Healthcare practices and issues of rural lesbians
by Julia Ann Dybbro

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Nursing
Montana State University
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Abstract:
Rural lesbians constitute a unique population of women in which scant has been published. Little is known of their healthcare experiences, practices, and issues. This qualitative study attempts to fill in the gaps between rural and urban lesbian studies. Purpose: The purpose of this study is to describe and document rural lesbians’ healthcare issues, practices, and experiences.

Method: A total of 14 rural self-identified lesbians were interviewed using open-ended questions and an ethnographic approach to data analysis. The interview questions centered on health status, healthcare experiences and practices, healthcare provider (HCP) preferences, philosophies around health and healthcare, disclosure of sexual preference to the HCP, and related tangents. Marginalization served well as the conceptual framework for this study as rural lesbians occupy the margins of rural mainstream society in several ways based on their gender, sexual orientation, and access to services.

Findings: All 14 informants were in good health and only three had serious health concerns in the past that involved extensive interaction with the healthcare system. There was an overwhelming preference for alternative healthcare and alternative HCPs although allopathic medicine was utilized with serious illness and in emergencies. A glaring lack of regular healthcare existed among the sample. Only 29% of the informants received annual PAP smears with the remaining PAP smear interval ranging from 2-18 years. Other healthcare issues emerging from the data included disclosure issues, isolation, drug and alcohol abuse, and depression and self-esteem issues. The barriers to optimal healthcare identified by the informants in the study included the lack of comfortable means for disclosing sexuality to the HCP, lack of anonymity and confidentiality in rural healthcare settings, homophobia in rural settings, and lack of financial resources. However, emerging from the data was a pattern of resiliency and creativity described by many of the informants as a way of adapting to living in the rural environment.
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A thesis submitted in partial fulfillment
of the requirements for the degree
of
Master of Nursing

MONTANA STATE UNIVERSITY-BOZEMAN
Bozeman, Montana

May, 1997
APPROVAL

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This thesis has been read by each member of the thesis committee and has been found to be satisfactory regarding content, English usage, format, citations, bibliographic style, and consistency, and is ready for submission to the College of Graduate Studies.

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Date 5/9/97
J. A. Dybbro was born in Fairbanks, Alaska before Alaska became a state. She always wondered as a child if this made her a Russian in reality. Her Father started one of the first grocery stores in Alaska and her mother was a W.W.II pilot in the Women’s Air Service Corps. Adolescence was whiled away on the Willamette River in Newburg, Oregon and horses became a passion in high school on Vashon Island, Washington. Horses continued to drain the bank account all through college at Washington State University but didn’t stop the slow progress towards an anthropology degree. Discovering one needed a PhD to work with Jane Goodall in the jungle, Julie went back to school to be a nurse so she could at least travel to the jungle. Travel she did, but the closest she ever got to Jane was at a lecture in Seattle where she at least got an autograph. After 10 years of nursing in ICU’s and home health, Julie careened back to school when it became evident there might be a different kind of fun to be had in the ever-powerful profession of nursing. Though not jungle-like, Montana was a great adventure nonetheless.
ACKNOWLEDGMENTS

Thankyou.......

For being the role model of a lifetime: my mother, Betty.

For guiding by excellent example: Helen Lee and Jan Buehler.

For the big whoop at the end: Patricia Stevens.

For beating me silly with humor: Teresa Henry.

For giving me context: Sarah, Linda, Keven, Laurie, Nancy, and Patty.

For giving me courage: The Informants Fourteen.

For divine sustenance: Mary B.

To my phantasmagoria of friends: Carol, Siggy, Tina, Robin, Kate, Kathy, Kalyn, Tracey, Pat, Pam, Cynthia, Boo, Sister, Sue, Karen, Jean, Linda, Laura.

And never without: Max and Stella. Woof.
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ABSTRACT

Rural lesbians constitute a unique population of women in which scant has been published. Little is known of their healthcare experiences, practices, and issues. This qualitative study attempts to fill in the gaps between rural and urban lesbian studies. **Purpose:** The purpose of this study is to describe and document rural lesbians’ healthcare issues, practices, and experiences. **Method:** A total of 14 rural self-identified lesbians were interviewed using open-ended questions and an ethnographic approach to data analysis. The interview questions centered on health status, healthcare experiences and practices, healthcare provider (HCP) preferences, philosophies around health and healthcare, disclosure of sexual preference to the HCP, and related tangents. Marginalization served well as the conceptual framework for this study as rural lesbians occupy the margins of rural mainstream society in several ways based on their gender, sexual orientation, and access to services. **Findings:** All 14 informants were in good health and only three had serious health concerns in the past that involved extensive interaction with the healthcare system. There was an overwhelming preference for alternative healthcare and alternative HCPs although allopathic medicine was utilized with serious illness and in emergencies. A glaring lack of regular healthcare existed among the sample. Only 29% of the informants received annual PAP smears with the remaining PAP smear interval ranging from 2-18 years. Other healthcare issues emerging from the data included disclosure issues, isolation, drug and alcohol abuse, and depression and self-esteem issues. The barriers to optimal healthcare identified by the informants in the study included the lack of comfortable means for disclosing sexuality to the HCP, lack of anonymity and confidentiality in rural healthcare settings, homophobia in rural settings, and lack of financial resources. However, emerging from the data was a pattern of resiliency and creativity described by many of the informants as a way of adapting to living in the rural environment.
CHAPTER I
INTRODUCTION

Lesbians as a population of women are a distinct subculture with characteristic behaviors and shared experiences. They are bound culturally by an affiliation with other women that may or may not include sexual, political, spiritual, social, psychological, and familial aspects. This is not to say that all lesbians are alike; they are as diverse a population as one could find.

Our society has struggled with the existence and acceptance of the lesbian individual as well as the lesbian culture. This societal non-acceptance has resulted in a healthcare system that does not adequately serve the needs of lesbians (Stevens, 1992). This study investigating the healthcare issues and experiences of rural lesbians would be unnecessary if lesbianism was accepted as a healthy variation of human sexuality. There would not be the perception as held by many lesbians that there was something to hide from the health care provider or that the healthcare system was anything but a safe place to get appropriate, quality, humane healthcare.

Purpose

To deliver quality health care it is imperative that the needs, perceptions, and common life experiences of the client be known. Using research, facts can be separated from myths concerning lesbian healthcare needs and client-perceived health issues. No studies have been published that address the health issues and practices of rural lesbians.
The purpose of this study is to begin documenting the personal and life experience of rural lesbians in relation to their health issues and practices. The findings will assist healthcare providers (HCP’s) to have a better understanding of rural lesbian health issues and therefore provide more holistic care to these clients.

**Background and Significance of the Study**

Lesbians are labeled the invisible minority in healthcare (Robertson, 1992). Stevens (1994) identified that 77% of the healthcare interactions experienced by the lesbians in her study were negative. The negative label stemmed from a) the providers’ assumption that the client was heterosexual, b) the providers’ disdain for the lesbian lifestyle, or c) the providers’ lack of knowledge around the healthcare issues and needs of the lesbian client. These reactions have promoted the invisibility of lesbians in healthcare because many lesbian clients choose not to disclose their sexual orientation in order to avoid a negative experience. In a survey of 110 gynecologists in Florida, 50% stated they did not think any of their clients were lesbian (Robertson, 1992). This finding seems unlikely and, again, points to either lesbians’ unwillingness to disclose who they are, or a significant percentage of providers are unaware of the sexual orientation of their clients.

It is not surprising that the end result of invisibility and negativity is sub-optimal healthcare for lesbians. Lesbians have a much lower rate of cancer screening and preventive healthcare visits than the general population (O’Hanlon, 1995). It appears that lesbians are actively avoiding interfacing with the healthcare system. This could put them at risk for increased morbidity and mortality with some very preventable diseases. Until recently there has been very scanty research on the actual health risks of lesbians. Many
lesbians and HCP's alike are under the false impression that all lesbians are at very low risk for sexually transmitted diseases (STD's). Research is in the beginning stages of documenting what constitutes risk behaviors for lesbians. Now we know, for instance, that the Human Papillomavirus (HPV) can be transmitted between women (Marrazzo, 1996). Since HPV causes the vast majority of cervical cancers, this indicates that lesbians could be at risk and should be receiving periodic PAP smears. This is just one example that substantiates the need for more knowledge about the healthcare practices and health issues of lesbians in order to design appropriate healthcare interventions and client education.

Rural lesbians may or may not have unique health concerns or barriers to optimal healthcare as has been reported in numerous studies about their urban counterparts. As previously mentioned, there were no published studies on rural lesbians found. In Bushy's (1993) article on rural women, she states “It is impossible . . . to discuss a woman's health status without considering her lifestyle in the context of family networks as well as the community in which she lives” (p.187). This statement may very well apply to rural lesbian women but the context of family and community may be profoundly different. Either way, however, the impact on health status remains significant.

The impact of homophobia on the rural lesbian dweller and the potential stress it creates also bears consideration. The duress of societal unacceptance has been found to have a very negative effect on urban lesbian's sense of internal well-being (Trippet, 1994). It warrants investigating whether the same is true for rural lesbians.
Research Question

In order to obtain information on the healthcare practices and perceived healthcare issues of rural lesbians, the following research question was used to guide this study: What are the healthcare experiences of lesbians living in a rural environment? Sub-questions were used to expand the above research question: a) What are the physical and mental health concerns of the rural lesbian? b) What are the healthcare practices of the rural lesbian? and c) Does the rural lesbian disclose her sexual orientation to the health care provider and what are the reasons for disclosure versus non-disclosure?

Conceptual Framework

The conceptual basis for this study is marginalization. Marginalization has been a long recognized concept in the fields of anthropology and sociology used to describe and characterize people on the periphery or fringes of the center (Mayer, 1970; Spradley, 1979). People on the margins occupy this fringe position by virtue of their “differentness” from those perceived to be at the center. The term implies that the “center” is the seat of power and the margins have considerably less power (Ferguson, 1990). Audre Lorde (1990) called this center the “mythical norm” because it had a narrow definition, i.e., “white, thin, male, young, heterosexual, Christian, and financially secure” (p. 282). All other members of society are measured decrementally against this definition.

Marginalization is the term used by Hall, Stevens, and Meleis (1994) to describe the process whereby individuals or groups of people on the periphery of society, by virtue of their decreased power, economic security, and social acceptance, find themselves at
the fringes of the established healthcare system as well. Being on the fringe means that the healthcare needs of the marginalized are often overlooked, ignored, or inadequately investigated.

Access is a key element that is compromised with marginalization. Full access implies that healthcare is affordable, geographically available, and socially and culturally appropriate (Stevens, 1993). Lesbians are marginalized in the healthcare system because of decreased social acceptance and full access is denied because of a lack of socially and culturally appropriate healthcare.

Vulnerability is a product of marginalization in that being on the edge of the center or mainstream means more exposure to potential (psychological or physical) harm (Hall et al., 1994). The physical harm could be manifested by sub-optimal or inappropriate healthcare and internalized homophobia creates a psychological strain via a marginalized person being bombarded by negative images of their identity.

The other side of vulnerability can be adaptive (Hall et al., 1994). There can be a reaction of resilience and durability that enhances the individuals ability to survive on the margins. There can be a creative ability manifested out of marginality and vulnerability that enhances maneuverability within an otherwise constricting environment. Lee (1991b) found in her study of rural adults that there was a significant relationship between the characteristic of hardiness and perceived mental and social health. In the case of rural lesbians, it would be helpful to ferret out their vulnerabilities and then capitalize on their adaptive behaviors in order to better accommodate their healthcare issues and needs.
Acknowledging that the healthcare experience of the marginalized can be very different from that of the mainstream helps to put their beliefs and behaviors into perspective. Knowledge and recognition of human diversity is an opportunity to empathically approach the healthcare needs of those on the margins.

This qualitative study provides a beginning to understand the experiences of rural lesbians in relation to their healthcare. The study describes through the informants' narratives the central domains of their experiences and perceptions as rural-dwelling lesbians interfacing with the healthcare system.
CHAPTER 2

REVIEW OF THE LITERATURE

Keeping the research questions and purpose of this study in mind, the review of the literature was divided into five major categories: a) lesbians’ healthcare experiences and provider preferences, b) lesbians’ mental and physical health issues, c) disclosure of sexual orientation to healthcare providers, d) barriers to optimal healthcare, and e) rural lesbian healthcare issues.

Lesbians’ Healthcare Experiences and Provider Preference

There is overwhelming evidence in the literature that lesbians have had a plethora of negative experiences when interfacing the institution of traditional healthcare in the U.S. and abroad (Conway & Humphries, 1994; Denenberg, 1995; Hall, 1994; Hitchcock & Wilson, 1992; James, Harding, & Corbett, 1994; O’Hanlon, 1995; Quam & Whitford, 1992; Robertson, 1992; Stevens, 1992; Stevens, 1994; Stevens & Hall, 1988; Trippet, 1994; Zeidenstein, 1990). Some of the negative experiences documented are a) attitudes ranging from blatant disdain with refusal to give care to embarrassment and uncertainty from the healthcare provider (HCP) when sexual orientation of the lesbian patient was disclosed, b) ignorance of lesbian lifestyles and sexual practices on the part of the HCP, rendering her/him ill-prepared to handle specific lesbian healthcare issues, c) inappropriate questioning and care based on an assumption of heterosexuality by the
HCP, d) exclusion of the patients' partner in the healthcare interaction, e) breech of confidentiality, f) attempts to refer to mental healthcare for "curing" of the lesbian lifestyle, g) rough physical handling, h) no comfortable opportunity to disclose sexuality, and i) a generally unsupportive atmosphere (Lucas, 1992; Stevens, 1992; Stevens & Hall, 1988).

One of the most common scenarios cited in the literature that renders a healthcare experience uncomfortable is the assumption of heterosexuality (Hitchcock & Wilson, 1992; Robertson, 1992; Stevens, 1992; Stevens, 1994; Stevens & Hall, 1988). Often, the lesbian client chooses not to or is not given an opportunity to disclose her sexuality and one of the first questions asked by the HCP is "Are you sexually active?" This immediately puts the lesbian client on the spot. If she is sexually active with women only and she answers the question "Yes," the next question, of course, is "What birth control method do you use?" She answers "None" and then must face the sequelae of questions as to whether she wants to get pregnant and why she does not use birth control. If she answers "No," then the HCP may query her as to why she is not sexually active; "Are you afraid of getting AIDS, is there some sexual dysfunction?" These circumstances cause a distancing between client and HCP if the client does not feel safe or confident in disclosing her sexuality under these circumstances and covers the questioning with outright lies or is vague in her answers. The end result is that the client feels uncomfortable, the HCP does not have the full picture, and the opportunity for a meaningful accurate exchange of information and appropriate education has been missed.
Stevens' (1994) study examined healthcare interactions from a wide variety of settings. Forty-five lesbians recounted 332 separate interactions, 77% of which were deemed negative by the respondents. What is even more significant is that 44% of the respondents stopped seeking healthcare as a result of the negative experiences. In Stevens' (1992) review of lesbian research, of the 19 studies exploring lesbians' healthcare experiences, all reported varying levels of negative experiences or fear of negative reactions from the HCP. Half of the studies stated that the respondents either delayed or hesitated using the healthcare system altogether because of the negativity and disclosure issues.

The good news is that negativity is not the only reaction lesbians have experienced, even though the literature is more heavily weighted on that end of the scale. In a 1980 study done by McGhee and Owen (Stevens, 1992), 73% of the respondents disclosed their sexuality to the HCP and of those, 42% said they got a positive response from the HCP. Another study revealed that respondents often felt comfortable disclosing to female HCP's.

The HCP preferences of lesbians have predictably been shaped by their collective experiences in the healthcare arena. Overwhelmingly, females were the provider of choice (Hitchcock & Wilson, 1992; Lucas, 1992; Robertson, 1992; Stevens, 1992). Lesbian HCP's took precedence over female HCP's in Lucas' (1992) study while the reverse was true in the study done by Trippet and Bain (1992). Female family practice physicians and female nurse practitioners were very close to one another at the top of the priority list of HCP's (Lucas, 1992). Female obstetrician/gynecologist physicians and
then female physician assistants came in 3rd and 4th in provider preference. Alternative providers were not mentioned in the study, although there is a large body of evidence in the literature that lesbians have a predilection for alternative practitioners including naturopaths, chiropractors, massage therapists, herbalists and homeopathics, acupuncturists, and energy healers (Robertson, 1992; Stevens & Hall, 1988; Trippet & Bain, 1992; Williams & Riehle, 1995). It is intimated this predilection comes from the perception that alternative practitioners are less judgmental, more holistic in their practice philosophy, have a greater emphasis on prevention and education, show more respect, and communicate better (Trippet & Bain, 1992). These perceptions are often coupled with a stated distrust of the mainstream medical model (Denenberg, 1995; Stevens, 1992; Trippet & Bain, 1992).

Lesbians' Health Issues

The main impetus of this literature review is not to make comparisons between the health issues of lesbians and heterosexual women; their issues may be similar in some areas and different in others. The importance lies in identifying the health risks and barriers to optimal healthcare of the lesbian community in order that they may be addressed. It is difficult to determine the prevalence of health problems in lesbians because of the lack of studies but the health issues identified in the literature include a) cervical and breast cancer, b) STD's, c) alcohol and tobacco abuse, d) depression and other mental health issues.

The literature points to a glaring lack of regular healthcare screening and check-ups in the lesbian population. On the one hand, lesbians say their top health priority is
cancer screening and detection and well woman care (Lucas, 1992). Lesbians, however, had a three-fold greater time interval in-between PAP’s than heterosexual women (O’Hanlon, 1995). In 2 large surveys, 5-10% of the respondents had never had a PAP screening. Zeidenstein (1990) found a 50% rate of yearly PAP smears in her study respondents, with the other half ranging from never to 3-5 years. Denenberg’s (1995) report cites that gynecological exams are deferred by lesbians secondary to lack of funds, lack of knowledge of their risk factors, and fear of a negative experience as mentioned earlier. The respondents who did not get yearly PAP’s felt they did not need gynecological care so often because of their lesbianism; many felt their risk for an abnormal PAP was far less than heterosexual women (Zeidenstein, 1990).

In general, lesbians may be in the lowest risk categories for sexually transmitted diseases (STD’s) and their incidence of the more common forms of vaginitis seem to be less than heterosexual women (Edwards & Thin, 1990; O’Hanlon, 1995). However, it is difficult to determine the exact risk that lesbians face in terms of STD’s and cervical and breast cancer for several reasons: a) very few studies on STD’s and cancer have been done that select specifically for lesbians (Edwards & Thin, 1990; Marrazzo, 1996), and b) it has been approximated that 70-80% of lesbians have had at one time or still have sexual relations with men (Cochran & Mays, 1988; O’Hanlon, 1995; Marrazzo, 1996; Zeidenstein, 1990).

Human papillomavirus (HPV) is associated with cervical cancer; transmission of HPV between women was thought to be rare. For those infected, the etiology was probably due to previous sexual contact with men (Conway & Humphries, 1994;
Edwards & Thin, 1990). Recent clinical findings as well as research on women who only have had sex with women is revealing that there may be a mode of HPV transmission between women (Edwards & Thin, 1990; Marrazzo, 1996). The recommendation coming from these recent research findings is for lesbians to get yearly PAP’s based on the prevalence of previous sex with men in the lesbian population plus the possibility of HPV transmission between women (Marrazzo, 1996).

The other STD’s are fairly well documented in their prevalence with lesbians. Bacterial vaginosis, the most common reported STD among lesbians, is found to be easily transmitted between women (Edwards & Thin, 1990; Marrazzo, 1996; O’Hanlon, 1995). Vaginal monilia (yeast) infections and herpes simplex virus are also reported clinically and found to be transmittable along with trichomonas, although the latter seems to have a much lower incidence of being spread between women. Lesbians are in one of the lowest risk categories for chlamydia and gonorrhea, and unless IV drug use is a factor, are also thought to be at low risk for HIV transmission if sexual contact is with women exclusively (Edwards & Thin, 1990; Chu, Buehler, Fleming, & Berkelman, 1990).

Breast cancer may pose a serious threat to lesbians’ health and longevity. No research has documented that lesbians have a higher incidence of breast cancer but studies report that lesbians tend to have a higher body fat ratio and a lower parity than the average female. It was surmised that their risk for breast cancer was higher than heterosexual women (Lucas, 1992; O’Hanlon, 1995). Brownworth (1993) cites Suzanne Haynes, Chief of Health Education at the National Cancer Institute, as saying the
incidence of breast cancer in lesbians is three times that of the general female population secondary to the risk factors mentioned above with the added belief that lesbians have a much higher alcohol and tobacco use. Self breast exam was performed by 21% of the lesbians surveyed as compared to 50-63% of the heterosexual women (Denenberg, 1995).

Studies report a higher rate of alcohol problems in lesbians; 20%-30% prevalence rate in lesbians compared to 10% in heterosexual women (Denenberg, 1995; Hall, 1994). There has been criticism of some of these studies in their convenience sampling techniques; i.e., surveys of bar patrons. Several subsequent studies have shown no higher alcohol consumption among lesbians (O’Hanlon, 1995; Rankow, 1995). However, it is not difficult to see how there may be a set-up or predisposition for alcohol abuse in the lesbian culture (Hall, 1994). Bars are often the only meeting place for lesbians. There may be an association between alcohol and the attempt to relieve stress. While this association has not been directly tested in the lesbian population, it is inferred in the literature (Bradford, Ryan, & Rothblum; 1994 Lipton, 1994).

According to three studies on lesbian’s health habits, the rate of smoking varied from 27% to 31% (Denenberg, 1995). This percentage seems to be similar to the smoking rate of women in general (27%), but the difference is that lesbians’ smoking rate increases with age whereas rates decline with older age in the general female population. Regardless of the increase or decline with age, smoking constitutes a significant health risk to lesbians as a whole if more than a quarter of the population is smoking.
Mental health issues documented in the lesbian population include depression, suicide, stress reactions, internalized homophobia, “coming out” or disclosure issues, religious conflicts, eating disorders, domestic abuse, relationship issues, and fear of homophobia including violence from hate crimes (Trippet, 1994). Some of the literature reports that lesbians have no higher depression and mental illness than heterosexual women (Bradford et al., 1994; Rankow, 1995). It has been postulated, however, that lesbians have a higher risk for depression secondary to the pressures of being homosexual in a non-accepting society with its concomitant lack of social support (Denenberg, 1995; Rankow, 1995). Several recent studies have shown that lesbians seek professional mental health services at a higher rate than heterosexual women (Bradford et al.). It has been speculated that lesbians have had to face and come to terms with the hard issues of being out, different, and oppressed. The more out the lesbian was, the greater the tendency to have used mental health counseling.

There exists an incredibly high risk for suicide in gay and lesbian adolescent youth. It has been suggested that homosexual youth constitute one third of all adolescent suicide (O’Hanlon, 1995). Suicide is the leading cause of death in lesbian adolescents (Denenberg, 1995). In Bradford’s et al. (1994) National Health Care Survey, there was an 18% suicide attempt rate across the life span. The older segment of the study respondents had a lower likelihood of suicide attempts and African American and Latina women had a higher attempt rate. It is unclear from the literature what mental health challenges are pushing these women to the brink of suicide. Depression and suicide rates, when not
broken down by age, appear to be similar in heterosexual and lesbian samples; the exception is adolescents, where young lesbian women are at heightened risk.

**Disclosure of Sexual Preference to Health Care Providers**

Lesbians live with a constant decision dilemma surrounding disclosure of sexual orientation. Every new encounter carries with it measured increments of risk-taking surrounding the disclosure question. The decision to disclose is often based on safety, relevance, and intimacy of the contact. All these factors are true in the healthcare arena as well. Hitchcock and Wilson (1992) asked 33 lesbians how they dealt with the issue of disclosure with HCP’s. It was discovered that the lesbians went through quite an elaborate internal process in order to weigh the safety of disclosing to their HCP.

The first step was to anticipate the risk of disclosure. This was akin to an assessment. Clues were obtained by a) the physical aspects of the office such as what magazines were on display in the waiting room, b) the characteristics of the staff such as eye contact and ease of interpersonal interaction, c) and the history intake form and whether there was a space to disclose sexual preference. If it was felt that their medical care may be compromised or their psychological comfort was threatened, disclosure was forgone. Disclosure could take on different forms, depending on the initial assessment. If neither choice of full disclosure or nondisclosure was made, the lesbian could drop different clues to the provider such as “I am absolutely certain there is no way I could be pregnant,” or “I have no need whatsoever for birth control,” thus leaving it up to the provider to figure out the rest.
When disclosure was made, the second step was assessing the reaction of the HCP. The positive or negative reaction of the HCP determined if the lesbian continued a relationship with that provider. It also affected encounters with future HCP’s: negative experiences had a silencing effect on future sexuality disclosures to HCP’s and sometimes even resulted in outright cessation of health care in order to avoid a negative encounter.

Another aspect surrounding lesbian’s decision to disclose to the HCP included relevance to the health concern (Cochran & Mays, 1988; Hitchcock & Wilson, 1992). If the lesbian perceived that her sexuality had no contextual relevance to her health concern, the decision to not disclose was often taken. Confidentiality was also found to be a factor. In one study, 63% of the respondents felt that sexual preference should be disclosed but only 28% of those felt the information should be written on the medical record (Lucas, 1992). There exists the real fear that if their sexuality was recorded, it could be used against them, for example, in child custody battles (Trippett, 1994).

There have been numerous studies on the rates of disclosure to HCP’s (Stevens, 1992). There was wide variability; from a low of 18% who disclosed to their gynecological HCP in the Midwest to highs of 73% disclosure in San Francisco and a 91% disclosure rate in a sample of 35 lesbian mothers seeking obstetrical care. Generally, there was a high rate of disclosure with mental health counselors as it was thought to be very relevant to their treatment (Hitchcock & Wilson, 1992). Hall (1994) reported in her ethnography of lesbians recovering from alcohol problems that there were often very negative reactions surrounding disclosure in alcohol recovery therapy groups.
The advice from one group leader to a lesbian participant was not to disclose her sexuality to the group, presumably because it would make them uncomfortable.

The reason for non-disclosure was overwhelmingly attached to fears of a) negative reactions from HCP’s, b) compromised health care in the form of less care, fewer referrals, and unsafe treatment, and c) a general discomfort around the whole health care interaction (Stevens, 1992). In fact, many studies cited the fact that lesbians often delayed or completely quit seeking health care because of disclosure issues (Cochran & Mays, 1988; Hitchcock & Wilson, 1992; Stevens, 1992).

Barriers to Optimal Health Care

Barriers are factors that create obstacles that keep lesbians from receiving the best and most appropriate health care they are due; as any individual is due. We have seen from the literature how the negative reactions from HCP’s, heterosexual assumptions, and disclosure and confidentiality scenarios have caused lesbians to shy away from the health care system. We have also seen that there is a lack of scientific research specifically looking at lesbian health issues and risks. Optimal health care access is barred to lesbians also because they often do not have insurance or do not have access to partners’ insurance policies as married heterosexual couples have, since lesbian partnerships are not legally sanctioned (Denenberg, 1995). Lesbians make less money than their heterosexual counterparts even though they tend to be better educated (Bradford et al., 1994; Denenberg, 1995; O’Hanlon, 1995). Estrangement from families and their possible financial support as well as job discrimination against lesbians have been noted as possible explanations for the above demographics (Denenberg, 1995).
There is a two-fold ignorance that creates another barrier. The first is ignorance among health care providers of the lesbian lifestyle and what that means and does not mean in terms of health risk and needs (Stringer, 1995; Williams & Riehle, 1995). For instance, the assumption that lesbians never have sexual relations with men, do not have children, and do not have domestic violence in their partnerships keeps the HCP from considering these options when looking at the lesbian client. The HCP who does not know of the risk behaviors which lesbians may participate in loses the opportunity to educate clients. One lesbian client was refused an HIV test because the HCP said since she was a lesbian, she did not need it (Williams & Riehle, 1995).

The second ignorance lies with the lesbian herself. Many lesbians are unaware of what constitutes risky sexual behavior or what their health risks are around cervical and breast cancer and STD’s because they do not see themselves in any of the statistics (Stringer, 1995). They too make assumptions based on an heterosexual interpretation of health information.

How the topic of homosexuality is taught in medical and nursing schools constitutes a barrier to optimal health care for lesbians by virtue of the lack of information conveyed to students (Wallick, Cambre, & Townsend, 1992). The average time devoted to gay and lesbian topics is three hours and most of that time is spent on the subject of human sexuality. According to studies done in the 80’s and 90’s, there is still a significant amount of homophobia among nurses, nursing students, and nurse educators (Eliason & Randall, 1991; Smith, 1993). In Randalls’ 1989 study (Stevens, 1992), 34% of the nursing students surveyed found “what lesbians do is disgusting”. This attitude
may reflect not only homophobia but also an ignorance of the lesbian lifestyle. It was found that those with the highest acceptance for lesbians had a personal familiarity with a lesbian, in other words, to know a lesbian predicted a higher level of tolerance and acceptance of the lifestyle. Homophobia flourishes in a culturally unaware health care system. It is the responsibility of higher education to turn out well qualified health practitioners and this must include cultural awareness diversity training (Stephany, 1992). Universities can be powerful progenitors of cultural tolerance and egalitarianism.

**Rural Lesbian Healthcare Issues**

No studies were located which addressed rural lesbian healthcare issues; in fact no studies were found that addressed rural lesbians from any aspect. Only one article was located during the literature review search. It was about the difficulty gay and lesbian dwellers face when trying to fit into rural communities (D’Augelli & Hart, 1987).

**Summary**

It is important to acknowledge the difficulties inherent in doing studies on lesbians. Sampling is a problematic issue. Lesbian research has relied on convenience and snowball sampling. Data are collected at lesbian cultural, political, or social gatherings. There must be the assumption made, therefore, that the lesbians being included in these studies identify with and participate in the lesbian culture. Because of the stigma against homosexuality in this country, it would be very difficult, for instance, to put an advertisement in the local newspaper requesting lesbian subjects for a research project. Lesbians have historically had an ability to blend into the mainstream of society because they do not always have obvious outward differences in their appearance.
(Hitchcock & Wilson, 1992; Trippet & Bain, 1992). It is difficult for all these reasons to get a true random cross-section of lesbians.

Many studies and articles were written that combine lesbians and gay men or lesbians and heterosexual women studied together (Eliason, 1996; Quam & Whitford, 1992; Smith, 1993; Stevens, 1992; Trippet & Bain, 1992). Lesbians have very different issues and views of themselves in relation to society than do gay men or heterosexual women. This is very well documented in studies about their healthcare experiences, issues, and perceptions (Bradford et al., 1994; Buenting, 1992; Denenberg, 1995; Eliason, 1993; Robertson, 1992; Stevens & Hall, 1988; Trippet & Bain, 1992). Add to this the confusion of ferreting out the healthcare issues of lesbians when many self-identified lesbians also have sex with men (Cochran & Mays, 1988; Conway & Humphries, 1994; Denenberg, 1995; Edwards & Thin, 1990; Marrazzo, 1996; Rankow, 1995; White & Levinson, 1995). These factors confuse the research picture we have of lesbians.

Lesbians as a distinct subculture are no more stereotypical than heterosexual women as a group. If one looked strictly at the demographics of most of the studies done on lesbians, one may be led to believe that the vast majority are white, upper-middle class, college-educated, and live in metropolitan areas (Bradford et al., 1994; Buenting, 1992; Hitchcock & Wilson, 1992; Stevens, 1992; Stevens & Hall, 1988; Trippet & Bain, 1993; Zeidenstein, 1988). It may be that the privilege of education and socioeconomic stability along with the anonymity afforded metropolitan dwellers makes for a more accessible, available, and willing study participant. It is a challenge to access the diverse segments of the lesbian subculture including the economically disadvantaged, lesbians of
color, rural lesbians, and those that choose not to openly participate in the lesbian subculture.

Five categories of information were developed from the review of literature on lesbians and healthcare. It was found from this review that lesbians have encountered an extraordinary amount of negative healthcare experiences. These encounters have taken on a variety of forms and intensities with the assumption of heterosexuality being the most common. Lesbians have been found to have a preference for women healthcare providers and may lean toward alternative healthcare practices and providers out of a developed mistrust of the Western medical system.

Because of a lack of studies on lesbians' health risks and disease susceptibility, there is scanty information to substantiate any strong statements of an increased or decreased prevalence or incidence of certain diseases. There is evidence that lesbians have a lower STD rate but new research shows that there is sexual transmissibility of many pathogens woman-to-woman that was previously unknown.

Many of the mental health issues of lesbians stems from dealing with external and internalized homophobia. The literature states that lesbians do not have significantly differing amounts of depression but that there is a higher incidence of suicide among lesbian teenagers.

Much has been written on disclosure of sexual orientation and there is a wide variety of experiences and adaptive behaviors that have come out of this phenomenon. Disclosure is generally based on perceived safety and acceptance from the HCP toward the lesbian client.
The barriers to healthcare identified in the literature were varied, including financial constraints, lack of insurance, ignorance of the HCP and the lesbian client of the healthcare issues and needs of lesbians, and the lack of information taught in medical and nursing schools around lesbian lifestyles and healthcare.

The last category of the review of literature was short because of the paucity of published information on rural lesbians. No studies were found that specifically addressed the healthcare needs or issues of rural lesbians.
CHAPTER 3

METHODOLOGY

Introduction

This chapter focuses on the research methods used to study the healthcare experiences, practices, and issues of rural lesbians. The design of the study, population, sample, data collection, protection of human subjects, and data analysis are discussed in this chapter.

Design of the Study

This study was an ethnography of the healthcare issues and practices of rural lesbians. Because of the lack of published research about rural lesbians, the population can be considered a relatively unstudied group. Spradley (1979) eloquently explains that the goal of an ethnography is "to describe and explain . . . variations in social behavior. If we are to understand this diversity, we must begin by carefully describing it." For this reason, the ethnographic approach was used to document and describe the life experiences of the informants and their perspectives on healthcare practices and issues, healthcare access, and the healthcare system as these areas relate to lesbians.

Population and Sample

The population for this study was rural lesbians. It is extremely difficult to determine the population size of lesbians living rurally because the U.S. Census does not ask for individual sexual orientation. The results would be unreliable even if the question
were asked. Because of the history of homophobia, many lesbians may not reveal their sexual preference on the U.S. Census.

The informants for the study met the following criteria: a) self-identified as a lesbian, b) at least 21 years old, c) lived at least 40 miles from an urban area (urban is defined by the U.S. Bureau of the Census as any place with greater than 2,500 persons) (Lee, 1991a), d) spoke and understood English, and e) volunteered to participate in the study.

All 14 informants, obtained by convenience and snowball sampling, lived in Western Montana. The first few informants were known to the researcher. Others were contacted by the original informants and asked if they would be willing to participate. Contact was made with several informants at a large reunion of lesbians who had lived in one particular area of rural Montana over the last 15-plus years. No one who was asked refused to participate. Many stated that they thought the study was an important step in bridging the gap between lesbians and mainstream society; this further induced them to participate.

Purposefully, the informants were chosen from different geographic areas around Western Montana and from different circles of acquaintances. To the best knowledge of the researcher, without breaking confidentiality, the informants did not all know one another. The sample was not, necessarily, the most vocal and high-profile members of the lesbian community. This was also purposive in order to avoid creating an “elite bias” sample (Sandelowski, 1979, p. 32).
Data Collection

Data were collected from October, 1995 through September, 1996. Once an informant expressed a willingness to participate in the study, a convenient, private, and comfortable meeting place was arranged with the informant. All of the informants chose to meet in their own homes. Ten of the informants were in a partner relationship; 3 couples were interviewed together and 2 couples were interviewed separately. This happened not by design but secondary to time constraints. The remaining 4 informants were interviewed alone. The interviews lasted from 1-2 hours and were tape recorded.

The first part of the interview process was demographic data collection (Appendix A). To help get a perspective on life events and choices that may have an effect on health beliefs and practices, informants were queried about a) where they were born and raised, b) family-of-origin structure, c) how old they were when they self-identified as a lesbian, d) their current definition of family, e) past sexual identities and practices (heterosexual/bisexual/lesbian), f) why they lived in a rural area, g) education, h) occupation, i) health status, j) financial status, k) age, l) child-bearing and rearing history, and m) whether or not they had health insurance.

The interview consisted of in-depth open-ended questions (Appendix A). A certain flow of questions was used in an attempt to elicit the informant’s beliefs and feelings around their own healthcare experiences in the past. Questions were asked, such as “What do you do when you have a serious illness?” and “Have you ever been hospitalized?” Then the questioning moved on to elicit preferences and beliefs around healthcare and health care providers (HCP’s). Examples of these questions are “Do you
have a regular HCP?" “Who do you go see when you are sick?” and “Does the sex of the HCP matter to you?” There were questions asked about whether and under what conditions the respondent disclosed their sexual orientation to the HCP: “Does it make a difference (for disclosure) whether the HCP is in a rural clinic versus Missoula?” and “If you were going into the HCP for a vaginal infection, would you disclose?” The last section of questioning delved into the informant’s beliefs around the general mental and physical health-related issues of the rural lesbian population: “Do you think rural lesbians have any higher rate of alcohol, drug, or tobacco use than lesbians who live in big cities?” Elaboration of issues and personal stories were encouraged. The emphasis of the interviews was on healthcare but the informants had many life experiences, though tangential, that related to their health beliefs and practices. Coming out and homophobia stories were examples of life experiences.

Protection of Human Subjects

Montana State University-Bozeman, College of Nursing’s Human Subjects Review was completed and the study met all the established criteria. A letter of introduction explaining the study was given to all the informants. The interview process along with the type of questions that would be asked was fully explained before permission to participate was requested. I inquired of the initial informants whether they knew of rural lesbians that may want to participate in the study, and if they would be willing to make the initial contact. In this manner, there was less pressure on the informants to consent than if the researcher asked them directly. All participants in the study read and signed a consent letter (Appendix B). The letter emphasized that the
participant could withdraw from the interview process at any time and there would be no pressure to resume the study at a later date. After consent to participate was obtained, permission to tape the interview was sought.

Confidentiality and anonymity of the participants was maintained throughout the study. Names were not attached to notes or tapes. Professional transcriptionists were utilized. The transcribed interviews used letters and numbers to differentiate them and only the researcher knew what names and numbers matched informants. The tapes were erased after the study was completed. The signed consent letters were also destroyed after completion of the study.

The potential benefit to the informants from this study was a sense of contributing insights of the lesbian subculture to nursing research, which may go on to help shape a more holistic and diversity-sensitive healthcare system. The risk involved included the potential for emotional feelings and psychological strain due to the personal nature of the questions.

Data Analysis

Data analysis started after the first interview was conducted. Prominent themes, categories, and important issues to the informant were noted and each subsequent interview built on the ones previous. As with any ethnography, it is important that the importance and relationship of the parts to the whole be defined by the informant (Spradley, 1979). As the interviews progressed, the themes and categories that stood out were emphasized and elaborated. Notes with themes, main ideas, categories, and tangents were made in the margins of the transcribed interviews as they were read. The margin
notes were very brief summaries; sometimes just a word. These notes were then compiled into lists and divided into categories. The main headings of the categories became the central domains or cover terms which represented the symbolic categories of the data. The data fell out into subcategories under their appropriate domain as the lists and notes from the margins were arranged and re-arranged into a meaningful organization. The transcribed interviews were read several times to ensure that all the relevant data was placed into an appropriate domain or subcategory.

Rigor of the study was tested using Guba and Lincoln’s (Sandelowski, 1986) criteria for qualitative analysis. Credibility, the interpretation by the informants that the domains, subcategories, and findings of the study were correct and true, was verified by several of the informants. Several rural lesbians who were not in the study also verified the “fittingness” (p. 31) of the findings in relation to their own experiences. Auditability, the ability of other seasoned researchers to be able to track and concur with the analysis and conclusion of the study, was accomplished through the members of the thesis committee. Confirmability, or the striving for neutrality of the findings, was achieved when the above three criteria were established and was also scrutinized by the committee members.

The researcher made every attempt to form a representative view of the informants’ life experiences. Undue emphasis in the analysis of the data was not focused on the bizarre nor the mundane (Sandelowski, 1986). Both the typical and atypical life experiences were represented in the findings to create a holistic picture of the population. "The artistic integrity, rather than the scientific objectivity, of research is achieved when
the researcher communicates the richness and diversity of human experience in an engaging and even poetic manner” (Eisner, 1981, as reworded by Sandelowski, 1986, p. 29).
CHAPTER 4

FINDINGS

Demographic Data

All the informants (N=14) for this qualitative study lived in rural Western Montana. Rural is defined here as a place with less than 2,500 persons (Lee, 1991a). All but one of the informants were Caucasian, with the exception being of South American descent. The informants were between the ages of 25-54 (with a mean of 40 years old), and had incomes ranging from $12,000 to >$60,000 a year. All but one of the informants had attended college, 11 had undergraduate degrees, two had masters degrees and two had completed at least one year towards a master's degree. Occupations were varied; tile contractor, crafts-person, counselor, musician and organic gardener, nursing supervisor, retail store-owners and managers, alternative healer, supervisor in a state agency, and wildlife habitat restoration expert. Fifty percent of the informants were self employed.

All informants were self-identified lesbians; two had been previously married and 10 of the 14 (71%) stated they had previously had sex with at least one man. When asked at what age they identified themselves as lesbian, the answers were from age five to 33. Eleven out of 14 of the informants were in committed partnership relationships ranging from one-and-a-half years to 13 years, with a mean of six years. One of the couples had an adopted child, and one other informant had raised two children from a previous
marriage with a man. Eight of the informants said they had health insurance, with five of these having their premiums paid by employers.

When asked why they lived in a rural area, they answered: “Because of the beauty of the country; the birds, trees, open spaces, and mountains.” “It's a spiritual thing.” “For privacy and solitude.” “Quality of life.” “I need absolute quiet.” “I like to be alone a lot, for quiet.” “So I can pee and go naked in my yard.”

In order to create a context for documenting the healthcare experiences of rural lesbians, I inquired of the past and present health status of the informants. All described their health as good to excellent at the time of the interviews. Three had a history of serious illness in the past; a malignant tumor of the spine, Graves disease, and Lyme disease. Many of the informants reported various musculoskeletal injuries and strains, either related to previous auto accidents or occupational injuries.

Three of the informants currently smoke cigarettes, three consider themselves recovering alcoholics, and an additional three have made the choice to abstain from alcohol, although they do not necessarily feel they have an alcohol problem.

Most of the informants stated they had used or currently use a mental health counselor intermittently for periods of time, usually in response to life stressors such as relationship issues and episodic mild depression. Two revealed that they had been suicidal as adolescents. One informant had a diagnosis of manic depression as an adolescent, and another stated that she periodically seeks counseling for incest survival therapy. All felt that they were mentally healthy today.
The distance the informants traveled for healthcare ranged from 5-70 miles. Various healthcare clinics and facilities were available within 20 miles of the informants. The closest urban center, Missoula, with an approximate population of 50,000, was between 45-100 miles away from the informants. This community had a wide variety of healthcare options available to the informants.

**Emergent Domains**

As explained in the data analysis section of chapter three, the interviews were coded and central themes or domains were identified. Three central domains emerged out of this process: a) Lesbian Healthcare Practices, b) Lesbian Healthcare Issues, and c) Barriers to Healthcare. Under these domains, recurring experiences and perceptions of the informants were broken down further into subcategories. The subcategories often overlapped and had influence on more than one domain, but were placed under the domain for which they had the most meaningful relationship.

**Lesbian Healthcare Practices**

This domain was broken down into the following subcategories: a) alternative versus allopathic and b) healthcare-seeking patterns.

**Alternative versus allopathic.** An overwhelming preference for alternative over allopathic (Western medical model) healthcare was expressed. This was one of the most common recurring themes in the interviews. By “alternative”, the informants referred to the following forms of healthcare: chiropractors, naturopathic doctors (ND’s), herbal remedies, homeopathy, energy healing, body work (massage, therapeutic touch, etc.), acupuncture, vitamin therapy, and spiritual healing (including Native American healing
rituals). Eight out of the 14 informants said they would go to a ND first for an ailment or illness. All said they used some form of the above-mentioned alternative healthcare at some point. All but two said they would use Western medicine if they were seriously ill and the alternative route was not working.

The two that said they tend not to use allopathic healthcare primarily utilized a form of energy healing. One of them was a practitioner and explained that this method of energy healing involves muscle strength testing using the body’s energy fields and numerical codes to diagnose and treat different ailments and illnesses. She and her partner use this on each other and their young daughter as well as their pets. One of them recounted the following story:

I was working for the Park service in California and I got bit by a tick and got Lyme disease. My insurance wouldn’t cover alternative medicine so I went to a regular doctor and they put me on Doxycycline and I was on it and just kept getting sicker and sicker. I couldn’t get out of bed, couldn’t hardly eat or drink anything. Finally I went to an energy healer practitioner (this was before my partner got her training) and in four hours she had me sitting up at a desk and in two weeks I was back in the field again. That was really the major change for me from Western medicine to alternative.

This same couple has a child and they utilize a pediatrician because their insurance does not cover alternative medicine. However, they have chosen not to immunize or use fluoride for their child because of their belief that these things compromise the immune system. Along with energy healing, they have utilized homeopathy for poison oak outbreaks, herbal remedies such as peppermint oil for upset stomach, and chiropractors for musculoskeletal ailments.
One informant who said she also preferred alternative over allopathic medicine said:

I don’t really agree with a lot of that whole technology. I believe that the root of that technology perpetuates illness within itself, like exposure to x-raying and all that kind of stuff disturbs the system.

Another informant made similar comments:

Western medicine uses a technological fix that doesn’t address the real root issues of health. I go to a ND because they have a better handle on that sort of thing. They look at my whole being versus one part of me that’s sick. Western medicine focuses on illness, alternative medicine focuses on wellness.

Some of the reasons for using alternative healthcare stemmed from an aversion to the Western medical model as well as the practitioners of that model:

I think a lot of AMA [American Medical Association] stuff is built along the tough lines of maleness, where being hurt is part of the sacrifice that you make to get a cure. There is a total lack of sensitivity to people’s pain thresholds, which I think is a male thing.

In all my history of Western medicine, dealing with my mother dying of cancer, the doctors that I’ve had to deal with were unfeeling and I felt they were disassociated. The only way they could get through dealing with pain was to disassociate. I have to admit, the nurses were really very empathetic and able and interested in you, but the doctors were cold, distant, very short, and very out the door.

Most of the informants stated that they were most comfortable with a combination of allopathic and alternative healthcare. There was a reluctance to let go of Western medicine, especially emergency medicine and specialists. The informant that had Graves disease said:

After I got diagnosed with the Graves, I tried to treat it alternatively and naturopathically for three years, and you know, I probably did more harm than good. I was going around for three years with a heart rate of 160. I was down to a bean pole. So I went ahead and had my thyroid irradiated and they had to do it
twice and I’ve never felt so toxic in all my life. I still go to an endocrinologist every year for a check-up but I try to use alternative medicine first for other things, unless it’s an emergency.

Another said:

If I had something wrong with me I would go to a MD first, to find out what I had, then I’d go to the ND to have it fixed, they have more of a holistic approach.

One informant summarized by saying, “The perfect combination would be a MD that was also a ND!”

Many of the informants who said they preferred a ND as their healthcare provider (HCP) did not exercise that option because their insurance did not cover alternative healthcare. The financial constraints of having to privately pay for the services was enough to prevent several of the informants from utilizing their preferred HCP. Several stated that short of having their insurance cover alternative HCP’s, the ideal would be to have an allopathic doctor that was open and knowledgeable about alternative therapies.

Healthcare-seeking patterns. Lack of regular healthcare was a recurrent theme throughout the interviews. Only four of the 14 informants (29%) received a yearly checkup with a PAP smear. The remaining ten informants stated their last PAP smear was anywhere from two to 18 years ago, with the most common answer being five to six years. Several in the study said they felt they should get a yearly PAP but that they “just did not think of it”. Others said:

It’s like gardening, I don’t pay much attention until I see that something’s wrong, then I pay attention.

I only go to get healthcare if something’s wrong.
There was a general theme of self-reliance among the informants. When asked what they did when they had a non-threatening health problem, they stated that they “took care of things themselves”. They took vitamins, herbs and teas, and sought the advice of friends for remedies and solutions to health problems.

Mammography was utilized even less often. Only two of the informants received mammograms according to their doctors’ recommendations. Most of the other informants had never received a mammogram. One informant said:

If I was told I should get a mammogram after the age of 40, I’d probably worry about it like everybody else would for awhile, but I probably wouldn’t do anything about it until I got a strong enough trigger, like someone close to me getting breast cancer or something.

All but one of the informants insisted that they would only get gynecological exams from women HCP’s. For general medical care, all but two said they had a strong preference for women HCP’s. There was no explicit gender preference when describing alternative HCP’s.

The majority in the study had no qualms about driving long distances for healthcare. Several said they would not got to a local HCP because of confidentiality issues:

My one neighbor works at the [local] clinic, and although she didn’t tell us the neighbor’s disease, she told us that he had a life-threatening disease, and I don’t appreciate that. We don’t have a right to know that, unless he tells us himself. There’s a certain trust that I have to have with my doctor that whatever they find out, they tell me and no-one else. I would feel the same way if I was straight; I mean what if it gets out that I’m pregnant, and then I have an abortion? When there’s a lack of confidentiality, it interferes with the choices that you make.
When asked how they chose a HCP the top priorities were familiarity, referral from a friend, and competency. Four of the informants said they went to their doctor because they knew her as a friend. Almost all the informants said if they didn’t have a HCP and needed one, they would rely on referrals from friends or word-of-mouth. Several said if there were lesbian HCP’s available, they would utilize them. One informant said: “If I heard that a clinic was run by a lesbian, I would definitely go there.”

Competency was an important factor in choosing a HCP. Several of the informants went to a doctor in a rural clinic about 40 miles out of Missoula:

We are very fortunate to have her in this area because she is so good and she has a fantastic bedside manner. But if it wasn’t for her, we’d be driving into Missoula. We used to live way up north and it was so conservative up there, we would drive 80 miles into Missoula to go to Planned Parenthood because it was more anonymous.

Disclosure of sexual preference was also an issue when determining access to HCP’s. That subcategory will be covered under the Barriers to Healthcare domain because the intonation from the informants was that sexual preference disclosure was more of an obstacle than a selection process in connection with HCP’s.

Lesbian Healthcare Issues

Even though several of the informants did not, at first, think that lesbians had any different healthcare issues than heterosexual women, it became evident as the interviews progressed that certain issues emerged that were unique to lesbians. Most of these issues fell into the realm of mental health. There is abundant literature linking psychological stressors with somatic ailments but that is beyond the scope of this study. The emphasis of these findings weigh heavier in the mental health arena but as one informant said:
Not getting on with your life and dealing with your issues predisposes you to get things like cancer; it’s not the only cause but it contributes.

The following subcategories emerged out of the domain of Lesbian Healthcare Issues: a) being out and coming out, b) isolation, c) drug and alcohol abuse, and d) depression and self-esteem.

Being out and coming out. One of the biggest life stressors mentioned by lesbians in the study was the act of coming out about their sexual preference. All the informants had a story about coming out or being out. One informant recounted this story of when she came out to her parents:

I came out to my parents when I was 18; they didn’t take it well. They told me to go to a psychologist and they sent me that day to a medical doctor, a male, and he asked me horrible, inflammatory, offensive questions. You know, how much I masturbated, who I slept with, how many times I did what sexually, what positions, you know, just all kinds of crazy questions to ask an 18-year-old. He was looking for proof of my sexuality so he could tell my parents. Then he did a full physical exam on me, including the sexual organs, and this was extremely offensive to me. This was a heavy thing for me, not having the acceptance of my parents. My self-esteem was extremely low. That’s when I started doing every drug I could get ahold of; LSD, pot, peyote, psilocybin, alcohol, anything that I could escape with and stay numb. My parent’s friends used to tell me I was the way I was because of my Dad’s brain injury in the Navy. A few years later is when I got married. I wanted to see if there was any truth to me having the ability to be heterosexual. I did it to please my parents. I was accepted by everyone. I’ve never had so much acceptance! I held out as long as I could but the marriage didn’t last. I haven’t been with a man since.

Another said:

I know a lot of lesbians as children weren’t treated... I mean like we were criticized our whole lives for not fitting in. Our mothers didn’t dig little lesbians, you know. We just didn’t wear the little dresses and stuff like that.

Two of the informants formerly lived in San Francisco and they recounted their feelings after coming to rural Montana to live:
We used to think we knew what the movement was all about, you know, protesting, wearing bumper stickers, but then we moved here and we lived way up north where it’s very conservative. I don’t think we really understood what it [the movement] was about until we came here. We were in a friend’s store up north and I said something about a “dyke” and our friend got extremely angry with me and told me NEVER to say that word in her store. You know, I think it might be a part of internalizing everything; we start taking our anger out on each other. We felt so free in San Francisco and then we came here and said, “My God, this is America, this could be Iowa or anywhere!” We all of sudden were very self conscious about touching each other, where in San Francisco, we walked down the street holding hands. We found that we were getting angry with one another here, if we felt the other one was standing too close in public or something, then we realized that there was an element of fear that was creeping in. I mean it’s illegal to be homosexual here. I think there’s this attitude of lesbians that live in the city that we all should be out, but it’s a different story out here in the country. I think, “I might get fired from my job if people find out here.”

Another informant had a similar experience:

I was working as a mental health counselor at a clinic in a small town in Oregon, my partner didn’t live with me then but she would come visit me on weekends. One day my supervisor called me into the office and said it had gotten back to him that it was perceived in the town that I was gay and they didn’t want that perception being brought out. I denied it because that was the way to take care of myself. I had a gay male friend of mine send me flowers at the office and come by to see me. I also started looking for another job right away. Now I work for the state here in Montana and I put a picture of that same gay male friend and I on my desk and I basically pretend that I’m heterosexual. I did have someone across the street yell at me in the town I work, “You’re a lesbian” and someone in the same neighborhood threw an egg at my car. I don’t live in the same town that I work and my partner quit coming to visit me in that town.

Two of the informants that owned and operated a store in a small rural town spoke of a way of assimilating into the community by not being blatant about their lesbianism:

Some lesbians wear their sexuality like a badge of protest. We don’t do that. We think people in this town know we’re dykes but what they saw first was two hard working women who remodeled a store and it’s “hat’s off” to anyone who’s in business that will put themselves through that. On top of that, we’re pretty nice
people. People like us and over time it dawns on them that we’re lesbians but they got to know us first as human beings and they liked us and if we are queer, it doesn’t really matter. There’s a faction out there that doesn’t come into the store because of it, but they’re the minority. We have presented ourselves with being concerned with the community; we coach soccer, donate to the school, civic club, booster club, and the sheriff’s department. People refer to us as “those girls,” in an endearing way. A few locals have come in and made little comments that let us know they “know” and that it’s OK.

These perspectives were expressed by informants when asked about coming out issues:

I think it has to do with how we view our lesbianism, like if it is the utmost thing in our lives. I don’t view it that way, I don’t think I am any different than anybody else just because I sleep with women! Being a lesbian isn’t at the top of my list of “who I am”.

I’ve just always chosen a route that gives me the most freedom to be who I am without compromising . . . I guess I just always wanted to keep a private side of myself. I just want to do my thing and not have people bother me.

Invisibility was mentioned by several in the study as the way lesbians have historically dealt with the public. There was a distinction made between this and being “closeted”. Being in the closet was an intentional denial of one’s sexual preference; invisibility was a way of blending in so as not to draw any attention:

We do have this ability to be invisible, I don’t know if it’s a gift or a curse. We can get by that way and hide all our lives.

We have this monthly meeting up here in the valley, it’s like a support group in a way, and it’s social; anyway, when we talked about being closeted and the fear and all, there were a lot of people who were resistant to talk about it. I don’t know . . . there’s just a whole different mentality here, I mean they poach animals in Montana. I don’t necessarily think people are always safe to “out” themselves here in the country.

There was roughly a split down the middle of the informants that came out to their co-workers. Here are the different views:
I don’t go around trying to make up stories. When I first brought my baby
daughter in to work everyone wanted to know who took care of her when I wasn’t
there. I said my partner did, and they asked, “What does he do?”, and I said,
“You mean, what does she do?”, and they just said, “Ya, what does she do?”
There was this one 60 year old woman at work and she just did not want to accept
it, she kept referring to my “friend”. Finally, I said, “You need to get this straight;
she is my partner. If you’re going to be a person that I relate to, you need to know
that.” She said, “Okay, I have it, I got it.” She’s addressed it properly ever since.

Oh my, no! I would never come out at work. They can make it very nasty for
you, very uncomfortable. The only place I would ever in my life come out at a job
was if I worked with other gays and lesbians. It’s survival and protection; you
learn as you go that people just can’t handle it.

Several of the informants stated that they felt the atmosphere was more liberal in
Missoula, yet lesbians still did not walk around town holding hands. The feeling was also
expressed that “older” lesbians had more self-confidence or did not have as much
concern about public opinion and appeared more at ease with themselves.

Isolation. Isolation came up as a common theme when the informants were asked
about lesbian mental health issues:

I think it can be hard, rural, with isolation. I think there is a social need that
doesn’t get met easily. I think it’s harder for gay people to have that sense of
belonging in a rural area. It’s sort of hard to fit in rural, anyway; I’m not from
here, I’m a woman living alone, I play the harp, I don’t have a tractor...all those
things make me a little weird and I feel like I don’t quite belong. So being a
lesbian on top of it, it’s hard to have that same belonging.

I think many minorities, but especially lesbians have repercussions from isolation.
I think we are bombarded by isolation with the media and TV because we are
constantly reminded that we are different.

There is a cause for lesbians to isolate...I don’t know, but I think some
lesbians want to separate themselves for insulation. They get asked, “Why are
you a lesbian? Were you raped? Did you have a bad experience when you were
young?” Isolation can be a chance to rejuvenate, so you don’t have to cope
constantly with being different.
Another informant said:

Isolation can be good and bad. It gives us the space to do what we want to do. The negative side is not being a full functioning member of society, and developing that social-political part of ourselves, we just get too involved in our emotional stuff.

Isolation was equated with being separatist to one informant:

There are those lesbians who hate men and don’t have anything to do with them. I think that’s an imbalance. It’s no different than in nature, there’s got to be a balance. What do those lesbians do with their male children? It’s not good to raise children thinking half the population is bad. There’s a wholeness in both sides of the story; masculine-feminine, right-left, all that kind of stuff.

**Drug and alcohol abuse.** There was a general consensus that lesbians did not abuse drugs and alcohol any more than the general population, yet there was the feeling that there was still a problem in the lesbian community. Marijuana was the drug mentioned most often but alcohol was considered a much more significant problem.

Many of the informants related how alcohol played a key role in their younger years because the only place for lesbians to be social was at the gay bars:

Before I even knew I was a lesbian, my cousin took me to a gay bar and all of a sudden it hit me: “This is who I am!” I felt so comfortable there.

Especially here in Montana, there just aren’t a lot of places for lesbians to meet. Particularly if you don’t drink and go to the bars, meeting people is a real problem. Loneliness becomes a real concern. I think it’s a way we try [using alcohol] when we are younger to cope with this enormous burden of being on the outside of society, of being different.

Besides being more predominant in younger lesbians, several informants felt that excessive alcohol use existed not so much on an individual basis but in certain groups of the lesbian population:
There are certain segments out here that don't seem as healthy, with the heavy drinking... it's on a psychological level; an inability to be willing to work on themselves.

**Depression and self-esteem.** As with drug and alcohol problems, the lesbians in the study did not feel that lesbians as a sub-population had any more or less of a prevalence towards depression and self-esteem issues. Many informants reiterated that as a result of being marginalized and ostracized from society, many lesbians suffered under the strain:

Many of the mental health issues of lesbians comes from a response to being lesbian in a society that either pretends we don't exist or wishes we didn't.

The causes of depression in lesbians was surmised to be from several causes: a) hiding or not coming to terms with their sexuality and who they were or b) having a self-esteem deficit as a result of constantly being reminded of their unacceptance in society.

One informant told of her own brush with depression and suicide:

The only time I ever sunk mentally was when I was in my first lesbian relationship. I was with this woman for four years and we lived together and no-one knew we were lovers. We didn't tell another soul. Her parents considered me another member of their family and treated me like a daughter, I mean it was very entangled. Then she started dating this man and was going to get married! That's when I went off the deep end. There wasn't anybody to talk to, she was the only other gay person I knew and no-one knew of our relationship so I literally cracked up. She wanted me to be in her wedding, I couldn't do it. That's when I was suicidal, and I am not normally a depressed kind of person. I didn't actually try to commit suicide but I thought about it. So I started pulling myself out of it by getting involved in other things, that's when I started mountain climbing. She did stick by me through the whole thing... we were living together and being sexual right up until she got married. From then on I made the decision I wasn't going to be in the closet anymore, that I'd meet people head on, because my personality is an honest personality. I can't say that I have had a problem with depression since.
One respondent thought lesbians’ self-esteem issues started early in life:

Two things: our lesbianism was never addressed as kids and we never had positive role models growing up. It has just been in the last 10 years that you even see lesbians mentioned or shown on TV. It was a double whammy; we didn’t have people like Greta Cammermeyer and Janet Reno to look up to as kids and our issues just weren’t addressed. It has to do with power and finding your voice. You can’t find your voice if you’re not accepted in society. Like in Montana, it’s still against the law, so if you’re a teacher, you can’t go out and say you’re gay! Your power is limited by what society is willing to accept. Now they are willing to accept more so we are getting more powerful. Everyone is knowing where the lesbians are and who they are in politics and organizations, it’s kind of one of those things that grows.

Two of the informants confided that they had personal histories with incest or sexual abuse as children but they did not equate that with their lesbianism:

I was going to say that many lesbians are survivors of incest and abuse but I think all women are, no more or no less in lesbians.

There was a connection made by several of the informants between alcohol use and self-esteem. It was recognized that there were those in the lesbian community with low self-esteem that were perceived as not “coping very well” and this was manifested by alcohol abuse.

Barriers to Healthcare

Barriers to healthcare were identified from the interviews as anything that stood in the way of lesbians getting the most appropriate and satisfying healthcare available to them. The data fell out into three major subcategories: a) disclosure, b) homophobia, and c) finances.

Disclosure. The issue of disclosure of sexual orientation to the HCP by rural informants in this study was influenced by previous experiences with coming out and
homophobia. How the informants dealt with disclosure can be divided into three strategies: a) assertively out, b) invisible, and c) resistant.

Several in the sample felt strongly about coming out to their HCP. This is an example of the assertively out:

I disclose to my general practitioner because I think it’s critical to the relationship I have with them. I didn’t disclose to the specialists that I went to because they were just short-term relationships. But with my GP, I don’t want to have to dance around any issues, especially if there is something serious because I’m going to want my partner in on the decisions and in the room for support and things like that. I had a practitioner once a while back and I had not disclosed to her and then I was going through a really hard break-up that was emotionally very painful. I finally called her up and told her what was going on and she was so sensitive, next time she saw me she threw her arm around me and asked how I was doing. It made me wish that I had told her from the very beginning, but I wasn’t sure of her acceptance. Now, I’m just up-front. In fact before I choose a GP I have an interview with them and I tell them, “These are my issues: incest survival and I’m a lesbian. Now do you have any problem dealing with any of that?”

The invisible strategy group, comprising the majority of the informants, generally did not disclose but said they would if they were assured that the HCP was open and accepting of the lesbian lifestyle. They felt most of their healthcare encounters for physical problems did not warrant disclosure and there was a reluctance to create an issue with sexual orientation when it was not deemed relevant to their healthcare:

The doctor doesn’t need to know my sexuality, unless there’s a mental illness or something like that. It’s not relevant to my healthcare. Physically, I don’t think my sexuality separates me from heterosexual women. If I was a gay man and AIDS being what it is today, I could see the connection.

All I wanted from the doctor the last time I went was nicotine patches, I don’t want to have to go through that whole coming out process with this person and they may freak out or clam up, who knows!
Those who were in the third strategy group, the smallest of the three, resisted disclosure based on the belief that it would potentially detract from their relationship with the HCP and cause less quality healthcare:

I just can’t be honest with them regarding my lifestyle, I wish that I could, but I don’t feel safe enough. I just wouldn’t want it to get in the way of my healthcare. Because of the social stigma against being gay, I think some doctors on a subconscious level are so biased that they would not give the same quality of care. Their bedside manner may not be as compassionate or humane or understanding. They may not make the extra effort such as inviting my partner in on medical decisions and stuff. It’s part of the healing when you’re sick; coming from the heart and the connection you have with your doctor. If the doctor was wavering on their commitment to understanding you, that might make a big difference. Maybe they wouldn’t make the same referrals and phone calls in your behalf, I don’t know . . .

There were other issues around the topic of disclosure. Confidentiality was mentioned; several of the informants had no problem with disclosure in a larger town or city but would not consider disclosing sexual preference to a HCP in the small town where they lived:

You hope that confidentiality is protected at the clinic, but I know what small towns are like and no, I would not disclose in this town because I run a business here.

Assumed heterosexuality was ubiquitous in healthcare encounters with all the informants. Unless the informant’s sexual preference was on the chart from previous visits, there were questions asked about sexual activity (presumably with men) and birth control. Some of the informants used these opportunities to set the record straight: “Women are my birth control,” or “I have no need because I’m a lesbian.” More often than not, the informants just skirted the issue and said, “No, I have no need for birth control.” It did create moments of discomfort for some:
When I told the doctor I didn't need any birth control because I was not sexually active, he wanted to know if I was afraid of getting AIDS and I had to suffer through more explanations.

Many of the informants said they would gladly be open about their sexuality if they were given a comfortable way to disclose:

If there was a column on the history intake form for sexual preference, you bet, I would be honest, because it would show me that they were open enough to at least ask.

There are lots of ways doctors could create an opening for me to disclose, even if they just asked me outright it would be OK.

Homophobia. Homophobia infiltrated so many of the stories from the informants that it was almost redundant to have a separate category. Several of the informants, however, made a specific point about recounting certain stories that epitomized homophobia to them, thus it felt important to list them separately.

Informants told of picking up on blatant or subtle cues while interfacing with HCP's. This often determined whether they went back to that practitioner or whether they disclosed their sexuality. Many of the informants described that their intuitive sense enabled them to detect subtle non-verbal nuances of homophobic behavior:

We used to go to this chiropractor, his wife was the receptionist, he was always very nice to us and referred to us as “the girls”, but his wife, they were strict Mormons, she was always cool to us. We felt it was because she was uncomfortable with us.

I listen carefully, if I hear someone tell a racist joke, I assume they are bigoted and I would never disclose my sexuality to that person.

One couple who adopted a child told this story:

Montana doesn't allow two women to adopt so we went through a single parent adoption. We had to get a special order from the court to have an independent
case study for the adoption, you have to have a home study to adopt. The only agency up here in this part of Montana for adoptions was Catholic Services and we knew we couldn’t do that. The case manager we got was really cool and it was no problem, she just put one name on the report. When we went to pick up the baby after the birth, even though the family had met us and accepted us as a couple, the hospital staff were pressuring the mother to keep the baby! They said things like, “Are you sure you want to give her up? You two look so cute together.” It scared us because we were sitting in the same room with her. The birth mother had already gone through hours of counseling around her decision and they were saying this stuff to her. Even when we confronted the hospital staff about their attitude with us adopting this baby, they denied having a problem with it. But there was this one really cool nurse; when it was time for us to leave with the baby, she said to the birth mother, “OK, it’s time to give the baby to its mother.”

We have all changed our last name to be the same, because that’s one way we know we could be solidified in society more easily. It’s ironic, but it does make a difference, especially in Montana, I mean, whether people put it together right away or not, it does solidify us as a family to others. We want to be treated as a family and that’s one way to do it.

There was a distinction made by one of the informants concerning the services available to lesbians in the city versus rurally:

In the city I think there are more mental health outreach places for lesbians to go. Living in a rural area, even if they had one, there would be a great deal of reluctance in going because . . . you know, those right-wing people out here . . .

Finances. A lack of financial resources was the most often-stated barrier to healthcare facing lesbians in this study. The informants themselves felt this barrier and they expressed the view that it was a pan-lesbian issue as well. There were several factors cited as the cause for this obstacle. The first was that lesbians were not as financially secure in general:

It seems like . . . the lesbians I know have less financial resources than the heterosexual women I know. I don’t think there are a lot of professional lesbians . . . in this state . . . not a lot with graduate degrees. I mean, it’s not like Seattle, I’ll tell you what!
I think lesbians, on the whole, don’t have a lot of money because they don’t have the two-income household, you know, that whole [social] structure thing.

Another informant felt that lesbians gravitated towards certain types of occupations and this contributed to their lack of financial security:

Lesbians notoriously are in non-traditional jobs, like carpentry and more male-oriented labor jobs. I don’t think as many are professionals, maybe there are more in the city, but out here, they do more of the independent kind of work. There’s no pensions, retirement, or insurance with those kinds of jobs. What are all of us going to do when we get old and can’t do that kind of work anymore?

The lack of health insurance was a concern for more than half of the sample. They felt there was discrimination in society because lesbians cannot legally claim their partners on their insurance policies as can married heterosexual couples.

As mentioned earlier, many of the informants had a preference for alternative healthcare, yet they felt this option was often not within reach because of financial constraints. Several of the informants stated that if they had the financial means, they would have different healthcare-seeking patterns. One said:

I don’t have insurance and so I’m real limited as to when I go to the doctor. One time I was really sick from being dehydrated from food poisoning and I avoided the doctor because of the money. I eventually had to go to the hospital. It ended up costing me a little over $200. One thing, though, I have noticed about being in rural Montana is people are really flexible with payments, and doctors even barter sometimes!

Many of the informants said they only go to the doctor when they are sick; the reason for most was financial. One informant put it this way:

If I had the money, I would definitely get more healthcare. I’d like to get a complete physical every year with a gynecological exam and a blood count. I’m really into that type of preparedness, I would like them to know my entire history. But in the city anyway, that whole exam with the blood count and everything was $300! Now, I can only pay for a part of that. I resent that I don’t have
insurance at this point, that I can’t afford it.

Summary of Findings

The majority of the 14 informants in this study were Caucasian, middle-aged (if one considers a mean age of 40 to be middle-aged), well-educated, and in committed monogamous relationships. There was a wide range of occupations as well as incomes with half the sample being self-employed. Fifty-seven percent of the informants had health insurance and all said they considered themselves physically and mentally healthy.


Under Lesbian Healthcare Practices there were two subcategories: a) alternative versus allopathic, and b) healthcare-seeking patterns. Most of the lesbians in this study preferred alternative healthcare providers (HCP’s) and practices over allopathic but would definitely use Western medicine in the event of an emergency or very serious illness or injury. There was a preference for women HCP’s, competency of the HCP was very important, and the informants did not mind driving long distances to get the healthcare they wanted. There was a glaring lack of regular healthcare among the informants; 29% received yearly PAP smears and the remaining had an average length between gynecological exams of 5-6 years with a range of 2-18 years. Most stated they only went to the doctor “when they were sick”.

The domain of Lesbian Healthcare Issues revealed that even though the informants stated that lesbians did not have any different healthcare issues from heterosexual women, there were mental health issues that had unique features for
lesbians. These issues fell into three subcategories: a) being out and coming out, b) isolation, c) drug and alcohol abuse, and d) depression and self-esteem. None of the informants stated they struggled with their sexuality. To the contrary, they expressed the perception that the mental health issues of lesbians were a result of the strain of being marginalized in a social/political system that did not accept the lesbian lifestyle.

The last domain, Barriers to Healthcare, had three subcategories: a) disclosure, b) homophobia, and c) finances. There were views, pro and con, for disclosing sexual preference to the HCP. Some felt it was an essential element of holistic healthcare and important for the awareness of the provider; others felt that it was non-essential and, indeed, could be detrimental if the provider had a disparaging view of lesbians. At the least, disclosure took time and energy and there was an element of risk that there would be a negative reaction from the HCP.

The informants told of experiences with homophobia in their families-of-origin, the workplace, and in healthcare. It was often manifested in subtle ways and the perception was expressed that there may be increased homophobia in rural areas. Assumed heterosexuality in the healthcare setting was a common phenomenon experienced by the informants. It was also noted by several of the informants that lack of anonymity and confidentiality in rural Montana made a difference as to where they received healthcare and whether they disclosed their sexuality.

Finances played a key role in the type and frequency of healthcare available to many of the informants. Even when the informants had health insurance, alternative healthcare was often not covered and this affected the perceived choices they had
available to them. It was expressed by many of the informants that the lack of financial security was a major problem with lesbians in general, getting adequate healthcare.
CHAPTER 5
DISCUSSION

This study set out to discover the healthcare practices and issues of rural lesbians. The researcher asked the question: What are the healthcare experiences of lesbians living in a rural environment? There were three subquestions that guided the main question: a) What are the physical and mental health concerns of the rural lesbian? b) What are the healthcare practices of the rural lesbian? and c) Does the rural lesbian disclose her sexual orientation to the healthcare provider and what are the reasons for disclosure versus non-disclosure? This discussion involves the more important findings from the study as well as a comparison to previously done work.

The demographics of this study, in part, are a reflection of previous studies, i.e., a well-educated, Caucasian sample. The majority of prior studies were also middle to upper-middle class and urban (Bradford et al., 1994; Buenting, 1992; Hitchcock & Wilson, 1992; Stevens, 1992; Stevens & Hall, 1988; Trippet & Bain, 1993; Zeidenstein, 1988). This sample differed financially; with several exceptions, the informants did not represent upper middle class. Approximately 57% of the sample made an estimated yearly income of less than $25,000/year. Over half of the sample held non-traditional jobs and only three were professionals in the traditional sense of the word. The last difference from previous studies is that all the informants lived rurally.
The informants in this study had a preference for alternative healthcare. The reason seemed to be centered on the desire for a more holistic, empathic form of healthcare. There was an intonation of distrust of the high technology of Western medicine secondary to potentially harmful effects. The perception was held that some of its practitioners were disengaged from the emotional part of healing. A reluctance to let go of Western medicine altogether existed and a middle ground between alternative and allopathic healthcare was sought. Trippet and Bain (1992) concluded in their study that the reasons lesbians did not seek traditional (Western) healthcare was because of a lack of a) available alternative therapies, b) holistic health care, c) preventive health care and education, d) good communication and respect, and e) women healthcare providers (HCP’s). The parallels to the present study are very close. However, Trippet and Bain stated “Underlying all five reasons for lesbians’ failing to seek traditional health care was the fear of discrimination or the actual experience of discrimination from health providers toward lesbians as women and as lesbians” (p. 151). This finding was not evidenced in the present study. There were no specific stories recounted that Western medicine was avoided because of the fear of discrimination based on sexual orientation.

The rural sample in this study had few qualms about driving great distances for healthcare. This is not altogether surprising in a state where people drive 80-200 miles or more to go out to dinner. Driving longer distances for healthcare for greater anonymity and confidentiality was mentioned several times by different informants. It was often perceived that confidentiality was problematic in small rural towns. Competency was also cited as a reason for driving longer distances for healthcare.
The findings of this study overwhelmingly agreed with many others that women were the preferred HCP (Hitchcock & Wilson, 1992; Lucas, 1992; Robertson, 1992; Stevens, 1992). The other point of agreement is the lack of regular healthcare sought by lesbians. Only 29% of the present study’s sample had received yearly PAP smears and routine checkups with an average time interval of 5-6 years. O’Hanlon (1995) found a three-fold greater time interval between PAP smears for lesbians versus heterosexual women. Zeidenstein (1990) had a 50% yearly PAP smear rate with the other half averaging 3-5 years. In Denenberg’s (1995) study, PAP smears were deferred because of lack of funds and knowledge of risk factors, and fear of a negative experience with the HCP. This study on rural women found that the informants either lacked the funds for healthcare or more often, the reason cited was that healthcare was only sought if something was wrong. Many of the informants claimed that they took care of problems themselves as best they could before seeking outside help.

The lesbians in this study perceived that alcohol abuse, isolation, depression and self-esteem were issues that rural lesbians struggled with as a population. They stated the belief that homophobia, both internal and external, was largely responsible. External homophobia was manifested in society’s unacceptance of the lesbian lifestyle; internal homophobia settled into the psyches of some lesbians and created low self-esteem and depression. The informants thought the way some lesbians coped with homophobia was by isolation and alcohol abuse. The review of literature found the general consensus that lesbians had no higher rate of depression than heterosexual women (Bradford et al., 1994; Rankow, 1995). However, it was speculated that homophobia was largely
responsible for lesbians' depressions (Denenberg, 1995; Rankow, 1995). Hall’s (1994) study on lesbians recovering from alcohol problems found that “discrimination, social isolation, and the sense that lesbian partnerships are not valued in society were factors that made [many] conflicts especially painful and relevant to lesbians’ experiences with alcohol use and recovery.” Hall also noted that bars were sometimes the only social meeting places for lesbians and this affected their cultural norms. The informants in the present study confirmed this relationship between bars as the only available social meeting place and alcohol problems.

The barriers to optimal healthcare identified in this study included disclosure issues, homophobia, and finances. How the informants dealt with disclosure can be divided into three strategies: a) assertively out, b) invisible, and c) resistant. Several in the sample felt strongly about coming out to their HCP. It was felt to be important to their relationship with their provider and there was a desire not to have to hide or dance around issues. Informants who used the invisible strategy, comprising the majority, generally did not disclose but said they would if they were assured that the HCP was open and accepting of the lesbian lifestyle and if they were given a good opportunity such as a question on the history intake form. They felt most of their healthcare encounters for physical problems did not warrant disclosure and there was a reluctance to create an issue with sexual orientation when it was not deemed relevant to their healthcare. However, some informants said mental health issues warranted disclosure. Several said disclosure to small rural town HCP’s was unlikely because of lack of confidentiality. The third and smallest strategy group, those that resisted disclosure of their sexual orientation,
refrained from doing so based on the belief that it would potentially detract from their relationship with the HCP and cause less quality healthcare.

Though there was recounting of homophobic behaviors from HCP’s, none of the informants told of negative experiences after disclosing to a HCP; nor did any of the informants intimate that they delayed or quit seeking healthcare because of disclosure issues. This is in sharp contrast to the literature review where many studies reported negative experiences after disclosure and subsequent delays and abstinence from seeking further healthcare (Cochran & Mays, 1988; Hitchcock & Wilson, 1992; Stevens, 1992). The rural environment may be a determining factor influencing this discrepancy. Many of the informants stated that their HCP was a friend. Familiarity and informal networks are common themes in rural environments. Bushy (1993) noted that “rural residents probably know most of the employees in . . . health care institutions” (p. 190). In the rural lesbian community this is probably even more true. Disclosure becomes a non-issue if both sides already are familiar with one another outside the healthcare setting. The informants in this study who were relative newcomers to the area depended on word-of-mouth and referrals for HCP’s thereby establishing a basis of safety for disclosure.

Homophobia remains a real concern for rural lesbians. There seemed to be a difference geographically, but not necessarily related to population size. The town where the informant had two negative incidences of being yelled at “You’re a lesbian” and having egg thrown at her car has one of the highest populations in the state; it is also considered one of the more conservative towns. Informants would drive longer distances for healthcare to the perceived “more liberal” town of Missoula. Bushy (1993) confirms
the difference in cultural beliefs of rural environments: “Generally, . . . rural persons are inclined to be more traditional and conservative in their views” (p. 191). Her study on rural women found that these conservative views made it difficult for women to break out of traditional “housewife” roles. Certainly lesbians do not fit into this genre of traditional in the rural sense.

Finances was probably the largest indicator of delayed or deferred healthcare in rural lesbians. Rural lesbians face a confounded financial strain. Lesbians make less money than their heterosexual counterparts even though they tend to be better educated (Bradford et al., 1994; Denenberg, 1995; O’Hanlon, 1995), and as stated, they were below some of the income averages reported in urban lesbian studies. Statistics of rural dwellers show that there are less job opportunities to match education levels in rural areas as well as lower wages (Bushy, 1993). In addition “The earnings of rural women ... are 50% below that of rural men as compared with the salaries of their urban counterparts, which are 34% below men’s” (p. 189).

What is interesting and a somewhat unexpected finding from the data is how rural lesbians adapt to rural conservatism. The couple who owned and ran the store in what they described as a very conservative small town had many of the characteristics admired by the local people; hard working and self reliant. They felt that as long as the locals had a means of ignoring their lesbianism, i.e., being discreet or invisible, they were accepted, even though they felt their sexual orientation was common knowledge. This strategy of being invisible and blending with the community points to adaptive behaviors that rural lesbians employ in order to live peacefully and healthily in their rural environment.
How isolation was viewed by many of the informants also exemplifies adaptive behavior. Isolation as a chance to rejuvenate was a theme that emerged from this study yet was not readily apparent in the literature.

**Implications for Practice**

It seems archaic to say that healthcare providers need to be open and aware of the needs of their culturally diverse clients. However, evidence points to the fact that homophobia in the healthcare setting continues to be a problem. It is the recommendation of the researcher that universities and other education centers for healthcare providers increase their focus on diversity training and include information on the healthcare needs and issues of lesbians. Lesbians’ issues with depression, breast and cervical cancer risks, STD transmission, child bearing, and domestic violence, to name a few, should be included in curriculums. The burden of this education should not fall on the shoulders of the lesbian client.

Based on the fact that many of the lesbians in this study did not feel their sexual orientation was relevant to their healthcare, it appears that lesbians may not be aware of their health risks. Because of the lack of definitive studies on lesbians and their risks, this is understandable. We do know, though, that several STD’s, including HPV, are transmissible between women. Depending on the sexual practices of lesbians (multiple partners or prior sex with men), this may constitute an increased need for screening. One of the primary tasks of HCP’s is patient education and in order to do this appropriately and thoroughly, the HCP needs to know the clients’ risk factors.
Based on the findings of this study, isolation, depression, financial strain, alcohol problems, and a preference for alternative therapies are rural lesbian healthcare issues. The implication is that, though not all rural lesbians are going to exhibit the above issues, the astute HCP should be aware of the red flags around these issues. This is no different than HCP’s who are alerted to the possibility of suicide in patients that express hopelessness; it is all part of the relevant history and assessment.

It is evident that rural lesbians rely on networking to select HCP’s. Unfortunately, there is no well-established information network for rural lesbians, especially newcomers to rural communities. The literature shows that lesbians avoid healthcare for fear of a negative reaction to their sexuality. The implication is that there needs to be information available on lesbian-friendly healthcare resources. This can be done through state gay and lesbian organizations, such as Pride! (in Montana: 406-442-9322 or 1-800-610-9322), or through local gay and lesbian organizations or women’s centers at universities. Local gay and lesbian-friendly businesses and coffee houses are potential areas to post resource lists. It is also feasible that local healthcare clinics and hospitals sponsor lesbian healthcare educational workshops for both lesbian clients and local HCP’s. This not only shows support for the lesbian community but serves as a means to disseminate important healthcare information as well as inform persons of the available local lesbian-friendly resources and services.

As mentioned, many of the lesbians in the study said they would disclose their sexual orientation on a history form if it was asked. Along with this, HCP’s can make
their offices and clinics more “open” by displaying posters or magazines that honor cultural diversity.

The financial constraints of rural lesbians is a formidable obstacle. The implications are that rural lesbian clients may need creative financial solutions to lower this barrier to adequate healthcare. This could include local fund-raisers by the lesbian community as well as local HCP’s to raise funds for basic health screening such as PAP smears and mammography. Local health clinics could offer payment plans and sliding scale fees based on income. One informant stated that she has even paid medical bills by the barter system. Pressure on state and local governments to include domestic partners on health insurance plans has been successful in some areas.

**Recommendations for Further Research**

In the state of Montana there are many diverse Native American populations. Gays and lesbians are called “two spirited” in these cultures. There may be a rich history and much to be gained by examining the experiences of this segment of Native American people. Many Native American tribes live on reservations that are located in rural areas. Getting a cross-cultural perspective on the perceptions, experiences, adaptive behaviors, and challenges of these two spirited people would be insightful.

Lesbians in this study, as well as in many studies done previously, had a low rate of preventative screening and regular healthcare. It has been surmised that lesbians and HCP’s may lack knowledge of lesbians’ health risks. Among other factors already mentioned, this knowledge deficit may contribute to lesbian’s not getting regular healthcare. In order to be able to plan and implement strategies to increase lesbians’
access to healthcare it would be helpful to know if, indeed, an increased awareness of health risks and recommendations increased lesbians’ use of healthcare.

The adaptive strategies and behaviors that lesbians employ to live in the rural environment also warrants further study. Combining previous work on the resilient and hardy characteristics of many rural people and rural lesbians’ adaptation to the rural environment would add to the present knowledge base of rural nursing theory and practice.

**Conclusion**

bell hooks speaks of the margins of society as a site of oppression (hooks, 1990). More importantly to all our futures she says, the margins are the site of great creativity and power; a site of resistance where the oppressed can redefine themselves on their own terms. This study has pointed out the many faces of marginalization of rural lesbians. Several of the faces bear the marks of a lifetime of difficulty as a result of being different. Fortunately, many of the faces also wear an expression of steadfast resilience. As one informant put it: “When lesbianism is seen as a positive choice, these studies won’t be necessary.” However, there is much to be learned from the creative adaptability of lesbians living in rural landscapes.
REFERENCES


APPENDICES
APPENDIX A

DEMOGRAPHIC DATA SHEET/INTERVIEW QUESTIONS

Demographic Data Sheet

1. Age?
2. Occupation?
3. Place of residence?
4. Members and relationship of household members?
5. Place of birth?
6. Place(s) of residence in the last 5 years?
7. Race?
8. Sexual orientation (lesbian/bisexual)?
9. Education?
10. Definition of family?
11. Where does family live?
12. When identified self as a lesbian/bisexual?
13. Ever had sex with men?
14. Ever had children?
15. Had or want children in lesbian relationship or on own?
16. Do you have insurance? If yes, what’s your deductible?
17. Why do you live in a rural area?
Interview Questions

1. Tell me about any health problems you currently have?

2. How about past health problems?

3. What kinds of issues about your body/mental health do you find particularly worrisome?

4. What do you do when you have a not-so-serious health problem?

5. How about a more serious problem?

6. How about a really serious health problem?

7. Who do you seek out when you have a health question or concern?

8. Where do you go for health care (include mental health) now? What are your available health care resources (including mental health)?

9. What are your current health care practices; how often and when do you see a HCP?

10. What kinds of things do you consider when you select a health care provider? How do you select a HCP Are things like location (geography), male/female, sexual orientation, race, age, education, traditional/non-traditional practice, etc., important?

12. What do you want a HCP to know about you when you go see them?

13. Do you think heterosexuality is assumed by HCP’s until told different?

14. Do you consider your sexual preference important for your HCP to know about?

15. Do you reveal your sexual preference to your HCP? When do you do this? How do you do this?
16. Has there been a situation where the care provided might have been different if your sexuality had been revealed or visa/versa if your sexuality had not been revealed?

17. What kind of responses have you gotten from HCP in the past concerning your sexuality?

18. What kinds of questions would you like your HCP to ask you, concerning possible health issues around being a lesbian?

19. If you have a partner, are they included in your health care decisions? Does your HCP include your partner when discussing your health issues or health care decisions?

20. What do you perceive the health concerns of the lesbian population are (include mental health if applicable)?

21. Do you perceive any differences in health issues between lesbians and heterosexual women (including mental health issues)?

22. What health-related risk behaviors do you perceive lesbians engage in (including physical and mental)?

23. If you were to design an ideal HCP and an ideal health care setting/facility, what would he/she/it be like?

24. What barriers or obstacles, if any, do you perceive stand in the way of you getting the best health care you could possibly get?
Dear potential study respondent,

First, let me thank you for considering being a participant in my Master's thesis study on lesbians. I am particularly interested in rural Montana lesbians' health care issues and practices. I am also very interested in the type and quality of health care experiences of rural Montana lesbians and their perceptions of whether their sexual orientation has an impact on their health care.

I am looking for lesbian-identified women who are at least 21 years old, who are able to converse in English, and who live in a rural area (rural is generally identified as any area outside of an urban center of 2,500 people or more).

The study involves a one-time interview that lasts 1-2 hours. The interview includes demographic questions such as age, race, when you became lesbian identified, why you live in a rural area, your definition of family, etc. The interview questions ask you to give information on your health status (past and present, physical and mental), how you handle health care issues in your life, your experiences in the healthcare setting, your feelings on the quality of health care you have received, what your perceptions are of lesbian health issues, what you would like to see different in the health care arena, etc. When I mention health care I am referring to any health care provider such as MD's, RN's, nurse practitioners, naturopaths, chiropractors, herbal therapists, mental health care providers such as counselors, etc.; in other words, any provider that deals with any aspect of your physical or mental health.

Confidentiality will be strictly maintained as dictated by the rigorous standards of research at Montana State University. The interviews will be audio-tape recorded to help me remember the information. No names will be mentioned or attached to these tapes. Each respondent will be assigned a number and the tapes will be labeled thus. The tapes will then be erased after the completion of the study, spring of 1997. No information that may lead to the identity of the respondents will be disclosed in the study write-up, such as place of residence or employment or nicknames, etc. These consent forms will be destroyed after being locked up for 5 years in the College of Nursing.
The interviews will take place at a location that is convenient to the respondent and maintains her confidentiality. This place can be the respondent’s home or any place she chooses. A risk of participating in this study is that some of the questions may be considered personal and some may bring up emotional feelings. The potential benefit of participating in this study is a sense of contributing your valuable insight to nursing research which, hopefully, will then go on to help shape a more holistic and less biased health care system.

There has not been any studies, that I know of, that have focused on rural lesbians. I hope this study will contribute to better understanding of rural lesbian health care issues.

If you wish to participate in this study, thank you, and please sign the consent line below. Be assured that you may withdraw your participation from this study for any reason, at any time, even in the middle of the interview. You will not be pressured to continue or to re-enter the study at a later date. If you have any questions about this study contact me at (406) 994-3783 and leave a message for me to contact you.

Sincerely, Julie Dybbro

Consent Form: I have read this consent form and agree to participate in the study. I have received a copy of this form.

Date:_____________ Signature:_______________________________