A COMPREHENSIVE GUIDE TO UNDERSTANDING LESBIAN SEXUAL
HEALTH: REACHING A VULNERABLE POPULATION

A dissertation submitted to the Faculty of the American Academy of Clinical Sexologists
in candidacy for the degree of
Doctor of Philosophy in Clinical Sexology
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DISSEPTION APPROVAL

This dissertation, submitted by Alexandra Karydi, has been read and approved by three committee members. The final copies have been examined by the Dissertation Committee and the signatures which appear below verify the fact that any necessary changes have been incorporated and that the dissertation is now given the final approval with reference to content, form and mechanical accuracy. The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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Abstract

There has been an increase in cases of lesbian women becoming ill, due to a lack of understanding and information about sexually transmitted diseases and other sexual habits. Throughout empirically study-based literature, researchers and writers compare and contrast heterosexual and homosexual women in categories of knowledge base, care-seeking behaviors, and attitudes. Lesbian women were more often inclined to perceive that health care providers would view them negatively should they reveal their sexual orientation. Studies suggest the need for further research in the field of sex health and disease among lesbians. The objective of this paper is to understand the different aspects of knowledge, attitudes and perceptions regarding sexual health in the lesbian population. This paper serves to fill a gap in the available knowledge to promote healthier and safer sexual behavior and break down stereotypes without undue harm in gay women. A limitation of this comprehensive guide is that the findings and research often are not derived from a large, population-based sample; thus, caution should be exercised in generalizing the findings on frequency of health behaviors, symptoms, and diagnoses in lesbian women. In addition, there is a lack of information and research being done on this population.
PREAMBLE

This paper is designed to serve as a manual to aid clinicians working with lesbian women. I thought it was important to define the word “lesbian” so there would be no confusion between gender identity and anatomy when identifying a woman as a lesbian. In the context of this paper, a lesbian is a biologically born female, who also identifies as a female, and who is attracted to and has sex with other self-identified females. It is possible to identify as a woman while not being anatomically so; for example, being a male to female transgender. A transgender woman would identify as a woman, but would not necessarily find the information in this paper useful, as it medically focuses on the female anatomical factors of disease. In addition, I do not feel this manual should be used when working with female to male transgender individuals. Although, these individuals may have female anatomical parts, they identify as male and have health concerns that should be respected and addressed separately.

My intention is not to harm, offend, or be insensitive to any individual or group of people, but be respectful of the unique needs of post and non-operative transgender women. For the sake of time and clarity, the focus of this paper is about a group of individuals who have been given little attention from society and are dying at alarming rates from treatable diseases.
Lesbian Sexual Health

Introduction

The World Health Organization (2013) defines sexual health as balanced physical, mental and social well-being. Individuals who have a positive, respectful approach to sexuality and sexual relationships, with the belief that sexuality encompasses pleasure and safe sexual experiences, free of coercion, discrimination, or violence are defined as healthy. Sexual health achieved and maintained includes the sexual rights and rewards of all individuals with respect, consent, and protection. Sexual Health is “an important part of physical and mental health” (National Strategy for Sexual Health and HIV, 2001). Together with the fundamental human rights to privacy, family, and equality, it is a key part of the human identity. Regrettably, lesbians throughout history have been ignored and excluded from consideration relative to other populations and groups (U.S., 2009).

More than just an orientation, the lesbian identity involves psychological responses, cultural values, societal expectations, and a woman’s own formulation of self (White & Levinson, 1995). Lesbians have been identified in the narrowest sense of the word in literature and studies, as a female homosexual, meaning a woman who is sexually attracted to other women (Patzel, 2006). Identity constriction prevents lesbians from seeking treatment or education in sexual health. Studies have suggested that because lesbians are rarely an identified population in women's health research, little is known about the lesbians' health risks (White & Levinson, 1995; Patzel, 2006).

The Movement Advancement Project (MAP) in March, 2012, published the Obstacles and Opportunities: Ensuring Health and Wellness for LGBT Families, which
argued that, due to inequitable laws and social stigma barriers, the health and well-being of LGBT families has been impeded (MAP, 2012). The MAP study established lesbians as categorically weighing and smoking more than heterosexual women, and consequently at higher risk for heart disease, stroke, and cancers (colon and cervical). Lesbians have fewer pregnancies and live births, thus allowing for uninterrupted estrogen over longer periods of time and putting them at greater risk for cancers including breast, uterine and ovarian cancers. In addition, lesbians can get sexually transmitted infections (STIs), such as bacterial vaginosis (BV) and the human papillomavirus (HPV), the virus responsible for cervical cancer. Lesbians have received little attention regarding sexual dysfunction, which can negatively affect relationships and health (MAP, 2012).

Current State of Lesbian Health

Cultural and social attitudes often lack initiative to take seriously the needs of LGBT research and census. Lesbians and bisexual women risk and face unique and significant health care problems. Dolan (2005) argued that most health care professionals have not had lesbian-specific training and therefore, do not know the specific health issues that lesbians and women who have sex with women face. Health care professionals also fail to ask about sexual orientation when taking personal health histories. Lesbians and women who have sex with women are often misunderstood as not being like women who only have sex with men. This misunderstanding can lead health care professionals to miss discussing important parts of women’s health (Dolan, 2005). The Institute of Medicine Committee on Lesbian Health Research Priorities (1999) argued that throughout history lesbian women have been the target of prejudice
and discrimination, as stigmatization of homosexuality continues to remain in our western culture, as well as throughout the world (Institute of Medicine, 1999).

DeHart (2008) conducted a study that focused on the theoretical approaches to lesbian health. She discovered the lack of specific recommendations for lesbian health maintenance and emphasized the need for studies to identify barriers to health care access. Additionally, the study found women experience low levels of confidence in their own capacity to detect abnormalities, emphasizing that clinicians need to find alternative behavioral models. The MAP study helped fill the gap in the research and identified barriers to care. These barriers included fear of revealing sexuality or sexual history, seeing their health care professional as being unaware of lesbian health issues, and not having health insurance (Dolan, 2005; MAP, 2012).

The lack of health insurance is more burdensome to the LGBT community. Obstacles and Opportunities: Ensuring Health and Wellness for LGBT reported that LGBT families have a reduced access to health insurance (MAP, 2012). Unlike married heterosexual couples, many lesbians do not get health benefits through their partners. “Family” health insurance policies exclude coverage associated with same-sex relationships (Dolan, 2005). Federal law allows employers to refuse to offer health benefits to same-sex partners of LGBT workers or to partners legally married. In some situations, employers may incur additional taxes if they offer such coverage. In addition, federal and state laws’ restrictions on caregiving and medical decision-making may deny leave to partners to take care of one another (MAP, 2012). The report also concluded that health care environments are often inhospitable to LGBT families. Health care
professionals such as physicians, counselors and support staff, may be uninformed, hostile, discriminatory, or refuse to treat LGBT people and their families.

The key disparities among LGBT adults and the general population are not only evident in the inability to acquire health insurance, but furthermore in limited admittance to care, the incidence of HIV/AIDS, race-based disparities, and chronic physical conditions such as diabetes, obesity and arthritis (MAP, 2012). Systemically health care systems lack training and acceptance of LGBT people and can discriminate and even refuse services. The data collected indicated that 29% of LGBT adults and 48% of transgender adults delayed or never sought medical care for themselves, versus only 17% of heterosexual adults (MAP, 2012). The LGBT community has lower rates of routine care and prevention, and higher rates of debilitating diseases like obesity, cancer, diabetes, and HIV/AIDS. LGBT people also have a higher incidence of psychological distress, which researchers attribute to the accumulated effects of stigma and discrimination. The LGBT families that are lower-income, living in poverty, or in rural communities have additional disparities and disadvantages. Although several studies provide information about the health status of the LGBT population, much is still unknown about this population from a lack of accurate data collection (MAP, 2012).

The Effects of Internalized Homophobia and Heterosexism

Considerations of sexual orientation remain largely hidden under heterosexual norms and traditions. Trettin, Moses-Kolko, and Wisner (2006) argued that heterosexism continues to control research and health care differences between heterosexual and LGBT populations. In particular, lesbians are at risk of oppression from heterosexist ideologies
as they hold the double minority status of being both female and homosexual. The literature that exists about homosexuality and mental health has been focused primarily on gay men, while research about lesbian mental health remains unknown. Trettin, Moses-Kolko, and Wisner (2006) reported no research on lesbian prenatal depression had ever been published.

Cultural and social attitudes towards lesbians may affect a woman’s own internal homophobia, influenced from years of social intolerance (White & Levinson, 1995). Internalized homophobia and the fear of coming out are unique to lesbians’ sexual health. One of the most difficult issues in a lesbian’s identity formulation, is whether, when, or who to disclose her sexual orientation or “coming out.” This process outs lesbians at risk but also impacts the extent of support or isolation experienced by family and friends (Kaschak, 2001). Balsam and Szymanski (2005) hypothesized that, the less “out,” the greater the level of internalized homophobia and more life discrimination a lesbian experiences. In addition, the greater the association with lower quality simultaneous same-sex relationship, the greater perpetration and victimization in the long and short terms.

**Barriers to Receiving Services.** Marrazzo (2004) reported that, although there are a large number of women in the United States who identify as lesbian, there is little information or resources that addresses lesbians’ health needs. The Institute of Medicine has encouraged focus on practicing better medicine, developing policy, and educating clients on sexually transmitted infections, Pap smear screening, and cervical dysplasia among lesbians. Lesbians and women who have sex with women have been excluded in risk classifications and assessment. However, research has demonstrated that lesbians
have reported: contracting sexually transmitted infections (STIs); receive infrequent Pap smear screening; having had previous pregnancy; induced abortion; and using hormonal contraceptive use (Marrazzo, 2004).

**Systemic Barriers.** Inequitable, prejudicial laws and policies in the justice system regarding sexual health restrict and hinder service to lesbians systemically (Simpson & Helfrich, 2005). In particular, lesbian mothers are vulnerable to these barriers as they must take into account their legal vulnerabilities. Lesbian mothers may experience discrimination in a legal context for being in a same-sex relationship. Shapiro, Peterson, and Stewart (2009) examined the role and level of legal and social support accessible to lesbian mothers in their country of residence and its effect on the mental health of lesbian and heterosexual mothers. The study included 52 lesbian mothers and 153 heterosexual mothers in the United States and 35 lesbian mothers and 42 heterosexual mothers in Canada, as both countries have very different legal rights for lesbian citizens. Their findings suggested that lesbian mothers from the United States reported more family worries about legal status and discrimination and more depressive symptoms than did lesbian mothers in Canada. They concluded that legal and social context controls the role of sexual orientation in maternal mental health.

**Institutional Barriers.** Mental health services used to treat lesbians need to be explored, as well as, factors that promote health and healing among the lesbian minority. Barriers are most noted when institutions adopt and practice ambiguous and inconsistent policies, when lesbian clients are assigned specific staff members, staff lack commitment to lesbian service, and heterosexism language prevails. (Simpson & Helfrich, 2005). It is important to gain an understanding of these barriers affecting lesbians in seeking
treatment and services relating to sexual health as it could reduce illness and fatalities in this community. Lesbian attitudes inhibit the individual pursuit of treatment. Lesbians consider how the heterosexual community will view them and treat them, particularly heterosexual female clients, staff members, officers of the court and police. (Simpson & Helfrich, 2005).
A Woman's Anatomy

The External Anatomy of a Woman

**Breast.** The breasts contain 15 to 20 lobes and are located in the upper ventral region of the torso and in women it holds the mammary gland that secretes milk functioning to feed infants (Yronwode, 2000). The subcutaneous adipose tissue covering the lobes contributes to the breast size and shape. There are many loopholes in each lobe, at the end of which are sacs where milk is produced in response to hormonal signals. Both men and women develop breasts from the same embryological tissues (Figure 1).

*Figure 1. Breast Anatomy*

During puberty, female sex hormones mostly estrogen, trigger the development of breasts. During pregnancy, the breast becomes reactive to a complex interaction of hormones that cause tissue development and enlargement in order to produce milk. The three responsible hormones are estrogen, progesterone and prolactin. In addition, the glandular tissue in the breast and the uterus change during the menstrual cycle. Fat fills the spaces between lobules and ducts. There are no muscles in the breast, but they lie under each breast and wrap the ribs with each breast containing blood vessels and vessels
that carry lymph. The lymph vessels run to smaller organs called lymph nodes, clusters of which are found under the arm, above the collarbone, and in the chest, and other parts of the body (Yronwode, 2000).

**Vulva.** The vulva is the external sexual organ of women, when opened and viewed from the top down one can see the Veneris Mons, clitoral hood, clitoris, and labia minora (Yronwode, 2000) (Figure 2).

*Figure 2. The External Anatomy of a Woman. Adapted “Anatomy Atlases,” by M. P. D’Alessandro, 2012. Copyright 1995-2013 by Michael P. D’Alessandro, M.D.*

**Mons Veneris.** The mons veneris means the "hill of Venus" in Latin, and is the pad of fatty tissue that covers the pubic bone below the abdomen but above the labia. The mons protects the pubic bone from the impact of sexual intercourse and can be a sexually sensitive area (Yronwode, 2000).
Labia Majora. The labia majora are the outer lips of the vulva, pads of fatty tissue that wrap around the vulva from the mons to the perineum, the area between the anus and vulva. The labia are covered with pubic hair, and have an abundance of sweat and oil glands which captures the scent that can be sexually arousing (Yronwode, 2000).

Labia Minora. The labia minora are the inner lips of the vulva. They are the thin stretches of tissue within the labia majora that fold and protect the vagina, urethra, and clitoris. The labia minora can vary in appearance from woman to woman. For example, they can be tiny and hide between the labia majora to large lips that protrude. Both the inner and outer labia are sensitive to touch and pressure and can be wonderful during sex play by being licked, bitten gently, and caressed (Yronwode, 2000).

Clitoris. The clitoris is a large organ about 4 inches in length and is analogous to the penis. Its function is purely sexual. The white oval spongy tissue is between the top of the labia minora and the clitoral hood. The glans of the clitoris are visible, but the organ itself is elongated and branched into two forks, the crura that extend downward along the rim of the vaginal opening toward the perineum (Yronwode, 2000).

Clitoral Glands. The clitoral glands have a covering tissue comparable to the foreskin of the penis known as the prepuce or the clitoral hood. The clitoris extends out during excitement, while the hood retracts to make the clitoral glans more accessible. The clitoral glands vary in size (Yronwode, 2000).

Urethra. Just below the clitoris the urethra opens. It functions only to pass urine. The urethra connects to the bladder. It’s located close to the anus (Yronwode, 2000).

Hymen. The hymen is a membrane that partially covers the opening of the vagina and can vary in appearance. Vigorous exercise such as gymnastics, horse riding or
tampon insertion can tear the hymen, a very thin membrane and universal representation of virginity. Bottom Left Figure is an imperforate hymen, which entirely closes the vagina, a rare condition that requires surgical intervention to provide for a normal flow of blood once menstruation begins. Bottom Right Figure shows the hymen after a woman has given birth (Yronwode, 2000).

**Perineum.** The perineum is the short stretch of skin starting at the bottom of the vulva and extending to the anus (Yronwode, 2000). Often torn during childbirth to accommodate passage, perineum tearing can be avoided by prenatal massage practice or using the fingers to manually stretch the vaginal opening.

**The Internal Anatomy of a Woman**

**Vagina.** The vagina functions in reproduction. It is the birth canal through which the baby passes during labor. The length of the vagina is on average three inches long. (Yronwode, 2000) (Figure 3).

**Bartholin’s Glands.** Located along each side of the vaginal opening, these glands deliver droplets of sweat that create lubricating fluid that keeps the inner labia moist during periods of sexual excitement (Yronwode, 2000).

**Cervix.** The cervix is the opening to the uterus and varies in diameter from 1 to 3 millimeters, depending upon the menstrual cycle. The cervix is sometimes plugged with cervical mucus to protect the cervix from infection. During ovulation the mucus becomes thin to allow the flow of sperm (Yronwode, 2000).

**Uterus.** The uterus, also known as the womb, is the internal reproductive organ. The inner lining of the uterus is called the endometrium, which grows and changes during
the menstrual cycle to prepare to receive a fertilized egg. At the end of the menstrual cycle when fertilization has not occurred the lining sheds. The uterus has strong muscles to push the child out during labor (Yronwode, 2000).

**Ovaries.** The ovaries have two functions. Firstly, it produces estrogen and progesterone, the female sex hormones. Secondly, it produces mature ova, or eggs. At birth, a woman’s ovaries contain nearly 400,000 ova, which are all she will ever have. During an average lifespan a woman will go through about 500 menstrual cycles. A single egg travels down the Fallopian tube that takes three to four days after maturation. This time is the period where a woman is fertile and pregnancy is probable. When the eggs have not been fertilized they are expelled during menstruation (Yronwode, 2000).

![Figure 3. The Internal Anatomy of a Woman. Adapted “Anatomy Atlases,” by M. P. D'Alessandro, 2012. Copyright 1995-2013 by Michael P. D'Alessandro, M.D.](image-url)
Cancer in the Lesbian Population

Breast Cancer

Margolies (2011) reported that there are various theories and hypothesis regarding lesbians and breast cancer risk. It is estimated that lesbians face double to triple the risk of breast cancer (Margolies, 2011); however, there needs to be accurate large-scale studies performed in order to determine the depth of these risk factors. Some factors that have been researched include reproductive-related risk factors and behavioral risk factors. These factors include nulliparity (not bearing offspring) or older age at first childbirth, more frequent alcohol consumption and obesity (Cochran, Mays, Bowen, Gage, Bybee, Roberts, White, 2001).

There are no known physiological or genetic differences between lesbian and heterosexual women. Theorists hypothesize that the stress and stigma of living in a society where homophobia and discrimination continue to have an impact may account for the difference in lesbian breast cancer rates (Margolies, 2011). However, without proper research, these factors remain theoretical, and lesbian women will continue to be at a higher risk for uterine, breast, cervical, endometrial, and ovarian cancers (U.S., 2009). Margolies (2011) emphasizes that nobody is sure what impact each possible behavior (i.e. alcohol use, obesity, etc.) factor might have on the rates of cancer, because there are many women with similar risk factors that never develop cancer. There are several commonly identified risk factors that focus on lesbians and cancer risk; smoking, alcohol consumption and abuse, body weight, pregnancy and breast feeding, and cancer screening.
Studies have determined that regular tobacco smoking is more prevalent among lesbian adults than heterosexual women, and that heavy regular drinking appears to be more common among lesbians, compared to other women. In addition, lesbians are more likely, on average, to weigh more than other women of the same age and height (U.S., 2009). Although there is evidence available regarding the risks of cancer in the lesbian community, there has been little effort to fund education and health care programs to target this population. Information that could save women’s lives continues to be unavailable or simply not used.

Lesbians are also less likely to bear children and to breastfeed during their lives, compared to heterosexual women. As a result, lesbians do not get the benefit of estrogen breaks that occur during pregnancy and breastfeeding, which are believed to protect women against breast, endometrial, and ovarian cancers. Studies have consistently shown that a lower percentage of lesbians receive mammograms, pap smears, and colonoscopies compared to other women. Margolies (2011) argued that this was partly due to financial problems and past negative experiences in the health care industry. Lesbians in a stable relationship compared to heterosexual women also in a stable relationship are less likely to have health insurance coverage from their partners as they are not seen as a spouse. Heterosexual women, on the other hand, can receive coverage through their partner’s employer (Margolies, 2011).

Even if routine screenings are provided free of charge, until health care providers understand what is relevant to a lesbian's life and needs, it is unlikely that much will change. Screening rates among lesbians will continue to be lower compared to heterosexual women. The tragic consequence of these barriers to routine screening is that
a higher percentage of lesbians are diagnosed with cancer at later, harder to treat stages of the disease (Margolies, 2011).

Brown and Tracy (2008) evaluated the breast, cervical, ovarian, lung, and colorectal cancer literature from 1981 to 2008, using an application of the cancer disparities grid to identify differences along domains of the cancer continuum focusing on lesbians as a minority population. They found 51 articles related to lesbians and disparities, which suggested that there were barriers to adequate screening for cancers including personal factors, poor patient-provider communication, and health care system factors. The review concluded that there was insufficient research on specific cancers and for specific aspects of the cancer continuum in lesbian women. Ultimately, the review demonstrated the need for transformation in social and public health policy, research and disease prevention for lesbians.

Cochran, Mays, Bowen, Gage, Bybee, Roberts, and White (2001) examined whether lesbians and bisexuals compared with national estimates for all women are at increased risk of certain cancers as a result of an accumulation of behavior risk factors and difficulties in accessing health care. The behavior risk factors included obesity, smoking, alcohol use, cancer screening behaviors, and self-reported breast cancer histories.

The study found that, when compared with the US female population, lesbians exhibited greater rates of obesity, alcohol use, tobacco use. They also were less likely to have offspring, use birth control, have health insurance coverage, or to have had a recent pelvic examination or mammogram. However, there was no difference found in self-
reported histories of breast cancer when compared with the US female population estimates (Cochran et al., 2001).

The study concluded that lesbians and bisexual women differ from heterosexual women in patterns of health risk and that they were at significantly higher risk for chronic diseases linked to smoking and obesity, such as cancer. There are limitations to these findings and studies: the majority of the existing studies on lesbian health, health care and behaviors have used relatively small populations without heterosexual controls. The lesbian samples may not be representative of the whole population as individuals remain hidden and the group is small (Cochran et al., 2001).

Understanding Cancer. Townsend and Craig (1980) described breast cancer as the process of uncontrolled growth of cells that cause a breast lump. Their research suggests that the most frequent point of origin is in the ducts. It has been estimated that it takes five to ten years from the time a single cancer cell appears to the time it becomes one centimeter in size, which is the minimal size that a lump may be detected by physical examinations (Table 1).

Early detection can prevent cancer cell invasion of blood vessels and the lymphatic system. Breast self-exams, mammograms, and physical exams are the three methods of detection. Cancer can metastasize through these systems and travel throughout the body where it remains, grows, and damages normal tissue (Townsend & Craig, 1980). The most optimum time to have a breast examination is 5 to 7 days after cessation of the menstrual cycles, when hormonal influences are at their minimal.
### Table 1. Early Detection Screening Chart

<table>
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<th>What</th>
<th>When</th>
<th>Why</th>
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| **3 yrs. after first intercourse, or no later than age 21 and until age 30.** | Pelvic examination
Pap test OR Liquid-based pap test | Once a year or Once a year every 2 yrs. | To screen for cervical cancer and precancerous cells |
| **In your 20s and 30s** | Breast self-examination (BSE)
Clinical breast examination (CBE) | BSE monthly
CBE every 3 yrs. | To screen for changes in breast tissue |
| **30 and older** | Pap, pelvic exam and HPV test | Every 3 yrs. | To screen for cervical cancer, precancerous cells and human papillomavirus |
| **40 and older** | BSE, mammogram and CBE | BSE monthly, mammogram and CBE once a year | To screen for breast cancer |

**Treatment of Breast Cancer.** The severity, location, and spread of cancer determine the course of treatment. Guidelines customize treatment as cancer spreads to specific areas, like the lymph nodes. Health care providers are encouraged to design a treatment plan that is individualized according to many factors unique to the client, with sexual orientation being one of the factors. Treatment may include surgery, radiation therapy, chemotherapy, or a combination of treatments. Successful treatment is often reflective of early detection (Townsend & Craig, 1980) (Figure 4).
Figure 4. Signs of Breast Cancer
As a cancerous growth occurs in the breast, it may take on any of the following appearances

<table>
<thead>
<tr>
<th>Appearance</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Lump</td>
<td>Usually single, firm and most often painless</td>
</tr>
<tr>
<td>Inverted Nipple</td>
<td>In a previously normal breast</td>
</tr>
<tr>
<td>Skin Swelling</td>
<td>A portion of the skin on the breast has the appearance of an orange peel</td>
</tr>
<tr>
<td>Superficial Veins</td>
<td>The skin surface veins on one breast become more prominent than the other</td>
</tr>
<tr>
<td>Skin Dimpling</td>
<td>A depression occurring in a localized area of the breast surface</td>
</tr>
</tbody>
</table>


Cervical Cancer

The Institute of Medicine Committee on Lesbian Health Research Priorities (1999) reported that cervical cancer is correlated to sexual behavior (e.g., multiple male sexual partners or partners who have had multiple sex partners, early age at first intercourse, and unprotected sex) and with the presence of human papillomavirus (HPV). Lesbians are at risk for cervical cancer, as there are many lesbians who have reported
having had heterosexual intercourse in the course of their lifespan. In addition, cervical cancer associated with HPV infection has been detected in lesbians, even in the absence of prior reported sex with men. Research has suggested that lesbians may have less routine Pap tests than is currently recommended, whereas other researchers have found no significant differences between heterosexuals and lesbians in Pap test screening behavior. In addition, it was argued that lesbians without prior male sexual partners may also be less likely to get Pap tests. Clinicians should conduct a thorough sexual history assessment of their lesbian clients and be informed that, for many lesbians, there are conditions that could contribute to less frequent Pap test screening, such as perception of low risk for cervical cancer and barriers to health care (Institute of Medicine, 1999).

Other Cancers

There is little research or information available on other cancers among lesbians (Institute of Medicine, 1999); however, with lesbians having higher rates of smoking, they are at increased risk of lung cancer. In addition, there have been reports that lesbians tend to be at risk for obesity which makes them at greater risk for colorectal, ovarian, or endometrial cancers (Institute of Medicine, 1999).

Lesbians are also less likely to have had children and to use oral contraceptives, which increases their risk for endometrial or ovarian cancers. However, it is important to note that there is still a lack of epidemiological data on these health risk factors needed to determine whether lesbians are at increased risk for these cancers (Institute of Medicine, 1999).
Sexually Transmitted Infections in Lesbians

There have been enough studies to demonstrate that women can acquire sexually transmitted infections (STIs) from male sex partners, however, findings regarding transmission between female partners remain ambiguous. National and local data gathering to estimate the risk of STI transmission between women has been limited, partly due to the fact that lesbians have been excluded (Institute of Medicine, 1999). Culturally, we have been unable to provide adequate guidelines for safe sex for lesbians and lesbians continue to perceive themselves at minimal risk for STI (Institute of Medicine, 1999). This perception has three apparent sources: studies have reported low prevalence of STI among women who report having sex with women; it is often presumed that lesbian sex is at lower risk of bacterial STI transmission for anatomic reasons; and the perception that lesbian relationships tend to be long-lasting and monogamous compared to other groups (Institute of Medicine, 1999).

Definitions of STIs

**Acquired Immune deficiency Syndrome (AIDS).** AIDS is caused by the human immunodeficiency virus (HIV). This virus damages the body's immune system and hinders it from fighting infections. The Centers for Disease Control and Prevention (CDC; 2013) reported that individuals with this disease became vulnerable to certain forms of cancer and opportunistic infections caused by pathogens (bacterial, viral, fungal or protozoan) that usually do not cause disease.

Research in the area of lesbian HIV transmission is inadequate. Marrazzo (2012) reported that information and research on women to women (WTW) viral transmission is
LESBIAN SEXUAL HEALTH

limited, however, the medical literature does have case reports of WTW sexual transmission of HIV. The CDC (2013) identified menstrual blood, vaginal discharge with infected white blood cells, and, lesions and small tears resultant from violent sex practices as sources of HIV transmission. Medical and health professionals need more information to gain a full understanding of the “mechanics” and associated risks (Marrazzo, 2012). There is no cure, however, pharmaceutical companies have developed numerous drug therapies to help the immune system and fight the virus.

Lesbians have been excluded from HIV prevention and research as they have been viewed at lower risk of HIV exposure. Researchers suggest lesbians that engage in sensation seeking behaviors are at increased risk of HIV, but are also more likely to engage in other risky behavior such as substance abuse, having sex or sharing needles with men who have sex with men (Institute of Medicine, 1999).

**Allergic or Chemical Vaginitis.** Genital contact with an irritant (e.g. Latex, spermicides, lubricants, detergent, soap, bath gel, silicone sex toys, and feminine vulva deodorants) causes an infection affecting the vagina and the vulva. The infection can be misdiagnosed as a yeast infection or new onset genital herpes (Marrazzo, 2012). The infection appears as a rash with symptoms including red, painful, irritated, or itchy vulva, and increased vaginal discharge. Individuals can treat allergic or chemical vaginitis by discontinuing allergen use or by taking an antihistamine to ease symptoms. Marrazzo advises educators to encourage women to consult their health care provider before applying steroid cream to the genital area (Marrazzo, 2012).

**Bacterial Vaginosis.** Bacterial Vaginosis (BV) is a loss of the normal protective lactobacilli (healthy vagina bacteria). The cause of BV is unknown, but douching is a
risk factor for BV. The symptoms include gray to yellowish homogenous discharge, strong odor, and sometimes vulva and vaginal irritation (CDC, 2013).

Transmission in the lesbian community is unknown, and has not been proven. The treatment consists of prescribing antibiotic vaginal cream or oral medication, such as metronidazole or clindamycin (Marrazzo, 2012).

**Chancroid.** Often misdiagnosed as genital herpes due to its similar appearance, chancroids are open sores or lesions in the genital area. It usually involves inflamed, painful groin lymph nodes and can be effectively treated with antibiotics. Diagnosed primarily in third world countries, chancroid is associated with an increased risk of transmission of HIV/AIDS (CDC, 2013).

**Chlamydia.** This infection is the most reported and is considered one of the most common STIs. It is caused by the bacterium Chlamydia Trachomatis. The CDC estimates 2.8 million Americans are infected with Chlamydia. Many cases are unreported and involve individuals who are unaware of the symptoms. Adolescents have the highest rates of contracting Chlamydia, with transmission occurring during vaginal, oral, or anal sexual contact with an infected partner (CDC, 2013).

Symptoms are considered mild by the CDC (2013); however they can be extremely damaging to a woman's reproductive organs causing serious complications and even infertility. Newborns can contract the infection during delivery, which can cause neonatal eye infections or pneumonia. It has not been studied or researched but it is possible that women to women transmission can occur. Treatment includes oral antibiotics such as Azithromycin and Doxycycline, whereas pregnant women are prescribed Amoxicillin or Erythromycin (Marrazzo, 2012).
Genital warts/Human Papillomavirus (HPV). HPV is the most common causes of STI in the United States (CDC, 2013). To date an estimated 50,000,000 Americans are affected with HPV and there were 140,981 new cases in 2013. HPV refers to a group of viruses that include 100 different strains or types (CDC, 2013). More than 30 of these viruses are sexual transmitted and can infect the skin of the penis, vulva, anus, and/or the inner lining of the vagina, cervix, or rectum. Infections that are high risk can cause cervical cancer and other genital cancers. Most HPV infections clear up on their own. As yet no known cure exists, but recently the vaccine Gardasil has been developed to protect against four types of HPV, the types that cause 70% of cervical cancer and 90% of genital warts (CDC, 2013).

Most likely WTW transmissions occur through direct contact of genital skin, or contamination of hands and fingers. It is known that inserting sex toys can cause infection, but transmission is theoretically possible when sharing toys that have not been cleaned between uses from one infected partner to another. There is no cure available; however, pap smears can evaluate the cervical changes that can be caused by the HPV virus. Marrazzo (2012) recommended that sexually active women of all orientations have yearly exams (Marrazzo, 2012).

Gonorrhea. The bacterium Neisseria Gonorrhea is responsible for this infection. It can be found in the reproductive track (i.e. cervix, uterus, Fallopian tubes, and urethra) or the mouth, throat, eyes and anus as it grows easily in moist areas (CDC, 2013). Marrazzo (2012) reported that woman to woman transmission is theoretically possible but not yet studied. The infection can become life-threatening if it spreads to the blood and joints; additionally, individuals infected with Gonorrhea are at higher risk of
contracting HIV/AIDS. Gonorrhea is treated with oral and intravenous antibiotics such as Cefixime, Ciprofloxacin, Ofloxacin, and Ceftriaxone. However, there has been an increasing amount of drug resistant strains that have become more difficult to treat (CDC, 2013).

**Syphilis.** Caused by Treponema Pallidum, syphilis is another bacterial infection. It is passed through direct contact with a syphilitic sore. This transmission can occur through vaginal, anal, or oral sex. At first, syphilis symptoms can be undetectable because they present mildly and disappear rapidly. The initial sores are often painless and appear on the penis, the vagina, mouth, anus, or the hands. Infected mothers can pass on the infection to their offspring. When left untreated, syphilis can advance to cause serious damage to the brain, nerves, eyes, heart, blood vessels, liver, bones, and joints (CDC, 2013). In addition, there can be loss of hearing, blindness, and psychiatric symptoms. Penicillin effectively treats syphilis, and the disease has decreased in the general population. However, infections among men who have sex with men has increased (CDC, 2013). Individuals with syphilis are two to five times more likely to contract HIV. Although limited in study, WTW transmission is considered extremely rare. (U.S., 2009).

**Pelvic Inflammatory Disease.** Pelvic Inflammatory Disease (PID) is an infection of the uterus, Fallopian tubes, and ovaries that is caused by various bacteria, most often chlamydia and gonorrhea. The infection usually starts 2 to 21 days after having sex with an infected person, but also can occur several months later. Symptoms include mild to severe abdominal pain, back pain, fever, nausea, bleeding between periods, pain with sex, and vaginal discharge. However, there are women who have no
symptoms. Infection can also occur after childbirth, abortion, or surgery on the female organs.

The infection can cause scar tissue that can block the Fallopian tubes causing infertility in 10% of women. Additionally, women can develop tubal pregnancies and abscesses (Marrazzo, 2012). Women have reported lasting lower abdominal pain for several months after PID. Lesbians are at risk but specific risks have not been studied. Treatment involves antibiotics; oral for mild cases, intramuscular injections for moderate cases and intravenous (IV) for severe cases (Marrazzo, 2012).

**Pubic Lice.** There are three kinds of lice that can live on humans: head lice, body lice, and pubic or crab lice. Pubic lice are also known in lay language as crabs (Marrazzo, 2012). Transmission occurs when there is close contact with an infected person, their clothes, or bed linens. Symptoms of pubic lice include itching and finding lice or nits (i.e. eggs or infant lice). Treatment includes medicated shampoos, cream rinses, and lotions. All partners have to be treated in a 30-day period. In addition, all clothing and bedding needs to be washed in hot water, dry cleaned or kept in isolation from the body for ten days to kill lice and eggs (Marrazzo, 2012).

**Scabies.** This is a skin infestation by mites that have burrowed in warm moist places on the body, including between fingers and toes, the wrist, armpits, breasts, skin folds, and waist. Symptoms include itching, especially at night, which can mirror other skin rashes and look different on different people and are diagnosed by getting a small skin scraping for microscopic examination. Since transmission occurs through close contact, including sex, with an infected person, lesbians are at risk of contracting this infection. A 5% permethrin cream can be used to treat the infected skin. Individuals
who contract the infestation should contact all sex partners of the month prior to infection to inform of the potential need for testing and treatment (Marrazzo, 2012).

**Trichomoniasis.** "Trich" is an infection that lives in the moist areas of the genitals of infected people (e.g. vaginal fluid, genital glands). Individuals may present as asymptomatic; however, infection can cause foamy discharge with foul odor, painful urination, itching or irritation. There is research that supports WTW. Treatment includes a single dose of an antibiotic, such as metronidazole; and all sexual partners should be notified and treated (Marrazzo, 2012).

### Research in Lesbians and Sexually Transmitted Infections

Studies that have reported that lesbians are at lower risk of STI have been limited, as they evaluated only small numbers of women and did not use newer diagnostic tests that are equipped to detect viral STIs. They also did not provide complete sexual behavior assessment or follow up adequately with participants (Institute of Medicine, 1999). However, there are various opportunities for woman to woman transmission of some STIs that require only skin contact (e.g. herpes virus), and where there is sharing of vaginal secretions via hands or sex toys that could introduce virus or bacteria into the vagina (Institute of Medicine, 1999).

Sexual health promotions that are aimed toward gay men or heterosexual women do not reach lesbians, and the promotions that are lesbian-specific do not sufficiently build their awareness on the need to practice safer sex (Carr, 2009). Assumptions or beliefs that lesbians are low risk for contracting an STI, and associated disorders, have the collateral effect of lowered cervical cytologies and hence unchecked cervical cancer (Carr, 2009)
In a study conducted by Edwards and Thin (1990), 27 lesbians attending a genitourinary medicine clinic were determined to have a significant prevalence of the viral STIs, herpes simplex and human papillomavirus. Feathers, Marks, Mindel, and et al (2000) reported that the majority of the literature on the STI/HIV prevalence and risk behaviors in women had not included the lesbian population. Studies and research often classify lesbians without information on specific sexual practices, among convenience samples and inconsistently as lesbians or WSW by sexual identity or behavior.

In 1990, Edward and Thin argued that misleading information about STI/HIV transmission and behavior in this female population may have affected negatively the availability of appropriate health care services. Twenty years later, there continues to be a need for more information about the true prevalence of STIs in this group and evaluation of the risk factors for female-to-female transmission of infections (Edwards & Thin, 1990). In a study conducted by Lindley, Kerby, Nicholson, and Ning (2007), significant health issues for lesbian and bisexual women were discovered surrounding STIs. For example, older lesbian or bisexual women with a history of heterosexual sex had a higher risk of STIs than those who had not had sex with men.

Lindley, Kerby, Nicholson, and Ning (2007) argued that little research has been conducted to assess sexual risk among lesbian and bisexual college women exclusively. The study used an Internet survey to examine sexual risk of 230 self-identified lesbian and bisexual female college students. The women (8%) reported being diagnosed with an STI such as HPV, BV and GH accounted for 84% of STI cases. Among the population: factors of older age, penile-vaginal intercourse, and younger loss of virginity associated with STI diagnosis. Understanding these factors and conducting similar research studies
are valuable in developing sexual health programs targeting lesbian and health care providers (Lindley, Kerby, Nicholson, & Ning, 2007). In addition, sexual health educators and health care professionals need to make their clients aware, regardless of their sexual orientation, that all STIs can affect the individual with irreparable lifetime damage, including blindness, bone deformities, mental retardation, cancer, infertility, fatal ectopic pregnancy in women, and death of an infant by infected mothers during gestation or birth (U.S., 2009).
The Biopsychosocial Impact of an STI: Genital Herpes

Genital Herpes

Genital herpes (HSV-2) is the number one sexually transmitted disease on countless university campuses around the United States (Mitchell & Jolley, 2001). A national study determined that 16.2%, or about one out of six people, aged 14 to 49 years have genital HSV-2 (CDC, 2013). The national percentage of persons infected with genital herpes has remained steady. Everyone is susceptible to this infection during the course of one's life and, when infected by the virus, they can then pass it on to their partners (Gordon & Mitchell, 1988).

Causes and Transmission of Genital Herpes

Genital herpes is a sexual transmitted infection caused by a virus called herpes simplex. The National Venereology Council of Australia (1998) reported that the most common form of herpes simplex virus is herpes simplex type 1 (HSV-1), which causes the usual cold sore. Herpes simplex type 2 (HSV-2) is responsible for genital herpes.

Genital herpes is not a new disease; in fact, evidence shows that human beings were infected with it over 2 million years ago (Llewellyn-Jones, 1985). Genital herpes is acquired through sexual contact (vaginal, oral, or anal sex) with someone who carries the infection. False perceptions still persist that the disease can be spread through kissing, touching, and caressing infected areas (Mitchell & Jolley, 2001). Once exposed to HSV-2 through sexual contact, an incubation period begins, lasting between 3-7 days before lesions form. During the incubation phase, there are no symptoms and the virus cannot be spread to other individuals. The contagious stage begins within two weeks of initial
infection (CDC, 2013). HSV lesions can appear during this time in multiple, small, grouped vesicular lesions on surrounding genital areas that became ulcerative and often result in pain and discomfort, also as known as “fever blisters,” (CDC, 2013; VanderPlate, Aral, & Magder, 1988). Women usually break out in sores on the vaginal area, external genitals, buttocks, anus, or cervix. Men can have an eruption of sores on the penis, scrotum, buttocks, anus, thighs or inside the urethra (i.e., the channel between the bladder and the penis) (CDC, 2013). Initial exposure results in the virus remaining dormant in the sacral ganglia, from which reactivation of lesions may result. Recurrence of lesions is presumed to be activated by a diversity of physical and biochemical stressors, with many researchers believing that the primary factor may be due to psychosocial stressors (VanderPlate, 1988). Triggers which could be responsible for recurring outbreaks may be from menstruation, immune system suppression (medication such as steroids or chemotherapy), infections (HIV), illness, surgery, friction, and fatigue (CDC, 2013).

On average, 50% of people infected with HSV-2 will show no symptoms. The CDC (2013) has argued that 30% to 60% of adults having antibodies to HSV-2 in their blood will have had no blisters on their genitals at any time. Formerly, doctors, researchers, and others believed that transmission only occurred when herpes sores manifested. However, Mitchell states that the majority of transmissions occur when the herpes blisters or sores are not present (Mitchell & Jolley, 2001). The herpes virus can make individuals vulnerable to HIV infection, as well as having a tendency to make HIV-infected individuals more communicable (CDC, 2013).
People who do manifest symptoms find they are difficult to treat. Individuals with herpes often report that the first outbreak of herpes is the most painful. Symptoms can reoccur with treatment making herpes a chronic lifelong viral infection. Some experience outbreaks as long as 40 years after the initial outbreak (CDC, 2013).

According to research, one in five individuals over the age of 12 has some kind of herpes simplex virus (CDC, 2013; Warren, 2002), it is more frequent in African Americans than in Caucasians (Bren, 2002). The HSV-2 is more common in females than in males, with one in four females being infected as compared to one in eight males. This may be due to the male-to-female transmission being more likely than female-to-male transmission (CDC, 2013).

Most people carry the disease without knowing, so there is a great need for public awareness and intervention (Lewis et al., 1999). For most people, the symptoms are minor or transient enough to pass without concern. Some of the symptoms can be mistaken for something else, such as a friction burn from unlubricated sex, a yeast infection, skin caught in a zipper, or a negative reaction to a new detergent. The first outbreak can occur within two weeks after the virus is transmitted and may heal within two to four weeks. Individuals can expect outbreaks typically to occur four to five times a year when first diagnosed with genital herpes (CDC, 2013).

**Treatment and Prevention of Genital Herpes**

Today, young people are considered to have the highest prevalence rates of STIs, especially since half the individuals diagnosed with HIV are adolescents. Therefore, knowledge, awareness, and perception of these STIs are important for prevention and
treatment. Prevention appears to be the most effective tool for reducing and eliminating STIs using both biomedical and behavioral models (U.S., 2009).

When a person is abstaining from sexual contact, he or she is avoiding transmission of sexually transmitted diseases, as well as genital herpes. Long-term mutually monogamous relationships with a partner can also reduce the chances of transmission, especially between a couple who has been tested and is aware that they are uninfected (CDC, 2013). However, these optimal methods of prevention are not widely or consistently used. For example, Baker et al. (2003) conducted a study using 445 heterosexual women that were randomly assigned to a skills training (ST) group based on the relapse prevention model or health education (HE) group to determine the effectiveness of preventing STIs. Results indicated that the women in the ST intervention had less likelihood of being diagnosed with an STI in the year following the intervention and had established higher risk reduction skills at the 12 month follow-up.

The skills training intervention consisted of (1) safer sex education, (2) consciousness raising and personalization of risk, (3) examining the motivational balance between the positive and negative aspects of safer sex, (4) understanding sexual rights, (5) setting goals for safer sex practices and reviewing them regularly, (6) identifying and coping with triggers to unsafe sex, (7) understanding relapse and developing skills to prevent further relapse, (8) using role-play to develop skills, (9) building social support for safer sex practices, (10) developing satisfactory healthy relationship with low risk partners (i.e. practice safe sex and fidelity), and (11) developing better lifestyle balance. The health education intervention included (1) safer sex education, (2) women and HIV classes, (3) communicating with partners about safer sex, (4) effects of drugs and alcohol
on safer sex, (5) contraception and pregnancy decision-making, (6) babies and children: coping and parenting, (7) violence against women, and (8) building self-esteem (Baker et al. 2003). Health care providers can diagnose genital herpes best after taking a sample from a visible outbreak for laboratory testing (CDC, 2013). When the individual is between outbreaks, a blood test that detects antibodies to HSV-1 or HSV-2 can be used; however, the results are often unclear. There is no cure available for genital herpes, though antiviral medication can usually shorten and prevent outbreaks during periods where medication is taken. Daily suppressive therapy for symptomatic herpes can reduce transmission to sexual partners (CDC, 2013). Treatment for genital herpes may include oral prescription antiviral medications that help heal sores sooner and reduce the amount of outbreaks.Suppressive treatment has been measured to be the most effective overall approach in reducing transmission (Van Vranken, 2007).

The Psychological Effect of Genital Herpes

Once HSV has been diagnosed, many individuals experience a great deal of emotional pain and shame. For example, Manne and Sandler (1984) state that many clinicians have observed individuals experiencing shock and emotional numbness, frantically searching for an immediate cure. When the person becomes aware of the chronicity of the disease, they begin to feel a sense of isolation and loneliness. There may be anger towards the individual(s) who infected them or may have infected them. The person may experience a great deal of fear over the consequences to their sexuality, in other words, the "leper effect" where they feel ugly, contaminated, and depressed (Manne & Sandler, 1984). For the most part, herpes is less painful than many other STIs and chronic diseases such as arthritis or heart disease. However, it does have a greater
social stigma, and may involve more psychological factors (Manne & Sandler, 1984). The extra precautionary steps infected individuals must take to avoid transmission to their partners may cause stress and sexual intimacy avoidance (U.S., 2009). Few studies have investigated the role of immune activation with neuropsychiatric disturbances in infected individuals (Vollmer, Chen, Lloyd, & Donovan, 2008). One such study examined the relationship between markers of immune activation and measures of emotional and somatic dysfunction among people infected with symptomatic genital herpes. The study discovered that levels of neopterin (present in body fluids were elevated levels indicate immune system activation, malignant disease, and viral infections) and IL-6 (produced by various cells (as macrophages, fibroblasts, T cells, and tumor cells) correlated significantly with measures of reported psychological distress and fatigue. Vollmer et al. (2008) hypothesized that communication may occur through autonomic afferent pathways between the local inflammatory site in the pelvis and the brain.

**Genital Herpes and Women**

Lesbians risk contracting herpes when physically intimate with an infected partner even where lesions are not present. Research suggests that 60% of sexually active adults have herpes (CDC, 2013). This high rate of infection is partly because most women who carry the herpes virus are unaware of it and have few or no symptoms. Women generally have “atypical” recurrence, where they may only experience itching and minimal discomfort (CDC, 2013). A quarter of New York City residents have herpes, with more women than men infected. The majority of these residents are asymptomatic or with few symptoms (Pharmaceutical Representative, 2008). Alarmingly, women seek less
treatment for venereal infections in clinics. Moreover, Levin et al., (1987) have found that women more commonly experience systemic symptoms than men.

The Fortenberry Study (1997) suggests that young symptomatic women and adolescent girls take more time to obtain care than asymptomatic females or symptomatic male adolescents. The factors affecting the time interval for care seeking included the perception of obstacles in acquiring care, lower self-efficacy for response to an STI, greater perceived seriousness of STI, prior history of STIs and stigma (Fortenberry, 1997). In young female university students, a prolonged care-seeking interval for medical advice was associated with greater knowledge and experience of STIs, and an increased sense of the stigmas associated with STIs. The findings suggested that the cognitive factors were independent of whether or not symptoms were present (Fortenberry, 1997).

Hart (1977) contends that the dissimilarities that appear to exist between females and males contracting herpes may be due to differences in anatomy and pathology. Women with genital herpes are 5-8 times more at risk of developing cervical cancer, which could prove deadly for some individuals (Manne & Sandler, 1984). Also, women and adolescent girls encounter problems with herpes due to the risk of involuntary infertility, neonatal transmission, and subsequent cervical cancer (Rosenthal et al., 1999).

Impact of Herpes in Pregnancy

Women with genital herpes can experience a safe pregnancy and a normal vaginal childbirth. HSV screening via blood test is impractical, unavailable in most commercial labs, and often times inaccurate for many pregnant women (The Complete Herpes Information Center, 2011). The most effective blood test available at present is the western blot antibodies to either HSV-1 or HSV-2 (true primary infection), which detects
HSV-2 infection in a person with previous antibodies to HSV-1 (CHIC, 2011). Moreover, the HSV infection can be harmful on prenatally infected neonates. The proportion of pregnant women carrying the virus ranges from 20% to 25%, and the risk of transmission is 30% to 50% higher in women who become infected near the time of delivery (Majeroni & Ukkadam, 2007). About 5% of cases occur in women whose first encounter with the virus occurs initially during pregnancy. While in the uterus, a baby risks transmission as the virus crosses the placenta, which is the lining of the uterine wall. Furthermore, mothers who contract the disease in the last few weeks of pregnancy are at the highest risk of transmitting the virus. Outbreaks tend to increase as the pregnancy continues; which may be due to the immune suppression that occurs to avert the mother's body from rejecting the fetus. For some women their first outbreak of genital herpes during pregnancy is not, in fact, a new infection; the outbreak is the first symptomatic recurrence of a longstanding infection. If genital herpes is acquired in the last few weeks of pregnancy, the risk of transmission is at its highest. Although rare, neonatal herpes infections are usually caused from infection during pregnancy (CHIC, 2011).

**Impact of herpes on newborns.** Approximately 2,500 newborns and infants die each year from birth complications of herpes infection. Even more babies are born with mental retardation, latent illness, eye and throat infections, and central nervous system damage because of maternal transmission (CHIC, 2011). In addition, herpes can be also be spread when individuals with active cold sores kiss the baby. The high infection rates, as well as, the common inadvertence of transmission warrants further education for mothers and their families regarding precautions against spreading the virus (CHIC, 2011).
Sexually Transmitted Infections and the Health Community

Singh, Chin, Brown, and Glezen (2006) emphasized that research needs to focus on clarifying sexual health myths prevailing among lesbians and health care professionals that hurt many women’s lives. Popular belief holds that lesbians face no risk of STIs, hence comprehensive sexual health care screening, such as Pap smears, is superfluous or unnecessary. However, all women with a cervix, who have been sexually active are at risk and deserve comprehensive health care screening. The assumption that lesbians are not at risk of STI has prevented these women from receiving health care that detects HPV and the presence of malignant or pre-malignant conditions that could have been treated and cured. Many women have lost their lives because of the inaccuracy of the belief. (Singh, Chin, Brown, & Glezen, 2006).

Health care providers’ failure to check for STIs such as genital herpes fuels the misconception of susceptibility. Some doctors believe no blood test exists to distinguish the two herpes types (Warren, 2002). Only one-quarter of men tested for STIs receive tests for genital herpes (TB & Outbreaks Weekly, 2002). Other studies have found similar negative findings of health care providers.

Doctors’ unfamiliarity with the importance of testing may contribute to low numbers of STI testing. The results gathered from a questionnaire distributed to General Practitioners in Coventry, England (Narouz, Allan, and Wade, 2002) indicated that 43% of respondents lacked knowledge that most individuals infected with the disease were unaware they had it. Furthermore, only 44% of those who responded to the questionnaire knew that that most herpes transmission occurs during the asymptomatic stage (Narouz et al., 2002). Narouz, et al., believe that doctors appear to have a lack of knowledge in some
areas about genital herpes, which indicates a need for more information and education about the condition.

In addition, Ashton et al. (2002) found that most physicians believed that counseling patients about sexually transmitted infections (STI) was ineffective, that their medical school training about STIs was inadequate, and that they were not responsible for sexually transmitted disease preventive services for their patients. Furthermore, many doctors reported low confidence, lack of accountability, and time limits that may have an effect on their sexually transmitted disease prevention practices (Ashton et al., 2002). Ashton and his colleagues contend that interventions influencing attitudes regarding STIs might improve primary health care provider prevention practices.

The failure of health care professionals to establish medical assessment and needed education could create an obstacle for the development of vaccines for many STIs, including genital herpes. Another obstacle, is that many individuals who are most at risk of contracting STIs will reject vaccines. Even for non-STI vaccines, acceptance falters. Additional resistance to sexually transmitted disease vaccination may be due to the stigma associated with such diseases (Lewis, Stanberry, Rasenthal, Stewart, Succop, & Bernstein, 2000). Although, students, in general, mentally approve of vaccination as an important way of preventing disease, they may not accept vaccinations themselves.
Sexually Transmitted Infections and Lesbian Youth

There is not much known about the specific developmental issues that lesbian youth face. Although there has been an increase in LGBTQ youth research, there has been little focus exclusively on lesbians (Institute of Medicine, 1999). It is important to include in this comprehensive guide the significance and impact of STIs on LGBTQ youth as they have statistically greater risk of STI contraction and less chance of receiving adequate resources or accurate information (Catallozzi, & Rudy, 2004).

Adolescent health care professionals need to build an awareness of how STI are associated with risky behaviors regardless of sexual orientation. Health care professionals should give LGBTQ youth the same considerations and precautions as heterosexual adolescents, and respect their uniqueness and resiliency, while honoring confidentiality as an integral part of physical and emotional health. Providers need to have a comprehensive view when dealing with sexual-identity issues and formation. Appreciating the differences that LGBTQ youth encounter can reduce their risk for contracting STIs and can improve the standards of care (Catallozzi, & Rudy, 2004).

Gay, lesbian, and bisexual adolescents are at increased risk for STIs when their educational and health needs are ignored. Benson and Hergenroeder (2005) reported that gay, lesbian, and bisexual adolescents are not unlike adolescents in general, with respect to engaging in high-risk sexual behaviors and contracting sexually transmitted infections. The epidemiological rates of gonorrhea, chlamydia, and syphilis have decreased in adolescents in the past 15 years, but, rates for these common reportable bacterial STIs have increased in recent years among men who have sex with men. However, little research has been done on female adolescents that have sex with female adolescents.
Benson and Hergenroeder (2005) argued that there is a need to gain an understanding of trends among gay, lesbian, and bisexual youth. The research suggested that the information on this population is inadequate, and that there is an inconsistent and homogenous standard for collecting data on sexual behaviors in adolescents. The lack of awareness reflects the need for healthcare professionals to provide and improve screening, diagnosis, and treatment of STIs in individuals engaging in same-sex behavior. In addition, their findings suggested that healthcare providers who work with adolescents need to be attentive and address the healthcare needs of gay, lesbian, and bisexual youth.

In general, little research has been conducted into young people's understanding, attitudes or knowledge of STIs other than HIV/AIDS, and little is known about their perceptions, despite the dangerous risk these diseases pose to them (Moore, Rosenthal, & Mitchell, 1996). According to Erikson's (1950) psychosocial model of development, adult identity forms from the numerous changes surrounding psychological, cognitive, and social development that occur during adolescence. This developmental process occurs between the ages of 10 and 20 and, under the right circumstances, includes the achievement of personal independence (Erikson, 1950) and maturity of cognitive reasoning skills (Piaget, 1920). Individuals in the adolescent stage of development regard themselves as mature adults, though they are still growing mentally, emotionally, and physically.

Sexual behavior is subjective to the individual's psychological and physiological characteristics, as well as, developmental and sociocultural factors. There has been a worldwide concern, increasing over several decades, for adolescent reproductive health problems (Nworah, Obiechina, & Ikpeze, 2002). Adolescent sexual activity places young
women in danger of unplanned pregnancies and males and females at risk for sexually transmitted diseases (Nworah et al., 2002).

Young adults, who are ignorant of issues such as fertility and STIs, inevitably face risks by engaging in immature sexual behavior that carries the capacity for lifetime damage emotionally, mentally, physically, economically, and socially. Therefore, it is imperative that preventive measures be taken and reinforced. Nworah et al. (2002) found that adolescents practice casual sexual activity, and the levels of high-risk sexual behaviors are elevated and common among this group. The health risk associated with adolescents practicing unsafe and risky sexual behaviors contributes to them contracting STIs, including AIDS, spontaneous abortions, stillbirths, prenatal death, neonatal morbidity, chronic pelvic pain, dyspareunia (i.e. Vaginal pain experienced during penetration due to medical or psychological causes), infertility, an increased risk of ectopic pregnancies and even death.

Moore et al. (1996) pointed out that a study done on Australian high school students showed high levels of knowledge about HIV transmission; however, their knowledge of other STIs did not match this level of knowledge. Additionally, poor knowledge about STIs other than HIV/AIDS has been found among older students. In this group, a large minority of young adults, who had heard of other STIs, thought that the diseases were not very serious and did not have long-term effects. They lacked the skills to access help if they had acquired an STI and had poor understandings of STI causes. Girls were found to have more knowledge than boys; likewise, older students had a greater knowledge than those who were younger (Moore et al., 1996).
In addition, Kuo and St. Lawrence (2006) argued that, among the students they questioned, there was adequate knowledge about HIV/AIDS; however, there were several misconceptions concerning contracting HIV/AIDS through kissing and mosquito bites, as well as individuals having "low immunization" being more at risk. In addition to the misunderstanding of the impact of the immune system, was the belief that there was a medication that cured HIV/AIDS, which suggests that there is confusion between antiviral treatment and treating opportunistic infections (Kuo & St. Lawrence, 2006). In the United Kingdom, Jones and Haynes (2006) noted that public health policy, which was aimed at reducing the spread of STIs in young people by raising their awareness of these diseases, was implemented with little research. In a survey among college and university students in the UK, higher levels of knowledge of STIs did not correlate to reduced risk-taking sexual behavior. Therefore, they concluded that awareness of STIs is inadequate in reducing risky behavior or in promoting safer sex in young individuals (Jones & Haynes 2006, Mirotznik 1991). In 1991, Mirotznik, conducted a study, similar to Jones and Haynes’, focusing on genital herpes. Participants were students from a U.S. college who were single, sexually active, and infection-free. Mirotznik found that, even though a large percentage of the student participants were aware of and understood the consequences of contracting STIs, many reported not being fearful of contracting them. Mirotznik concluded that this finding demonstrated that, to some degree, little has changed over the last decade in terms of gaining and adapting better preventative measures for reducing STIs (Mirotznik, 1991).

An Internet survey, conducted during the 2001-2002 academic year, by Lindley, Nicholson, Kerby, and Lu (2003) examined the health risk behaviors, including HIV/STI
associated behaviors, of self-identified lesbian, gay, bisexual, and transgender (LGBT) college students in the United States. Of the 450 LGBT college students that completed the online survey, eighty-nine percent reported having sex with someone of the same sex and 45% had multiple (6 or more) sex partners during their lifetime. Students reported using a condom regularly during penile-vaginal (61%) and anal sex (63%), but fewer than 4% used a condom or other barrier during oral sex. Only 28% used a condom or other barrier during their last sexual encounter. The study concluded that, compared with heterosexuals, LGBT college students faced greater risks of contracting HIV/STIs, and LGBT students needed targeted on-campus prevention programs (Lindley, Nicholson, Kerby, & Lu, 2003).

According to Moore et al. (1996), research suggests that immigrants with little or no English have very limited knowledge regarding the acquisition of STIs, as well as, their long-term physical and psychological effects. In addition, various ethnic groups appear to have differences in their knowledge and response to STIs, with some groups having an increased risk of infection (Rosenthal, Moore, & Brumen, 1990). For example, in the United States, African American and Hispanic individuals have the largest number of AIDS cases (Rosenthal et al., 1990). Compared to Caucasians, African American and Hispanic adolescents had less knowledge about AIDS and STIs and were more likely to engage in risky sexual behavior (Rosenthal et al., 1990). Australia has a diverse population of ethnic groups with different cultural backgrounds, including Greeks, Italians, Vietnamese, and other non-English speaking Australians. Rosenthal et al. (1990) compared ethnic groups with Anglo-Australians and found that these groups had different cultural attitudes towards sex. They had lower levels of knowledge and
misperceptions about AIDS and STIs, placing an increased risk of infection on members of these groups (Rosenthal et al., 1990).

In contrast, a study done by Kuo and St. Lawrence (2006), examining the sexual behavior and self-reporting incidence of STIs of White and Chinese American adolescents in a nationally representative sample, found that Chinese American youth reported significantly lower rates of sexual intercourse than White youth. The two groups were compared in prevalence of sex initiation, casual sex partners, number of sex partners, age of first sexual intercourse, and history of STI diagnoses. The Chinese American group that was sexually active was less likely to report irregular sexual partners and reported having a lower number of sexual partners over a year-long period. However, there was no difference in self-reported STIs, and in both groups regardless of: having been romantically involved; being older in age; not living in a two-parent household; having relaxed attitudes about sex; and using substances (Kuo & St. Lawrence, 2006). On the other hand, Rimberg and Lewis (1994), concluded that the level of AIDS-related knowledge in an older adolescent population in university settings answered approximately 80% of the questions correctly when asked about how HIV is transmitted and how AIDS is treated. However, some students still maintained the belief that AIDS could be prevented by using oral contraception and diaphragms. The study demonstrated that university students misperceive effective contraception with STI prevention (Rimberg & Lewis, 1994).

In 1991, Wright, Gabb, and Ryan conducted a study in 33 Australian secondary schools. The student participants, with the mean age of 15.08 years, were asked to rate their knowledge of sexual and reproductive health. Results indicated that their knowledge
The transmission of STIs varied and that their knowledge of prevention and of the asymptomatic characteristics of many STIs was frighteningly low, and, more often than not, incorrect. Although one-third of the students surveyed had had sexual intercourse at least once, surprisingly half were not concerned about catching any STIs (even though there was a lack of accurate knowledge of how STIs are transmitted). Furthermore, results showed that the students were unable to recognize the symptoms of STIs and the long-term consequences of contracting them; furthermore, they also lacked the knowledge about the consequences of allowing infection to go untreated. Wright et al. stated that their findings were a disappointment in light of widespread media coverage and public STI awareness initiatives, especially involving HIV/AIDS. These initiatives stemmed from both the State and Commonwealth Health Departments of Australia, which paid specific attention to the younger generation at that time (Wright et al., 1991).

Moore and colleagues (1996) point out that by the mid-1990s, a large amount of money had already been spent on campaigns to educate and increase awareness of young people about HIV/AIDS. While these efforts have been effective in creating awareness, they have not been enough for preventive action. Moreover, other STIs, about which people know little, have a greater incidence, prevalence, and consequent morbidity among adolescents and young adults, and therefore, need more resources devoted to them (Moore et al., 1996).

Moore et al. (1996) contend that an increased knowledge of STIs among young adults will increase their awareness of the risks, and, the increased awareness of STIs may result in safer sex and a decrease in the risk of HIV/AIDS. For example, social cognitive theory suggests that an individual's behavior is uniquely determined by shared
interactions among environmental influences, behavior, and personal factors. Personal factors include *self-efficacy*, which is the belief in one's capacity to perform the behavior (Shrier, Ancheta, Goodman, & Chiou, 2001). According to Shrier et al., there are several intervention strategies that should be included from a social cognitive perspective: (1) increase awareness and knowledge of the consequences of a behavior; (2) implement social and self-regulative skills training to interpret the knowledge into preventive action; and (3) provide opportunities for guided practice and corrective feedback in applying the knowledge and skills which may, in turn, suggest changes in social norms and encourage the desired behavior change towards prevention of STIs (Shrier et al., 2001).

Rosenthal, Biro, Cohen, Succop, and Stanberry (1995), understanding where young people gain their knowledge about HIV and other STIs is another important area. For instance, significant others play a crucial role, as they are potentially able to change perceptions and attitudes and thus can potentially influence an individual's behavior. Young people see their peers and parents as key influences. Reduction in risk taking behavior has been linked with perceived parental support or family closeness, communication within the family, parenting style, and parental supervision and monitoring (Rosenthal et al., 1995). However, adolescents and older students described their parents’ sexual attitudes as non-liberal, their proclivity toward discussing with their young adults sex or safe sex unlikely, and their point of view on the communication process rarely inviting (Rosenthal et al., 1995). Parents are not the only source of information; young people are increasingly exposed to large amounts of information through mass media, educational institutions, school programs, teachers, and health care professionals (Moore et al., 1996). Media power has a great effect, with numerous “Dear
Doctor’s magazine and newspaper columns, where experts answer questions publicly posed (Moore et al., 1996). The credibility of the source remains an important factor affecting the persuasiveness of the information being given; the higher the credibility of the source, the more effective the changing of behavior (Moore et al., 1996). There is a need to determine the sources of young individuals’ information about STIs, and their impact on behavior and values, taking into account whether or not those individuals regard those sources as credible and thus persuasive. Moore et al. (1996) argued that both sexes wish to receive further information from booklets and education-based programs, although girls still prefer to gather information from books or magazines. Health professionals were found to be high on the list of preferred sources of information about STIs; however, young people rarely use this source of information (Moore et al., 1996). In an earlier study by Marks, Malizio, Hoch, Brody, and Fisher (1983), findings showed that a majority of students would not choose to seek care related to sexual behaviors by a private physician and would not be willing to discuss these problems if their parents were informed of what was discussed with the physician. One of the reasons given was a fear that confidentiality might be broken and that they did not perceive the physician as the health care professional of choice for certain problems relating to a sexual nature.

Moore et al. (1996) cite several other reasons for why students do not use health professionals as a source of information. These include the high cost of consultations, concerns that moral judgments would be made about them, doubts about confidentiality (with particular fears that information would reach their parents), the perceived disease orientation of doctors, and feelings of doubt as to their ability to broach such a sensitive
topic with a doctor. If physicians are to meet the health care needs of adolescents and young adults, they must adjust their approach to the age of the patient, including means of payment and confidentiality (Marks et al., 1983). Paradoxically, the most commonly used source of information for students was the mass media, although individuals believed that there is a lack of credibility, and this was not a preferred source of information. Just because an information source is frequently used does not mean the source is accurate or effective. Therefore, there is a need to make the sources that students prefer and trust more accessible (Moore et al., 1996). In Nigeria, young female adolescents identified the radio as their preferred source of information, while the majority of these participants believed that remedies could be gained from prayer houses and non-scientific practice. Traditional medical practitioner influences (e.g. superstitions, misinformation, and poverty) have a negative influence on the control of STIs in developing countries (Nworah, Obiechina, & Ikpeze, 2002). Women expect that their partners will blame them and inflict violence for a positive STI result (Rakwar et al., 1999). Women believe that a positive result reflects their own responsibility and introduction of the infection into the relationship. Research tends to show that two-thirds of women believe they are at risk of contracting HIV from their regular partners, a finding likely related to ignorance or uncertainty about a partner's sex habits (Rakwar et al., 1999).
Lesbian Women’s Knowledge, Perception, and Attitudes Regarding STIs

Singh, Chin, Brown and Glezen (2006) argued that lesbians do not perceive themselves at significant risk of acquiring STIs. There is a significant knowledge and perception gap between health providers and their lesbian patients on sexual health practices and facts. There seems to be information on lesbian safer sex practices documented in the literature, but there seems to be inadequate arrangement and guidelines on how to reach out and motivate safer sex practices in the lesbian community.

In addition, young people believe they are invincible to the likes and misfortunes of others (Moore et al., 1996). Cognitive egocentrism, aka the “personal fable,” predominantly manifested in adolescents, contributes to the bias of optimism and misplaced notions of invincibility. For example, teenagers will have sexual interactions with many peers, one after the other, assuming they are safe from diseases as these relationships appear to be monogamous. However, the reality is, that over a short period of time, these teens have engaged in polygamous relationships without taking appropriate precautions. The adolescent thought process is based on unrealistic beliefs about one's susceptibility to harm and disease and seems to be specific to this age group (Moore & Rosenthal, 1992; Weinstein, 1986).

According to Moore et al. (1996), the extent to which a person misunderstands their risk of contracting an STI and the relationship between risk perception and risk practices are important in planning effective intervention strategies and are of particular relevance to this research. The question that needs to be answered is whether individuals engage in these practices despite recognizing their risky nature or whether they perceive, rightly or wrongly, that their risk of infection is low (Moore et al., 1996), and therefore,
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the risk of being infected with an STI is more likely to be perceived as low. Individuals may not want to admit their own vulnerability to disease.

In 1993, the Australian Broadcasting Commission conducted a nationwide survey of individuals aged 14 to 24. The survey indicated that young men and women believed that they were unlikely to contract an STI, including HIV/AIDS. Eight-five to ninety-one percent of respondents felt their contraction of herpes or other STIs was against the odds (Moore et al., 1996). By contrast, Moore and Rosenthal (1994) state that STIs are more frequent among young individuals in the United States, claiming that up to 86% of all STIs occurred amongst individuals 15 to 29 years old.

Unfortunately, adolescents and young adults are predominantly at high risk due to their high levels of sexual activity, sexual experimentation (often with multiple partners over short periods), experimenting with anal intercourse, and their failure to use contraception consistently or even at all (Moore & Rosenthal, 1994; Rimberg & Lewis, 1994). Research in university settings has shown negative results in terms of individuals changing their sexual behavior (i.e. even when provided with information and free condoms students continued to have unprotected sex). Although older adolescents and college students seem to have some knowledge about HIV/AIDS, their knowledge was not associated with safer sex behavior (Rimberg & Lewis, 1994). Believing that one is not at risk of contracting an STI reduces the chances that sexual behavior will be altered (Rimberg & Lewis, 1994).

An individual's personality characteristics may also play a significant role in the lack of behavior change in using safer sex practices. Rimberg and Lewis (1994) contend that one such variable is "sex guilt", which is defined as "a generalized expectancy to
self-mediated punishment for violating, or anticipating violating standards of proper sexual conduct” (p. 454). For example, in a survey within the university context, women who were using no or ineffective methods of contraception were found to have a much higher level of sex guilt (Robinson, Bockting, Ross, Miner, & Coleman, 2002).

Moore et al. (1996) showed that there may also be a link between an individual's risk perception and specific personal beliefs on HIV/AIDS risks. Some of these included having a strong stereotype of a person living with HIV/AIDS, having a sense of personal control over whether they contracted an STI, and believing more than his or her peers that the prospects of having an STI was undesirable. Sadly, young individuals link STIs, including HIV/AIDS, to risk groups rather than risky behavior. Because the social representation of people with HIV/AIDS focuses more on gay men, injecting drug users, and sex workers. It is predictable that the stereotype a young individual holds will be of someone unlike him or herself. These stereotypes help the individual distance him or herself by focusing on the differences, rather than the possible similarities between him or herself and those who are infected with an STI. Personally knowing someone with HIV/AIDS can change this perception.

Moore et al. (1996) contend that perception of risk can be reduced when an individual's belief of becoming infected is something over which he or she has control and imply that the issues of mastery and the ability to take responsibility for one's own sexuality are important in allowing young people to determine their risk realistically. Tversky and Kahneman (1974) identified that stereotyping might serve as an ego-defensive distancing function by permitting individuals, or society, to deceive themselves. In other words, individuals may believe that they are different from the
stereotype, and that their dangerous behaviors, although analogous to that of the stereotype, are somehow less dangerous (Moore & Rosenthal, 1994). The task for health educators and the medical profession is to change these false beliefs by, not only providing people with information about HIV/AIDS, but also other STIs, which they are more likely to contract (Moore & Rosenthal, 1994).

Attitudes toward disease states are negative, but in the case of STIs, it is even more so, and to such an extreme that attitudes may distort an individual's ability to think about a particular disease in a realistic manner (Moore et al., 1996). This attitude is due partly to the negative image that STIs carry; for example, they have long been regarded as particularly unpleasant medical conditions, and individuals are shrouded in shame and secrecy due to the assumption that it is associated with unclean sex (Moore et al., 1996). University students' attitudes towards STIs have been found to be more negative than other non-sexual medical conditions (Moore et al., 1996). STI symptoms are seen as unpleasant and unattractive. In the past, society has not sympathized but censured people who are unfortunate enough to contract STIs. For example, in the United States there are states that have enacted laws expressly to criminalize HIV transmission or exposure, charging those accused with criminal transmission of HIV (Moore et al., 1996).

In addition, society associates immorality with STIs, which impedes the effectiveness or even the implementation of appropriate future preventative educational campaigns (Moore et al., 1996). An example of this was found in a study with students from a university in the United Arab Emirates, conducted by Ganczak, Barss, Alfaresi, Almaazrouei, Muraddad, and Al-Maskari (2007). Their results found a startling variance in knowledge about transmission and recovery from STIs which put young Arabs at risk
of contracting STIs, especially HIV. Results also indicated that there was a prevalence of fear and intolerance for those living with HIV in the community. Ganczak and his colleagues argued for the urgent education need to be fulfilled via media, schools, and health professionals. This educational need is an exceptionally challenging feat due to the authoritarian and the strict religious regime in place which forbids discussing material deemed as being able to provoke sinful acts. Findings on young people and the general public are important as a reflection of other segments, such as the lesbian population. It demonstrates the quantitative difficulty in doing this type of research and why it has been has been limited and challenged. Singh, Chin, Brown, and Glezen (2006) argued that there are resources targeting the lesbian community, such as annual Gay Pride events and LGBT community and health centers. However, even with the increase in visibility, sexual health research has focused predominantly on gay men since the emergence of HIV/AIDS in the U.S. in the early 1980s. There seems to be little interest from the federal government or private sector for investing in the field of lesbian health research (Singh, Chin, Brown, & Glezen, 2006).

There is a lack of facts and information available for health care providers on lesbian sexual health. This leaves lesbians marginalized and left to confront cultural challenges and discrimination when discussing sexual behavior issues with health care providers. In addition, the field of sexual and reproductive health neglects to encapsulate the issues and risks that lesbian women face (Singh, Chin, Brown, & Glezen, 2006). The public health sector of the lesbian community needs further research on issues including: the improvement of the health status and health care of lesbians, the confirmation of the beliefs/myths about lesbian STI transmission, and the dismissal of the misconceptions
about the health risks of lesbians. (Singh, Chin, Brown, & Glezen, 2006). In addition, research needs to focus on how lesbians are acquiring their knowledge and how these sources could be interfering or reinforcing inaccurate information and negative beliefs on lesbian sexual health.

Lindley, Friedman, and Struble (2012) reported that lesbians turn to the Internet for information regarding their sexual health; although, research has not examined extensively the availability of online sexual health resources for this population. Lindley, Friedman, and Struble’s (2012) study examined the volume, scope, and readability of sexual health information available to lesbians on the Internet. With the aid of a content analysis on 46 functioning websites, their findings suggest that one third of the websites were located outside the US, two were US government sites, and between half and three fourths of the sites provide information on STIs and HIV/AIDS (52% to 72%). However, there was limited information on safer sex practices (12% to 56%), reproductive cancers (24% to 36%), intimate partner violence (16%), family planning issues (0% to 12%), or other preventive health practices, such as mammograms and gynecological exams (4% to 44%) for lesbians. They concluded that the lesbian community is in need of comprehensive and reliable sexual health information on the Internet that can be easily understood. The information needs to encourage safer sex and other preventive practices among lesbians.
Lesbian Safe Sex

Roberts (2006) argued that there is a need for health care practitioners, therapists, and the public health sector to be educated and educate the lesbian community about safe sex and sexually transmitted infections. Although their risk for infection has been argued to be lower, lesbians are still subject to infections. For example, if HIV or any other virus is in one of four body fluids (e.g. blood, semen, vaginal fluid, and breast milk) it has the potential to reach the blood stream (Roberts, 2006).

Safe sex is defined as sex acts that do not let one person's blood, semen, vaginal fluid, or breast milk get inside another person's body. The San Francisco AIDS Foundation created guidelines that reduce transmission of STI. The guidelines argue that kissing with an open mouth is safe, unless either of individuals have a cut or sore in their mouth or bleeding gums. It is recommended that individuals wait 30 minutes before kissing after they brush or floss, as blood in the saliva could contain the virus. In addition, women should be advised to use mouthwashes that are free of silicates (aspirin) which can also make gums bleed (Roberts, 2006).

A healthy vagina means safer and better sex. However, research shows (Roberts, 2006) that lesbians are “closeted” and worried about coming out to their doctor. Out of fear or lack of sexual health knowledge, women have untreated STIs and often engage in uncomfortable and painful sex. Lesbians who have never slept with men or done so only a few times believe they are risk free. However, a woman with a greater number of solely female partners is associated with increased risk of BV, herpes, and HPV in various studies (Roberts, 2006).
Health care professionals should educate safer sex practices with a positive direction (i.e. “sex can still be passionate while safe”) that can be fun and that limit exchange of fluids, such as frottage (rubbing against the person or dry humping with clothes on), nipple and breast play, sharing sex toys with a condom on, genital touching with gloves, oral sex with a barrier, self-masturbation, fantasy, talking dirty, reading or watching pornography, cyber relationships, voyeurism and exhibitionism. In addition, women should be told to get tested regularly and get their partners tested (Roberts, 2006).

Latex use is important in lesbian relationships as well as heterosexual ones. Partners can insert fingers inside each other’s vagina, although, it can be risky if there are sores or cuts on their fingers, mouth or vagina. Women should be encouraged to use the safer practice of wearing latex gloves. As with latex condoms, water based lubricant should be used instead of oil based (e.g. Vaseline, baby oil, and hand lotion) because it will damage the latex. Saliva or blood contact with menstrual blood facilitates the risk of contraction of STIs; therefore, oral sex on a woman is risky, especially when she is menstruating. The vulva can be covered with a piece of a latex dam, also known as a dental dam as it is used in dental offices, during oral sex. A standard plastic wrap can also be used to keep the vaginal fluids out of the partner’s mouth (Roberts, 2006).

Plastic latex gloves can be suggested for hand-vaginal or hand-anal contact, but need to be changed often when moving from vagina to anal play. This practice is also known as “fisting”. It is very important to educate women not to touch their partner and then themselves with the same hand without washing their hands first. Gloves should be worn when blood is involved, whether from menstrual cycle, piercing, cuts or shaving, but gloves need to be disposed of carefully (Roberts, 2006).
Sex toys are safe by themselves, but it is risky to share them. When sharing dildos or vibrators, women should cover the object with a condom and replace with a fresh one each time a different person uses it. A finger cot or gloves provide protection in case of chafing or sores on the hands and fingers; and nails should be trimmed to reduce the odds of damaging the latex or vinyl. In addition, toys should be cleaned with antibacterial soap or even boiled if there are not battery operated (i.e. glass dildos). Needles, regardless of the reason they are being used (play piercing, IV drug use, permanent piercing or tattooing) should never be shared (Roberts, 2006).

Lesbians who enjoy BDSM [i.e. Bondage & Discipline (B&D), Dominance and Submission (D&S), and Sadomasochism (SM)] should be educated by therapists and health care professionals that these types of activities are safe if there is no blood involved. Cleanliness is tantamount during sex play potentially involving blood. For example, when sex partners pierce the skin, needles or the piercing apparatus should be cleaned with bleach between uses. To avoid the exchange of bodily fluids imperative to safe sex practices, therapists and health care professionals should direct women to preserve razors for personal use only, and take precautions to assure feces and urine, if present in sex play, touch only body exteriors, away from mucous body openings (Roberts, 2006).

A dental dam can be used as protection during oral sex and rimming (oral-anal contact). Therapists and health care professionals can recommend use of water-based lubricants for the prevention of chafing and possible skin breaking. When dental dams are unavailable, women can substitute with a condom by cutting the tip down the side to form a flat prophylactic barrier. Dental dams should be used consistently when
performing oral sex on a recipient that is on her menstrual cycle. Therapists and health care professionals should suggest basic personal hygiene: a bath or shower, as a delightful sex prelude (Roberts, 2006).

Richters, Prestage, Schneider, Clayton (2010) reported that there was little evidence of dental dam use for prevention of STIs between Australian women. Lesbians who practiced rimming (oral-anal contact) or had fetish sex involving blood were more likely to have used a dental dam. Women who had more partners, casual, or group sex did not show a significant increase in the use of dental dams. They concluded that some women avoided giving oral sex during their sex partner’s menstruation. Some women used latex gloves and condoms more than dental dams.

Other safer sex practices include breast/nipple play, massage, dry kissing, masturbation and body to body rubbing. Lesbians should be educated about these safer sex practices. Touching a lover's breasts is safe but precautions need to be taken if the partner is HIV positive. The other partner can lick, suck, kiss, and bite them as long as there's no blood or breast milk.

Alcohol and illicit intoxicants may be enticing as they can be viewed as recreational (i.e. for pleasure or increased sexual pleasure). Additionally, these substances can be used as a means of self-medicating social anxiety and shyness before sexual activity. However, using these substances interferes with judgment and decision making. Lesbian clients should be encouraged to be cautious and avoid these chemicals, as they will be less likely to practice safer sex when under the influence (Roberts, 2006).

Partners need to be encouraged to be honest about their exposure to an STI. Until appropriate medical treatment can be obtained, partners should be told to abstain
from sexual activity. Singh, Chin, Brown, and Glezen (2006) argued that clinicians and educators need to extend STI preventive measures toward the lesbian community. The focus should not be mainly on treatment but on prevention of other STIs or reoccurrence. Communication between the partners should also be encouraged if the exposure to a partner has already occurred.

The LGBT community in itself is a good resource for health professionals to use to spread safer sex awareness among the community. Women have identified a number of factors that encouraged the practice of safer sex with other women. These factors and resources included; personal value sets, word of mouth, physician feedback, friends in the queer community (i.e. defines the grouping of lesbian, gay, bisexual, and transgender people), women’s music festivals, a woman’s partner, gay media, gay bars, and gay resource centers. A great concern for Singh, Chin, Brown, and Glezen (2006) during their study was the finding that several women expressed lack of sexual health awareness, and, when asked to identify a name of a major health concern, most did not feel at personal risk of acquiring STIs. This finding emphasizes the importance of creating opportunities for lesbians to be educated and made aware of the sexual health issues common to women of similar identities (Roberts, 2006).
Lesbian Mothers and Pregnancy

There has been an ever increasing need to improve prenatal care for pregnant lesbians. Singer (2012) emphasized the importance of health care providers to recognize their heterosexist thinking and language in assessing lesbian clients. Laws are changing and there is an increase in social acceptance of non-traditional families. Therefore, it will be necessary for health care professionals concerned with fertility and neonatal care (i.e. Doctors, nurses, geneticists, and midwives) to practice sensitivity when conducting intake histories.

Clinicians need to acknowledge that not all women become pregnant through intercourse. These assumptions can be detrimental to the health of a lesbian mother and her child. Getting impregnated carries risk if by unprotected sex with a man or by sperm donation/implantation. Women should be educated about the risk of donated sperm and the risks of having unprotected sex with men. They need to ascertain his HIV test as negative at least six months after his last possible risk of infection. However, when the sperm is bought from a licensed sperm bank, all their donors are tested meticulously (Roberts, 2006).

Regardless of sexuality or sexual practice, every woman should be given an opportunity to disclose her history in a non-threatening, judgment-free environment, as this environment can set the stage for the rest of the pregnancy (Singer, 2012). Future mothers, lesbian or not, considering having a child should be counseled on the lifetime commitment they would be making and whether they are ready to take on the responsibility. Future parents should be challenged on how they would handle childcare
responsibilities and balancing work and family, as well as being prepared to parent a special-needs child if they have one.

Trettin, Moses-Kolko, and Wisner (2006) identified that barriers exist in lesbian research and health care, and the importance of altering these barriers to promote better care to this minority population. They found that health care professionals had little interest in postnatal depression in lesbian women. Although, postnatal depression affects as many as 15% of women in the first three months postpartum, little is known about lesbian women’s emotional well-being after they give birth. The unique stress factors experienced by lesbians can be highlighted during pregnancy, where they are more vulnerable to postnatal depression.

Lesbian pregnancy could increase discrimination, objectification and alienation. The cultural norm that only heterosexual women should have children may distance lesbian mothers from those holding the belief. Pregnancy for lesbians could also increase psychological stress by increased hostility and isolation (e.g. Family and friend discrimination, rejection) harassment and assault, conflict about one’s sexual orientation, hiding sexual orientation, and concerns about STIs. In addition, lesbians are also vulnerable to difficulties with structural, financial, cultural, and legal barriers to health care and other service providers (Trettin, Moses-Kolko, & Wisner, 2006).

Clinicians need to understand that lesbians may not disclose their sexual orientation to family members because of fears of misunderstanding, rejection, or oppression; and that this secret may create a limited social support during her pregnancy and after, which in turn increases her risk of anxiety, decreases positive affectivity, and lessens self-esteem. However, lesbians in relationships are more likely to share
housework and childcare, which has the effect of decreasing stress and protecting against depression in pregnancy (Trettin, Moses-Kolko, & Wisner, 2006).

**Options for Lesbian Couples Conceiving a Child**

There has been great improvement in recent years in fertility options for same-sex couples. Lesbian clients have several options that primarily depend on the age and health of the woman and their desire to conceive. In addition, Markus, Weingarten, Duplessi, and Jones (2010) reinforced that lesbians have conceived and raised children within the context of heterosexual marriage. In addition, lesbians may choose to become parents through former heterosexual relationships, foster care, adoption, step-parenting, or donor insemination (DI). Little attention is focused on the unique needs of the lesbian couple, including the role of the often times invisible partner, during preconception and DI. Their findings suggested the need for an increase in knowledge of lesbian health among providers (Markus, Weingarten, Duplessi, & Jones, 2010).

**Assisted Reproductive Technology.** Assisted reproductive technology (ART) is a general term referring to methods used to achieve pregnancy by artificial or partially artificial means. ART can be used with fertile couples for genetic reasons (American Society for Reproduction Medicine (ASRM), 2006). ART is also used in couples that are affected with certain communicable diseases, such as HIV and AIDS, to reduce the risk of infection. Examples of ART include in vitro fertilization, intracytoplasmic sperm injection (ICSI), cryopreservation, and intrauterine insemination (IUI). The emotional risks are higher, because the use of ART may cause stress and feelings of vulnerability, guilt, or inadequacy. More research is needed in understanding the pervasiveness of
heterosexism in distorting knowledge and in maintaining a lack of understanding about prenatal depression in lesbian women (ASRM, 2006).

**Ovulation Induction.** Ovulation Induction (OI) is a treatment that stimulates the woman’s ovaries to release eggs, to maximize the opportunity for conception through intercourse or artificial insemination (IUI). The American Society for Reproduction Medicine (ASRM) (2006) recommends this type of treatment when women are producing low levels of hormones for ovulation, or are not ovulating at all. Medication (tablets or injections) stimulates the woman’s hormones (ASRM, 2006).

**Artificial Insemination.** Artificial insemination (AI) is a technique where sperm is inserted directly into a woman’s cervix, Fallopian tubes, or uterus (ASRM, 2006).

**Intrauterine Insemination.** In Intrauterine insemination (IUI), sperm is placed in the uterus. It is a simple procedure with few side effects (ASRM, 2006).

**In Vitro Fertilization.** In vitro fertilization (IVF) means “outside the body.” IVF is usually used when the woman or man is infertile. Fertilization occurs in a laboratory dish where the sperm is introduced to the egg and attached in the dish. IVF requires significant physical, emotional, and financial resources as well as time. Stress and depression are common symptoms when dealing with infertility (ASRM, 2006). Women are required to take fertility medicines, which may cause bloating, abdominal pain, mood swings, headaches, and other side effects. IVF medicines must be given by injection, often several times a day, which cause bruising (ASRM, 2006).

**Partner in Vitro Fertilization.** Reciprocal or partner in vitro fertilization (IVF) is common in lesbian couples where one partner provides the eggs and the other partner carries the pregnancy (ASRM, 2006). This is attractive to many lesbian couples as both
women can be physically involved in the pregnancy. The physical involvement can increase feelings of attachment and involvement in the pregnancy. Once a couple has chosen a sperm donor, they will begin a process of synchronizing their menstrual cycles by taking oral contraceptive pills. The partner who is donating eggs will also take medications to stimulate the maturation of multiple eggs. The partner who will have the embryo implanted will take medications to help prepare the uterus for implantation. After 6 to 9 weeks, depending on how long it takes to synchronize the cycles, the eggs will be retrieved from one partner using ultrasound guidance and fertilized with the donor sperm in the laboratory. The embryo will then be placed in the uterus of the partner who will carry the pregnancy using a small catheter, and she will be monitored for pregnancy (ASRM, 2006). When both wish to be biological mothers they can decide who should become pregnant first. In some countries, there is also the option known as intrapartner oocyte donation (Werner & Westerståhl, 2008), where one female partner provides the oocyte and the other female partner acts as an embryo recipient. The embryo is then created by using IVF with registered anonymous donor sperm. The idea is to give lesbian couples the opportunity to give birth to a baby that was genetically related to her partner (Woodward & Norton, 2006). The intra-partner oocyte donation could offer an alternative to individual donor insemination in some countries (Werner & Westerståhl, 2008).

**Intracytoplasmic Sperm Injection.** Intracytoplasmic sperm injection (ICSI) is an assisted reproductive technology (ART) used to treat sperm-related infertility problems. ICSI is used to enhance the fertilization phase of in vitro fertilization (IVF) by
injecting a single sperm into a mature egg. The fertilized egg is then placed in a woman's uterus or Fallopian tube (ASRM, 2006).

**Surrogacy.** Surrogacy is an arrangement where a woman carries and delivers a child for another couple or person (ASRM, 2006). The surrogate may be the child's genetic mother (called traditional surrogacy), or she may be genetically unrelated to the child (called gestational surrogacy). In a traditional surrogacy, the child may be conceived via home artificial insemination using fresh or frozen sperm or impregnated via IUI (intrauterine insemination), or ICI (intracervical insemination) performed at a health clinic. A gestational surrogacy requires the transfer of a previously created embryo, and for this reason the process always takes place in a clinical setting. Financial compensation may be involved in surrogacy arrangements, but this is not standard (ASRM, 2006).

Lesbian couples conceiving through assisted reproduction in a clinical setting have been growing in number. However, legislation concerning fertility treatment varies from country to country and significantly affects lesbian women’s choices. Other socioeconomic, cultural, and legislative conditions translate into other concerns and motivate alternate strategies relevant in understanding lesbian family options. Responsibility for providing appropriate options and recommendations for lesbian couples seeking guidance on fertility and parenting issues lies with clinicians and therapists (Werner & Westerståhl, 2008).

There is always a risk of over-simplifying the needs of lesbian women since they differ in aspects of class and ethnicity; however, Werner and Westerståhl (2008) recommended strategies for donor choice and parenting. Consultations, posters and
forms should convey open, non-judgmental attitudes, without assuming that all patients are heterosexual. Clinicians need to have knowledge about lesbian women’s issues and options available when they are trying to conceive and during the pregnancy. Clinicians should consider connecting lesbian couples with parenting groups made up of other lesbian couples to create conversations that reflect situational-specific issues. Health care providers should likewise provide and advocate for high-quality receptiveness in the health care system towards lesbian couples seeking help (Werner & Westerståhl, 2008). Healthcare professionals are in a great position to help educate and assist lesbian women in reaching their procreative goals safely and efficiently.

Chabot and Ames (2004) argued that teaching future health care professionals should be within a framework of the diversity among families and not on the traditional model and view of family functioning. Their study offered a model that outlines the major decisions involved in understanding family systems and the decisions that lesbian couple may experience. Lesbian women have difficulty accessing information and support, making decisions on who will be the biological mother, and negotiating parenthood within a larger heterosexist context.

Educational institutions need to develop curriculum that train students about working with lesbian families and their experiences regarding a number of contemporary family topics (e.g., infertility, the role of motherhood, family management, and reproductive issues). Family practitioners, therapists, psychologists, and counselors working with lesbian couples or individuals who are planning for or experiencing parenthood must be able to recognize that lesbian couples need support and guidance on parenting and infertility. In addition, lesbian couples may have similar or dissimilar
experiences compared to heterosexual couples; thus, having knowledge of community support groups for referral is particularly important (Chabot & Ames, 2004).

Chabot and Ames (2004) emphasized that in order for change to occur and lesbian couples to get their needs met, change has to happen across agencies. Human service agencies can offer support and connect families to necessary resources. The staff can be trained to be knowledgeable of the uniqueness of the transition to parenting for lesbian couples to best assist them. In the medical field, lesbian couples could interact with a variety of medical personnel including infertility specialists, reproductive technology specialists, labor and delivery staff, obstetricians, pediatricians, and blood technicians. All of whom should have appropriate and accurate knowledge of the types of issues and decisions faced by these couples and the kinds of services they need, regardless of their sexual orientation. Infertility specialists are encouraged to acknowledge that infertile lesbians often are an unsupported group, and their need to have a child is just as emotionally stressful as that of a heterosexual couple (Chabot & Ames, 2004).

**Home Insemination**

Lesbian couples and infertile couples have the option to conceive by home insemination, which is an alternative to IVF treatment as it is cheaper and easier to perform (Pride Angel, 2013). Home insemination is the process of performing artificial insemination within a home environment. Artificial insemination is a method which involves sperm being placed into the reproductive tract of the female using a syringe. Sperm can be placed in the neck of the cervix, known as intracervical insemination, or at the base of the cervix, known as intravaginal insemination, or in the womb itself, known
as intrauterine insemination (IUI). However, IUI can only be performed by a qualified medical practitioner within a clinical environment as the sperm requires washing to prevent cervical shock (Pride Angel, 2013).

Home insemination can be undertaken by the use of a home insemination kit, a complete kit containing ovulation tests, syringes, semen containers, and many other items to aid conception. The advantages of using in-home insemination rather than a clinic environment, include relaxed environment, involvement of partner, high pregnancy success rate, and lower costs. There are numerous Internet sites that sell home insemination kits. Given that home insemination carries a risk of infections, infection screening prior to insemination should be sought. (Pride Angel, 2013). The standard home insemination kit may include a digital thermometer, a female fertility test, ovulation tests, pregnancy tests, latex free syringes, semen sample containers, basal body temperature chart, and artificial insemination instructions (Pride Angel, 2013).

Artificial insemination is best attempted just before ovulation, as this is the most fertile time of the menstrual cycle and usually occurs 14 days before the start of the next period. However, for each woman, this fertile time frame varies depending on the length of the woman’s menstrual cycle. A woman can determine her fertile window by a change in body temperature, or a change in cervical mucus, as successful conception depends on estimating the precise monthly cycle. It is recommended by fertility specialists that clinical artificial insemination be performed by a regulated fertility clinic, as women should undergo necessary health screening and infection testing of the donor (Pride Angel, 2013).
Sexual Dysfunction in Lesbians

Sexual problems are assessed using the criteria for sexual dysfunction in the diagnostic and statistical manual of mental disorders (4th ed., text rev.) (2000). The criteria include lack of desire, arousal difficulties, lubrication, inability to achieve climax, anxiety about sexual performance, climaxing too rapidly, pain during intercourse, and not finding sex pleasurable. Sexual dysfunction can occur in lesbian women as it does in heterosexual populations, and can have a profound effect on one's relationship.

Dinesh and Benjamin (n.d) reported that the rates of sexual dysfunction in lesbians are not known as there has been very little research into the prevalence and etiology of sexual dysfunction in lesbians. Their research suggested that the diagnosis and management of sexual dysfunction presenting in lesbians women did not differ from heterosexuals. Although, there still needs to be further research in the area, some factors will most likely differ. For example, lesbians can face intrapsychic conflicts such as negotiating life cycle decision (e.g. Career choices, retirement). In addition, lesbians may also be dealing with identity development and ‘coming out’ issues.

Couples may be at different stages of coming out, which may be placing more pressures on the relationship. Health care professionals and therapists may find it helpful to become knowledgeable in the assessment and management of sexual dysfunction in lesbians. Jasenza (2000) examined the various aspects of lesbian sexuality. It suggests a postmodern view of sex and gender as an alternative, and argues a multi-contextual model for conducting sex therapy surrounding the complexities of sexual issues in lesbian couples. Therapists may be reluctant or unaware that lesbian women often are receiving inaccurate information or are not given the opportunity to explore their fluidity and
multidimensionality of sex and gender, sexual behavior, thoughts, attractions, feelings, and sensations, and the powerful feelings, impasses, surprises, and confusion that therapists often experience doing the work with heterosexual couples.

**Lesbian Sexual History Assessment**

Clinicians are recommended to perform a thorough sexual history assessment when working with lesbian clients. There is not a specific questionnaire designed to assess sexual issues with lesbian clients. However, an assessment of sexual history should include the following questions: “Have you ever had sexual intercourse with a man?”; “During the past 12 months, how many partners have you had sexual activity with?”; “In the past 5 years, when having sex with a partner, how regularly have you come to sexual climax?” (1 = no sexual relations; 6 = about all the time); “In your lifetime has it been possible to enjoy being sexual by yourself (masturbating)” (1 = never happened; 4 = usually possible); “During your lifetime, how important has sex been to you?” (1 = could have gotten along without it; 5 = very important) (Matthews, Hughes, & Tartaro, 2006).

It is important to include questions related to early onset of sexual activity such as: “What was your age when you first had sexual intercourse after puberty?”; “What was your age when you first had sexual activity with a partner, other than intercourse?”; “What was your age the first time you came to a sexual climax by masturbation?” These questions aid clinicians in assessing for sexual disorder, including arousal, orgasmic, and desire, as they can be experienced by an individual or a couple during any stage of a normal sexual behavior and could be affecting their relationship.

Future research needs to focus on assessments of sexual problems and identify relevant factors in lesbians' sexual experiences. Clinicians gaining further understanding
can challenge the development of measures sensitive to the sexual experiences and relationship dynamics of lesbians. In addition, clinical interventions with lesbians who have problems related to sexual functioning may be developed that are more accurate in treating sexual problems in this population (Matthews, Hughes, & Tartaro, 2006).

**Lesbian Sexuality**

Averett, Yoon, and Jenkins (2012) attempted to bring into light that there was a limited amount of information on lesbian sexuality and it was mostly outdated. The study used an online survey that recruited via numerous online lesbian communities and snowball sampling. Averett, Yoon, and Jenkins (2012) reported that 456 lesbians over the age of 50 responded to the closed, Likert scale survey and open-ended questions and provided a preliminary understanding of older lesbian sexuality. The results from the study demonstrated that older lesbians have experienced fluidity in past romantic and sexual relationships; that there has been a decrease in focus on sexuality in the context of relationships, with more focus on stability and continuity. In conclusion, the authors indicated that further research was needed to provide greater specificity and detail about older lesbian conceptions of sexual behavior and sexual identity labels.

Future research should also focus on explicitly assessing attitudes regarding sexual behavior and experiences in lesbians. Matthews, Hughes, and Tartaro (2006) argued that lesbians were more likely than heterosexual women to perform activities that are usually suppressed in most societies. Lesbians reported masturbating, engaging in sexual activity at an earlier age, and having a greater number of sexual partners in the past 12 months, demonstrating a wider range of sexual expression.
What is Lesbian Bed Death?

Lesbian bed death is a term used in the lesbian community, but is not exclusive to that population. Over the course of a long-term relationship, individuals will report a decline in sexual activity over the course of their relationship. Ren (2012) examined the term lesbian death bed which was defined as avoiding and lack of intimacy within the relationship. The term, lesbian death bed, was defined as a pattern when both partners mourn the loss of their previously active sex life and do not know how to recapture it. The study concluded that there is a need to further examine lesbian women dynamics in a relationship and the cycles they experience.

In contrast, Iasenza (2002) explored the validity of lesbian bed death and the myths about lesbian sexuality. The author argued that there is a lack of clarity in defining the term and providing empirical validity. The study examines the overuse of gender socialization theory, and the generalization of lesbian women's sexual experiences, while obscuring the diversity of lesbian sexual experience. This article critiques the use of the term “lesbian bed death” and provides examples from sex research and lesbian literature of the panoply of lesbian passions and play. The author argued that therapists assumed that if their couples improved their communication and emotional dynamics, that their client’s romantic and sexual relationship would improve.

Van Rosmalen-Nooijens, Vergeer, and Lagro-Janssen (2008) examined the term lesbian “bed death” among lesbian women by exploring the wishes and expectations of lesbian women with respect to health care professionals in an attempts to evaluate services. They conducted a study that involved semi-structured audio recorded interviews with 30 self-identified lesbian women, and classifying and analyzing the most
important themes. Their results indicated that women had few sexual problems except for "bed death," a quasi-complete cessation of sexual activity. They concluded that "bed death" may be linked to the person’s gender and not to her sexual orientation. In addition, lesbian women identified that clinicians often lacked basic knowledge about homosexuality. However, Matthews, Hughes, and Tartaro (2006) argued that heterosexual women have sexual problems that are affected by health and psychosocial related factors. The lesbians and heterosexual women in their study did not differ in frequency of sexual activity. In addition, lesbian couples reported a lower frequency of sexual activity than heterosexual women, and the discrepancies in sexual desire were associated with higher rates of relationship dissatisfaction, which may be an area for further assessment for therapist working with lesbian couples.

**Relevance to Couples Therapy**

Casquarelli and Fallon (2011) aimed to demonstrate that premarital counseling programs helped engaged couples develop interpersonal and problem-solving skills that enhanced their marital relationships. They also examined the limited services for same-sex couples by exploring the needs of lesbian, gay, and bisexual partners, as well as develop recommendations for providing affirmative premarital counseling, with implications for counseling practice, training, and research.

Mohr, Selterman, and Fassinger (2013) investigated the association between dimensions of romantic attachment and relationship functioning. The study used a cross-sectional sample of people in same-sex relationships, with the goals of replicating basic findings from research on heterosexual couples and advancing understanding of the unique issues faced by same-sex couples. The study used a sample that included 274
female couples, 188 male couples, 34 women whose female partners did not participate, and 39 men whose male partners did not participate.

The pattern of results was identical for women and men, but the effects were stronger in male couples for some associations between attachment variables and indices of positive relationship functioning. In addition, the monogamy was positively associated with relationship quality only when participants or their partners reported moderate or high levels of attachment anxiety. In conclusion, the author reported that attachment did not moderate links between minority stressors and relationship functioning.

Nichols (2005) focuses on research concerning sexual behavior of lesbian couples, such as romance, friendships, and lack of intimacy. The author explores the social perception and biases that lesbians are less sexual than other women. The sexual frequency in lesbian couples is comparable to that of heterosexual couples. The study concludes that there is a need to conduct surveys of women to examine further women's sexual attractions and behavior. Iasenza (2010) encouraged therapists to explore the various roles they have when working with their clients, including creating safety, interviewer, sex educator, sexual detective, empathic listener, co-meaning-maker, hypothesis generator, coach, witness, sex-affirmative parent, and assignment-giving teacher. All contain unique transferences and counter-transferences for couples and therapists. In addition, it is the therapist’s duty to learn the role their own experiences, values, and biases play in couples therapy and the influence they have on their clients (Iasenza, 2010).
Nichols (2005) identified that earlier focus on lesbian bed death had been unclear on the dynamics involving lesbian relationships. Clinicians need to assess and tailor couple therapy to exemplify and open a dialogue where women who have sex with women’s sexual needs, including longer in duration, more likely to include non-genital acts and a greater variety of behaviors, and more reliably resulting in orgasm. In therapy, there needs to be a reformulation of how clinicians treat the lesbian couple and the female sexual response. For example, the therapist should not make assumptions based on sexual orientation or over-generalize intimacy and sexual problems based on heterosexual couples theories on relationships (i.e. “Lesbian can’t have intercourse, therefore, they cannot have sexual dysfunctional behavior or experiences”).

Felicio and Sutherland (2001) emphasized the important of clinicians being mediators for lesbian couples, and to respond to their needs, whether they are legally married or not. This will open discussions that are not constrained by biases, but that help the couples build an environment that allows them to sort out their differences. Clinicians need to be conscious of their homophobic beliefs and attitudes, these are real important issues, as heterosexist assumptions about the dynamics of a couple can negatively interfere in the treatment of same-sex couples. In conclusion, clinicians should evaluate the extent of the couple’s functioning as a lesbian couple or the extent the couple is imitating heterosexual pairs. Therapists need to encourage their clients to find their own rituals and relationship norms that will increase intimacy and passion.
**Female Sexual Disorders**

Matthews, Hughes, and Tartaro (2006) reported that pain associated with sexual activity (34%) was the most frequently reported symptom among heterosexual women and low frequency of orgasm (20%) was the most frequently reported symptom among lesbians. There were fewer (8%) lesbians than heterosexual women (22%) who met criteria for moderately high levels of sexual dysfunction. In addition, they found, as have previous studies, that there exists a relationship between sexual dysfunction and alcohol use among women.

As in the general population, there were higher levels of sexual dysfunction among lesbians when there was reported use of alcohol during sex. Alcohol has been used as a means of increasing sexual enjoyment, reducing anxiety, or to avoid unwanted negative thoughts or images associated with past traumatic sexual experiences. However, alcohol use can lead to problems with sexual functioning (Matthews, Hughes, & Tartaro, 2006). Mental health providers who are treating lesbians with sexual problems are recommended to evaluate whether alcohol is being used as a coping mechanism. In addition, women treated for alcohol and drug related problems should also be assessed for sexual functioning (Matthews, Hughes, & Tartaro, 2006). Studies have suggested that lesbians were three times as likely to report seeking mental health services for sexual problems; however, additional research is needed to determine the potential moderating effect of therapy or counseling for sexual problems among lesbians (Matthews, Hughes, & Tartaro, 2006).

**Vaginismus.** Vaginismus (DSM-IV-TR code 306.51) is defined as a sudden and involuntary tightening of the pelvic floor muscles in anticipation of vaginal penetration
Vaginismus can be caused by a physical problem such as a birth defect or surgery. Primary vaginismus is diagnosed when women have never been able to have vaginal penetrations. Secondary vaginismus is diagnosed when women lose the ability to have vaginal penetration such as after gynecologic surgery, in postmenopausal, or after radiation due to cancer treatment. Although these women could have vaginal penetration, they are now faced with painful or impossible intercourse and gynecologic exams. The main cause for secondary vaginismus is the loss of lubrication and elasticity in the vagina.

Women report feeling trapped within themselves with the painful symptoms, panic and anxiety, and feelings of inadequacy. In addition, partners suffer equally with feelings of frustration, helplessness, rejection and inadequacy. Inaccurate sexual information and the lack of understanding of the woman's body will worsen the crisis, often leading to alienation and even disintegration of the relationship (Katz & Tabisel, 2012).

Katz and Tabisel (2012) recommend a medical evaluation, though diagnosing vaginismus is relatively simple. It requires identifying an inability, or great difficulty, with one or more of the following “Five Penetrations of Life”: finger, tampon, applicator, intercourse or use of penis-size dildo, and a gynecologic exam. Therefore, women may not be able to have any of the five penetrations; or she may be able to have four of those five penetrations, with intercourse being the missing one; or she may have any combination in between (Katz & Tabisel, 2012). Treatment of primary vaginismus falls
into two categories. Some women can self-treat with education, encouragement, and self-help home (dilator) kits obtained from their doctors, counselors, the Internet, or sex shops. Other women cannot cure their vaginismus on their own and need further intervention in the form of individualized treatment by clinicians with knowledge and expertise in treating vaginismus. An effective intervention is the DiRoss Methodologysm by Dr. Katz and Dr. Tabinel. The treatment is practical, focused, short-term, and individualized. There are two clinicians present during treatment, a licensed mental health worker and a physical therapist, so that any emotional and/or physical concern may be addressed immediately. A typical session is 50-55 minutes long and dedicated to the particular needs of the client (Katz & Tabisel, 2012).

**Dyspareunia.** Dyspareunia (DSM-IV-TR Code 302.76) refers to difficult or painful sexual intercourse, and is far more common in women than men, where it is described as pain with initial penetration, and/or during thrusting, and/or after intercourse (an aftereffect) (4th ed., text rev.; DSM–IV–TR; American Psychiatric Association, 2000). For example, women might report that using tampons and gynecologic exams are painful, and that doctors are unsure or unaware of the source of the problem (Katz & Tabisel, 2012)

Dyspareunia may develop due to medical causes, such as vaginal infections, sexually transmitted diseases, skin conditions, hormonal problems, or conditions of the intestines, or genitals, or urinary system (4th ed., text rev.; DSM–IV–TR; American Psychiatric Association, 2000). Physical causes include vaginal abrasions, scars, nerve damage, complications from a vaginal delivery, and size incompatibility (e.g. Dildos). There may also be functional causes, such as genital irritation due to excessive hygiene or
sensitivity to cleaning agents, poor hygiene, and friction irritation due to sports, such as
cycling or horseback riding, and insufficient vaginal lubrication. Finally, there are also
psychophysical causes, such as postpartum crisis, interpersonal difficulties, forced sexual
encounters, and vaginismus (Katz & Tabisel, 2012).

Dyspareunia can be a source of great conflict and anxiety for the woman who
suffers from it, causing marked distress and interpersonal difficulties. Although
intercourse is possible, the accompanying pain has been associated with a more negative
attitude toward sexuality, with more sexual function impairment, and with lower levels of
sexual adjustment. Unfortunately, many women will endure painful intercourse,
depriving themselves of the healthy intimacy that should be the cornerstone of their
relationship. Clinicians need to assess their lesbian clients thoroughly to identify the
particular type of dyspareunia the woman has and to offer the appropriate intervention.
The clinician who takes the time to obtain a complete and careful medical and sexual
evaluation can help resolve most of these issues with appropriate treatment and
interventions (Katz & Tabisel, 2012).

**Vulvodynia.** Vulvodynia is a complex condition that requires careful assessment
by a knowledgeable and competent clinician. There are three types of vulvodynia
conditions: Infectious Vulvodynia, including candida, cyclic vulvitis, chronic vaginitis,
some herpes infections; Vulvar Dermatoses (formerly called vulvar dystrophies),
including lichen sclerosis, lichen planus, lichen simplex chronicus, erosive vaginitis,
steroid rebound dermatitis; and Dysesthetic (idiopathic) vulvodynia, including vulvar
vestibulitis (Katz & Tabisel, 2012). Infectious vulvodynia and vulvar dermatoses are
diagnosed by examination and laboratory tests that can be regulated with medical
interventions. However, the most common type of vulvodynia is dysesthetic (idiopathic) vulvodynia, so subtitled idiopathic because the condition occurs without an apparent cause. The typical symptoms of dysesthetic vulvodynia include burning, throbbing, itching, stinging in the vulva, pins and needles sensation, diffused or generalized vulvar pain, urinary urgency and/or frequency. The symptoms have been associated with stress-related conditions, such as irritable bowel syndrome, headaches, fibromyalgia, chronic fatigue syndrome, sleep problems, eating disorders, and temporomandibular joint (TMJ) problems (Katz & Tabisel, 2012).

Katz and Tabisel (2012) identified seven main causes for this distressing condition, each necessitating a careful evaluation and individualized intervention including vulva dryness, alteration balance of bacteria, excessive vulva friction irritation, substance sensitivity and allergy, poor vulva hygiene, hormonal effects, and emotional stress that is directed to the vulva. Women who suffer from dysesthetic vulvodynia experience the pain and suffering that can lead to depression or anger at the medical field for not being able to help, withdrawal from life's activities, difficulties sustaining relationships, and avoidance of sexual intimacy.

In addition, the woman’s support system, which may include her partner, family and friends, can become frustrated, impatient, resentful, hopeless, angry and withdrawn. The approach to treatment has to be body-mind directed, with a competent clinician who will be patient and knowledgeable enough to diagnose the problem and offer an appropriate treatment plan (Katz, D. & Tabisel, R. L. (Vulvodynia). Available at www.womentc.com. Last accessed (1/13/13).
Female Orgasmic Disorder (FOD). Female Orgasmic Disorder (DSM-IV-TR Code 302.73) occurs when there is a significant delay or total absence of orgasm associated with the sexual activity (4th ed., text rev.; DSM–IV–TR; American Psychiatric Association, 2000). Studies suggest that it is prevalent in 11-41% of women worldwide and can have a tremendous impact on quality of life, relational satisfaction, and general well-being. However, there is no information available on the impact of FOD in the lesbian population.

In order for clients to meet the criteria for diagnosis in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision, there needs to be a delay or absence of orgasms that causes a problem in the relationship with the sexual partner. FOD is associated with a traumatic experience, but can also be acquired through problems within relationships. There are those for whom the problem is of lifelong duration, while others experience the problem in generalized settings or specific situational settings (Katz & Tabisel, 2012).

Diagnosis is based on the clinician's judgment of the client’s sexual experience, adequacy of foreplay and norms for her age. The symptoms are not related to substance use, medication, drug abuse, or caused by a general medical condition. Associated features will be present, as well as possibly previous traumatic experiences, inadequate genital stimulation, and poor communication by both partners.

Women who experience occasional orgasmic problems that are not persistent and/or do not result in distress or interpersonal difficulty are not considered to meet any diagnostic criteria to suggest a disorder. These occasional orgasmic problems are usually the result of poor or inadequate sexual stimulation by a partner often due to lack of focus,
intensity or duration (Katz & Tabisel, 2012). Clinicians have to differentiate between the following disorders, as some disorders have similar or even the same symptoms. These include alcohol use, anxiety, depression, emotional problems, distraction, medical illness, negative body perception, and stress. Treatment can include psychosexual education, such as informing the client that the capacity for orgasm increases with age, and female orgasmic disorders are more common in younger women. Many women increase orgasm capacity as they acquire more knowledge of the responses of their own bodies. Masturbatory training may also be helpful in the treatment of the female orgasm disorder, as well as counseling and psychotherapy (Katz & Tabisel, 2012).

**Female Sexual Arousal Disorder.** Female Sexual Arousal Disorder (DSM-IV-TR Code 302.72) is the second most common sexual dysfunction in women, following desire disorder. There are three subsets: genital arousal disorder, subjective arousal disorder, and combined arousal disorder (4th ed., text rev.; DSM–IV–TR; American Psychiatric Association, 2000). The genital arousal disorder occurs when women have pleasure in the mind concurrent with decreased or no genital lubrication, swelling, or sensation of genital tingling and warmth. The subjective arousal disorder occurs when there is a genital response to sexual stimulation but no mental awareness of sexual pleasure. The combined sexual arousal disorder is when both the genital and mental responses to sexual stimulation are absent (Katz & Tabisel, 2012). There are psychological and biological causes of female sexual arousal disorder (Katz & Tabisel, 2012). Prolonged illnesses such as diabetes, multiple sclerosis, and vascular disease can lead to genital arousal disorder due to peripheral neuropathy and decrease and loss of genital sensation. In addition, depression, hormonal imbalance following menopause or
childbirth, certain medications such as birth control bills, or relationship problems can lead to both genital and subjective arousal disorders (4th ed., text rev.; DSM–IV–TR; American Psychiatric Association, 2000).

A comprehensive psychosocial and medical evaluation is needed for better understanding lesbian women, and should be performed by a clinician who is familiar with the field of female sexual medicine. Treatment plans include, but are not limited to: sex therapy, relationship therapy, discontinuation of certain medications, off-label use of Viagra, Wellbutrin, and testosterone, Zesta lotion, EROS clitoral therapy device, herbal treatments such as ArginMax, vibrator therapy, lubricant use, and hormone therapy, such as topical estrogen (Katz & Tabisel, 2012).

**Female Hypoactive Sexual Desire Disorder.** Female hypoactive sexual desire disorder (HSDD) (DSM-IV-TR Code 625.8) may occur in up to one-third of adult women in the US. However the number of lesbian women affected by HSDD is unknown. The essential features are a deficiency or absence of sexual fantasies and desire for sexual activity that causes marked distress or interpersonal difficulty (4th ed., text rev.; DSM–IV–TR; American Psychiatric Association, 2000). The evaluation of female HSDD generally requires examining multiple factors that impact female sexual desire. Contributors to HSDD include several female reproductive events that change sexual desire, such as menstrual cycles, hormonal contraceptives, postpartum states and lactation, oophorectomy and hysterectomy, and perimenopausal and postmenopausal states. As with other female sexual disorders, HSDD can greatly impact the quality of life of a female client. Best treatment options focus on female reproductive life events that may impact sexual desire. Various options in the treatment of HSDD in women
include lifestyle changes, treatment of coexisting medical or psychiatric disorders, switching or discontinuing medications that could impact sexual desire, hormone therapy and marital therapy (Katz & Tabisel, 2012).

Female Sexual Aversion Disorder. Sexual Aversion Disorder (SAD) (DSM Code 302.79) is defined as a "persistent or recurrent extreme aversion to, and avoidance of, all or almost all, genital sexual contact with a sexual partner" which causes distress or interpersonal difficulty (4th ed., text rev.; DSM–IV–TR; American Psychiatric Association, 2000). Kaplan (1987) emphasized that individuals with SAD have a phobia and exhibit all forms of avoidant behavior towards sexual contact. There has been very little new published data on SAD since the publication of DSM-IV, and the precise prevalence remains unknown including its impact on lesbian women.

DSM-5 Sexual Dysfunctions

The American Psychiatric Association DSM-5 (2013) has combined female sexual desire and arousal disorders into one disorder, now named female sexual interest/arousal disorder. Research had suggested that sexual response is not always a linear process, and that there is difficulty making a division between phases, such as desire and arousal (APA, 2013). The changes in the DSM-5 are meant to improve diagnosis concerning duration and severity criteria. In addition, sexual dysfunctions now require a minimum duration of approximately 6 months and more precise severity criteria (APA, 2013).

Furthermore, vaginismus and dyspareunia have been combined into the genito-pelvic pain/penetration disorder in the new DSM-5. The DSM 5 taskforce had argued that there was a high comorbid and difficult to distinguish between the two disorders
(APA, 2013). In addition, the diagnosis of sexual aversion disorder has been removed due to rare use and lack of supporting research. These changes have been defined as providing a threshold for making a diagnosis and differentiating temporary sexual difficulties from enduring sexual dysfunction (APA, 2013).

In conclusion, I am unsure that merging these diagnoses is protecting the women in a way that helps with treatment. The focus of the DSM-5 is to aid clinicians with detailed and accurate diagnostic criteria that would best tell the clinical diagnosis and treatment. However, in the future there needs to be further research, field trials, and improvements made in sexual dysfunctions in women, especially lesbians.
General Lesbian Health Issues

Mental Health

The U.S. (2009) reported that lesbian women are at great risk of developing depression and anxiety. Although all women are susceptible to depression and anxiety, research has demonstrated that lesbian and bisexual women report higher rates of depression and anxiety than heterosexual women. The causes of the higher rates include social stigma, rejection by family members, abuse and violence, being treated unfairly in the legal system, hiding some or all aspects of one’s life, and lack of health insurance. In addition, lesbians often experience a lack of social support and may feel they have to conceal their lesbian status from family, friends, and employers. They are also victims of hate crimes and violence, such as corrective rape. As long as discrimination against lesbians exists and there continues to be a lack of legal protection and rights, depression and anxiety will continue to spread or persist in lesbian women. In 2007, Hunt and Fish asked lesbian and bisexual women from Great Britain to complete a survey about their health, and discovered that, in a year period, one in five lesbian and bisexual women reported intentionally hurting themselves compared to 0.4 percent of the general population. They also found that, of the female responders, half of lesbian and bisexual women under the age of 20 have self-harmed, and that three fourths of those who have self-harming behavior within a year, such as cutting themselves, with one in five having swallowed pills or objects. Respondents identified scratching themselves, punching walls, or breaking their bones as self-harming behaviors. It was also estimated during the study that one in 20 of the general population have eating disorders, while one in five lesbian
and bisexual women indicated that they have had, or have been told that they have had, eating problems (Hunt & Fish, 2007). For example, one in ten lesbian and bisexual women reported having been diagnosed with bulimia or compulsive eating, and seven percent reported having anorexia. Eating disorders are exacerbated when drugs and alcohol are involved, which has been identified to be a significant problem in the lesbian community and requires further research (Hunt & Fish, 2007). Depression has been linked to decreased libido; however, using medication to treat mental illness can often further reduce sexual desire and functioning. Antidepressants interfere with our ability to experience sensation. For example, women may have physical reactions to arousal, such as an engorged vagina, wetness, and muscle contraction, but will not feel their arousal. The medications most associated with having a negative effects on sexual functioning is selective serotonin reuptake inhibitors (SSRIs). It is the responsibility of health care professionals to develop a treatment plan and solution to treat depression, while supporting their clients’ sexual health (Newman, 2004). For example, there are medications that can be used with SSRIs that treat the depression while increasing the libido (i.e. Dehydroepiandrosterone (DHEA), Wellbutrin, and Viagra).

**Intimate Partner Violence**

Intimate partner violence (IPV) is defined when one person purposefully causes physical, emotional, medical, psychological, economic, and/or mental harm to another. According to the 2011, NCAVP: Report on Intimate Violence in LGBTQ & HIV Affected Communities in the U.S., IPV can occur in lesbian relationships as it does in heterosexual relationships, with approximately 47% of lesbians reporting experiencing
IPV from a female partner in their lifetime. Lesbians are less likely to report abuse. Some reasons explaining the phenomena of less disclosure include: the existence of less available help services, fear of discrimination, threats from the batterer to “out” the victim, or fear of losing custody of children. Future studies should expand on the lesbian mother and the effect domestic violence has on her children, as well as, (developing) better methods of educating and treating lesbian youth. Studying the understanding and perceptions of clinicians treating lesbian victims or abusers would benefit the knowledge base to enable improved performance. With the acquisition of additional data on the lesbian-clinician relationship, researchers and writers in the field could develop a treatment manual to aid clinicians in evidence-based practices (Hunt & Fish, 2007).

**Alcohol and Drug Abuse**

Lesbians are dependent upon and abuse substances (e.g. Alcohol, cigarettes, marijuana, inhalants, and cocaine) at greater rates than heterosexual women. Lesbian women use alcohol and illicit substances as a coping mechanism for emotional reactions to social stigma and heterosexism. The bar and associated “drinking and drugging” venues serves as a primary means of socialization, particularly for younger lesbian and bisexual women. In general, less social norms and responsibilities restrict lesbian and bisexual drug use. For example, lesbians are less likely than heterosexual women to have children and, therefore, not as likely to engage in other social and family activities that serve to limit drinking among heterosexual women (U.S., 2009). White and Levinson (1995) reported that lesbians are three times more likely to use alcohol than heterosexual women. A third of lesbians aged 22-52, who reported physical abuse from a partner, also
admitted to the consumption of alcohol or drugs during the abuse. In a study conducted by Fortunate and Kohn (2003), lesbian batterers and non-battered lesbian were tested using the Millon Clinical Multiaxial Inventor- Third Edition (MCMI-III), Michigan Alcohol Screening Test (MAST), and the Conflict Tactics Scale (CTS). The 33 lesbians battered reported at greater rates than the 67 non-battered lesbians: aggressive, antisocial, borderline, and paranoid personality traits, higher alcohol dependence, drug dependence, and delusional clinical symptoms. Fortunate and Kohn concluded that clinicians should use the topic of substance abuse as a means to discuss relationship conflict and assessing IPV. Further, more in-depth research focusing on larger, more diverse samplings and including couples could provide nuance to understanding the link between drug-use and domestic abuse among lesbians.

Pregnancy has been found to influence the use of alcohol and illicit substance. Research suggests that there may be a lower prevalence of substance use in pregnant lesbian women as compared to non-pregnant lesbian women and pregnant heterosexual women. However, pregnant lesbian women may be at increased risk for depression as they may have to abstain from alcohol and be separated from routine social activities. The U.S. (2009) reported that, although substance abuse continues to be a serious public health problem for the LGBT population, recent data suggests that substance use among lesbians, especially alcohol, has declined over the past two decades. Awareness of and concern regarding health issues have increased to positively impact lesbians. Some threads of social stigma and oppression of lesbians has declined. Norms associated with drinking in some lesbian communities have shifted. However, a high rate of both heavy
drinking and drug use among young lesbians and some older groups continues to prevail (U.S., 2009).

**Smoking**

Heart disease and cancers, such as lung, throat, stomach, colon, and cervical have all been linked to smoking. Lesbians have been found to be more likely to smoke, compared to heterosexual women (Hunt & Fish, 2007). Researchers argue that this is due to social factors, such as low self-esteem, stress resulting from discrimination, concealing one’s sexual orientation, and tobacco advertising targeted towards gays and lesbians (U.S., 2009).

**Heart Disease**

Of all causes, heart disease kills most women (USDHHS, 2012). Obesity, smoking, stress, as well as, other factors are prevalent in lesbians, thus increasing their risk for heart disease. Factors women have absolutely no influence over, such as race, age, and genetics, correlate to disparate risks for heart disease. The biggest risk factors for heart and cardiovascular disease, such as smoking, high blood pressure, lack of exercise, diabetes, and high blood cholesterol can be managed. Some heart and cardiovascular disease risk factors, such as inactivity, are also indicated as cancer risk factors (U.S., 2009). Sedentary women develop heart and cardiovascular disease at a rate two times that of active women. The more overweight, the higher a person’s risk for heart disease (U.S., 2009). There is much more research needed with lesbians in this area, as well as effective models of educating and providing services to reduce fatalities and medical complications in this already vulnerable population.
**Obesity**

Obesity increases the likelihood of heart disease and cancers of the uterus, ovary, breast, and colon. Compared to heterosexuals, lesbians have higher body mass index (BMI) statistics and may store more abdominal fat and have greater waist circumferences (U.S. 2012). They are at higher risk for heart disease and other obesity-related issues, such as premature death. Studies have suggested that social factors affect lesbian obesity, such as ambivalence toward weight issues, relative to heterosexual women. However, there is more research needed in these areas to explore the depth of the issue in this community. Exploring under-researched areas of lesbian bodily health (e.g. Differences in diets, activeness, and cultural size norms) would help clinicians and practitioners in better customizing health plans for lesbian women. The knowledge base concerning lesbians and obesity has unfulfilled research needs in the impact categories of ethnicity, age, health status, education, female partner cohabitation, and disabilities (Hunt & Fish, 2007). Past research to date has identified that lesbian and bisexual women of African American or Latina ethnicity, older age, poorer health status, lower educational status, lower exercise frequency, and cohabiting with a female relationship partner increases a lesbian woman’s possibility of having a higher BMI. In addition, research discovered that lesbian women are less likely to eat fruits and vegetables every day than other populations (U.S., 2009).

**Polycystic Ovarian Syndrome**

Polycystic Ovarian Syndrome (PCOS) is a common hormonal reproductive problem in women of reproductive age (ages 20 to 40), with approximately five to ten
percent of women affected. PCOS is a health problem that upsets a woman’s menstrual cycle, fertility, hormones, insulin production, heart, blood vessels, and appearance. The condition is identified as enlarged and numerous small cysts located along the outer edge of each ovary (U.S., 2009). Women with polycystic ovary syndrome may experience infrequent or prolonged menstrual periods, excess hair growth, acne, and obesity. In adolescents, infrequent or absent menstruation may signal the condition. Difficulties in becoming pregnant or unexplained weight gain might signal PCOS among adults or adolescents (U.S., 2012). There is no known direct cause of polycystic ovary syndrome; however, early diagnosis and treatment may reduce the risk of long-term complications, such as type 2 diabetes and heart disease. Research suggests that there is evidence that lesbians may have a higher rate of PCOS than heterosexual women, though there is no known cause for the higher rates. There is more research needed in this area as there is no information that tells the depth of the problem with lesbian women (U.S., 2009).

**Osteoporosis**

Osteoporosis affects the bones by making them weak and brittle, such that a fall or mild stresses, like bending over or coughing, can cause a fracture, usually in the hip, wrist, or spine area. Osteoporosis happens when bone cell growth and creation lags behind old bone tissue removal. Osteoporosis affects women of all races, with Caucasian and Asian women past menopause identified as those at highest risk. Treatment includes medications, dietary supplements and weight-bearing exercise that can help strengthen your bones. The U.S. (2009) reported that the rate of osteoporosis in lesbian women has not yet been well studied.
As women age from menopause onward, estrogen levels deteriorate. This developmental change has an overwhelming effect on the vagina, making it thinner, less elastic, drier, and more prone to chafing, irritation and bleeding. The functional changes experienced include feeling dry, pinchy, chaffy; the genital lips may 'stick together'; natural lubrication may become insufficient; intercourse is progressively uncomfortable and painful (dyspareunia), or no longer possible (secondary vaginismus); gynecological exams are progressively difficult or no longer possible (secondary vaginismus); urinary frequency and urgency may rise as the lower third of the vagina and urethra share a common wall affecting both; emotional and relationship distress, feelings of insecurity and loss of sexual interest (libido) may all arise. There are also environmental factors that intensify the problem, such as dry indoor heat in cold climates, insufficient hydration (drinking), the drying effect of certain medications - including those for allergies, and excessive hygiene (i.e. Doucheing) (Katz & Tabisel, 2012).

Menopausal and postmenopausal women can resume vaginal functions with few disruptions. Women are encouraged to use vaginal estrogen cream, vaginal moisturizer, vaginal lubrication for penetration, penetration re-training using dilators, environmental adjustments, and psychotherapy. However, as there is little medical and public support for elderly lesbian women experiencing menopausal and postmenopausal problems, lesbian women are left to believe they are alone and accept their limitations as inevitable (Katz & Tabisel, 2012).

The different types of menopause include: natural menopause (the cessation of menstruation); surgical menopause (the result of the surgical removal of both ovaries-
oophorectomy, often a component of total hysterectomy); induced menopause (medications that stop ovarian (estrogen) production, i.e. Lupron injections for the treatment of endometriosis or breast cancer); menopause can also occur as the result of pelvic and vaginal radiation for cancer); and postmenopausal (the woman's stage of life after menopause, starting 2 years after her last period) (Katz & Tabisel, 2012).

Averett, Yoon, and Jenkins (2012) argued that research has been consistent in its findings on older lesbian sexuality, identity, and romantic relationships. Studies have concluded that, of the older lesbians, there were many who had been previously married to men, as they viewed marriage to men as the only option. In previous studies, argued that older lesbians who married a man were found to have had their first emotional, physical, or sexual relationships with another woman on average at the age of 29, and later than those who had not married men. In addition, studies described lesbian sex as kissing; hugging, and cuddling and less goal oriented towards having an orgasm and emphasized the importance of clinicians and health professional not defining sex on hetero-normative standards. However, there continues to be a need for an in-depth qualitative study of the language of sex and intimacy among lesbians. It is especially important to explore sexuality, such as sexual behaviors older lesbians engage in and their frequency, in the elderly lesbian population (Averett, Yoon, & Jenkins, 2012).
Cultural Difference in Knowledge and Perception of Lesbian Sexual Health

Little research has been conducted regarding the cultural differences in the lesbian population. Although, there has been some interest in the Caucasian lesbian population, in regards to sexual health behavior and there is a dearth of information on marginalized lesbian populations.

African American Lesbians

In the last decade, there has been a focus and an increased interest in health among African American women in general; however, there is a little information on the sexual health needs and issues of African American lesbians. Mays, Yancey, Cochran, Weber, and Fielding (2002) examined the national patterns of health care disparities that result in disadvantages among racial or ethnic minority women. They identified that there are personal, regional, and socioeconomic factors that influence risk (i.e. Poverty and limited educational opportunities), and that sexual orientation is a contributing factor to poor health care. The study argued that the rates of preventive care used were lower among lesbians and bisexual women, with Hispanic and African American lesbians and bisexual women (also?) lacking in available medical care.

In the Hispanic and African American populations, greater percentages of lesbians lacked health insurance than standardized estimates of similar heterosexual women. In addition, although the women reported that they had full-time employment, they were less likely than heterosexual women to have access to health insurance through a spouse or relationship partner (Mays, Yancey, Cochran, Weber, & Fielding, 2002).
Muzny, Sunesara, Martin, and Mena (2011) attempted to examine the prevalence of infection with Chlamydia Trachomatis, Neisseria Gonorrhoeae, Trichomonas Vaginalis, Mycoplasma Genitalium, syphilis, and HIV among African American women who have sex with women (AAWSW), and compare socio-demographics, sexual risk behavior characteristics, and STI diagnoses. Their results suggested that AAWSW were at high risk for STIs, and this class participated to a greater extent than heterosexual women in sexual risk-taking behavior. However, sexual health services provided to AAWSW often lacks information and accurate knowledge regarding healthy sexual behavior. In addition, there needs to be appropriate counseling and screening for STIs for African American women who have sex with women (Muzny, Sunesara, Martin, & Mena, 2011).

Reed, Miller, and Timm (2011) reported that when AAWSW are compared to heterosexual women, their results suggested that young sexual minority women experience a disproportionate amount of pregnancy, repeat pregnancy, and parenthood. Their study found that pregnancies, whether planned or not, were common among the participants and within their sexual minority community and that pregnancy it established sexual identity and same-sex relationships. The study found that the black cultural environment viewed pregnancy and motherhood as an adaptive survival strategy for women who are largely socially undervalued (Reed, Miller, & Timm, 2011).

Mays, Yancey, Cochran, Weber, and Fielding (2002) reported that their findings suggested higher rates of tobacco use among African American lesbians and bisexual women than among African American heterosexual women. The negative health issues accompanies tobacco use, makes reduction of use all the more necessary. However
public health interventions often overlook, or at least fail to target, the need for cessation and reduction among lesbians and bisexual women. They also discovered that there were significantly higher rates of obesity in Hispanic and African American women, regardless of sexual orientation (Mays, Yancey, Cochran, Weber, & Fielding, 2002).

The differences between lesbians and bisexual women and heterosexual women could be related to protective factors (i.e. Supportive family, financial security). Lesbians and bisexual women repeatedly show higher-than-expected rates of health risk behaviors and less use of preventive health care services. The results of this type of study emphasize the importance of considering factors that are not recognized as influential in women's health. For example language can thwart health care access, especially among a population of low literacy and education levels. Other influencing factors that affect women’s health include sex, social, cultural, and economic factors of minority women's opportunities, exposures, and derisions (Mays, Yancey, Cochran, Weber, & Fielding, 2002).

In addition, more research is needed in the area of how sexual orientation influences beliefs and attitudes about illness affecting minority women when receiving health services, the types of jobs they are more likely to occupy, the neighborhoods in which they live, and their experiences of racism, discrimination, oppression, and marginalization. Future studies need to examine the needs and issues of racial or ethnic minority lesbians and bisexual women to gain a better understanding of these multiple influences and create relevant culturally responsive interventions, programs, and policies for lesbian women in their communities (Mays, Yancey, Cochran, Weber, & Fielding, 2002).
Latina Lesbians

Kim and Fredriksen-Goldsen (2012) used a population-based sample to assess health disparities among Hispanic lesbian and bisexual women by comparing them to Caucasian minority women and heterosexual Hispanic women. The first demonstrative study of its kind, its results indicated that Hispanic lesbian and bisexual women had an increased risk of smoking, lifetime asthma, and disability compared with heterosexual women. Racial and ethnic disparities reflect that Hispanic lesbians were more likely to report lifetime asthma than Caucasian lesbians. There is further research needed in understanding the high prevalence of obesity, smoking, and mental distress in Hispanic lesbians, but these indices could explain the increasing risk of it asthma among Hispanic lesbians.

Cochran, Mays, Alegria, Ortega, and Takeuchi (2007) referenced information supporting the conclusion that LGB adults face elevated risks for mental health and substance abuse disorders from dealing with years of anti-gay stigma. However, the assumption of increased morbidity among ethnic and racial minorities as a result of pervasive discrimination has received little focus. The National Latino and Asian American Survey (NLAAS), a national household probability psychiatric survey, found that, of 4,488 Latino and Asian American adults, 4.8% of persons interviewed identified as lesbian, gay, bisexual. Female responders that identified as lesbian/bisexual women were more likely than heterosexual women to experience a lifetime history of depressive disorders. The study argued that there appears to be a small elevation in psychiatric morbidity risk among Latino and Asian American individuals with a minority sexual
orientation. However, much more information is needed as the Latina lesbian population remains largely ignored and understudied.

**American Indian and Alaska Native (AIAN) Lesbian**

Lehavot, Walters, and Simoni (2010) conducted a study, a first of its kind that examined American Indian and Alaska Native (AIAN) women and their experiences in living in an oppressive society. The focus of the study explored the effects of colonization and violence toward AIAN women with a history of early starting, frequent, and ongoing sexual and physical abuse. The loss of their sense of agency or mastery (i.e. the ability to account for individualized choices and actions) contributes to these women’s poor physical and mental health (Lehavot, Walters, & Simoni, 2010). In their study, 152 sexual minority AIAN women were interviewed to examine health concerns of AIAN women who identified as lesbian, bisexual, or “two-spirit.” The results appeared to suggest that disproportionate violence levels make sexual minority women vulnerable to health outcome disparities (Lehavot, Walters, & Simoni, 2010).

The responders identified a high prevalence of both sexual (85%) and physical (78%) assault that has been associated with worse overall mental and physical health. The types of abuse reported were associated with worse physical health, including acute health problems such as bruises and head injuries, and non-psychiatric medical diagnoses, such as infectious diseases and pain disorders. In addition, the abuse has been associated with health risk behaviors and social impairment (Lehavot, Walters, & Simoni, 2010). There is a need for interventions and preventions with two-spirit Native women that aim to both decrease levels of abuse and increase mastery. Clinicians are
recommended to assess past and current abuse and sexual orientation in their treatment of AIAN women. Also when working with Native communities there needs to be a focus on incorporating mastery into prevention interventions related to one’s culture and upbringing (Lehavot, Walters, & Simoni, 2010).

**Asian American**

Asian American lesbian and bisexual women are significantly more likely than heterosexual women to report risky health behaviors (i.e. Engaging in HIV risk behaviors, using substances, and experience suicidal ideation [two to three times higher than for exclusively heterosexual women]) (Lee and Hahm, 2012). The risky behavior reported among all Asian American women may be aggravated by the fact that these women have a dual minority status. Clinicians are recommended to use thorough screening for this subgroup, so that appropriate assessment and services can be provided. There is a need for further research and intervention strategies for Asian American lesbians. All lesbian populations and cultures need the improvements in accuracy and effectiveness of the measures used to gather data and information. Clinicians can then be better prepared in their observation, argument, and understanding of lesbian health needs, as well as be better able to guide health promoting efforts for the vulnerable subset within this population. Researchers have to use representative samples with multidimensional measures of sexuality to enhance the extent of our understanding of sexual orientations and health. In addition, future research should explore and test longitudinal and mediated pathways of risk among lesbian subcultures to identify key mechanisms for prevention and intervention programs to target.
The Sexual Health Model: An Approach towards Prevention and Education in the Lesbian Community

Robinson et al. (2002) define sexual health as an approach to sexuality grounded on reliable knowledge, awareness of personal behavior, values and affect congruent within the personality structure. It involves the ability to be intimate with another person, to be able to communicate one's sexual needs and desires, be sexually functional, to act conscientiously and responsibly, and to have appropriate sexual boundaries. Sexual health is not only aimed at an individual but also has social factors, where one has to show respect and understanding for individual differences and diversity within cultures. Most importantly, sexual health centers on freedom from sexual dysfunction, sexually transmitted diseases, and sexual assault and coercion (Robinson et al., 2002).

Robinson et al. (1996) argued that individuals have not been given adequate knowledge and information about their personal susceptibility to STIs and how to achieve sexual health; they have gained their knowledge, in general, from the media and from their peers through social interaction. This is where the Sexual Health Model can be relevant. The Sexual Health Model can not only be adequately customized to be relevant to groups' varying needs, it also allows individuals to infer their own risk status, permitting them to set their own standards best suited for them, and enabling them to somewhat customize a healthy sexual lifestyle suitable to their needs (Weinstein, 1986). For example Bockting, Robinson, Forberg, and Scheltema (2005) identified that the Sexual Health Model makes assumptions that when individuals become more comfortable talking about sex, increase their awareness of their culture and identity, have
knowledge about their health and functioning, more confident in relationships and more positive about themselves (i.e. their body and sexuality), their self-care is improved and they are able to practice safer sex and needle use.

Table 2 Lesbian Sexual Health Curriculum. *Intervention curriculum for Sexual Health seminar targeting the lesbian and women who have sex with women community and conceptually based in the Sexual Health Model.*

<table>
<thead>
<tr>
<th>Components of the Sexual Health Model</th>
<th>Lesbian Sexual Health Curriculum</th>
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<tr>
<td>1. Talking about sex</td>
<td>Sexual words exercise; small group discussion</td>
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<tr>
<td>2. Culture and sexual identity</td>
<td>Affirmation of lesbian identities and expression through lecture, slideshow and video.</td>
</tr>
<tr>
<td>3. Sexual anatomy and functioning</td>
<td>Discussion of sexual health (i.e. breast care); slideshow affirming genitals; and lecture on effects of hormones on sexual functioning.</td>
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<tr>
<td>4. Sexual health care and safer sex</td>
<td>Presentations and Q&amp;A (Questions &amp; Answers) about HIV/STDs and sexual health maintenance by lesbian-identified physicians; and role play on safer sex techniques.</td>
</tr>
<tr>
<td>5. Challenges: overcoming barriers to sexual health</td>
<td>Alcohol and drugs, harassment, and violence confronted through lecture, video, role play and small group discussion.</td>
</tr>
<tr>
<td>6. Body image</td>
<td>Exploration coming out</td>
</tr>
<tr>
<td>7. Masturbation and fantasy</td>
<td>The power of touch and self-nurturing addressed through discussion and video.</td>
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<tr>
<td>8. Positive sexuality</td>
<td>Exploration of lesbian sexuality through lecture, video and small group discussion.</td>
</tr>
<tr>
<td>9. Intimacy and relationships.</td>
<td>Dating, love, partnership and marriage addressed by a couples panel and small group discussion</td>
</tr>
<tr>
<td>10. Spirituality and empowerment</td>
<td>Lecture and ritual facilitated by lesbian leaders.</td>
</tr>
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</table>
The model has been successfully used to develop HIV/STD prevention interventions for men who have sex with men and African-American women; a sexuality-based approach to prevention was shown to be effective in preventing relapse to unsafe sex and improving knowledge and attitudes toward condom use (Bockting, Robinson, Forberg, & Scheltema, 2005).

The Sexual Health Model (Robinson et al., 2002) is derived from three sources of empirical and theoretical information. It consists of (1) a recognized sexological approach to comprehensive sexuality education; (2) a basis of recommendations for culturally specific, relevant, and normative models of sexual health resulting from the target community's experience; and, (3) an interface supportive of qualitative and quantitative research on sexual attitudes, practices, and risk factors for a range of populations and the contextual milieu for safer-sex-decision-making (Robinson et al., 2002).

The Sexual Health Model (Robinson et al., 2002) has been applied mainly to long-term HIV prevention through the use of Sexual Attitude Reassessment seminars presented in a range of populations, such as medical students, physicians, health professionals, clergy, and people with disabilities. However, the comprehensive structure of the model allows it to be used in educating and preventing all STIs. It originated in sexuality education, consisting of four dimensions that consider why individuals may or may not adopt certain behaviors in relation to STI prevention, as well as defining 10 key components seen as essential aspects of healthy individual sexuality (Rimberg & Lewis, 1994; Robinson et al., 2002). The dimensions are defined as perceived susceptibility to the disease and perceived barriers to adopting new behaviors (Rimberg & Lewis, 1994).
Figure 5 Application of the Sexual Health Model to Sexually Transmitted Diseases

1. Talking about sex
2. Culture and sexual identity
3. Sexual anatomy functioning
4. Sexual health care and safer sex
5. Challenges
6. Body image
7. Masturbation and fantasy
8. Positive sexuality intimacy and relationships
9. Spirituality


Change will occur if the perceived susceptibility of contracting the disease is high, when severity is high (for example, the chance of dying after contracting the
The Sexual Health Model defines 10 key components portrayed to be significant attributes to constitute a healthy sexuality. They are: talking about sex; culture and sexual identity; sexual anatomy and function; sexual health care and safer sex; challenges to sexual health; body image; masturbation and fantasy; positive sexuality; intimacy and relationships; and spirituality (Robinson et al., 2002). In order to apply the model successfully, it is important to consider the significance of the background of the target populations.

Background characteristics include sociocultural factors, interpersonal relationships, or individual history (Robinson et al., 2002). These background characteristics affect one's sexuality in terms of sexual satisfaction, functioning, and communication, as well as STI risk-reducing outcomes such as attitudes towards condoms, intentions to use contraception, and committing to a monogamous relationship (Robinson et al., 2002). The most effective manner of changing one's perceptions is to know how to direct the knowledge in a manner simple to apply and comprehensive to the member of the target population (Robinson et al., 2002).

A potentially valuable use of the model could be applied in school to provide a better foundation for those not yet sexually active or beginning to experiment. In order to employ the Sexual Health Model, the specific needs and attributes of the target group, in this case adolescents in schools, must first be gathered (Robinson et al., 2002). Questionnaires and focus groups can be used to gain insight into which of the 10
dimensions within the model the target groups have the least amount of knowledge and by which they are most affected.

The gathered information used to customize the model connects with relevance the target group and its specific concerns. For example, if group discussions and surveys suggest difficulty in discussing sex between partners, topic areas of contraception use and disclosure are implemented as needed. With the information inputs the customized model deals more with the issues of concern to a particular group. The Sexual Health Model can be applied to a number of contexts such as medical training programs, Sexual Attitude Reassessment (SAR) seminars, in universities, and, most importantly, in schools, as part of the curriculum. Those groups who apply this model, as part of their sexual health education, should seek to motivate and empower individuals to not only learn about their sexuality but to use that new knowledge in adopting safer and more responsible sexual habits (Robinson et al., 2002).
A Modern View to Treatment: What Clinicians Need to Know

Clinicians are responsible for the identification and treatment of lesbian sexual health issues and concerns. Dandeneau and Fontaine (1996) reported that it was the duty of researchers and theoreticians to move society to a greater understanding of the issues, and that without their involvement lesbians will continue to be ignored and misunderstood. Petersen, Shrader, Hutchings, and Brake (2011) argued there is a need to integrate health care in diverse populations by: improving access to treatment, information, and referrals; changing behavioral practices that affect disease; and improving the cross cultural interface, treatment for the medically disenfranchised: and diagnoses and adherence in general. Research in the field suggests a lack of sensitivity training and limited experience among graduate mental health professionals with gay and lesbian clients. This is an interesting dilemma if lesbians are willing to seek help and get treatment (Petersen, Shrader, Hutchings, & Brake, 2011).

The lack of awareness that society exhibits, with respect to lesbian health, indicates the need for further studies and implementation of services that reach and treat lesbians affected by sexual health issues. Specifically, in the mental health field, there is a need for thorough professional development to build the skills and competency needed to work with lesbians. Historically, abuse has been invisible to those within the lesbian community and to those viewing it from the outside. Information and data have been gathered from studies done in the last ten years; however, society has made necessary adjustments to provide care and education to reduce prevalence rates of STIs and improve the lesbian’s quality of life (Petersen, Shrader, Hutchings, & Brake, 2011). Research indicates that heterosexism and lack of training concerning its manifestations
and effects obstructs lesbian sexual health services (e.g. Clinicians have a standard talk that begins with contraception methods without making a sexual orientation and needs inquiry or determination).

Lesbian women have reported in various researches that clinicians and physicians appeared to have a lack of knowledge regarding lesbian sexual health issues. There needs to be an open discussion about the reasons for the lack of sexual health discussions with clinicians and mental health professionals. There is a need for the lesbian community to be educated in visiting the local Planned Parenthood, or other appropriate medical centers, for regular gynecological care (Petersen, Shrader, Hutchings, & Brake, 2011).

Marrazzo, Coffey, and Bingham (2005) emphasized throughout their study that there is a need to design interventions to prevent the sexual transmission of vaginal fluid between women. The belief is that the risk of STI transmission between women continues to be low; therefore, interventions need to include educational information explaining the risks (i.e. how transmission occurs in lesbian women). Lesbians may not only underestimate the risk of STI with women but also underestimate the risk derivable from sex with men in the past.

The knowledge clinicians are able to convey to their clients should include interventions that focus on themes of personal responsibility, care for partner’s well-being and health, and focus on a range of common sexual practices, such as “digital-vaginal” penetration and use of vaginally inserting sex toys. In addition, interventions should be framed in sexual enjoyment and healthy sexual terms, rather than in terms that suggest prevention of disease.
Marrazzo, Coffey, and Bingham (2005) ascertained that women who identify themselves as lesbians often do not disclose their sexual behavior or orientation to physicians when they seek care, as they fear negative reactions. This places women at risk for delayed detection of cervical cancer, as they may be reluctant to get an annual Pap smear screening. There is a serious concern involving a lack of sensitive health care that includes knowledge specific to lesbian health concerns and to sexual practices as they relate to risk of STI transmission between women. Health care professionals should seek continual education in attitudes, knowledge, and practices in providing care to lesbian women. Hunt and Fish (2007) surveyed lesbian and bisexual women’s health needs in Europe. Their data supported previous research and studies demonstrating that health care professionals lack knowledge of lesbian health needs, where only one in ten lesbian and bisexual women said that health care workers had given them information relevant to their sexual orientation and only one in five lesbian and bisexual women had been told that they did not need a Pap smear test (Hunt & Fish, 2007).

Hunt and Fish (2007) recommend that physicians and clinicians train staff and agency personnel in anti-discrimination policies that includes how to refrain from inappropriate comments or questions about sexual orientation. For example, in the Stonewall study, one in fifty, equivalent to 37,000 lesbian and bisexual women in the United Kingdom, were refused a Pap smear test despite requesting one. There needs to be explicit uniform policies for clinical settings that protect lesbian couples from capricious practices. For example in the Hunt in Fish study, one in eight lesbians was told that their partner could attend consultations, and one in eleven reported that their physician's office displayed a non-discriminatory policy. In addition, there needs to be improvements in
client care as many lesbians reported that healthcare workers either ignored them, or continued to assume that they were heterosexual, with only one in fourteen given an opportunity to come out as lesbian or bisexual (Hunt & Fish, 2007). Hunt and Fish (2007) revealed the need to increase visibility to allow women to discuss their health issues with a health care worker. Confidentiality policies and complaint procedures need to be clear and more effective, perhaps, as six percent of lesbian and bisexual women identified incidents of health care workers making inappropriate comments after revealing their sexual orientation. Individualized and tailored services need to be developed, as it was discovered that only two percent of lesbian and bisexual women have attended a service tailored towards their needs and, three quarters of lesbian and bisexual women reported being too scared to get tested for STIs (Hunt & Fish, 2007).

In conclusion, little research has been done on lesbian knowledge and attitudes toward personal safety and STIs. The problem is compounded by the facts that those infected are often unaware and society tends to limit the extent of health care people seek. The disease is more detrimental to the anatomy of a woman than that of a man, as other diseases such as cervical cancer can develop as a result of genital herpes in women. Furthermore, the state of limited research warrants the assessment of LGBT youth knowledge and attitudes. With increased research, members of this population can learn to change their behavior to reduce the spread of disease, perhaps to eradication negative and unhealthy risky sexual behavior. The Sexual Health Model focuses on individuals most at risk with education most relevant and needed for cultivating sexual health. Increased system-wide education will help create a safe global environment where lesbian women can express their sexuality in satisfying and safe ways.
References


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Lesbian Sexual Health


