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Views of Hospice and Palliative Care Among Younger and Older Sexually Diverse Women

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Abstract

The aim of the present study was to explore end-of-life health care attitudes among younger and older sexually diverse women. Self-identified lesbian and heterosexual older women as well as lesbian and heterosexual middle-aged women were recruited. Results indicated that lesbian women held significantly more positive beliefs about hospice services and the role of alternative medicines in health care. No differences among sexual orientation were found for comfort discussing pain management but heterosexual women reported a significantly greater desire for life-sustaining treatments in the event of an incurable disease and severe life-limiting conditions (eg, feeding tube, life support, no brain response). Additionally, as expected, older women in this study held more positive beliefs about hospice and more comfort discussing pain management than middle-aged women.

Keywords

hospice, palliative care, LGBT, aging, sexual minority, death and dying

The goals of palliative and hospice care are to achieve the best quality of life for patients during the dying process and to assist their families with direct care needs while saying goodbye to their loved one. According to recent data published by the National Hospice and Palliative Care Organization,[1] an estimated 1.56 million patients received services from a hospice team in 2009, with 83% of these hospice patients aged 65 years old or older and 38% aged 85 years old or older. The vast majority of patients (81%) were European American and as such, important research efforts have focused on understanding this disparity. These efforts are part of a movement to understand how diversity impacts access to quality health care which is an ever-increasing value among professionals as our American society continues to diversify.

As a result, a solid foundation of information exists on attitudes, values, beliefs, issues of discrimination, and issues of access that may prevent ethnic and racial minorities from utilizing end-of-life health care.[2–11] However, relatively little information exists about sexual minorities and how their beliefs and culture influence end-of-life decisions. There is a very real need; by 2030, approximately 1 in 5 people will be 65 and older, and roughly 4 million of those will be lesbian, gay, bisexual, or transgendered (LGBT) persons. Furthermore, given that older women significantly outnumber older men, it is likely that a significant proportion of older members of the sexual minority population will be lesbian women.[12]

Despite the dearth of research examining attitudes of sexually diverse women toward hospice and palliative care, a body of literature exists regarding lesbian women's experiences and expectations for treatment within the traditional health care system. Lesbian women are described as remaining largely invisible with the literature documenting a variety of barriers for lesbian women in seeking health care and in communicating openly with their care providers. Most notably, these barriers include discrimination (homophobia and heterosexism), unequal treatment, feelings of exclusion, and lack of insurance.[13–22]

Recent research efforts indicate that many lesbian women, unsatisfied with the traditional medical system, choose to focus on complementary and alternative medicine (CAM) for treatment. Complementary and alternative medicine modalities include a wide variety of methods, often comprising of behavioral (eg, relaxation), manual manipulation (eg, types of massages, acupuncture, and chiropractics), and food supplement

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and botanical modalities (eg, vitamins and herbs). In an early study, Trippet and Bain[23] conducted a study of 503 women (78% who identified themselves as lesbian) and found that 38% of the lesbian women used natural modalities, including herbs and natural remedies. More recently, Mathews et al[24] collected information on CAM use as part of a survey of lesbian and heterosexual women's health (aged 20-86 years; *M* age = 43 years). Eighty-two percent of the entire sample reported CAM use and significant predictors of CAM use included a lesbian sexual orientation, less health-related worry, and perceived discrimination in health care settings. Bowen and colleagues[25] surveyed 150 community-dwelling sexual minority women (aged 24-69 years) and found that 68% of the women wanted access to an alternative provider and reported high levels of trust in both traditional and alternative providers. Therefore, it may be that with equal trust in both sciences, lesbian women may seek alternative medicine because they feel more supported by these providers than by their physicians.

Lesbian women's experiences and expectations for treatment within the traditional health care system may also be influenced by the generation in which they grew up and the zeitgeist of the times regarding sexual orientation. The older lesbian and gay population in the United States is estimated at 1.75 to 3.5 million.[26] Unfortunately, many older LGBT persons today have hidden their sexual orientation out of a very real fear of discrimination and persecution. In the United States, the political movement for gay liberation emerged in the late-1960s beginning with the Stonewall[27] riots on June 28, 1969. For many older persons today (60 years and older), this liberation movement occurred when they were already young adults, after years of hearing hostile messages of the immorality of their feelings, worrying what would happen if others found out, and feeling alone. Prior to Stonewall, those who did try to meet endured police harassment, entrapment, arrest, and public outing in the newspapers,[28] whereas currently middle-aged LGBT persons grew up in era after Stonewall when "I" became "We." After Stonewall, there was a greater sense of LGBT community for those "coming out," increased education and activism for equal and fair treatment, and greater awareness and sensitivity in society which has progressively gotten better with time. Andersen and Fetner[29] explored how birth cohort, time, and country (United States and Canada) interact in their effects on attitudes toward homosexuality over a 20-year period and found that by 2000, public acceptance for homosexuality had increased significantly in both countries and within all cohorts. This is not to say that individuals who grew up post-Stonewall did not experience discrimination and stigmatization; however, most LGBT researchers and scholars recognize Stonewall as a pivotal event in PRIDE history, separating very private LGBT persons from less private LGBT persons.

Because sexual orientation and cohort are likely to influence attitudes toward hospice and palliative care, the purpose of the present study was to explore these attitudes and beliefs among sexually diverse middle-aged and older adult women specifically about pain management, hospice, and preferences for life-sustaining treatments. Based on the extant literature, level of health care system distrust and beliefs in CAM were also examined as other factors that may influence these women's decision to engage in end-of-life care health care services. We hypothesized that lesbians would have less favorable beliefs about hospice and pain management, a higher preference for life-sustaining treatments, and a more positive attitude toward CAM than heterosexual women. We also predicted that older women would have more positive beliefs about hospice and pain management but a lower preference for life-sustaining treatments compared to middle-aged women. Finally, we expected to see an interaction for health care system distrust such that older lesbian women would have significantly more distrust than older heterosexual women compared to the difference between the middle-aged groups.

Methods

Participants and Procedure

Self-identified middle aged and older adult heterosexual and lesbian women were recruited through undergraduate students at the University of Colorado at Colorado Springs (UCCS) who received extra credit for their recruitment of older adult family members or friends, through the UCCS Gerontology Center Participant Registry, through UCCS staff members, and through Colorado Springs, Pueblo, Boulder, and Denver Pride Centers' newsletters and events. Participants were asked to complete a self-report questionnaire in person or online exploring beliefs that may affect decision making at the end of life. Participants were classified into age and sexual orientation groups based upon self-report.

Lesbian older adult women (n = 30; 90% White) ranged in age from 60 to 81 years (mean [M] age = 66 years, standard deviation [SD] = 5.5 years) with a mean level of 18 years of education (SD = 2.5 years). Forty-five percent identified living alone. Their level of religiosity/spirituality was reported as follows: 20% very religious/spiritual, 60% somewhat, 13% not very, and 7% not at all. Thirteen percent rated their current health status as excellent, while 40% said very good, 40% said good, and 7% said fair. Eighty percent identified having a Living Will and 83% have a Durable Power of Attorney for health care.

Heterosexual older adult women (n = 31; 87% White) ranged in age from 60 to 77 years (*M* age = 64.8 years, SD = 4.6 years) with a mean level of 16.8 years of education (SD = 2.4 years). Thirty-nine percent identified living alone. Their level of religiosity/spirituality was reported as follows: 26% very religious/spiritual, 61% somewhat, 10% not very, and 3% not at all. Seven percent rated their current health status as excellent, while 55% said very good, 36% said good, and 3% said fair. Seventy-four percent identified having a Living Will and 67% have a Durable Power of Attorney for health care.

Lesbian middle-aged adult women (n = 35; 97% White) ranged in age from 35 to 59 years (*M* age = 50 years, SD = 7.3 years), with a mean level of 16.5 years of education (SD

= 2.7 years). Forty-three percent identified living alone. Their level of religiosity/spirituality was reported as follows: 27% very religious/spiritual, 47% somewhat, 9% not very, and 18% not at all. Fourteen percent rated their current health status as excellent, while 46% said very good, 26% said good, 9% said fair, and 6% said poor. Fifty-one percent identified having a Living Will and 54% have a Durable Power of Attorney for health care.

Heterosexual middle-aged adult women (n = 49; 88% White) ranged in age from 35 to 59 years (*M* age = 50.5 years, SD = 5.5 years) with a mean level of 16 years of education (SD = 2.5 years). Fifteen percent identified living alone. Their level of religiosity/spirituality was reported as follows: 22% very religious/spiritual, 45% somewhat, 18% not very, and 14% not at all. Twenty-five percent rated their current health status as excellent, while 31% said very good, 39% said good, and 6% said fair. Fifty-one percent identified having a Living Will and 41% have a Durable Power of Attorney for health care

Measures

Several questions within the measures were modified slightly to be inclusive of diverse sexual orientations. For example, questions about marriage were changed to marriage/partnership and questions about children were changed to loved ones. Several questions were also added to one of the measures to ask more specific questions about end-of-life care, as described below.

End-of-Life Care Questionnaire[8] is a self-report questionnaire developed at Duke University to assess beliefs that may affect decision making at the end of life. The original measure consisted of 6 sections and included questions taken or modified from previously developed measures. Respondents answer using a 5-point Likert scale ranging from *strongly agree* to *strongly disagree* for each of the scales. Sections of the questionnaire relevant to this study are described here. The Preferences for End-of-Life Care scale includes 8 statements exploring beliefs about the desire to live as long as possible with a terminal illness. Johnson and colleagues developed statements based on a review of the literature or with minor modification from the AARP North Carolina End-of-Life Care Survey, which was based on the Missoula Demonstrations Project's Community Survey.[30] Higher scores indicate a greater preference for life-sustaining therapies in the event of a terminal illness. Cronbach α for the scale was .71 in the original study. In the present full sample, Cronbach α was calculated to be .66, indicating adequate reliability. Calculated separately by sexual orientation, for lesbian women it was.63 and for heterosexual women it was .68. The Beliefs about Pain Management scale includes 8 statements exploring beliefs about using pain medications. These questions were taken or modified from the AARP North Carolina End-of-Life Care Survey and Reese's Hospice Barriers Scale.[11] Higher scores indicate greater comfort with discussing pain and pain medication. For this sample, Cronbach α was calculated to be .68, indicating adequate reliability. Calculated separately by sexual orientation, for lesbian women it was .63 and for heterosexual women it was .71. The Hospice Beliefs and Attitudes scale includes 8 statements examining attitudes toward hospice care, including desire for hospice care and beliefs about the type of care hospice provides. These items included some developed by Johnson and colleagues and others from the Hospice Barriers and Hospice Values Scales.[11] Higher scores indicate more favorable beliefs about hospice. Cronbach α for the scale was .74 in the original study. For this sample, Cronbach α was calculated to be .73, indicating adequate reliability. Calculated separately by sexual orientation, for lesbian women it was .69 and for heterosexual women it was .72.

Health Care System Distrust Scale[31] is a 10-item self-report scale with 4 items measuring honesty, 2 items measuring confidentiality, 2 items measuring competence, and 2 items measuring fidelity. Respondents answer using a 5-point Likert scale ranging from *strongly agree* to *strongly disagree*. Higher scores indicate greater distrust in the health care system. In the initial validation study, Cronbach α was .75 and item–total correlations ranged from .27 to .57. For this sample, Cronbach α was calculated to be .83, indicating good reliability.

Holistic Complementary and Alternative Medicine Questionnaire (HCAMQ)[32] is an 11-item self report questionnaire consisting of 6 items about attitude toward CAM items and 6 items about holistic health (HH items).

Items were selected to cover a wide range of content in each of these areas. Responses to each item are made using a 6-point Likert response format ranging from *strongly agree* to *strongly disagree*. A total score can be obtained as well as individual scores for CAM and HH. As the scale is designed, lower scores on the HCAMQ indicate more positive attitudes toward CAM and HH; however, to simplify the analyses for this study, higher scores will indicate more positive attitudes toward CAM. The HCAMQ has solid evidence of convergent and divergent validity.[32] For the current study, using the same response format, 3 questions designed specifically to understand how participants think about complementary and alternative treatment for hospice care and pain management were added to the end of the original measure. These included

1. If I were experiencing pain, I would seek out alternative medicine for treatment before going to a physician.
2. I would want my palliative and hospice care to incorporate complementary and alternative medicines.
3. If I were dying, I would rather utilize complementary and alternative medicines than traditional medical care.

Therefore, a total of 14 items were included under the HCAMQ section of the questionnaire packet for this study. For this sample, with the additional questions added, Cronbach α was calculated to be .81, indicating good reliability. Calculated separately by sexual orientation, for lesbian women it was .82 and for heterosexual women it was .80.

Table 1. Adjusted Means for Each Measure Across Sexual Orientation and Age

Scale	Sexual Orientation	Middle-Aged Women, *M* (SD)	Older Women, *M* (SD)	Total, *M* (SD)
Beliefs About Pain	Heterosexual	3.29 (.08)	3.57 (.10)	3.43 (.07)
	Lesbian	3.33 (.10)	3.75 (.10)	3.54 (.07)
	Total	3.31 (.06)	3.67 (.04)	3.49 (.05)
Hospice Beliefs	Heterosexual	3.74 (.08)	3.93 (.10)	3.41 (.06)
	Lesbian	3.94 (.09)	4.20 (.10)	4.07 (.07)
	Total	3.84 (.06)	4.06 (.07)	3.95 (.05)
Preferences for Care	Heterosexual	1.81 (.07)	1.76 (.09)	1.78 (.06)
	Lesbian	1.68 (.08)	1.55 (.09)	1.62 (.06)
	Total	1.74 (.05)	1.65 (.06)	1.70 (.04)
Health Care Distrust	Heterosexual	2.94 (.10)	2.91 (.12)	2.92 (.08)
	Lesbian	3.00 (.11)	2.76 (.13)	2.88 (.09)
	Total	2.97 (.08)	2.83 (.09)	2.90 (.06)
Alternative Medicine	Heterosexual	4.32 (.09)	4.29 (.11)	4.30 (.07)
	Lesbian	4.53 (.10)	4.52 (.11)	4.53 (.07)
	Total	4.43 (.07)	4.40 (.08)	4.14 (.05)

Results

Demographic variables for the heterosexual women and lesbian women were compared to assess the equivalency of the 2 sexual orientations at each age group. Among the older adults, orientations were not significantly different on level of education, $t_{59} = 1.37$, $p > .05$. Additionally, chi-square analyses revealed no significant differences on ethnicity, currently living alone, level of religiosity/spirituality, current health rating, having a Living Will, and having a Durable Power of Attorney (POA) for health care. Among the middle-aged adults, orientations were not significantly different on level of education, $t_{82} = 0.85$, $p > .05$. Chi-square analyses also revealed no significant differences on ethnicity, level of religiosity/spirituality, current health rating, having a Living Will, and having a Durable POA. The percentage of lesbian women and heterosexual women who currently live alone did significantly differ, $\chi^2 = 8.31$, $p < .05$, with more lesbian women living alone. However, living alone did not significantly correlate with any of the measures.

Demographic variables were also compared for the middle-aged and older women to assess the equivalency of the 2 age groups for each sexual orientation. Among the lesbian women, age groups were not significantly different on level of education, $t_{63} = 1.72$, $p > .05$. Additionally, chi-square analyses revealed no significant differences on ethnicity, currently living alone, level of religiosity/spirituality, and current health rating. However, the percentage of middle-aged and older lesbian women significantly differed on having a Living Will, $\chi^2 = 5.77$, $p < .05$ and having a Durable POA, $\chi^2 = 5.83$, $p < .05$. Older lesbian women had completed significantly more Living Wills and Durable POAs. Additionally, having a Living Will significantly correlated with the Beliefs about Pain Management total ($r = -.25$, $p < .05$) and Hospice Beliefs and Attitudes total ($r = -.28$, $p < .05$), and having a Durable POA significantly correlated with Hospice Beliefs and Attitudes total ($r = -.28$, $p < .05$). Consequently, these demographic variables were statistically controlled for in the following analyses to avoid potential confounds. Among the heterosexual women, age groups were not significantly different on level of education, $t_{78} = 1.32$, $p > .05$. Chi-square analyses also revealed no differences on ethnicity, level of religiosity/spirituality, and current health rating. However, the percentage of middle-aged and older heterosexual women significantly differed on currently living alone, $\chi^2 = 8.31$, $p < .05$, having a Living Will, $\chi^2 = 4.25$, $p < .05$, and having a Durable POA, $\chi^2 = 5.51$, $p < .05$. A greater number of older heterosexual women reported living alone, having a Living Will, and having a Durable POA. However, correlations revealed no significant relationship between these variables and the measures used.

Finally, the type of survey participants completed (paper copy vs online) significantly correlated with religious/spiritual faith total ($r = .20$, $p < .05$) and CAM total ($r = -.17$, $p < .05$). Those who completed a paper copy endorsed more spiritual/religious faith and less positive beliefs about CAM than those who completed the survey online. As such, the type of survey was included as a covariate in the relevant analyses to control for any overlapping variance.

A series of 2-way analyses of covariance (ANCOVAs) was conducted to examine the effects of sexual orientation and age group on each of the measures covarying having a Living Will and Durable POA. Results are presented by measure and adjusted means for each group are provided in Table 1 for comparison.

Beliefs About Pain Management

The ANCOVA revealed a significant main effect for age, $F_{1,138} = 12.37$, $p < .01$, with a moderate effect size ($\eta^2 = .08$). Older adult women reported significantly more comfort discussing pain management than middle-aged women. The main effect for sexual orientation was not significant, $F_{1,138} = 1.39$, $p = .24$, $\eta^2 = .01$, and the interaction of sexual orientation by age was not significant, $F_{1,138} = 0.53$, $p = .47$, $\eta^2 < .01$. These results provided partial support for the hypotheses.

Hospice Beliefs and Attitudes

Significant main effects were found for age, $F_{1,138} = 5.43$, $p = .02$, and for sexual orientation, $F_{1,138} = 6.06$, $p = .02$, with moderate effect sizes for both ($\eta^2 = .04$). Results showed that older adult women held significantly more positive beliefs about hospice care than middle-aged women and that lesbian women held significantly more positive beliefs than heterosexual women. The interaction was not significant, $F_{1,138} = 0.11$, $p = .74$, $\eta^2 < .01$. These findings provided mixed support for the hypotheses.

Preferences for Care

The ANCOVA revealed a significant main effect for sexual orientation $F_{1,138} = 4.04$, $p = .05$, with a relatively small effect size ($\eta^2 = .03$). Heterosexual women reported a significantly greater desire for life-sustaining treatments than lesbian women in the event of an incurable disease and severe life-limiting conditions (eg, feeding tube, life support, and no brain response). Notably, this result was opposite of the hypothesized direction. The main effect for age was not significant, $F_{1,138} = 1.12$, $p = .29$, $\eta^2 < .01$, and the interaction of sexual orientation by age was not significant, $F_{1,138} = 0.27$, $p = .60$, $\eta^2 < .01$.

Health Care System Distrust

The ANCOVA revealed no significant differences for sexual orientation, $F_{1,138} = 0.14$, $p = .71$ $\eta^2 < .01$, or age, $F_{1,138} = 1.29$, $p = .26$, $\eta^2 < .01$. Additionally, the interaction was not significant, $F_{1,138} = 0.80$, $p = .37$, $\eta^2 < .01$. These findings did not support the hypotheses.

Holistic Complementary and Alternative Medicine

For this ANCOVA, in addition to covarying having a Living Will and Durable POA, type of survey was also included. A significant main effect was found for sexual orientation, $F_{1,138} = 4.37$, $p = .04$, with a relatively small effect size ($\eta^2 = .03$). Lesbian women reported significantly more positive beliefs about the role of alternative medicines in health care compared to heterosexual women. This result was consistent with the hypothesis. The main effect for age was not significant, $F_{1,138} = 0.04$, $p = .85$, $\eta^2 < .01$, and the interaction of sexual orientation and age was not significant, $F_{1,138} = 0.01$, $p = .92$, $\eta^2 < .01$.

Discussion

The aim of the present study was to explore similarities and differences of end-of-life health care attitudes among middle-aged and older adult lesbian and heterosexual women. Although some of the results were not in the expected direction, there were some significant and nonsignificant findings with hopeful implications. Regarding the results for sexual orientation, heterosexual women and lesbians reported similar levels of comfort discussing pain management. Overall, both orientations held positive views of hospice care with lesbian women holding significantly more positive beliefs than heterosexual women. Heterosexual women reported a significantly greater desire for life-sustaining treatments than lesbian women in the event of an incurable disease and severe life-limiting conditions (eg, feeding tube, life support, and no brain response). Lesbian women reported more positive beliefs about the role of alternative medicines in health care compared to heterosexual women. Finally, no significant differences were found on level of health care system distrust, with both groups endorsing average levels of each.

Although not in the expected directions, the findings that lesbian women held significantly more positive beliefs about hospice care than heterosexual women and that heterosexual women reported a significantly greater desire for life-sustaining treatments than lesbian women in the event of an incurable disease and severe life-limiting conditions (eg, feeding tube, life support, and no brain response) have hopeful implications for end-of-life health care treatment. These findings suggest that unlike other minority groups (eg, African American persons), lesbian women may not be as hesitant to engage with end-of-life services. Perhaps, given that many homosexual individuals with AIDS have received hospice and palliative services, these teams may be perceived as more experienced with diversity than the traditional medical system. Similarly, rather than viewing hospice and palliative care services as part of the traditional medical system, these lesbian women view its emphasis on comfort over cure as more similar to CAM. In this case, hospice and palliative care services might be considered, like CAM, more counter-culture health care and therefore, a more respectful, sensitive service.

The absence of significant differences on level of health care system distrust was equally surprising, given the considerable literature documenting the experienced discrimination and real fear by lesbian persons in health care.[13–22] And the interaction of age by sexual orientation was not significant, ruling it out as an explanation for the nonsignificant main effect for sexual orientation. One possible explanation for these findings involves how level of distrust was measured. Here, most of the questions on the measure involved statements of health care competence rather than sensitivity (eg, If a mistake were made in my health care, the health care system would try to hide it from me; people die every day because of mistakes by the health care system). Competence distrust and sensitivity distrust may be 2 different constructs in considering how individuals seek out services in this population, even though racial and ethnic minority differences have been found using this scale.[8] The study by Bowen and colleagues[25] may lend additional support for this possible explanation; they found that 68% of the 150 community-dwelling sexual minority women they surveyed wanted access to an alternative provider but reported high levels of trust in both traditional and alternative providers.

Regarding the findings for age differences, the hypotheses that older women would endorse more favorable beliefs about hospice, more comfort discussing pain management, and lower preference for life-sustaining care compared to middle-aged

women had partial support. We found that older women held more positive beliefs about hospice care and reported more comfort discussing pain management than middle-aged women. Perhaps, due to greater exposure to death and dying in their peer group, older women are more aware of and comfortable with the mission of hospice and palliative care services. However, no differences were found by age for preferences for care. This may be because both age groups reported a low desire for maintaining life at any cost.

Strengths of the present study were inclusion of middle aged and older adult lesbian women and the use of standardized assessment measures. These strengths notwithstanding, several limitations deserve mention. Notably, participants in the present study were all relatively high functioning, white adults who lived in an urban area. Given that lower levels of formal education and health literacy are related to lower rates of health care utilization, lower rates of completion of some form of advance directive, higher rates of hospitalization, and higher use of expensive emergency services,[33,34] the attitudes and beliefs endorsed by individuals in this study may not be representative of individuals with lower levels of education. The applicability of these findings to ethnically and racially diverse individuals may also be limited. The sparse literature on lesbians of color suggests that they face additional levels of discrimination and exclusion from the health care system, a victim of triple jeopardy—female, lesbian, and racial minority.[35–37] Future research efforts should attempt to compare sexual and racial minorities with sexual minorities to assess any level of added distrust and concerns about end-of-life health care.

The present study focused on exploring similarities and differences among lesbian and heterosexual women on beliefs and attitudes about hospice and palliative care. However, lesbian women are not the only sexual minority group and future research should assess how other sexual minorities (eg, gay, bisexual, and transgender individuals) compare to lesbian and heterosexual women on beliefs and attitudes about hospice and palliative care and potential barriers to utilization. As end-of-life care professionals strive to be culturally competent in their practices, empirically based information on how all sexually diverse individuals approach health care during the dying process needs to be available.

It is also important to note that this was a nonrandom study conducted in a limited area of the United States. As such, sampling bias is a limitation to the current study. The LGBT population is diverse in terms of cultural background, ethnic or racial identity, age, education, income, and place of residence. The degree to which sexual orientation or gender identity is central to one's self-definition, the level of affiliation with other LGBT people, and the rejection or acceptance of societal stereotypes and prejudice also vary greatly among individuals. For this study, lesbian participants were recruited through Colorado PRIDE centers and these women may hold different values and beliefs about the health care system than those who are more isolated or less connected to the LGBT community. Their responses may not represent those who would be uncomfortable disclosing their sexual orientation in any setting, even an anonymous online survey. Replications with larger, more diverse samples would increase the ecological validity of the findings.

Despite these limitations, the initial findings of this study seem promising—standing in contrast to the current literature based on lesbian women's perceptions of traditional health care as highly distrusting and suggesting that lesbian women hold positive views toward hospice and palliative care. These findings suggest that unlike other minority groups, lesbian women may not be as hesitant to engage with end-of-life services, specifically those including CAM and/or hospice care. Examination into the underlying basis for these initial findings seems warranted.

Declaration of Conflicting Interests

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