Bisexuality: The Invisible Sexual Orientation in Sexual and Reproductive Health Care

L. E. Ross

Lori E. Ross, PhD;[1] Jennifer M. Goldberg, RM;[2] Corey E. Flanders, PhD;[3] Abbie E. Goldberg, PhD;[4] Mark H. Yudin, MD, MSc[5]

[1]Division of Social and Behavioural Health Sciences, Dalla Lana School of Public Health, University of Toronto, Toronto, ON

[2]Division of Clinical Public Health (Family and Community Medicine), Dalla Lana School of Public Health, University of Toronto, Toronto, ON

[3]Department of Psychology and Education, Mount Holyoke College, South Hadley, MA

[4]Department of Psychology, Clark University, Worcester, MA

[5]Department of Obstetrics and Gynecology, St. Michael's Hospital and University of Toronto, Toronto, ON

J Obstet Gynaecol Can 2018;40(8):1057–1060

https://doi.org/10.1016/j.jogc.2018.02.022

Sexual minority women* (including, but not limited to, women who self-identify as lesbian, bisexual, or another non-heterosexual identity and/or engage in same-sex sexual behaviour) have specific sexual and reproductive health needs that are relevant to the practice of obstetrics and gyneacology.[1–7] However, there has been very little study of sexual minority women relative to heterosexual women in the field of obstetrics and gynaecology, and the SOGC's most recent policy statement on sexual orientation was published in 2000.[2] The title of this statement, "Lesbian Health Guidelines," points to another significant limitation in our knowledge about the sexual and reproductive health needs of sexual minority women: the focus of existing research, practice, and policy in this area has almost exclusively been on lesbian-identified and/or female-partnered women, to the exclusion of bisexual women. This focus, while reflective of the field of medicine as a whole,[8] represents a serious gap, considering that across a variety of population-based surveys in a number of countries, there are more bisexual women than there are lesbians.[9] For example, data from the Canadian Community Health Survey (2003 and 2005) indicate that 0.8%, or 71 000 Canadian women self-identify as lesbian, compared with 0.9%, or 85 000 Canadian women who self-identify as bisexual.[10] Further, this is an especially serious gap among women of reproductive age or potential considering that many more bisexual women than lesbian women desire and/or have children.[11] For example, one US-based survey found that 59% of bisexual women reported having children, compared with 31% of lesbians.[12] The objectives of this commentary are, therefore, to increase knowledge and awareness about bisexuality among providers of sexual and reproductive health care, share information about health disparities for bisexual women, and provide strategies for integrating this knowledge into clinical practice.

Corresponding Author: Dr. Lori E. Ross, Division of Social and Behavioural Health Sciences, Dalla Lana School of Public Health, University of Toronto, Toronto, ON. E-mail: l.ross@utoronto.ca

Competing interests: The authors declare that they have no competing interest.

Received on December 20, 2017

Accepted on February 25, 2018

*Although our focus in this commentary is on cisgender women who seek sexual and reproductive health care, we acknowledge that people of other genders, and particularly trans men and non-binary people, will also access these services. There are unique considerations in the delivery of appropriate care to these groups that are unfortunately beyond the scope of our commentary; however, we invite the interested reader to refer to SOGC's forthcoming Gender-Inclusive Language Policy[36] for more information.

Sexual orientation can be defined on the basis of self-identity (e.g., bisexual, lesbian), sexual behaviour (i.e., sex of one's partners over a particular time frame), or sexual attraction (particularly in studies of youth).[13,14] These three definitions of bisexuality overlap imperfectly[15]; for example, across studies, we see that many heterosexual-identified women report at least some lifetime same-sex behaviour[16,17] and, therefore, could be classified as either heterosexual (based on identity) or bisexual (based on sexual behaviour). Further, these discrete categorizations of sexual identity have been critiqued, and there is evidence of substantial fluidity in women's self-identities and sexual behaviours across the lifespan.[13]

Bisexuality is uniquely invisible in the health care context. Particularly in the context of sexual and reproductive health

care, when women present with primary male partners, they are often presumed to be heterosexual (at the same time, bisexual women who present with female partners are often assumed to identify as lesbian). Further, health care providers may presume that only the gender of one's current primary partner—and not one's sexual orientation identity or history of sexual behaviour—is relevant to the care to be provided. However, there is ample evidence that bisexual women in particular are at elevated risk for a variety of poor health outcomes, relative not only to heterosexual women but to lesbians as well.[18] This research reveals significantly higher rates of depression, anxiety, and suicidality (among other outcomes) in bisexual women compared with women of other sexual orientations.[19] However, there is some limited evidence that bisexual women are at elevated risk for a variety of poor sexual and reproductive health outcomes as well. For example, analysis of data from the US National Survey of Family Growth (2002) indicated that bisexual women were substantially more likely than other groups to self-report having had a viral sexually transmitted infection (STI) in their lifetime.[20] When identity-based definitions of sexual orientation were used, 17.2% of bisexual women, 8.8% of heterosexual women, and 2.3% of lesbians reported a lifetime viral STI.[20] Other population-based research has found that bisexual women report earlier sexual debut and greater rates of emergency contraceptive use and pregnancy termination compared with their heterosexual and lesbian peers.[21] Further, bisexual women access preventative sexual and reproductive healthcare (e.g., recent Pap testing) at lower rates than heterosexual women[22] and are more likely than women with only male partners to report an abnormal Pap test result.[23] It is notable that some of these conditions for which there is evidence for disparities can be prevented or ameliorated with early intervention; as such, identifying bisexual women as potentially at risk for these health concerns could facilitate delivery of appropriate prevention/intervention to alleviate or ameliorate these health disparities. In summary, bisexuality has significant implications for provision of health care, including care for sexual and reproductive health, but typically remains invisible without specific action on the part of the health care provider.

We propose three main actions that providers can take to make bisexuality visible in their practice and, in turn, to ensure that their bisexual patients receive optimal health care:

1. Providers can **explicitly invite their clients to disclose their sexual orientation and sexual behaviour**, including on clinic forms that allow for self-identification. Indeed, the recent revision of the Ontario Perinatal Record includes a space to record the patient's sexual orientation, confirming its relevance to the provision of perinatal care.[24] Patient intake forms and interviews are also opportunities to ask questions about sexual orientation using a simple question such as, "How would you identify your sexual orientation?" Although some patients may choose not to disclose when first asked (particularly if this is their first encounter with a new provider), explicitly asking these questions indicates to patients that the information is relevant to their health care and will not be stigmatized, potentially facilitating self-disclosure later in the clinical relationship. Many providers have not had access to training and support to develop tools and strategies for asking their patients about sexual orientation; however, some excellent guidance documents are publicly available.[25–27] Still other documents are available to help providers understand the context of sexual minority people's reproductive lives, and thereby increase provider confidence in asking these questions.[28,29] It is important to note that for questions about sexual orientation to have their intended effect (i.e., to permit preventive interventions among potentially at-risk populations), all patients, and not only those the provider suspects may identify as a sexual minority, must be asked. This is particularly relevant for bisexual women, in that many of them will present for sexual and reproductive health care with a male primary partner and, thus, may be presumed to be heterosexual.
2. Providers can **create a clinic space that facilitates self-disclosure of sexual identity** (i.e., implicitly and/or explicitly sends messages that client self-disclosures will be welcomed and treated respectfully). Again, various guidance documents are available on this point,[30] but key elements include representation of a diversity of relationship and family structures in clinic imagery and use of non-heterosexist language (e.g., partner in place of husband/wife; parent in place of mother/father) in clinic forms, such as intake forms that patients are asked to complete upon a first visit. Note that although many bisexual women partnered with men are able to fit their experiences into the language of a heterosexist form, they too perceive such forms as signals that their disclosure of a non-heterosexual identity will not be welcomed, and indeed, the perception of a bisexual-unfriendly environment could lead them to switch providers.[31]
3. Perhaps the most significant action providers can take to support the health of their bisexual patients is to **examine and address relevant assumptions that can profoundly impact the quality of sexual and reproductive health care delivered**. There is ample evidence that bisexuality is associated with intense stigma and specific forms of discrimination.[32] Further, there is some evidence that health care providers, like others in society,

have sometimes internalized these assumptions in ways that limit the care they can provide to their bisexual patients.[33] Primary among these is the belief that bisexuality does not exist, which leads to the assumption that all women partnered with men are heterosexual and, in turn, that all women partnered with women are lesbians. Providers can work to interrupt this assumption when they meet new patients and create space for disclosure of a bisexual orientation. Providers can also educate themselves about bisexuality to address other prominent (and discriminatory) assumptions about bisexuality, such as that it is not a stable, healthy, long-term sexual identity.[34,35] Training opportunities are available to help providers establish competency in understanding and meeting the health needs of their bisexual patients (for example, in Ontario, through Rainbow Health Ontario).

By addressing these issues in clinical practice, providers can work to ensure that *all* sexual minority women receive equitable sexual and reproductive health care, and in so doing, work towards elimination of the health disparities experienced by bisexual women.

Acknowledgements

This commentary has been informed by insights from the Postpartum Well-Being Study, which was supported by the National Institutes of Health under Grant R01MH099000 (awarded to L. Ross & A. Goldberg). The authors wish to thank the participants and staff of that study, as well as CiCi Guo for assistance in manuscript preparation.

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