A woman who has sex only with women, and who has a history of no other risks for HIV infection, and whose sex partners have no other risks, is at extremely low risk of becoming infected with HIV. However, women who have sex with women may also engage in other risk behaviors, and prevention messages have often overlooked this fact. As a result, women who have sex with women may incorrectly assume that their female partners have no other HIV infection risks.

In fact, in a community-based sample of 498 women in Northern California—77 percent of whom identified as lesbian, and 16 percent as bisexual—three-quarters of those surveyed reported having had sex with men in the previous three years. Of these, 40 percent reported having engaged in unprotected vaginal or anal sex with men during this period. The survey also found that 10 percent of all survey participants reported having injected drugs in the previous 15 years, and 71 percent of these women reported a history of sharing needles.

Studies have also found that women who engage in sex with both women and men were more likely to engage in high-risk behaviors or activities that can lead to high-risk behaviors—such as injection drug use, sex with bisexual men, and sex with men who inject drugs—than women who engaged in sex only with men.

In a study of eight sexually transmitted disease (STD) clinics in Los Angeles County, 13 percent of the women who identified as bisexual, compared to six percent of women who identified as heterosexual, reported having had anal sex with male partners. In another study of women at high risk for HIV infection, 48 percent of those who reported having had sex with both men and women, compared to 12 percent of the women who reported having sex only with men, had exchanged sex for money or drugs.

While the risk of HIV transmission during sex between women is extremely low, women who have sex with women may engage in other behaviors, such as injection drug use and unprotected sex with men, that put them at high risk for infection. It is essential, therefore, that test counselors assess the full range of clients’ risk behaviors.

This issue of PERSPECTIVES explores risk issues that may affect women who have sex with women. The Implications for Counseling session underscores the value of “client-centered” counseling sessions that focus on understanding each client and each client’s particular risks and concerns.
Infection Rates

Several studies of women in high-risk populations found that women who had sex with both men and women had higher sero-prevalence rates than women who had sex with men only.5,6 One high-risk sample of female injection drug users found an HIV sero-prevalence rate of 15 percent among those who identified as lesbian, compared to a rate of 13 percent for women who identified as bisexual, and 11 percent for those who identified as heterosexual.7

Studies of women who either have sex with men or use injection drugs in addition to having sex with women, report high rates of unsafe behavior. For example, in a study of women who identified as lesbian, of those who had engaged in anal intercourse with men since 1980, less than 10 percent had always used a condom.8 Reasons for this include the absence of prevention messages targeted to women who have sex with women and men, and the fact that women in this population may engage in sex with men with less frequency and therefore not adopt a habit of condom use.

In addition, service providers anecdotally report that injection drug users are more likely to share needles with women who identify as lesbian than with those who do not identify as such.9 Reasons for increased sharing may be based on the incorrect belief that lesbians are not infected with HIV and, therefore, that sharing is not unsafe.10

Transmission is Attributed to Unsafe Sex with Men or Injection Drug Use

In nearly all studies, researchers attribute cases of HIV infection among women who have sex with women to unsafe sex with a male partner or to injection drug use. Researchers conducting studies that include a large number of women who are infected with HIV report finding no clinical or statistical evidence of transmission between women during sex.11, 12, 13

Among the studies is one of 960,000 women—144 of whom had tested HIV-positive—that found no evidence of sexual transmission between women.14 Of 106 HIV-infected women in the study whom researchers interviewed, none reported having sex exclusively with women since 1978.

Large studies of women who have a history of sex only with women find no cases of HIV infection that cannot be attributed to higher risk behaviors. In a study of 164 women with AIDS who reported having sexual contact only with women since 1977, 93 percent reported injection drug use and 7 percent reported receiving a blood transfusion since 1985.15 A survey of nearly 500 women who identified as lesbian or bisexual found that all of the six women who were seropositive reported a history of injecting drugs or having sex with men.16

Related Issue: Estimating the Number of Women Who Have Sex with Other Women

Researchers have struggled in their attempts to study the number of women who engage in sex with women or identify as lesbian or bisexual. The work is made difficult by several factors. For instance, social stigma may inhibit lesbians or bisexuals from coming out. As a result, researchers have reported wide-ranging results.

Findings from a Kinsey Institute study in the 1940s, which continues to be cited, showed that 10 percent of men identified as having been “more or less exclusively homosexual” for at least three years of their adult lives.30 The survey did not measure same-sex behavior between women. Using the findings as a guide, however, researchers in more recent years have suggested that about 7 percent of women at some point in their lives consider themselves lesbian or bisexual.31, 32

About 9 percent of adult women in a recent survey reported having some experience of homosexuality in their adult lives, with experiences ranging from sexual feelings to behaviors.33 In the survey, 4.3 percent of women reported having engaged in same-gender sexual behavior since puberty and 1.4 percent identified themselves as lesbian or bisexual. These findings have been disputed by other researchers and gay rights activists.

In the United States, studies show that urban areas have higher percentages of women who identify as lesbian and bisexual than rural areas. In a study of women in the 12 largest U.S. cities, 2.1 percent of those surveyed reported having had sex with a woman in the past year, while in rural areas, .6 percent reported this.34 Researchers attribute a higher urban concentration of women who identify as lesbian or bisexual to greater acceptance, less scrutiny, and the existence of established lesbian communities in those areas. This may lead women to feel safe enough to express their sexuality openly.
Related Issue: Understanding Self-Identification

Many factors affect the way people define their sexual orientation or identity. Thirty-eight percent of lesbian and bisexual women interviewed in one study believed that revealing their sexual orientation would adversely affect the delivery of health care services they receive.\textsuperscript{28} Other surveys have found that lesbian and bisexual women often receive “substandard” care or are denied care.\textsuperscript{29} Other factors that may prevent women from being open about identifying themselves as lesbian or bisexual include concerns about employment, housing, child custody discrimination, and social stigma.

Societal discrimination and prejudice against homosexuals and one’s own internalized homophobia or denial can affect how a person identifies to oneself or to others. Discrimination and homophobia, which refers to irrational fear of or dislike of homosexuals or homosexuality, can affect views toward HIV transmission risks and the risks a person takes. For instance, a woman might engage in sex with other women, yet not identify as lesbian. Because of this, she may not recognize risks of sex she has with other women. Shameful feelings that a woman may attach to homosexual or bisexual identity— but which may actually be a result of societal oppression—can also lead to low self-esteem and harmful behaviors such as unsafe sex.

Some people underestimate or overestimate their risks because they focus not on the risks of specific behaviors, but on risks they associate with certain people, based on sexual orientation.

Understanding Terms

The terms “lesbian” and “bisexual” have many connotations. People may use these terms for any of a variety of purposes: to define specific sexual behaviors; to define sexual identity, regardless of a person’s behaviors; and to define social, political, or cultural identity or the communities to which a person belongs.

Health care professionals generally apply broader, more useful definitions when considering sexual behaviors. They often use the term lesbian to describe a woman who engages in sex primarily or exclusively with women either currently or in the past. They use the term bisexual to describe women who engage in sex with either women or men, without regard to whether a person primarily engages in or has engaged in sex with men or with women. Because of the broadness of these definitions, they may overlap.

As a result, they say, lesbians may perceive themselves invulnerable to HIV infection regardless of their risk behaviors, including non-sexual behaviors like injection drug use. In addition, HIV prevention programs, failing to recognize the spectrum of issues in a person’s life, do not develop effective interventions. And, some clinicians fail to identify symptoms of HIV infection among lesbians and bisexual women.

A prospective study involving HIV risks and women who had sex only with women followed 18 couples in which one partner was infected with HIV and the other uninfected. Partners engaged in unprotected sex—defined as oral and oral-anal sex, including oral sex during menstruation, and sharing sex toys.\textsuperscript{17} After six months, none of the seronegative partners had seroconverted.

Concerns

Researchers conclude that the risk of transmission from sex between women is very low. But, they do not rule out the possibility of risk.

Additionally, providers of women’s health services state that documentation of cases is “nearly impossible” because the Centers for Disease Control and Prevention (CDC) does not record woman-to-woman sexual behavior as an “exposure category” for HIV transmission.\textsuperscript{18} And, for the purpose of HIV reporting and prevention efforts, the CDC classifies as lesbian only those women who have had sex exclusively with women since 1977. This excludes any woman who has had sex with a man even once.

Some researchers also question the usefulness of some of the existing research studies, stating that such studies may “mask” transmission from sex between women.\textsuperscript{19} Studies typically attribute cases of female HIV transmission to sex with men or injection drug use, based on the fact that the elevated risk of these behaviors is so well-established.\textsuperscript{20,21}

To support the possibility of transmission, some researchers state that other infections can be transmitted between women. For example, a study of bacterial vaginosis, an STD, demonstrated transmission of this infection between women through the exchange of vaginal secretions.\textsuperscript{22}

Case reports also prompt attention to the issue. Medical literature as early as 1984 reported a case of HIV infection in a woman who had
sex with women, but who had no other identified risk behaviors. There are also other case reports on the subject. HIV service providers and some women with HIV infection also assert that there are unpublished cases in which sexual behavior with women was the only risk.

Possible Risks from Sex Between Women

While researchers consider the probability of infection to be extremely low compared to other behaviors such as injection drug use or unprotected penis-to-anus sex, sex between women can involve contact with vaginal or cervical fluids or with blood. It can, therefore, pose a possible risk for HIV infection. Sexual behaviors between women that can involve such contact include: oral sex; vaginal and anal intercourse involving fingers, hands, or fists; rimming, oral-anal contact; the sharing of dilators and other sex toys; whipping, piercing, or clamping, which refers to applying a clamp device to nipples or genital areas to produce a pinching sensation. These are also behaviors that women—regardless of sexual orientation—may engage in with men or that men may engage in with other men.

Oral sex between women, which refers to mouth-to-vulva contact, poses a possible risk of HIV infection because it can involve the exchange of infected blood or secretions from the vagina to the mucus membrane of the mouth. Risk becomes much higher during menstruation. Vaginal or anal intercourse can involve contact between cuts on the fingers or hands and blood or secretions from a partner’s vagina or anus. Rimming can put a person at risk for HIV, other STDs, and parasites through contact with feces and blood. Contact with blood may occur through cuts in a person’s mouth, cuts in or around the anus, or blood in feces.

Whipping, clamping, and piercing, can involve contact with blood or vaginal secretions. A person may, for instance, draw blood by sucking or biting on a partner’s nipple or on a genital clamp. Sharing needles, for example when piercing or tattooing the skin, is an especially high-risk behavior. Infection risks of any of these behaviors are highest when barrier protections are not used or when objects are shared.

Women can reduce or eliminate risks through several means, such as wearing latex gloves for vaginal intercourse with hands or fists, using latex dams for oral sex, and cleaning and applying condoms to shared sex toys, when possible. In addition, women can reduce their risks by ensuring that partners are free of cuts, scratches, or sores on the hands or fingers or in the vaginal or anal area.

Implications for Counseling

Regardless of whether a client identifies as heterosexual or homosexual, it is important to avoid assumptions about the gender of a person’s current or former sexual partners or other risk behaviors.

In performing a risk assessment of female clients who have sex with women, it is especially important to be aware of the broad range of risks clients may face. The label “lesbian” and its mistaken aura of invulnerability to HIV transmission has led many counselors to dismiss the fact that these clients may have engaged in unsafe sex with men and unsafe drug injection, either in the past or present, and to dismiss the possible risks of sex between women. Recognize that studies show that women who engage in sex with both women and men may have significantly high rates of unprotected sex with men. Risk assessments must, therefore, involve questions about behaviors that may appear to some to be inconsistent with the client’s identified sexual orientation.

Sex with Men and Injection Drug Use

Women who identify as lesbian and also engage in sex with men may not readily disclose that they have had sex with men. They may be uncomfortable disclosing this for various reasons. For instance, they might believe that such sexual behavior negatively affects their identity as a lesbian; they may not readily recall sexual experiences with men; they may not view their sex with men as being risky; or they may not consider such sexual behavior to be “authentic” sexual expression.

Women may identify as lesbian and engage in sex with men for the purpose of conceiving a child. They may also have contact with male semen, and therefore potential HIV risk, when they undergo donor insemination to conceive a child.

Ask clients if they have injected drugs in the past or if they currently inject drugs. Recognize that few education or prevention efforts have focused on sexual behavior of female injection drug users who have sex with women or with women and men. As a result, women who inject drugs may be aware that this is an unsafe behavior, but unaware of their own risk of becoming infected or infecting others through sharing needles or having unprotected sex with women.

Be aware that women who report that they are heterosexual or engage in sex only with men may actually have a history of sex with women. Be alert to the possibility that a client in a primary relationship with a man may have unpro-
Cultural Competence

Some counselors may find it challenging to talk about sexual behaviors between women. These counselors may feel they lack appropriate knowledge; they may feel uncomfortable with such discussion; they may believe clients will not be open to counseling intervention; they may be expressing homophobic beliefs; or they may incorrectly assume that women who have sex with women already know about their risks. When counselors recognize resistance or fear in themselves, it is important to explore the reasons for these responses and to acknowledge the responsibility to provide competent counseling about both same-sex and opposite-sex behaviors. It may be useful to discuss these issues with colleagues in staff meetings or with a supervisor.

Counselors do not need to be experts to discuss sexual behavior but they do need a basic understanding of the topic. There is nothing about sexual behavior between women that necessarily requires “special” skills-based training any more than a counselor needs special training to discuss sex between women and men, or between men. But, counselors must be open to considering their own biases about women who engage in sex with women and women who identify as lesbian or bisexual. Counselors who feel they lack knowledge about sexual behavior in general or about sex between women in particular, or counselors who want to explore further their own feelings of others’ sexual identity and behaviors, can attend diversity trainings or inservices on human sexuality, read about the subject, talk with other counselors who are versed on the subject, and listen to clients’ experiences.

Sex Between Women

Recognize that a woman who has sex only with women, and who has a history of no other risks for HIV infection, and whose sex partners have no other risks, is at extremely low risk of becoming infected with HIV. However, be aware that there are women with HIV who have sex with other women.

When discussing sexual behavior between men or between men and women, counselors have clearer information about HIV transmission rates and cases of transmission. For instance, when discussing unprotected anal sex between men, counselors can explain that there are thousands of cases of HIV transmission attributable to this behavior. This information can help motivate clients to avoid unprotected anal sex.

For sexual behavior between women who have no other risk factors, however, there are only isolated anecdotal reports of transmission and, hence, little compelling information to support anyone in avoiding certain behaviors. The lack of cases clearly attributable to sex between women may lead counselors and clients to dismiss or deny the reality that sex between women can pose possible risks. Be careful not to collude with a client’s belief that they have absolutely no risk of HIV infection through sex with women.

Review specific risk behaviors and the fact that contact with body fluids such as vaginal or cervical secretions or blood can pose a risk. Ask questions about specific behaviors, including oral sex, contact involving fingers or hands, and the use of sex toys such as dildos and vibrators. Recognize that sexual behaviors between women may include all the behaviors of sex between women and men, except activities that involve the penis.

Ask about clients’ views toward or experiences with other STDs as a result of having sex with women. They may feel they are at risk of other STDs and may be motivated to avoid unsafe behaviors for this reason. Help clients gain an awareness of risks for STDs other than HIV, including chlamydia, yeast infections, and herpes. Point out that most STDs are transmitted through the same behaviors as HIV infection.

While the risk of oral sex is generally considered to be very low, review a client’s oral sex behaviors. Explain that the risks of becoming infected with HIV or other STDs increase when the recipient is menstruating, has a vaginal infection, or has open sores or blisters. Risk also increases if the partner performing oral sex has sores in her mouth. Ask about precautions the client takes to reduce risks. For instance, does she refrain from flossing or brushing her teeth immediately before sex? Explain that oral-anal sex can put a person at risk for infection with parasites, various forms of hepatitis, and other diseases.

It may be useful to ask about the client’s views toward and experiences with barrier methods for oral sex and oral-anal contact. If the client appears open to discussion, explain the role of latex dams, plas-
tic wrap, and “lollies,” which resemble latex dams in size but are designed specifically for use during sex.

Explain that anal or vaginal sex involving hands, fingers, or fists may lead to contact with menstrual or other blood and vaginal and cervical secretions. Explain that risks increase when a person penetrates more than one part of one’s own or a partner’s body. Assess clients’ willingness to use protection methods such as gloves or finger cots, which are pieces of latex that cover a single finger, and what might make them feel more motivated to use these. Recognize that many people, men and women, do not use gloves or cots, and that there is no reason to expect women who have sex with women to be any more willing to use such protection than anyone else.

Explain that to reduce risks, it is important not to share sex toys, such as dildos, vibrators and anal plugs, without cleaning them or applying a new condom for each different use. People can clean sex toys using a solution of one part bleach to 10 parts warm water, followed by a thorough rinsing in water.

Acceptance of Risks

Assess how comfortable clients are with the risks they face and learn to what extent they may wish to change behaviors. Help clients consider what HIV infection risks, if any, they are willing to accept. As an example, a woman who has sex with both men and women may decide she is more comfortable engaging in a wider range of risk behaviors with female partners than she is with male partners. Or, a female client who has sex only with women may decide she is comfortable accepting the risks of some behaviors, such as inserting fingers into a partner’s vagina, but other risks are unacceptable, such as sharing sex toys

References

34. Lauman, 1994.
without cleaning them first.

The level of risk that clients consider acceptable may vary significantly for women who are aware that their partners—whether women or men—are infected with HIV.

Be prepared to discuss feelings clients may have about the lack of evidence of HIV transmission between women and the limited amount of research on the subject.

**Test Site Issues**

Recognize concerns women who have sex with women may have about visiting HIV counseling and testing sites. In urban areas, sites are often conveniently located to populations of gay men; these are not necessarily the same areas where large populations of lesbians or bisexual women live or visit. At counseling and testing sites, clients may notice an abundance of prevention literature for gay men or for heterosexuals, but little, if any, information targeted to women whose risks may include sex with women or sex with women and men. Validate concerns such as these. Make sure that relevant prevention literature is available for all clients and that public messages that affirm safer sex between women are as prominent as other safer sex messages.

**Positive Test Results**

Women with HIV infection, regardless of their sexual orientation, face numerous challenges such as receiving adequate medical care and other services, dealing with HIV-related medical conditions unique to women, finding a community of peers with HIV infection, and retaining custody of children. Additional challenges can apply to women who identify as lesbian or bisexual. These women may face isolation, discrimination from medical providers, and societal scrutiny about the manner in which they became infected.

When women who have sex with women test positive, explain to them the importance of support, and help them see that there are other lesbian and bisexual women living with HIV. Find referrals, such as women’s health clinics and lesbian- and bisexual-focused service agencies, that will be supportive of female clients regardless of their personal identity.

---

**Case Study**

*Linda is a 24-year-old who identifies as a lesbian, and is testing for the first time. She says she isn’t concerned about becoming infected, but is testing because her friends have discussed getting tested. She says she avoids engaging in oral sex when a partner is bleeding, but she doesn’t use barrier protection during sex with women. She says her knowledge about HIV risks comes mostly from what partners have told her.*

**Counseling**

Validate Linda’s decision to get tested.

To clarify Linda’s needs for information, ask her what she understands about HIV risks. Provide information about risks and discuss and explain any information that is unclear to her. Acknowledge, if appropriate, that there has been little education for lesbians about HIV infection risks, and so it makes sense that she might lack some of the facts.

Support Linda for her commitment to avoid oral sex when a partner is bleeding. Ask her how she came to this decision. Ask Linda to discuss other sexual behaviors she engages in with women. Discuss these and the possible contact with her partners’ blood or vaginal fluid that they might involve.

As with any client, ask about other possible risks. Ask whether Linda has engaged in sex with men and whether she has injected drugs. If she answers yes to either of these questions, explore these behaviors and the possible contact with her partners’ blood or vaginal fluid that they might involve.

If it becomes clear that her behaviors might pose a risk of infection, assess whether Linda understands this. If she does not, help her understand her risks. Ask her how she feels about learning that her behaviors might put her at risk. If she does not already recognize it, help her understand that for people who choose to be sexual, nearly any behavior can pose some risk for infection, and that it is up to each person to decide, based on accurate information, what level of risk is acceptable.

If she expresses concern about risks from her behaviors, learn what, if anything, she might want to do to reduce her risks. For instance, does she want more information? Does she want to change behaviors? If so, does she need help in making changes? Present her with options in terms of actions such as altering unsafe behaviors and asserting to partners her need to engage in safer forms of sex.

Provide referrals for more information or support. These may include support groups at women’s health clinics or support groups or individual support from agencies that specifically serve women who identify as lesbians or bisexual.
Test Yourself

Review Questions
1. The following are among the factors that affect women’s decisions to openly identify or “come out” as lesbian or bisexual? a) social stigmas attached to lesbians and bisexuals, b) fear of workplace discrimination, c) fear of how others will view them, d) any of the above may be true.

2. True or False: It is important to understand a person’s self-identification related to sexual orientation, but not to make assumptions based on this about the gender of a person’s sexual partners or about non-sexual risk behaviors in which a person might engage.

3. True or False: Once a woman identifies as a lesbian she will never have sex with a man again.

4. True or False: Women sometimes engage in cunnilingus while menstruating.

5. According to a recent study, what percentage of women with symptomatic HIV infection have had a female sexual partner? a) less than 1% b) results were too inconclusive to draw any conclusions, c) nearly all, d) 30%.

6. According to studies of adult women, a) 1 percent; b) about 10 percent; c) 80 percent; d) nearly 100 percent; report engaging in sex with women at some time in their lives.

7. True or False: Studies have found that women who reported having sex with both women and men were more likely than women who had sex only with men to have used injection drugs or engaged in sex with men who inject drugs.

8. True or False: Medical, psychological, and social concerns of women who have sex with women are no different from those of women who have sex only with men.

Discussion Questions
1. How can counselors respond when female clients who engage in sex with other women express feelings of being overwhelmed after hearing, perhaps for the first time, that transmission between women can occur?

2. How can counselors ensure that the counseling and testing site is one in which staff members clearly communicate that women who have sex with women are welcome?

3. How can counselors respond when clients express anger at the lack of prevention efforts for women who have sex with women, the conflicting messages about the risks of sex between women, and the lack of services for women with HIV?

4. How can counselors be careful not to collude with female clients who report that because they have sex only with women they have no risk for HIV infection?

Answers
1. D. Any of the above may be true.
2. True.
3. False. Women may identify as lesbian but engage in sex with men.
4. True.
5. D. 30%.
6. B. About 10%.
7. True.
8. False. Women who have sex with women may have different medical, psychological, and social concerns compared to women who have sex only with men.

Using PERSPECTIVES
PERSPECTIVES is an educational resource for HIV test counselors and other health professionals.

Each issue explores a single topic. A Research Update reviews recent research related to the topic. Implications for Counseling applies the research to the counseling session. Also included are a Case Study and two sets of questions for review and discussion.

HIV Counselor PERSPECTIVES Volume 5 Number 3 September 1996

Editor and Writer: John Tighe
Research and Writing Assistance: Lisa Allard
Primary Clinical Consultant: Marcia Quackenbush, MFCC
Clinical Consultants: JD Benson, MFCC; Jaklyn Brookman, MFCC; Michael Lee, LCSW; Robin Ortiz-Young; Patricia Sullivan, MFCC
Production: Kelly Costa
Administrative Support: Julie Balovich; Megan Carr; Jennifer Cohen; Cathy Hultin; Sandra Kriletich; Dorothy Stinnett

PERSPECTIVES is published six times a year and is distributed to HIV test sites. Any part of PERSPECTIVES may be reprinted, provided acknowledgment of the UCSF AIDS Health Project is included.

PERSPECTIVES is based largely on input from HIV test counselors and other health professionals, and is grateful for their involvement. Among those who contributed to this issue: Wendy Blank, Amber Hollibaugh, Lori Mier, Marj Plumb, Naomi Prochovnick.

Executive Director: James W. Dilley, MD
Publications Director: Robert Marks
Designer: Saul Rosenfield

For subscription information please contact: UCSF AIDS Health Project, Box 0884, San Francisco, CA 94143-0884. (415) 476-6430.

Printed on recycled paper.
DID YOU KNOW?

You can access a FREE searchable archive of back issues of this publication online! Visit http://www.ucsf-ahp.org/HTML2/archivesearch.html.

You can also receive this and other AHP journals FREE, at the moment of publication, by becoming an e-subscriber. Visit http://ucsf-ahp.org/epubs_registration.php for more information and to register!

ABOUT UCSF AIDS HEALTH PROJECT PUBLICATIONS

The AIDS Health Project produces periodicals and books that blend research and practice to help front-line mental health and health care providers deliver the highest quality HIV-related counseling and mental health care. For more information about this program, visit http://ucsf-ahp.org/HTML2/services_providers_publications.html.