues in the WSW population, it is of utmost importance that assessment of mental health and possible suicidal ideation be evaluated for every patient.

**Obesity and Risk for Cardiovascular Disease**

Many sources suggest that WSW may tend to have higher rates of obesity than heterosexual women (Dibble, Roberts, Robertson & Paul, 2002; Mravcak, 2006; Roberts, 2006). "Lesbians are more likely than heterosexual women to have high BMI, waist circumference, and waist-to-hip ratio; however, they are also more likely to engage in regular exercise" (Mravcak, 2006, p. 285). There is conflicting information on the risk of cardiovascular disease for the WSW population. Roberts (2006) states "research has found increased risk for cardiovascular disease in lesbians" (p. 584). On the other hand, Mravcak (2006) states "there is no proven increase in the risk of cardiovascular disease among lesbians and bisexual women" (p. 285). Risk factors for cardiovascular disease in the WSW population provided by Roberts (2006) include: "higher rates of obesity, smoking, alcohol use, and less intake of fruits and vegetables" (p. 584).

"Based on the currently available data, the committee [performing the report] concludes that it is not possible to determine whether lesbians are indeed at higher risk for cardiovascular disease than women in general" (IOM, 1999, p. 68). More research on the rates of obesity and cardiovascular disease in the WSW population is clearly needed. However, regardless of sexual orientation, the individual risk factors associated with obesity and consequential risk for cardiovascular disease need to be addressed for every patient.
Sexually Transmitted Diseases and Reproductive Health/Services

Women who describe themselves as having same sex orientation may identify themselves as lesbian. However, sexual behavior is not the same as sexual orientation and these should not be confused (Hutchinson, Thompson & Cederbaum, 2006). Obtaining an accurate sexual history is important to identify risk factors for sexually transmitted diseases and safe sex practices. Sex practices of WSW vary widely and the most important thing a provider can do is refrain from making assumptions. The risk for sexually transmitted disease (STD) transmission in WSW changes based on sexual practices and the STD organism (Hutchinson, Thompson & Cederbaum, 2006). There is little is known about transmission of sexually transmitted diseases (STD) between two women. “Transmission of some STDs between women is known to occur; for other STDs, transmission between women is possible in theory but has not been proven” (Mravcak, 2006, pp. 281, 282). Mravcak (2006) provides a table in her article showing known transmission of STDs between women to include: herpes simplex, genital warts associated with human papilloma virus (HPV) and trichomoniasis. Included in the table is the description of theoretical STD transmission between WSW: chlamydia, gonorrhea, syphilis, hepatitis B, and HIV (Mravcak, 2006). Bacterial vaginosis, while not a sexually transmitted disease, is commonly found in the WSW and their female partners (Mravcak, 2006, Roberts, 2006) and it is believed to be transmitted between women (Roberts, 2006). As identified earlier in this paper, most WSW have a history of male sexual partners. This fact increases STD risk for these women and their partners. However “lesbians are less likely than bisexual or heterosexual women to be tested regularly for STDs” (Mravcak, 2006, p. 282). Many WSW may not believe that they are at risk for acquiring STDs and may even delay treatment when symptoms arise (Hutchinson, Thompson & Cederbaum, 2006). Health care providers may not have accurate information about the risks of
sexually transmitted infections for the female patients who are assumed to not be engaging in heterosexual intercourse (Hutchinson, Thompson & Cederbaum, 2006). This may result in the provider choosing to omit needed routine screening for these patients. (Hutchinson, Thompson & Cederbaum, 2006). Health care providers need to teach safe sex practices for WSW. Some recommendations given by Mravcak (2006) include: avoid contact with any visible genital lesions, cover sex toys that penetrate more than one person’s vagina or anus with a new condom for each person, use a barrier during oral sex, and use latex or vinyl gloves and lubricant for any manual sex that might cause bleeding. The Centers for Disease Control and Prevention (CDC, 2006) states

No barrier methods for use during oral sex have been evaluated as effective by the Food and Drug Administration. However, natural rubber latex sheets, dental dams, condoms that have been cut and spread open, or plastic wrap may offer some protection from contact with body fluids during oral sex and thus may reduce the possibility of HIV transmission (Fact Sheet for HIV/AIDS Among Women Who have Sex with Women).

The CDC (2006) also suggests the importance of knowing a partner’s HIV status since there is a potential for HIV transmission through menstrual blood. For WSW at this time, oral sex with a monogamous known partner whose HIV status is negative, with no lesions, or other risk factors, does not require barrier methods (CDC, 2006).

Reproductive health services are important topics to discuss with WSW patients. In the United States, approximately 6 to 14 million children have parents who are lesbian or gay (Mravcak, 2006). WSW may have children from previous relationships with men, or may choose to become pregnant through a sperm bank, known donor, or through heterosexual intercourse. Adoption and foster care are also options for WSW in many states. Other than dealing with societal stigma, studies have shown that children of lesbians have comparable development, and life skills adjustment to children in heterosexual families (Roberts, 2006). “The American
and/or practices, the population is diverse and each woman should be treated respectfully as an individual.

Information and research on WSW is very new and has much room for improvement. It is clear from the literature review that there is a need for more research on the WSW population and the health disparities discussed. Research could be improved by standardization of terms (i.e. lesbian, WSW, homosexual), inclusion of sexual orientation in tumor registry, improved research methodologies, and an increase in the number of studies aimed at the WSW population. Snyder (2011) performed a comprehensive literature review of medical publications on LGBT from 1950-2007 that also concludes there is a need for more specific and comprehensive research.

It is also evident from the literature review that many providers are not accessing information that is currently available. This is evidenced by continued culturally insensitive care, lack of knowledge about proper health screening and disparities, discrimination, and the continued assumption by some health care providers that all women are heterosexual until proven otherwise.

Guiding Philosophy

Practitioners are responsible for creating a safe and caring atmosphere for each patient. A “safe” environment is defined by the patient. What one patient defines or describes as a safe environment, another may not. It is important to identify the parameters of safety for every patient. Key factors contributing to providing a safe and caring context are: reflection, environment, language, and knowledge. See diagram 1.

Context is all the “in-betweens” of the reflection, environment, language, and knowledge. Most of context is made up of what is not said with words or language. These four factors
Contribute essential ingredients for creating a safe and caring context. A truly safe and caring health care context cannot be achieved by omitting any of the four elements. For example, a health care provider who provides a safe environment but does not use inclusive language is not providing safe care.

Reflection of one’s own feelings and possible biases about the WSW population is the first step in establishing a caring and safe patient-provider relationship. Acknowledging these feelings and examining one's own biases is a necessary part of providing a safe and caring environment. McManus (2008) states “awareness of how one’s own attitudes affect clinical judgment and the development of a non-homophobic attitude are important steps in providing culturally competent care” (p. 35).

Sustained behavioral change is generally accomplished only after a thorough process of self-questioning, in which a person explores his or her feelings, thoughts, and values as well as the reasons why he or she does and does not want to change. With respect to increasing competency in LGBT health, clinicians may find it helpful to start by asking: “How do I feel about learning more about LGBT health?” “What factors are motivating me?” “What factors are holding me back?” “What are my short-and long-term goals?” and “Do I have the resources and support I need to reach these goals?” (Potter, Goldhammer & Makadon, 2008, p. 9).

Self-reflection can be uncomfortable at first. This is a normal part of learning and takes practice. Reflection is an on-going assessment of one’s own feelings, reactions and motivations. It cannot be done once as a single exercise; it is always evolving based on new experiences and interactions. “Most of us, unless we feel uncomfortable, shaken, or forced to look at ourselves, are unlikely to change. It is far easier to accept our current conditions and adopt the least line of resistance” (Johns, 2004, p. 40). The process of self-reflection is a personal mission of growth and development which requires continual self-evaluation.

Environment is the first factor that a WSW patient will experience. The waiting room can be a significant indicator of the level of acceptance a WSW patient can expect. The
presence/absence of a posted non-discriminatory policy, the art/pictures displayed and the kinds of reading material available are all examples of environmental factors that a WSW patient will notice immediately. An example of a non-discriminatory statement is: “This office appreciates the diversity of women [and men] and does not discriminate based on race, age, religion, ability, marital status, sexual orientation, gender, or perceived gender” (O’Hanlan, Dibble, Hagan & Davids, 2004, p. 232). The environment will likely affect the WSW patient’s openness about their sexuality: “If the environment is perceived as completely unsafe, questioning by the provider will elicit an inaccurate history” (Zeidenstein, 2004, p. 301). Many waiting rooms and clinics have brochures, posters, and educational materials that “reflect heterosexual experience” (Zeidenstein, 2004, p. 301). Including posters/pictures depicting same sex couples, having brochures available that include same-sex experiences, including a visible non-discriminatory policy, and including a visible symbol that the WSW population will recognize as a sign of safety are all ways to make an environment more welcoming to the WSW population (Hutchinson, Thompson & Cederbaum, 2006; McManus, 2008; Mravcak, 2000; Spinks, Andrews & Boyle, 2000; Roberts, 2006). McManus (2008) gives examples of symbols that health care providers can display to demonstrate a safe environment for the LGBT population

- a pink triangle (symbol of homosexuality in the concentration camps of Nazi Germany),
- a rainbow flag (an icon for the LGBT community since 1978, when it was first used in the San Francisco Gay Pride Parade),
- or the Human Rights Campaign’s equality symbol (a blue square with a yellow “equal” sign, which is well known to LGBT persons as a sign of acceptance) (p. 35).

Language used by the provider, staff, and in brochures and history/intake forms is also a strong indicator of safety for the WSW patient. Using inclusive, non-judgmental, and open ended questions are important to convey caring and safety for each patient. This provides a space for each patient to be as open as she chooses to be. A few examples of open-ended and non-
judgmental language include asking “Do you have a partner or a spouse?” instead of “do you have a husband?” or “are you married?” Also asking “do you, or have you had, sexual relations with men, women, both, or none?” (Hutchinson, Thompson & Cederbaum, 2006; McManus, 2008; Mravcak, 2006; Roberts, 2006; Spinks, Andrews & Boyle, 2000). This question is more likely to end with an honest response in comparison to simply asking the patient if they are sexually active (McManus, 2008). “By taking a little time and asking a few sensitive questions, health care providers can create an environment of trust and inclusion” (Spinks, Andrews & Boyle, 2000, p. 139).

It is important to remember that a patient’s experience in a healthcare facility is impacted by all of the individuals they encounter during the process of care. These people include the person who makes their initial appointment on the telephone, the valet in the parking garage, the receptionist who greets them on arrival, the nursing assistant who takes their vital signs, and so on. Therefore, it is vital that everyone who works in the healthcare arena, including administrative and janitorial staff, receive training (Potter, Goldhammer & Makadon, 2008, p. 17).

Potter, Goldhammer and Makadon (2008) identify three domains of learning: attitudes, knowledge and skills. They discuss the impact attitude has on the patient-provider relationship and health outcomes. These authors suggest that each practitioner examine his/her emotional reactions and assumptions about the LGBT population. To help clarify one’s feelings towards the LGBT population, Potter, Goldhammer and Makadon (2008) suggest an exercise of writing down the first reaction to the words “lesbian”, “gay man”, heterosexual man”, heterosexual woman”, “bisexual” and “transgender” (p. 12). This could be a useful tool to begin reflection and examination of one’s attitudes. The three major areas of knowledge needed to care for an LGBT patient, as described by Potter, Goldhammer and Makadon (2008), are the need to have the skills and ability to create a safe environment, understanding the health consequences of stigma (including specific health care needs) and how to support and council LGBT patients. Skill
development is defined as “developing objectively measurable behaviors that demonstrate ability” (Potter, Goldhammer & Makadon, 2008, p. 17). They suggest that one of the very most important skills for provider development with the LGBT population includes how to “communicate sensitively and effectively” (p. 17).

Knowledge and competency are associated with caring practice. Understanding the different health risks for WSW than heterosexual women is valuable and necessary to provide quality care. The ability to refer patients to other providers who are known to be open and non-discriminatory is helpful (Spinks, Andrews & Boyle, 2000) and will enable patients to further trust their provider. The availability of information and resources on WSW specific health considerations is essential when providing care to the WSW population. (See table 1).

Conclusion

In a qualitative study by Bjorkman and Malterud (2009) on lesbian women’s experiences with health care, three essential qualities were described as necessary for the health care provider: awareness, attitudes and medical knowledge. This study reinforces the importance of personal attributes that play a role in developing a safe and caring patient-provider relationship. Some suggestions given in the literature for providing a safe and caring health care context for the WSW population include: using health questionnaires that are inclusive of same sex relationships and/or sexual practices, educational materials and/or brochures that are inclusive of same-sex relationships and sexual practices, open-ended questions from providers, using a non-judgmental approach to questions, images or posters with same-sex couples, and providing a non-discriminatory statement. (Roberts, 2006; Mravcak, 2006; McManus, 2008). While it is important to understand the common health disparities found in the WSW population, the WSW population itself is full of unique individuals from every walk of life. Each individual will
present a unique set of health issues and needs. Understanding the uniqueness and diversity of each individual allows the opportunity to provide individually-tailored health care for members of this population.
References


Diagram 1

CONTEXT

Environment

Reflection  Language

Knowledge

Safe and Caring Patient-Provider Relationship
Table 1 WSW/LGBT Online Resources for Providers

<table>
<thead>
<tr>
<th>Resource</th>
<th>Website</th>
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<tr>
<td>American Association of Suicidology</td>
<td><a href="http://www.suicidology.org/web/guest/stats-and-tools/special-populations">http://www.suicidology.org/web/guest/stats-and-tools/special-populations</a></td>
</tr>
<tr>
<td>Atlanta Lesbian Cancer Initiative</td>
<td><a href="http://www.thehealthinitiative.org">www.thehealthinitiative.org</a></td>
</tr>
<tr>
<td>Centers for Disease Control (CDC)</td>
<td><a href="http://www.cdc.gov/lgbthealth/women.htm">http://www.cdc.gov/lgbthealth/women.htm</a></td>
</tr>
<tr>
<td>Fenway Community Health</td>
<td><a href="http://www.fenwayhealth.org">http://www.fenwayhealth.org</a></td>
</tr>
<tr>
<td>Gay and Lesbian Medical Association</td>
<td><a href="http://www.glma.org">www.glma.org</a></td>
</tr>
<tr>
<td>Gay, Lesbian, Bisexual, Transgender Health Access Project</td>
<td><a href="http://www.glbthealth.org">www.glbthealth.org</a></td>
</tr>
<tr>
<td>Human Rights Campaign</td>
<td><a href="http://www.hrc.org">www.hrc.org</a></td>
</tr>
<tr>
<td>National Coalition for LGBT Health Rainbow Access Initiative</td>
<td><a href="http://www.lgbthealth.net">www.lgbthealth.net</a></td>
</tr>
<tr>
<td>The Mautner Project, the National Lesbian Health Center</td>
<td><a href="http://www.mautnerproject.org">www.mautnerproject.org</a></td>
</tr>
<tr>
<td>The Safeguards Project</td>
<td><a href="http://www.safeguards.org">www.safeguards.org</a></td>
</tr>
<tr>
<td>University of California San Francisco – Lesbian Health Research Center</td>
<td><a href="http://www.lesbianhealthinfo.org">www.lesbianhealthinfo.org</a></td>
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</table>

From Fenway, 2008; McManus, 2008,