Women's Health Issues 26-S1 (2016) S63–S70

ELSEVIER

WOMEN'S HEALTH ISSUES

www.whijournal.com

Original article

"I Have to Age in This Body": Lesbian and Bisexual Older Women's Perspectives on a Health Behavior Intervention

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Article history: Received 5 October 2015; Received in revised form 11 March 2016; Accepted 25 March 2016

A B S T R A C T

Background: Despite the body of literature that suggests lesbian and bisexual (LB) women are more likely to be overweight or obese than heterosexual women and the overwhelming evidence that tailored interventions are most effective at changing behavior, a vacuum of culturally appropriate programs designed specifically for LB women still exists. The purpose of this study was to qualitatively examine LB women's perceptions of Project LOLA (Living Out, Living Actively), a 16-week intentional health promotion program tailored specifically for LB women aged 40 and older.
Methods: Researchers conducting this qualitative descriptive study employed a template approach to text analysis to capture insights into participants' perceptions of Project LOLA. Data were derived from two primary sources: weekly support group facilitator notes of participants' comments and participant focus group interviews conducted at the conclusion of the study. PEN-3, an ecologically oriented model that identifies individual, family, community, and systemic influences on behavior change, guided the analysis.
Findings: Study participants emphasized the importance of incorporating culture into health interventions for LB women. They valued having a safe space to talk about their health issues and health-related changes. Interacting with people who understood the culturally specific norms of the LB community was cited as particularly beneficial.
Conclusions: Interventions tailored to LB women may generate stronger results and/or be better received if they are designed in a culturally relevant and supportive manner. Such interventions hold promise as a tool to help address health disparities faced by this population.

As the U.S. female life expectancy continues a linear increase from 73.1 years in 1960 to 80.7 years in 2010 (World Bank Group, 2016) modifiable risk factors associated with chronic illness, such as obesity, become increasingly important to address. Numerous studies have indicated that a higher proportion of lesbian and bisexual (LB) women are obese (body mass index $\geq$ 30 kg/m^2) compared with mainstream heterosexual women (Boehmer, Bowen, & Bauer, 2007; Case et al., 2004; Valanis et al., 2000). For example, the 2013 National Health Interview Survey reported more lesbians (36.7%) and bisexual women (40.9%) were obese compared with heterosexual women (28.3%; Ward, Dahlhamer, Galinsky, & Joestl, 2014).

A factor related to obesity in the LB population may be stress, although no studies have globally evaluated stress using an established psychological test, such as Perceived Stress Scale, as it relates to weight status (Cohen, Kamarck, & Mermelstein, 1983; Kivimaki et al., 2006; Mouchacca, Abbott, & Ball, 2013; Wardle, Chida, Gibson, Whitaker, & Steptoe, 2011). Compared with the mainstream heterosexual population, sexual and gender minorities (SGM) report experiencing higher levels of stress and unique stressors (Brooks, 1981; Meyer, 1995, 2003, 2010; McElroy, Wintemberg, Cronk, & Everett, 2016). A recent study evaluated perceived heterosexual discrimination, a distal measure of stress, among 155 lesbians completing an online survey. Compared with normal weight participants, lesbians who experienced heterosexist discrimination were 2.5 times more

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1049-3867/$ - see front matter © 2016 Jacobs Institute of Women's Health. Published by Elsevier Inc.
http://dx.doi.org/10.1016/j.whi.2016.03.011

likely to be overweight or obese (Mereish, 2014). Researchers suggest that eating "comfort food" may be an individual's attempt to obtain relief from chronic stress, as many people turn to high-fat and high-carbohydrate comfort foods when feeling stressed (Canetti, Bachar, & Berry, 2002; Dallman et al., 2003).

Beyond addressing both physical activity and eating habits, research has identified social support as an important component of health behavior change (Metzgar, Preston, Miller, & Nickols-Richardson, 2015; Wing & Jeffery, 1999). Although LB women use mainstream, commercial, group-based weight loss programs, Fogel, Young, and McPherson (2009) reported that lesbians have additional barriers to the already complicated issues surrounding weight loss, including a sense of fear about disclosure of sexual identity when entering a group of unfamiliar people. They described specific needs for an effective support group environment for lesbian women, including 1) an environment free of sexual identity-based judgments, 2) an inclusiveness that allows open discussion about having a same-sex partner and concerns related to sexual identity, and 3) programs that inherently support the development of community. These elements are important components of an inclusive intervention, although not necessarily a tailored one.

Tailored interventions that address superficial characteristics of the target population (e.g., same language, cultural music, or food) or take into account the deep structure of the participants' culture(s) (e.g., social, historical, environmental, and psychological influence on health behavior) may be particularly effective in improving health in the targeted minority population (substance abuse for SGM individuals, Resnicow, Baranowski, Ahluwalia, & Braithwaite, 1999; rehabilitation and disability services for disabled individuals, Hasnain et al., 2011).

The PEN-3 Cultural Model

Airhihenbuwa's (1995) PEN-3 model (Figure 1), which emphasizes the importance of culture in shaping health behaviors and outcomes, has informed numerous health promotion interventions (Iwelunmor, Newsome, & Airhihenbuwa, 2013). The PEN-3 model includes three core domains, the first of which pertains to the cultural identity of the participants. Inclusion of cultural identity as a core domain highlights the multiple levels on which an intervention can influence health behaviors, including the individual (or "person" level), the extended family, and the neighborhood (or "community"). The second domain of the PEN-3 model is about relationships and expectations. Knowledge, attitudes and beliefs individuals hold about health and health promotion efforts and the people (nurturers) and things (enablers) act as reinforcements. The third domain of the PEN-3 model, cultural empowerment, is the most important and unique contribution of the model. This domain pertains to the cultural appropriateness of health promotion efforts and considers whether health-related perceptions, enablers, and nurturers are positive (factors that lead to engagement in healthy lifestyle choices; for example, increased physical activity, increased consumption of fruits and vegetables, reduction of sugar-sweetened beverages and alcohol), negative (factors that deter individuals from engaging in healthy lifestyle choices), or existential (neither positive nor negative from a cultural perspective; Airhihenbuwa, 1995; Garcès, Scarinci, & Harrison, 2006; Scarinci, Bandura, Hidalgo, & Cherrington, 2012).

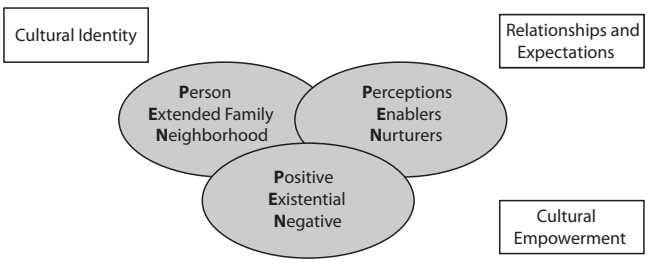

Figure 1. PEN-3 model.

Culturally Tailored Health Promotion Intervention with LB Women

The body of literature suggests LB women are more likely to be overweight or obese than heterosexual women. A strong body of evidence indicates that tailored interventions for minority populations are most effective at changing behavior. However, limited progress has been made in developing culturally relevant approaches to health promotion for LB women. This is in part owing to a lack of data, because none of the many randomized controlled trials on obesity and/or fitness-related lifestyle interventions report sexual and gender minority status (Franz et al., 2007; Rizer, Mauery, Haynes, Couser, & Gruman, 2015). Furthermore, as Mason and Lewis (2014) noted, compared with racial and ethnic minority interventions on obesity, less is known about the important elements for successful intervention among LB women.

To address this gap in the knowledge base, in 2012, the U.S. Department of Health and Human Services' Office on Women's Health funded culturally tailored interventions to address unhealthy weight in the LB population aged 40 years and older. Researchers involved in a randomized controlled trial called Project LOLA (Living Out, Living Actively) conducted the qualitative descriptive study described herein. The purpose of the study was to use a cultural lens to capture insights into participants' perceptions of an intentional health promotion program for LB women aged 40 and older. The following research questions were posed: 1) How, if at all, did participants' cultural identity shape their experience of a health promotion program? 2) How, if at all, did participants' relationships and expectations shape their experience of a health promotion program? And 3) How, if at all, did a culturally tailored health promotion program empower LB participants to make healthy behavior changes?

Materials and Methods

Participants and Intervention

Project LOLA was a 16-week randomized controlled intervention trial that took place in Columbia and St. Louis, Missouri. Eligibility included being 40 years or older, being overweight or obese, and self-identifying as lesbian or bisexual. Transgender women were also eligible for inclusion. Project LOLA provided weekly support group meetings, encouraged physical activity, and discussed nutritional options (see Fogel et al., 2016, pages S7–S17 in this issue). Project LOLA was designed using the following strategies provided by Kreuter et al. (2003): 1) peripheral strategies (e.g., images in promotional and educational material), 2) linguistic strategies (e.g., language that resonates within the community), 3) evidential strategies (e.g., embedding the purpose of the program in both the altruistic concept of representing the LB community and older women deserving to