



SUPPORTING THE HEALTH OF SEXUAL MINORITY WOMEN

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INTRODUCTION

This publication provides an introduction to understanding and addressing sexual minority women's (SMW) health. Although SMW have the same preventive health requirements as all women, they also have unique disparities and health care needs. The first half of this publication describes the physical and behavioral health issues that disproportionately affect sexual minority women (SMW) due to stigma and a shortage of culturally affirming care. The second part highlights evidence-informed practices that hold the most promise in supporting SMW who access health centers. A case example of a patient is presented to illustrate how a disparity can be addressed through the integration of primary care and behavioral health services, and by using a trauma-informed approach.

WHO ARE SEXUAL MINORITY WOMEN?

The term “sexual minority women” (SMW) describes the broad group of women who identify as lesbian, bisexual, queer, questioning, and other non-heterosexual identities, as well as women who have same-gender partners but identify as straight. Despite some common stereotypes, SMW may display a range of gender expressions, from very masculine to very feminine. SMW also can be found in every demographic group; that is, they may be any race, ethnicity, age, or religion; they come from all socioeconomic backgrounds; and they may be single, partnered, married, and with or without children. Moreover, there are many transgender women and people with non-binary gender identities who identify their sexual orientation as lesbian, bisexual, queer, or another term that falls under the sexual minority umbrella.^a



a. For definitions of these terms, see Glossary of LGBT Terms for Health Care Teams, at www.lgbthealtheducation.org/wp-content/uploads/2018/03/Glossary-2018-English-update-1.pdf

BARRIERS TO HEALTH CARE AND WELL-BEING

Stigma and discrimination towards sexual and gender minorities continue to occur frequently throughout the U.S., even in health care settings. Throughout their lifetimes, SMW must navigate various forms of bias directed against their gender and sexual orientation. SMW who are members of a racial/ethnic minority, have a disability, and/or are from another marginalized group can face additional stigma and bias from multiple directions. For example, many Asian American, African American, and Latinx SMW report feeling rejected or invisible within the larger lesbian, gay, bisexual, transgender, and queer (LGBTQ) community due to their race/ethnicity; many also describe the need to hide or de-emphasize their sexual orientation within their racial/ethnic community and religious institution, as well as at work and school.

Coping with stigma, identity concealment, and discrimination can lead to stress, isolation, and internalized homophobia and transphobia, all of which can contribute to health disparities. External stigma, whether enacted as violent attacks, verbal harassment, or institutional biases can lead to disruption of a sexual or gender minority person's general psychological processes, such as coping, emotional regulation, and interpersonal functioning. Internal stigma-related stressors, like internalized homophobia and expectations of rejection, can have similar effects. These negative processes are thought to contribute to a higher prevalence of depression, anxiety, substance use disorders, and post-traumatic stress symptoms in sexual and gender minorities, which can subsequently lead to poor self-care, decreased engagement in treatment, and physical health problems.

Additional common barriers to health and wellness for SMW include:

- Lack of access to culturally appropriate medical and support services
- Heightened concerns about confidentiality
- Stress created by fear of losing a job, housing, family, friends
- Lack of opportunities to talk about sexual orientation, gender identity, or sexual behavior in clinical settings.^{1,2,3,4}

COMMON HEALTH DISPARITIES

Research studies have found multiple disparities in health services, behaviors, and outcomes for SMW. The most researched areas of concern include the following:

Substance use

In comparison to sexual majority women, SMW are significantly more likely to:

- Smoke cigarettes⁵
- Use illicit drugs⁶
- Binge drink alcohol⁶

Mental health

In comparison to sexual majority women, SMW are significantly more likely to have:

- Any mental illness; severe mental illness; at least 2 co-occurring disorders⁶
- Major depressive episode in the past year; generalized anxiety disorder⁶
- Suicidal ideation and attempts⁷

Physical health

In comparison to sexual majority women, SMW are significantly more likely to:

- Be overweight/obese⁸
- Report poor general physical health^{8,9,10}
- Have activity limitations^{8,10}
- Report asthma⁸

Harassment, abuse, and intimate partner violence

In comparison to sexual majority women, SMW are:

- At higher risk for violence and harassment from peers and family during adolescence¹¹
- At equal or higher risk for intimate partner violence¹²



Sexual health

SMW are not at increased risk for sexually transmitted infections (STIs), but should still be screened for STIs according to current guidelines for women.¹³ Providers should also be aware that HPV and herpes simplex are transmissible from woman to woman.¹⁴

Breast cancer

In comparison to sexual majority women, SMW have:

- Lower rates of mammography screening
- More risk factors for breast cancer, but no evidence of higher incidence of breast cancer^{15,16}

SMW should be screened according to guidelines for all women, and they may need additional education and support to access mammography.

Cervical cancer

In comparison to sexual majority women, SMW have:

- Lower rates of receiving Pap smears

SMW have 37% prevalence of high-risk HPV and should be vaccinated and screened as per guidelines for all women.¹⁷

BISEXUAL WOMEN AND DISPARITIES

According to national demographic surveys, bisexual women represent a higher percentage of SMW than lesbian women; and yet, bisexual women are often the least visible and most stigmatized members of the sexual minority community. Bisexuality challenges the binary view that people can only be either straight or gay; perhaps because of this defiance of expectations, bisexual people may experience rejection and disdain from both straight and gay communities. Myths and negative stereotypes about bisexual people abound; e.g., that they are “just going through a phase,” or that they are promiscuous and more likely to be unfaithful to a partner.

As a highly stigmatized group experiencing excessive minority stress, bisexual women have even greater health disparities than lesbian women. Studies document a higher prevalence of depression, anxiety, suicidal ideation, poor general health, eating disorders, and experiences of physical and sexual abuse among bisexual women as compared to lesbian women.^{18,19,20} For example, the 2015 National Survey on Drug Use and Health found that 47.5% of bisexual women respondents reported any mental illness, compared to 27.3% lesbian women, and 20.4% straight women.⁶ Bisexual women are also more likely than other SMW to delay or not access health care due to cost and non-cost reasons (e.g., lack of transportation, or difficulty getting an appointment at a convenient time).²¹

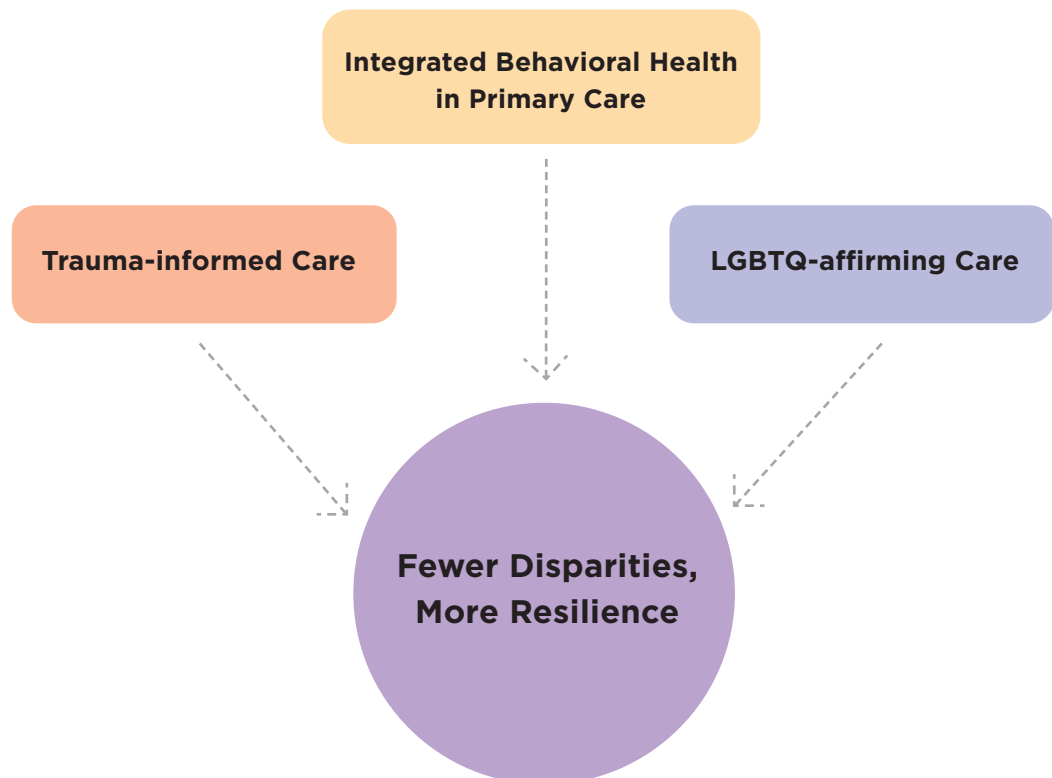


BEST AND PROMISING PRACTICES

Despite the existence of disparities among SMW, it is important to recognize that the majority of SMW lead healthy lives and demonstrate resilience in the face of stigma and bias. As such, an important role for the clinician is to help bolster resilience, validate identity, and strengthen positive self-regard in SMW patients and clients.

Figure 1 presents a diagram of three organizational practices that hold particular promise for improving the physical and behavioral health of SMW. An ideal model of care integrates these three practices to achieve excellence and equity for SMW--and all health center patients.

Figure 1: Model of Care for Improving Health Equity





LGBTQ-affirming Care

The critical components of LGBTQ-affirming care include:

- Accurately identifying LGBTQ patients through routine collection of data on sexual orientation and gender identity
- Building trust with LGBTQ patients through engagement with the local LGBTQ community
- Providing a safe and inclusive environment by training staff to use LGBTQ-inclusive communication techniques, and by adding inclusive language and images to forms, marketing materials, and policies
- Helping patients enhance resilient coping and utilize harm-reduction techniques

Publications and online training resources on LGBTQ-affirming care can be found at www.lgbthealtheducation.org

Trauma-informed Care

All patients can benefit from health care organizations that use a trauma-informed approach.²² SMW often experience trauma, such as childhood maltreatment and adult sexual assault.²³ Using a trauma-informed approach acknowledges the need to understand a patient's life experiences in order to deliver effective care. Trauma-informed care has great potential to improve patient engagement, treatment adherence, health outcomes, as well as provider/staff wellness. A core principle of trauma-informed care is to transform the culture of an entire health care setting to create a sense of safety, trustworthiness, and collaboration between patients and staff. On a clinical level, a trauma-informed approach shifts the focus of health care away from "what is wrong with you?" to "what happened to you and how can we help?"

Universal trauma screening is recommended for all patients seeking health care. The sooner the trauma is recognized, the easier it is to prevent health risks and chronic disease later in life. For example, health centers can use the following routine screening question to assess for intimate partner violence.

“The next questions are about you and a partner. By ‘partner’ we mean current or former: husband/wife, boyfriend/girlfriend, domestic partner, romantic partner, or sex partner. Has a current or former partner...

- *Made you feel cut off from others, trapped, or controlled in a way you did not like?*
- *Made you feel afraid that they might try to hurt you in some way?*
- *Pressured or forced you to do something sexual that you didn’t want to do?*
- *Hit, kicked, punched, slapped, shoved, or otherwise physically hurt you?”*

Response options for each:

1. Yes, in the past year
2. Yes, but not in the past year
3. No

More information on trauma-informed care and screening can be found on the website of the Substance Abuse and Mental Health Services Administration (SAMHSA) National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraint (NCTIC): www.samhsa.gov/nctic/trauma-interventions

Behavioral Health Integration

Behavioral health integration improves access, engagement, and health outcomes for patients with co-occurring behavioral health or substance use disorders through systematic coordination of primary care and behavioral health services.²⁴ Behavioral health integration models include: 1) coordinated in-house primary care with either an outside behavioral health agency or an in-house co-located behavioral health department (on a different or same floor), or 2) fully integrated care teams consisting of a primary care and behavioral health care provider. Given that SMW have increased risk for certain substance use disorders and mental illnesses, a coordinated system with primary care can serve them well. More information on behavioral health integration can be found on the SAMHSA-HRSA Center for Integrated Health Solutions website: www.integration.samhsa.gov

PUTTING PRINCIPLES INTO PRACTICE: A CASE EXAMPLE

Below is a case example of using a trauma-informed and LGBTQ-affirming approach with an SMW patient being seen at a health center that uses the behavioral health integration model.

Liza is a 30-year-old cisgender woman seeing a primary care provider (PCP) at a local health center. At her last exam, Liza had a BMI of 29, a slightly higher-than-normal blood sugar level, and was told that she needs to diet and exercise more in order to prevent type 2 diabetes. Liza also has a history of depression. Liza lives with her wife of 3 years, who is a caring partner. However, Liza and her wife have a long-standing habit of indulging together in treats and desserts whenever Liza is feeling down. How can the health center make sure Liza's health care experience is affirming and effective today?





Because there is a higher prevalence of obesity among SMW, there is concern that SMW may also have an increased risk for type 2 diabetes risk. Of note, a 2018 analysis from the Nurses' Health Study II (one of the largest prospective cohort studies of chronic disease in American women) found that lesbian and bisexual women had 1.27 times the risk of developing type 2 diabetes compared to straight women, and that the risk was greater at younger ages (under 50). The difference in risk between SMW and straight women was explained by higher BMI in the SMW subjects.²⁵

In Liza's case, she has a clear risk of developing diabetes that can be prevented with changes in her health behaviors. Research shows us, however, that simply telling someone to lose weight is rarely enough, and that many different cultural and environmental factors play important roles in influencing weight gain and loss.²⁶ In fact, a second analysis of the Nurses' Health Study II found that

despite having a higher BMI and diabetes risk, SMW subjects ate higher quality diets and exercised more than the straight study participants. These seemingly opposed findings raises the question of what else may have contributed to obesity and diabetes in the SMW subjects. The authors concluded that stigma-related psychological distress, as well as behaviors such as smoking, and binge drinking, likely added to the increase in diabetes risk.²⁵ Other studies suggest that binge eating as a maladaptive coping mechanism for discrimination may account for obesity in SMW.²⁷ Additionally, some researchers have suggested that SMW communities are more accepting of overweight bodies than straight women and gay male communities, and that some SMW may see themselves as being of a healthy weight even when they are overweight or obese.²⁸ In sum, it is clear that interventions to address weight, diabetes, and related health issues among SMW need to take larger social and cultural issues into account.

Liza's health center can take several steps to ensure she is engaged in care and has the tools and supports necessary to support her in preventing diabetes. What follows is an ideal scenario for Liza:

First, in the waiting room, Liza notices educational health brochures focused on different populations, including one that talks about LGBTQ health. Seeing this brochure makes Liza feel welcomed, and it increases the likelihood that she will feel comfortable being open about her sexual orientation and her concerns with health center staff. Liza also appreciates the friendly attitude of the front desk staff, and the fact that they did not try to guess her gender or mistakenly refer to her as "sir," which happens on occasion because Liza is tall and has short hair.

The staff ask Liza to complete a registration form, which includes sexual orientation and gender identity questions alongside other demographic questions, as well as clear information about how these data will be protected and used for health care purposes only. Liza is also given a tablet to complete universal screeners for depression, anxiety, intimate partner violence, and drug and alcohol use. The demographic and screening information are directly transmitted to Liza's PCP in real time. When Liza meets with the PCP, the PCP notes that Liza has an elevated score for depression and had experienced feeling unsafe in a previous relationship. During the exam, the PCP briefly discusses Liza's scores and then initiates a warm handoff to a behavioral health care manager who is located on the same medical floor and is part of the broader care team. During this session, the

care manager asks Liza about some of the stressors and situations in her life that may have an impact on her diet and her feelings of hopelessness. By doing so, the care manager raises Liza's awareness of how her ability to lower her weight is not a personal failing, but rather rooted in a complex array of factors that includes her environment, and experiences of stigma and abuse. For example, Liza begins to recognize that her ex-partner's behavior, along with disapproval of her sexual orientation by some family members, have made her hypervigilant and more likely to conceal her identity. This, in turn, creates stress that contributes to Liza's depression and eating patterns. Additionally, the potential trauma associated with her previous relationship may play into a fear of disappointing her wife by eating fewer desserts. Together, Liza and the specialist can discuss healthier ways Liza can express her love and appreciation to her wife. In Liza's case, this brief intervention is not sufficient to manage her depression and diabetes risk, so the care team makes an additional referral to an in-house behavioral health provider who can further work with Liza to help instill positive self-regard, and help Liza believe that she does not need to always conceal her identity or expect to be victimized based on her sexual orientation. The health center also supports Liza in signing up for a nutritional program at a local facility that is known to be welcoming to LGBTQ people.

CONCLUSION AND RESOURCES

In addition to adopting a trauma-informed approach and behavioral health integration model, there are a variety of other organizational-level as well as individual clinical-level strategies for supporting the health of SMW and other LGBTQ people. Box 1 provides a list of resources on the National LGBT Health Education's website that have information, tools, and tips for offering culturally affirming care and services for SMW and other sexual and gender minorities in health centers.

Box 1: Resources Relevant to SMW Health Care on the National LGBT Health Education's Website

Webinars: www.lgbthealtheducation.org/lgbt-education/webinars/

- Best Practices in Behavioral Health for Sexual Minority Women
- Lesbian and Bisexual Women's Health: Prevention, Wellness, and Empowerment
- Breast Cancer Risk and Prevention in Lesbian and Bisexual Women
- Understanding Bisexuality: Challenging Stigma, Reducing Disparities, and Caring for Patients
- Importance of Behavioral Health Integration for LGBT Patients
- Same-Sex Domestic Violence: Considerations, Suggestions, and Resources
- Implementing Routine Intimate Partner Violence Screening in a Primary Care Setting
- Obesity, Feeding and Eating Disorders, and Body Dysmorphic Disorder among LGBTQ Youth
- LGBT Health Disparities & Hypertension Control Opportunities with the American Heart Association

Publications: www.lgbthealtheducation.org/lgbt-education/publications/

- Ready, Set, Go! Guidelines and Tips for Collecting Patient Data on Sexual Orientation and Gender Identity (SO/GI)
- Learning to Address Implicit Bias towards LGBTQ Patients: Case Scenarios
- Focus on Forms and Policy: Creating an Inclusive Environment for LGBT Patients
- Providing Inclusive Services and Care for LGBT People: A Guide for Health Care Staff
- Glossary of LGBT Terms for Health Care Teams

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