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**SHADOW DANCING IN THE WINGS: LESBIAN
WOMEN TALK ABOUT HEALTH CARE**

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ABSTRACT

Women who claim a lesbian identity as part of their cultural articulation have to date been poorly represented within research particularly within a New Zealand setting. Rather than couch this single identifier within a contextualised environment, research has predominantly sought to pathologise lesbian existence at an individualistic level.

Lesbian women are a minority group for whom crucial differences from the dominant culture may not readily be recognisable. Such differences may be associated with existing in a society where silence and invisibility subsume a meaningful and tangible cultural expression.

This study aims to explore the factors which hinder or facilitate sense of safety for lesbian women, when accessing health care, in order to provide information from which health professionals may judge the appropriateness of their current service delivery.

A participatory approach grounded in both critical social and feminist research has been utilised to explore issues relevant to health care and it's access with seven women who claim lesbian as part of their identity. The representational void is uncovered and forms a suitable backdrop from whence to explore with these participants health issues and factors relevant for them in the context of their daily lives.

The concept of cultural safety gives power to the users of services to determine whether or not they feel safe. From the perception of the service user then, cultural safety assumes that the nurse (or other health care professional) is the extraordinary element as opposed to the neo-colonial held view that the user is the extraordinary member of the interaction (Ramsden, 1995).

Cultural safety is the term originally employed in New Zealand to describe the partnership between nursing and the indigenous people intent upon removing barriers in order to facilitate safe access and delivery of health care. From this juncture the Nursing Council of New Zealand (1996) acknowledging that prejudicial and judgmental

attitudes exist with regard to lesbian women has fostered awareness. Subsequently the need for appropriate qualitative research has been recognised.

In support of the tenets of cultural safety this study will prove useful to nurses and other health professionals intent upon ensuring safe care provision for this marginalised group.

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There is one other remaining to be acknowledged, and I make it so! It is with your guidance that I have found myself in the position of wanting to 'boldly go'!

FOREWORD

I have often wondered at the chosen titles of books, articles and theses and mulled over potential meanings. I will take a moment to share my rationale for the metaphor employed in the title of this work.

Shadow raises imagery of another world (within a world), with muffled enveloping silence and difficulty in visual acuity. Those residing beyond the shadow consign the shadow world to an imitation of their original, however it is possible that the shadow is ever present and constitutes an original, independent self manifestation.

Dancing invokes the notion of a medium for story telling. The interpretation however is diverse and the received message may not always be as replete with clarity as the observer would claim. Furthermore the message may be distorted at the source, or interpreted for the masses by the most dominant voice (usually a critic). Dancing is about life, it is active expression and culturally diverse.

Wings represent the rim, edge, off stage, boundary, and border or off centre where marginalised groups reside without the 'correct' voice, having been exiled from the central environment.

PREFACE

In order to facilitate a level of appreciation for my cultural experience, I have included an exemplar from my earliest memories regarding the possibility of including lesbian as part of my identity. I vividly recall a time many years ago as an adolescent, when I began to understand within myself that I just might be in possession of a different cultural outlook to that of my peers of the time. I headed for a large library to seek some knowledge regarding these feelings and following a considerable search found an impressive and weighty tome (I cannot recall from which discipline this might have been) which contained the word lesbian within. Feeling ultra transparent and suitably guilty I took this volume to the least populated area of the library and began to read. From memory the definition hailed from a pathological foundation and I clearly remember the considerable list of probable associated factors which were considered contributory to developing or becoming a lesbian.

Some way down this list I came across 'adoption' and there it was! I had found the answer and the explanation for these different feelings. Realistically it was for me a double edged sword as I now found myself in the dubious position of placing blame upon an area of my life (my adoptive status) which had until that very moment been non problematic for me. Conflicting with this concern was the tangible relief at being able to externalise the fault for this errant way of being in the world, should it become necessary.

Reflecting back upon this memory from the present time with many kilometres of my journey accounted for I can see the humour of the situation. I can also reach out and touch the raw emotions of that period in my life. Coming home to announce that you were pregnant (outside wedlock) had until that time been the worst possible event, yet somehow I knew that this was significantly more problematic than getting pregnant. Casting about for someone to talk to proved futile. I believed that if there was something 'wrong' about me I had better be absolutely certain before I went sharing it with anyone else. It would be humiliating if I was wrong and it was only a phase all girls my age passed through. However worse than that was the possibility that I was right and the perceived consequences of articulating such cultural difference from all that I had been brought up to believe in.

I made the acquaintance of two travelling companions about this time who have remained faithfully by my side to this day. Their names are 'silence' and 'bury it deep' and frankly they are the strategies I employed throughout many of the strands of my life in order to get by. Though still with me (old habits die very hard) they have for the most part assumed their own identities and become 'fairly quiet' and 'reasonably distant' from my more recent daily life.

Living as lesbian in a world replete with heterosexual imagery is not unlike holding dual citizenship (consequently possessing two passports). It is likely that one of these countries will be more highly respected, more powerful, and more valued on the global power stakes than the other country. Thus lesbian women live in the world, representing at the very least a bi-tribal status (may be more than bi-tribal depending upon how many times removed from the standard employed measurement of 'norm' an individual finds themselves). This bi-tribal attribute means that lesbian women are positioned within two worlds and find themselves having to actively engage with the two cultural polarities on a daily basis (Brown, 1997). It is my hope that this bi-tribal exploration will identify aspects of life which are inconsequential to those holding the prized citizenship (read heterosexual), yet crucial to those dwelling elsewhere.

This work comprises a portion of an on going journey both professionally and personally which strives toward a forum where cultural diversity can be appreciated for what it is. This as opposed to a seemingly infinite quest to position diverse ways of being as mechanisms with which to evaluate commitment to prescribed social/cultural roles (Bennett, 1992). Failure of such evaluation is then employed to continually shore up existing dominant patterns. This latter quest seems to be necessarily limiting the future potential for growth and movement beyond current narrowly defined levels.

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CHAPTER ONE

INTRODUCTION

This introductory chapter presents an overview of the direction and aims of the research study. Positions regarding both the meaning of health and of being lesbian are briefly outlined. The stance of refuting the pathological explanations surrounding lesbian existence is explored. The relevance of this work to the profession of nursing is discussed employing the concept of cultural safety and noting recent responses from nursing leadership pertinent to this topic. An exploration of heterosexism, homophobia and gender is utilised to connect this work to the world where lesbian women reside.

This study employs a participatory approach cognisant with both emancipatory and feminist processes to explore in a contextualised fashion, aspects of lesbian lives related to health care. The work originally aimed to investigate factors, which might hinder or facilitate lesbian women accessing health care. That aim as stated is contained within this work, however primacy was more readily afforded to issues relevant to the daily lives of the participants, which necessarily impact upon their sense of health and wellness. From this juncture the second aim is applicable. The provision of information regarding lesbian women pertinent to health affords nurses (and other health care professionals) the opportunity to measure current practice towards this group and make adjustments and alterations should they be required to ensure that culturally safe access, to health care is a reality for lesbian women.

The meaning of health within this work is viewed within the context of the lesbian's whole life, incorporating physical, emotional, political and social well being, and considered to be much greater than the mere absence of disease.

If health care providers are to create an atmosphere that is sensitive and supportive to the health needs of lesbians, a basic understanding of the cultural experience of being lesbian is necessary (Thompson, 1998, p.111).

Some research studies contain aspects, which detail past negative experiences, such as child abuse, incest and violence, as potentiating lesbian lives. Lehmann Lehmann and Kelly (1998) for example discuss risk factors associated with lesbian sexuality and cite among such risk factors 'a history of physical, sexual or mental abuse during childhood or adolescence' (p.382). While historically lesbians were deemed to be failing morally (Hall & Stevens, 1991), this continues to be perpetuated in the present by the assumption that such failing derives from a history of rape or incest (Lee, 1998). Another not uncommon stereotypical assumption connects physical abuse to the subsequent development of a lesbian (Bradford, Ryan & Rothblum, 1994).

What such accounts have in common is an assumption that lesbian equates pathology and therefore a cause is required. Causes are not sought for those existences, events, or ways of being in the world, which are considered normal.

This work refutes any stance, which would attempt to further pathologise women who as part of their identity claim a lesbian affiliation. I acknowledge that theories abound regarding causation of this way of being in the world.

Recent scientific research into sexuality has reflected a determination to discover a biological key to the origins of homosexuality. Highly publicized new studies have purported to locate indicators of sexual orientation in discrete niches of the human body, ranging from a particular gene on the X chromosome to the hypothalamus, a structure of the brain (Somerville, 1996, p.254-255).

Genetic theories seek to discover an illusive causative gene mutation (Le Vay, 1996). In-utero theories seek to discover some causative factor during pregnancy usually focused upon hormonal imbalance (Freidman & Downey, 1994) while early childhood trauma for example violence, child abuse or incest seeks to lay the blame upon other forms of socially non accepted behaviours. These research directions potentially both entice and lull homosexual people into a false sense of security. Should a causative agent be discovered within the corporal body, blame is removed from the site of the individual and equitable legal protection would in all likelihood eventuate. This reprieve would however expire once a 'cure' was determined. Should a causative agent not be

determined then homosexuality will once again be consigned a deviant choice effected by individuals and as a result sanctions would continue to be acceptable.

Any person seeking health care in any agency should feel safe and protected. Lesbian women should not feel obliged to 'become' heterosexual when seeking health care. Safe care exists when the person/ individual can engage with a health agency without adopting the persona of the agency, in this case the persona of heterosexualism. All people have a right to feel safe and comfortable when accessing health care. Culturally congruent health care for all people living in this country, is contained within the spirit of the Treaty of Waitangi, this country's founding document.

Heterosexuality in institutions can be viewed as a form of cultural capital. Silence and invisibility are considered basic requirements to assure tolerance within institutions when not a member of the dominant culture (Laurie, 1993). Contained within this view is a form of liberal tolerance, which may acknowledge the presence of lesbians while concomitantly demanding that any cultural expression of this way of being be withheld from the dominant world by means of silence and invisibility (Hartman & Laird, 1998).

Within this paradigm resistance is further evidence of the depth of illness, particularly in view of the medical language of normalcy. Living under such external control and restraint it becomes all but obligatory to adopt the view of the restraining agent. This is usually manifested by a serious self-restraint or self-inhibition (Bornstein, 1994). Under such conditions it is likely that any obvious indicator or mark of a differing cultural expression will be shied from (Brown, 1997).

This same strategy of cultural capital is frequently employed at the level of the family unit. The lesbian woman may be accepted within the family albeit under a cloak of secrecy and silence (Hartman & Laird, 1998).

Such a position has important moral and ethical overtones to the extent that it forces gay men and lesbians into costly or unacceptable compromises, subterfuge, dishonesty, and invisibility (Hartman & Laird, 1998, p.266).

My interest specifically lies with an endeavour to identify the situation from a New Zealand context. I do not believe that research, from countries other than New Zealand, can readily be generalised to this environment. Almost without exception, literature reflecting lesbian women's problematic encounters with health care providers is from overseas. Although a recent piece of New Zealand research, identified that nurses felt overwhelmingly under prepared for assisting people with matters concerning sexuality (Giddings & Wood, 1998), there is little New Zealand research in this or related areas.

Personally I have encountered situations within a professional environment which were other than positive simply because I culturally identify as (among many other things) a lesbian woman. From a professional position, incorporating many years of clinical practice as a registered nurse I have had occasion to be both witness and hear stories from peers and colleagues, which demonstrate the negativity towards lesbian women. Though well within the realm of anecdotal evidence this along with available overseas research, proved the impetus to question the health care that may be meted out to individuals who identify as lesbian in New Zealand.

The 1998 Ministerial Taskforce on Nursing states

The nursing concept of health includes the impact of culture, gender and socioeconomic status on both people's understanding of good health and their access to it. Key areas of nursing involve working alongside people to teach health and safety practices, and helping others to maximise health in difficult circumstances (p. 22).

Nursing is about holistic caring for people by provision of a service underpinned by scientific knowledge (Ministerial Taskforce on Nursing, 1998) the basis of which is the arts, sciences and nursing directed toward well-being on both individual and community levels (Rasmussen, 1997). This profession trades on the strength of being advocates and non-judgmental in their outlook towards individuals in their care. Cultural safety resulting in culturally congruent care has been a significant focus of nursing in New Zealand in recent times (Ramsden, 1995).

Yet nurses (along with other groups) have been slow to appreciate that culture in reality can hold very different meaning from the pervasive white/non-white category or race relations, readily invoked when the concept of culture is broached.

The skills of cultural safety should work as well for homosexual people being nursed by heterosexual nurses as for people who differ by the apparently simpler context of their ethnicity (Ramsden, 1995, p.9).

This work seeks in part to convey this wider meaning by illuminating aspects of a lesbian culture and its impact upon matters of health.

The regulatory body for nurses (Nursing Council of New Zealand) is attempting to show leadership towards culturally sensitive care of lesbian and gay clients. In 1996 The Nursing Council of New Zealand released a document containing eight categories of cultural safety, one of which was "the relationship between nurses and midwives and those who differ from them by sexual orientation" (p.4).

People should be able to express degrees of felt risk or safety. Someone who feels unsafe will not be able to take full advantage of the primary health care service offered and will subsequently avoid the service until dramatic and expensive secondary or tertiary intervention is required (Nursing Council of New Zealand, 1996, p. 3).

In response to this a policy statement from the New Zealand Nurses Organisation was released early in 1997, calling for a collective and concerted response in order to fulfil the responsibilities implied by the Nursing Council. Currently there is recognition that both discrimination and prejudice exists in nursing towards lesbian and gay patients (New Zealand Nurses Organisation, 1997).

For the purposes of this work a lesbian woman is defined as any woman who self identified as lesbian. This definition contains difficulties as there is a significant schism pertaining to the quintessential characteristic makeup of a lesbian (Lemon & Patton, 1997). The advantages and disadvantages of this definition will be discussed within the method chapter.

CULTURAL CONCEPTS

The next section of this introductory chapter offers a discussion surrounding concepts such as heterosexism and homophobia, which add clarity to the topic as a whole. I consider concepts of patriarchy, hegemony, heterosexism and homophobia to be crucial to any useful exploration of the health care needs of lesbian women. From this platform gender will be explored integrating these concepts within to facilitate a sense of cohesion and reality to their interdependent relationships.

The central institution in men's domination over women is heterosexuality. Heterosexuality is institutionalised as a particular form of practice and relationships, of family structure, and identity. It is constructed as a coherent, natural, fixed and stable category as universal and monolithic (Richardson, 1996, p.2).

Given that heterosexuality is deemed to be the single correct human manifestation of interrelationships it is not surprising to find that humanity tends to assume that every member of society is indeed heterosexual (Gray, Kramer, Minick, McGehee, Thomas & Greiner, 1996). Homosexuality is not only different; its difference is embedded at a critical point of social organisation namely reproduction of the species. As a result homosexuality is seen as a threat to society on religious, ethical, political and medical grounds. Social unacceptability of homosexuality and lesbianism is assumed, therefore if not a 'disease' or 'character disorder' it must be codified as a gender identity disorder (Badinter, 1995), that requires explanation and treatment rather than social structures or attitudinal shifts.

The system of male dominance known as patriarchy is supported by the creation of categories of 'other' or 'deviants', differing from the dominant group and assumed to be inferior (Lerner, 1993). Misogyny defines the hatred of feminine qualities in women, while homophobia generally serves to define hatred of feminine qualities in men, affording the patriarchal society the opportunity to define itself in opposition to something (Badinter, 1995). Traditionally, women's subordination has been regarded as God-given, natural, and housed efficiently in the biological role of women to reproduce and nurture (Itzin, 1992).

Patriarchy is the father of racism, sexism, and homophobia. Patriarchy maintains racism through its inherent structure of hierarchical power with whites on top and blacks on the bottom. Sexism, the system by which women are kept subordinate to men, is the axle upon which the wheel of patriarchy turns and homophobia is the linchpin that holds it together (Rhue & Rhue, 1997, p.119).

Homophobia is a powerful arm of heterosexism, in fact heterosexism nurtures the climate for homophobia, assuming that the world is and must be heterosexual.

Heterosexism is the precursor to homophobia upholding the binary dualism system.

The categories of heterosexual / homosexual (lesbian) exist on the premise of gender division (Jackson, 1995).

Behind all homophobia, regardless of its development, expression, or motivation, is the background of heterosexism. Behind all heterosexism is the background of gendered identities (Hopkins, 1992, p.123).

Both heterosexism and homophobia work co-operatively to ensure the continuance of the seat of patriarchal power, the nuclear family. The nuclear family is employed as a metaphor by the patriarchal order to signify heterosexual morality (Hopkins, 1992).

From a heterosexist perspective the natural form of sexual expression for women is heterosexuality (Wolfe & Penelope, 1993). Positioning lesbian as 'other' acts to legitimatise heterosexuality, by constructing it as an individual problem contained within the corporal body, society at large is required to do nothing. Viewed from this position lesbians are seen to be women who can live without the sexual and economic privileges associated with dependence on males, and are therefore a threat to male dominance and control, the nuclear family (read heterosexual morality), and sexism (Pharr, 1993).

Many phobias fall within the remit of medical science however homophobia falls well beyond that category, having never been viewed as a phobia which would merit from some form of treatment. Antagonism towards lesbians is inappropriately labelled under the heading of a phobia. People with phobias have a tendency to view their fears as irrational and exaggerated and are usually motivated to alter this phobia (Fernald, 1994). Society does not seek to punish or sanction individuals who are claustrophobic, and

agrophobes are not recipients of ignorance or intolerance. Homophobia then is extremely unlike other such phobias (Hopkins, 1992).

Richmond and McKenna (1998) consider the prevalence of homophobia among the nursing profession to be a significant cause of concern. They offer a definition of homophobia "as a dislike or distrust of homosexual life-style based upon personal, social or cultural beliefs" (p.367).

GENDER

A gender perspective is a means of situating others and ourselves, which takes into account societal differences between men and women. Gender illuminates the ideal and expectations about men and women and girls and boys that are societally shared. These encompass ideas about what is typically feminine or masculine, and how people of different sexes should behave in a variety of situations. Gender relationships often expose both difference and hierarchy. Power tends to be linked to gender affording certain rights (most commonly the rights of men) over other rights (most commonly the rights of women) (Muecke, 1996; Senior & Viveash, 1998).

The organisation of gender on a grand scale is dependant on a single structural fact, that of global dominance of men over women. This provides the main foundation for relationships among men, which defines a hegemonic form of masculinity in society, most men benefit from the subordination of women, and 'hegemonic masculinity is the cultural expression of this ascendancy' (Connell, 1987, p.185). A dominant version of masculinity is privileged over other masculinities and all femininities. Other patterns are subordinated rather than eliminated, and this necessitates a collective strategy, in order to perpetuate the continuation of control.

The most important feature of contemporary hegemonic masculinity is heterosexuality, closely related to the institution of marriage according to Connell (1987). Homosexuality provides a key form of subordinated masculinity, and the hegemonic construction denies other models from gaining cultural articulation. From this perspective, spinsters, lesbians, prostitutes to name a few, are all denied cultural expression, because they articulate marginalised forms of femininity. All of these other

models challenge the institution of heterosexuality and afford a form of patriarchal resistance (Richardson, 1993).

Heterosexuality serves to bolster rigid gender role expectations (Gray et al., 1996).

" 'Heterosexuality' is a patriarchal narrative told about bodies and desires which, polices women's and men's adherence to correct gender and erotic behaviours"... (Wilton, 1996, p.127). Gender is inextricably linked to heterosexism by defying premises concerning the connections of binary opposites of sex and gender categories. Breaking the rules of accepted and expected gender behaviour is seditious and homosexuality is among the most discernible example of such sedition (Hopkins, 1992).

There could be no fear or hatred of gays and lesbians if there were no concept of a proper gender identity and a proper sexual orientation (Hopkins, 1992, p.126).

A lesbian image undermines the patriarchal gender boundaries that separate the sexes, in terms of the active / passive dualism, a dichotomy crucial to the definition of gender in patriarchal culture (Creed, 1995). Therefore as women outside male definition, lesbian women do not exist in reality, rather they are a deviant minority tolerated as long as they do not impinge on the lives of men and 'their' women (Phillips, 1991; Thompson, 1995). Thus " heterosexism is an ideological system that denies, denigrates, and stigmatises any nonheterosexual form of behaviour, identity, relationship, or community" (Herek, 1992,p.89).

The patriarchal meaning attached to lesbianism is used as a policing strategy, which teaches women to have negative and ambivalent feelings towards certain illegal, wrong and wicked desires (Ferguson, Zita & Addelson, 1981). Heterosexual women are discouraged from coalescing politically with lesbian women by the patriarchal tools of homophobia and heterosexism. When this strategy fails, lesbians are demonstrated as deviant monsters, in order to frighten other women back in line (Hoagland, 1988; Pharr, 1993; Phelan, 1993). Women who resist the heterosexual alliance, have labels of deviancy attached and it is normal for several deviant labels to surround one 'normal' way of doing things, e.g. spinsters (could not get a man), lesbians (man-haters), or at the extreme pole, sluts and whores, are all used to steer women towards marriage and motherhood, under the patriarchal system (Ferguson et al., 1981; Richardson, 1993).

The fear of being identified lesbian and the associated consequences, for many women, acts as a powerful form of control and oppression, serving to minimise the strength of women as a group, and endeavouring to negate the realisation that there are other ways of being in the world. The fictitious dichotomy of lesbian/non-lesbian coupled with powerful anti lesbian rhetoric limits the actions of all women. The fear of attracting the label of lesbian serves to discourage women from challenging sexist practices. Silence is equated with good behaviour while canvassing for change will attract (at the very least) the label of bad behaviour (Lee, 1998). Gender and sexuality (at the very minimum) doubly remove 'deviant' women from the white male, the patriarchal measurement of normal from which deviations are calculated (Rosser, 1994).

The assumption which gender rests upon relates closely to those social roles, which are sanctioned as being appropriate manifestations of masculinity or femininity in the Western world. Furthermore sanctioned human relationships are those held in opposition to one another and can only be manifested in a male/ female representation. Heterosexual relationships are not viewed as an individual preference, something into which people drift, or a socially constructed institution. Women service men emotionally, materially and sexually within patriarchal structures (Walby, 1995). Within this view gender is precisely divided into two equal parts though the power differential is anything but equal. This neat division is steeped in the historical refining of culturally sanctioned and approved roles, which are constantly reiterated by their very enactment.

When engaging in discussions or explorations regarding gender it is vital to make strong and clear connections to the power of gender. It is crucial to explicitly connect the power of gender, which realistically is male power. The binary of masculine/feminine is a pivotal dualism upon which the world expresses very explicitly its 'natural' heterosexuality. There is little doubt that the world is exclusively heterosexual in its outlook (Brown, 1997) founded upon binaries of male/female, masculine/feminine and heterosexual/homosexual (to put names to those binary poles, which are most relevant to this work).

Gender is neatly posited around displays of normalcy which are culturally defined and refined to the point where they become the accepted common sense (hegemonic) way of being in the world. This is the view from the centre and it effectively nullifies the

potential for alternate manifestations to gain any real sense of cultural articulation. Human behaviour is viewed through a lens of heterosexual experience (read norm) and all else is compared and contrasted with this position (Brown, 1997).

Heterosexism refers to the general assumption that the heterosexual orientation is functional, preferable, superior and morally desirable (Hopkins, 1992). Heterosexuality is a belief that the singular correct, normal, God-given method of human sexual relating is through heterosexual relations (Gray et al., 1996; Richardson, 1996; Wolfe & Penelope, 1993). The embedded naturalness in Western Society is so commonly accepted that it is rarely alluded to, rendering it covert rather than explicitly obvious (Valderde, 1985). It is this belief that heterosexuality is entirely natural that renders it so problematic (Bornstein, 1994).

The hegemonic construct of heterosexuality limits the response to lesbianism. Lesbian existence must either be completely denied (euphemisms employed to suggest that the right man has yet to come along) or alternatively situated within the binary of masculine/feminine (Wilton, 1996). Oppressive gender roles are linked closely with anti lesbian posturing. Hostility towards lesbians contrives to sustain and bolster traditional gender roles. Consequently a significant feature of heterosexism is the depth of established gender roles (Fernald, 1994). Lesbians are doubly marginalised within normative gender roles. On one hand they are embedded within the category 'feminine' while simultaneously digressing from the constructed stereotype femininity severely enough to be classed as non-women (Wolfe & Penelope, 1993).

To be heterosexist is to value and see as "normal" prescribed male- female gender dichotomies and to devalue anything other or label "abnormal" that which breaks down those dichotomies and divisions (Gray et al., 1996, p.207).

Lesbian women are deemed to be women who fail to do their gender appropriately and draw the notion of a masculine aura as a consequence. There exists no space or place beyond this masculine/ feminine dichotomy. Given the binary of masculine/feminine should an individual be unable or unwilling to subscribe to the socially sanctioned way of enacting gender there is little alternative but to place that individual in the

oppositional category. Simply put if an individual is not doing a feminine form of gender then they must be doing a masculine form of gender.

Lesbian women are categorised as female while yet lacking the socially accepted link to femininity and it's performance. Such deviation from the normal perceived way of being in the world contributes to lesbian women stereotypically being depicted as masculine (Fernald, 1994). Yet a female body sits very uneasily within the only available alternative, the male category. As a consequence there are women and then there are lesbians who will be perceived as craving to be men.

Thus a lesbian women who may express herself in an alternative style to the heterosexual norm ascribed for women will find herself enacting a masculine form of gender according to the mainstream. This despite merely attempting to signify some levels of difference from that of the wider socially prescribed category of 'woman'. While for other lesbians, it may indeed be a means of resisting the prescribed sanctioned form of femininity.

To facilitate smooth integration into the culture, gender is repeatedly performed to demonstrate it to newcomers. In order to belong to this cultural group it is essential to comply and learn the performance. Gender as normative performance ensures a legacy of invisibility and silence to those who fall outside such a limiting script. Those who challenge the particular performance will be sanctioned, unpopular and labelled troublesome. Expulsion from the centre toward the margins is the result for those who fail to perform their gender according to the master's plan. Conversely such alternatives are resisted and consequently their very existence is marginalised.

Gender as performance (Butler, 1991) is represented by a ripple in a pond, which once tentatively commenced spreads wider and further. Once established maintenance requires the repeated dropping of pebbles into the pond to maintain the ripple effect. Should the ripple cease or falter, other reflections may become possible. However the rippling causes enough surface interference and distortion to prevent other representations from becoming visible to the observer. This does not mean that they do not exist merely that the constant rippling motion distracts us concomitantly preserving our ignorance of potential alternative patterns. The 'doing of' the ripples means that we

are distracted from seeing detail beyond that particular pattern, it represents the single available pattern.

Gender then is performed constantly and repeatedly and is realised in the action of the performance as opposed to existing independently in the social world (Butler, 1991). Therefore gender may in fact be a consequence of the culture, that is, gender being generated by the culture. This would imply that it is the culture which creates and maintains the gendering of people as opposed to a natural phenomena (Bornstein, 1994). The performance is utilised to demonstrate the way it is done, and each enactment further embeds the notion of gender signalling that this is how it has always been. The actors are drawn from the pool residing within the mainstream who acquiesce to perform the script faithfully as it has been performed throughout history. Cultural membership requires continual integration of the performance into daily life (Bornstein, 1994).

It is not that alternatives do not exist naturally, rather that they have been subsumed by a predatory form of dominance which invokes serious consequences to those who attempt to test the commitment of that predatory mechanism. It is perhaps impossible to project our nature when we have rarely seen it, rather that which we do see camouflages both the opportunity to become and the setting for it to happen (Bennett, 1992; Bornstein, 1998).

It is crucial to not accept the view from the centre as being the sole available view (Brown, 1997). The pervasiveness of the mainstream permeates our inner images of self. The aggregated cultural fiction of the mechanisms with which to exist in the world mitigate against an appreciation of alternate ways of being from people who either need or want to distance themselves from the prescribed norm. Thus each generation of people who find themselves existing in the cracks and fissures of the normative form of expression have the arduous task of inventing themselves (Bennett, 1992). Historically this is a reinvention however the lack of cultural articulation surrounding the existence of such fissures means that each generation makes little gain against the monolithic structure known as normative cultural expression.

To find such spaces as cracks and fissures an inordinate period and energy is expended wading through that dominant cultural expression (Lukes & Land, 1990), which is totally irrelevant, and non-representative to such people. However given the singular normative cultural expression this proves to be the commencement point for us all irrespective of potential differences. The mainstream attempts to smooth over such cracks and fissures by virtue of invoking historically embedded and negative cultural myths.

When we explore and closely examine gender at play, question the binary, bend the rules and constantly draw attention to the fact that the rules are indeed flexible we gain the opportunity to move beyond the binary itself (Bornstein, 1994). If the dominant performance of gender ceased in the stillness other possibilities and spaces would become obvious to us. However the rules surrounding appropriate and acceptable social behaviour link to how those in charge (read patriarchal order) like it done. This is the connection between gender and power as it is those who wield the power in society who effectively determine the accepted and expected social performance. Given that any cessation of gender as it is currently performed is unlikely to be instigated by the centre, it falls to those of us beyond the central position to make the cracks and fissures visible.

There's a real simple way to look at gender: Once upon a time, someone drew a line in the sands of a culture and proclaimed with great self-importance, "On this side, you are a man; on the other side, you are a woman". It's time for the winds of change to blow that line away. Simple (Bornstein, 1994, p.21).

CHAPTER OVERVIEW

Chapter two provides a comprehensive literature review of relevant research.

Chapter three outlines in detail the methodology and methods employed within this work and the rationale for these choices.

Chapter four offers an interpretation of the findings within this work commencing with an exploration of the cultural differences experienced by lesbian women.

Chapters five utilises the literature as a guide to illuminate health care issues for lesbians.

Chapter six covers further discussion surrounding the interpretation of the findings focusing upon the complex decision making process to disclose to health care providers and the perceived consequences of such disclosure.

Chapter seven presents the discussion and conclusion of the work including recommendations for future directions.

CONCLUSION

This chapter presented the particular stance of this research outlining definitions of health, of claiming lesbian as an identity and repelling the pathological explanations of this identity. Placing lesbian women under the umbrella of cultural safety demonstrated the applicability of this topic to nursing. The world in which lesbian women reside was illuminated by an examination of the concepts of heterosexism, homophobia and gender to afford an insight into the potential difficulties encountered when cultural expression incorporates a lesbian identity.

The next chapter will provide a literature review of relevant research. The focus of this review includes research involving lesbian women and health care issues. An extension to this includes some research with health care professionals held attitudes to assist in the illumination of the potential difficulties, which may be encountered when attempting to access health care.

CHAPTER TWO

INTRODUCTION

The chapter commences with a discussion highlighting the importance of lesbian health. This is followed by a brief historical exploration of the medicalisation of lesbianism and the stereotyping afforded these women. An exploration of the past is essential to more fully appreciate the present context. It is only from this juncture that we can begin to consider the future (Morris, 1993). The subsequent review of the literature is divided into three streams to include lesbian health care experiences, professional attitudes exposed, and finally nursing attitudes towards lesbian women.

In response to limited availability of research and literature relevant to lesbian women, for the purpose of this research it is necessary to utilise a diverse approach encompassing both historical and contemporary literature. Given the societal invisibility of this segment of the population, research and literature available from all disciplines will be employed within this work.

An exploration of available literature demonstrates that there is limited research relevant to lesbians (Gully, 1997; Leifer & Young, 1997; Thompson, 1998). This paucity of research relating to lesbian health issues is predictable given the invisibility and marginalisation of this group in society (Platzer, 1993; Simkin, 1998; Tinmouth & Hamwi, 1994; Wagner, 1997; Zeidenstein, 1990). The majority of available literature and publications relating to lesbian health issues are from North America (Platzer, 1993; Thompson, 1998). Very little research exists within a New Zealand context relevant to the care of lesbian women (James, Harding & Corbett, 1994; McCauley, 1996).

THE IMPORTANCE OF LESBIAN HEALTH

As recently as twenty years ago, most disciplines including medicine saw the male subject as the norm, both experimentally and clinically. Broom (1995), states " an assumption that the health of males is the norm for health - indeed that the male body is the bodily norm, and that if women suffer they do so because of their own physically - based deficiencies" (p.107). The converse has been argued to address this essentialist

imbalance, citing the oppressive social structures, equating to hardship and life stresses that women encounter, which necessarily impacts upon their health and wellness (Batcup & Thomas, 1994). LoBiondo - Wood & Haber (1994) state " the historical exclusion of women from clinical research is now well documented. Men have been the subject in the major contemporary research studies related to adult health" (p.24).

In a society where women have been almost invisible with regard to the biomedical model (Altekruse & Rosser, 1992; LoBiondo - Wood & Haber, 1994; Thompson, 1998), lesbian women have been even more precariously situated, by being completely invisible (Saphira & Glover, 1999; Simkin, 1998; Tinmouth & Hamwi, 1994; Wagner, 1997; Zeidenstein, 1990).

A Ministry of Women's affairs document (1998), concerning itself with a report on the convention of the elimination of all forms of discrimination against women, mentions lesbian women just twice in eighty four pages. Though included in a comprehensive list of groups consulted, the only direct reference to lesbian women surrounded the issue of the legal challenge for same sex couples to marry. This document forwarded by the Minister of Women's Affairs, Hon. J. Shipley, demonstrates the continued invisibility of this group.

It also provides a good example of an effort to equalise the disparity between couples (meaning heterosexual couples) and lesbian couples while perpetuating the separate and marginal categorisation of lesbian women. The operational paradigm is heterosexual and all else is situated in comparison to that measurement of the norm (Brown, 1997). If lesbians were visible entities, then it is possible to assume that the notion of women surviving independently from men might begin to filter into social truth (Hoagland, 1988), thus reducing the prevailing heterosexism which is the root cause of many of the negative health experiences of lesbians.

Simply adding lesbian women into a document tackling inequalities as opposed to conceptualising specific inequalities relevant to this group is little more than tokenism. Such tokenism deflects the opportunity for an in- depth analysis prompted by probing questions to uncover potential differences for diverse groups of women (Bhavnani, 1997). Equally as important such deflection prevents the development of strategies

aimed at overcoming such inequalities thus preserving the status quo. Personal communications with the New Zealand Medical Council and the Ministry of Health confirmed that neither body has a policy specific to lesbian women's health in New Zealand (personal communication 28/06/99).

This neglect needs to be addressed in order to ensure provision of an atmosphere where lesbian women can feel safe, comfortable and secure when accessing health care. By reaching a level of knowledgeable understanding of relevant health issues to lesbian women health providers would be better positioned to ensure affordable, accessible and appropriate health care.

The most important aspect of sexual orientation particularly in relation to overall health and well-being, is that the woman is comfortable with her identity – whatever it is, and however it may change over time – and that she feels supported and accepted by the people around her (Leifer & Young, 1997, p.30).

MEDICALISATION OF LESBIANISM

Lesbianism has historically been defined as immoral, sinful and evil and these definitions have given licence to persecution (Hartman & Laird, 1998). In the past common practices levelled at homosexual people included hanging, burning, drowning and beheading (Zeidenstein, 1990). Historically all of society's patriarchal institutions have viewed lesbianism negatively, labelled by church leaders as sinners, by the law as criminals, by the health professionals as pathological and by the sociologists as deviant (Conrad & Schneider, 1980; De Monteflores & Schultz, 1978; Zeidenstein, 1990).

Western research paid scant attention to lesbianism until the latter part of the nineteenth century, and when the gaze of the medical profession turned towards lesbianism, it pronounced it to be a disease, congenital in its nature. Lesbians were therefore perceived as sick, troubled, guilt ridden, miserable and unhappy people (Doyle, 1967), demented, dangerous and doomed to an immature existence (Phelan, 1989).

The twentieth century denoted the advancement of technological societies, which increasingly valued scientific solutions for social problems. Institutions with invested

interest in social control, specifically the state and church, relinquished aspects of this responsibility to the remit of medicine (Conrad & Schneider, 1980; Hall & Stevens, 1991). Medicine's prowess in the region of social control evolved from its authoritative ability to determine 'normal' in both behaviour and people, concomitantly providing expertise in the determination of 'abnormal'.

Lesbians were thus medicalised and pathologised, although in essence few studies were developed specifically from a suitable population. Instead the majority of knowledge or information regarding lesbians was generalised from studies of male homosexuality (Belote & Joesting, 1976; Chafetz, Sampson, Beck & West, 1974; Conrad & Schneider, 1980; Hall & Stevens, 1991; Kenyon, 1968). This pathologising by medicine granted society permission to publicly condemn lesbianism (Hall & Stevens, 1991). Lesbians were attributed a sickness role by virtue of their sexuality. As a result of this sickness model, many health professionals spoke in terms of curing this deviant sexual preference (Chafetz et. al, 1974, Conrad & Schneider, 1980; Kenyon, 1968; Saphira, 1984).

In 1974 during the annual convention of the American Psychological Association, it was determined that homosexuality would no longer be categorised as a mental illness (Belote & Joesting, 1976; Haldeman, 1994; Hall & Stevens, 1991; Lamberg, 1998; O'Neill, 1996). It seemed apparent at this juncture that medicine had effectively demedicalised homosexuality concomitantly surrendering its position as agents of social control over lesbians and gay men.

Less well known perhaps is the debate some three years later surrounding the drafting of the third *Diagnostic- Statistical Manual of Mental Disorders* (DSM 111) in which 'ego-dystonic homosexuality' was constructed as a psychiatric disorder. This category afforded the opportunity for physicians to diagnose lesbian and gay men should they exhibit unhappiness or distress regarding their sexual orientation (Hall & Stevens, 1991). Haldeman (1994) notes that what was viewed as 'ego-dystonic' reactions to homosexuality are in fact internalised responses to a hostile society. This category was maintained until the 1987 revision of DSM 111, when it was removed in preference for a category of 'sexual disorder not otherwise specified' (Haldeman, 1994; Hall & Stevens, 1991; Lamberg, 1998; O'Neill, 1996). This particular category can be invoked

should there be “persistent and marked distress about one’s sexual orientation” (DSM 111, 1987, p. 296).

Since the removal of homosexuality as a mental illness in 1974 a segment of biomedical researchers have attempted to prove that homosexuality has as its causative agent, brain science, genetics, and endocrinology (LeVay, 1996), or abnormal prenatal hormone activity (Friedman & Downey, 1994). The focus has therefore shifted from a psychological pathology to a physical matter (Silverstein, 1991). Should a deficiency be reversible then the sexual orientation of a child could be correctable (Friedman & Downey, 1994). A core of biomedical research seeks discovery of evidence to ultimately support in utero- diagnosis of homosexuality (Silverstein, 1991). This provides an excellent example of the medical model’s role as an agent of social control. Medical means are employed to eliminate or minimise behaviour, which is not captured within the ‘norm’ (Batcup & Thomas, 1994).

Five years following the removal of homosexuality as a mental disorder empirical evidence demonstrated that many health professionals believed that lesbians were perverse, immoral, disgusting (White, 1979), and more recently repulsive, disgusting, and sorrowful (Young, 1988). A significant number of physicians and nurses continued to view lesbianism as pathology correlating it with immorality, perversion and danger. This perception allowed for levels of discomfort when providing care to the point where services were regularly refused to lesbian women (Hall & Stevens, 1991). In the present time it is clear that the attitudes of health providers towards lesbian women continue to harbour strong elements of fear and prejudice in the practice arena (Brogan, 1997). Hayter (1996) notes both negativity and a lack of willingness to provide care for people perceived as sexually deviant.

Despite homosexuality no longer being officially categorised as a mental illness, various degrees of homophobia continue to permeate many levels of society including medicine (Tinmouth & Hamwi, 1994). Friedman and Downey (1994) report that antihomosexual attitudes continue to be prevalent in many branches of the American medical community. O’Hanlan (1996) concurs with this belief citing many studies, which reveal a significant prominence of homophobic attitudes across the general category of health professional in the United States.

Many practitioners still adhere to the officially debunked "illness" model of homosexuality, and many base their treatment on religious proscriptions against homosexual behaviour (Haldeman, 1994, p.221).

LESBIAN STEREOTYPES

Historically lesbian women have been depicted in a stereotypical fashion, conveniently based upon heterosexist notions of the world. A critical historical analysis of conceptualisations of lesbian women demonstrates that for close on a century lesbian women have been characterised as sick, dangerous, deceitful, aggressive, tragically unhappy, contagious and self-destructive (Hall & Stevens, 1991). It is widely assumed societally that one woman plays the part of a man (butch) while the other takes on the part of the woman (femme) such is the persuasiveness of the heterosexual world view (Kitzinger, 1985). Such characters are frequently depicted as social misfits, who desperately endeavour to imitate heterosexual relationships (Davis & Lapovsky Kennedy, 1990; Nardi, 1997).

Lesbian women are narrowly defined in terms of their purported sexual acts, negating the potential for sexual relationships to be attributed to a portion rather than a complete part of life (Haldeman, 1994; James, Harding & Corbett, 1994; Jenefsky & Miller, 1998; Platzer, 1993; Richardson, 1993; Saphira & Glover, 1999; Wojciechowski, 1998; Zeidenstein, 1990). Failure to acknowledge or include contextualised identity (inclusive of social, emotional, affectional, political and intellectual) with sexual behaviour maintains this highly reductionist definition. Lesbian women in this light are nothing more than the sum of their sexual behaviour, subtly reinforcing much of the pathological characteristics ascribed by the medical profession.

Any definition of sexuality based solely on behaviour is bound to be deficient and misleading. Sense of identity, internalised sociocultural experiences, and importance of social and political affiliations all help define an individual's sexual orientation, and these variables may change over time (Haldeman, 1994, p.221).

Furthermore

Defining lesbians solely on the basis of sexuality denies the fact that lesbians are raped, have sex for money, get pregnant or may have sex with men through choice (Lampon, 1995, p.171).

Lesbian relationships are stereotypically characterised by society as being of limited duration, informal arrangements which rarely conjure up images of long term commitment, emotional and socio economic stability. Life long partnership or children rearing are seldom mentioned facets of such relationships (Oerton, 1997; Platzer, 1993). Once again this provides an excellent example of the manifestation of heterosexuality as the norm against which all else is defined. Concepts such as couples or families are heterosexual first and subsequent mention of lesbian and gay couples or families maintains the division from sanctioned normalcy (Brown, 1997).

The most comprehensive survey carried out to date in the United States demonstrates that the majority of lesbian women are in long-term relationships despite the myth purporting that lesbian women are unable to form stable, committed involvement's (Bradford, Ryan & Rothblum, 1994). Saphira and Glover (1999) in their NZ health survey regarding lesbian women reported that 71% were in steady relationships with 17% citing duration of greater than ten years. "The inability to marry legally and cover one's partner for work related benefits further serves to propagate the myth that long-term same sex relationships do not exist" (Walpin, 1997, p.128).

It is frequently societally assumed that lesbian women do not have, and harbour no future desires to have children. All aspects of family life and relationships are depicted as somewhat less tangible and less relevant than heterosexual relationships (Platzer, 1993). This notion supports the ideologies surrounding family values, which have been constructed to preserve the moral integrity of society, and further fuel negative beliefs, fear, ignorance and uncertainty about gay men and lesbian women (Hartman & Laird, 1998).

Zeidenstein reported in her 1990 United States study regarding gynaecological and childbearing needs of lesbian women that 70% wanted children. Simkin (1998) suggests that it is erroneous to subscribe to the notion that lesbian women do not want children

and consigns such a belief to myth. Such narrow myths expressed by stereotyping may mitigate against access and provision of appropriate health care services and may preclude active involvement in the decision making processes surrounding health and treatment (Thompson, 1998).

Lesbian women constantly receive negative messages from the environment, regarding their identity. Consideration needs to be afforded to the necessity of developing an identity in an informational vacuum. Growing up into an identity which is socially sanctioned, cannot be spoken of, has no language to describe it in positive or helpful ways is problematic (Wolfe & Penelope, 1993). Further stress is added by their devalued status within the dominant culture, and they may experience tremendous difficulty in achieving and maintaining a sense of self esteem considering the negativity displayed by society, coupled with the danger of internalising homophobia (Card, 1995; Deevey, 1995).

Disclosure of sexuality to colleagues or employers is one of many significant decisions as it may adversely affect job prospects and relationships in the workplace (Craven, McCurdy, Rosier & Roth, 1985; Deevey, 1995). Disclosure to family and friends may be just as difficult a decision, often with negative results (Craven et. al, 1985). Isolation, anxiety and shame compound the stress of living on the margins of society (Deevey, 1995; Liggins, Willie, Hawthorne & Rampton, 1994; MacEwan & Kinder, 1992).

Lesbians must deal with the stigmatization, verbal and physical abuse of a homophobic society. They may face rejection by family, friends, co-workers and religious groups, and may be denied housing, employment, custody and legal representation (Wagner, 1997, p.16).

Lesbians historically have been an invisible, underground subculture (Heart, 1994), stigmatised with ample historical and sociological evidence to support the rationale of responses such as discrimination, distancing socially, and defensiveness (Saphira, 1984; Stevens & Hall, 1988). " Male dominated science has not taken women, including lesbians, seriously enough to engage in the necessary research on which the helping professions could adequately base their theory and practice" (Chafetz et. al, 1974).

Despite the passing of a quarter of a century little would appear to have changed in this respect and a body of relevant research with, which to guide practice is still outstanding.

LESBIAN HEALTH CARE EXPERIENCES

The vast majority of research studies on lesbian women's experiences of traditional health care resoundingly reflect negativity. Recent studies have shown that their interaction with health care professionals is often problematic, resulting in lesbian women both delaying and failing to seek traditional health care (Hall & Stevens, 1991; Simkin, 1998; Trippet & Bain, 1992; Zeidenstein, 1990). Almost without failure these studies describe the fear of discrimination, the health professional's reaction to their disclosure, the assumption by health professionals that lesbianism is abnormal and evidence of mental illness (Calvert, 1982; Robertson, 1992; Trippet & Bain, 1992).

Hitchcock and Wilson (1992) found that lesbian women would avoid seeking health care that was not of an emergency nature without first having determined that the provider was safe. Saphira and Glover (1999) in their NZ survey on lesbian women reported that 5% of their respondents expressed negativity (regarding their sexual orientation) by health care providers. However scrutiny and careful assessment mediate this by these lesbian women, that pre-empted disclosing to a health care provider.

Trippet and Bain (1992) employed a quantitative/ qualitative instrument with a convenience sample of lesbian women gained from three women's cultural events in the US. These women described that fear of, or the actual experience of discrimination as a significant barrier to seeking health care. Furthermore they expressed a felt lack of respect from traditional health providers coupled with poor communication skills.

Robertson (1992) interviewed 10 self-identified lesbians in the US regarding their health care experiences. The assumption of heterosexuality was identified as a significant barrier coupled with delaying health care seeking due to the potential for negative responses from health providers. This assumption is cited frequently as a significant problem (Calvert, 1982; Gentry, 1992; Ministry of Women's Affairs (NZ), 1987; Rankine, 1997), which results in poor communication between the lesbian clients

and the health care providers. In these circumstances care delivery is focused on such issues as partners being male, a need for contraceptive or sexually transmitted disease education and advice (Calvert, 1982; Gentry, 1992; Lucas, 1992).

The heterosexual assumption and therefore penetrative sex results in lesbian women's accounts of sexual history, being treated with both suspicion and disbelief (James et al., 1994). Various types of vaginitis, which can be sexually transmitted, are of concern to this group. Bignall (1996) reports the presence of bacterial vaginosis in seven of 13 exclusively lesbian women in a British study. However ignorance on the part of many health professionals precludes this information being disseminated to the appropriate populace (Bernhard & Dan, 1986).

Lehmann et al. (1998) found in their US study employing a written questionnaire that only 13% of the respondents had no history of penile-vaginal intercourse. They move smoothly to report that 57% had annual cervical screens "which in lesbians without a history of penile intercourse seems an unwise use of medical resources, and the frequency of tests should be individualised" (p.384). Without further discussion on this aspect of their study it is unclear quite what their intended meaning is, however implicitly these authors do not consider lesbian women to be in the same risk group as those women who have a history of penile-vaginal intercourse. This in part perpetuates the commonly held belief that lesbian women do not require cervical screening, while demonstrating the need for clear unambiguous messages to be given to women such as

Research shows that lesbians have cervical abnormalities as often as straight women. Even if you have never had sex with a man you could have a cervical abnormality (Health Waikato Cervical Screening Programme [pamphlet], 1996).

Hall (1994) engaged an ethnographic study which involved 35 lesbian women in the US involved with long term alcohol recovery, described their experiences with identification of the problem, help seeking and barriers to recovery in health care interactions. According to these lesbian women interactions with health care providers are of paramount importance with trust, conceptual congruence, and styles all being key issues. However all participants said that the persuasiveness of the heterosexual culture, compounded by ignorance of issues pertinent to lesbians as highly problematic to

forming a trusting relationship with health care providers. Disclosure of lesbianism often resulted in silence and provider's unwillingness to even utilise the word 'lesbian'.

Hitchcock and Wilson (1992) involved 33 self-identified lesbians in their qualitative US study regarding disclosure of sexual orientation to health care professionals. They identified four disclosure positions taken up by lesbian women namely passive disclosure and passive non-disclosure (leaving clues without articulating sexual orientation); active disclosure (specifically stating sexual orientation) and active non-disclosure (either presenting as heterosexual or not refuting the heterosexual assumption). They further identified formalising (extending legal validity to the relationship) and scouting (collecting data regarding health care providers in order to assess safety) as being relevant concepts for lesbians seeking health care. These lesbians believed that they could not assume a positive response to the disclosure and some felt that they could only gain positive health care if they did not disclose their orientation, thus sacrificing their psychological comfort for physically safe health care.

Compounded vulnerability was reported by 77% of participants in one United States study, involving 45 lesbian women relating their experiences of health care. This feminist narrative study gave voice to an overwhelming number of negative interactions further illuminating the difficult balance between physical and psychological safety surrounding the issue of self-disclosure. Furthermore it was apparent that negative social judgements from health care providers has the potential to negatively impact upon both quality and type of care afforded to lesbian clients (Stevens, 1994).

Self-disclosure of sexual identity heightens anxiety for lesbian women, who fear a homophobic reaction encompassing stigmatisation, breaches of confidentiality, exposure to hostility or physical harm, compromised care, or lose of custody of children (Brogan, 1997; James et al., 1994; Matthews, 1998). Disclosure of sexual orientation to health providers is equated with the strong probability of diminished care (Rankine, 1997; Thompson, 1998; Wojciechowski, 1998).

A survey study from the US found 80% of older lesbians reported discrimination because of their lesbian identity and the majority mistrusted traditional health care (Deevey, 1990). Lesbian women believe that the medical institution acts in a hostile

fashion towards them, and they perceive a gaping void where sensitivity and knowledge to their unique health needs is concerned (Matthews, 1998; Rankine, 1997).

Issues of determining sexual preference are an important aspect of the health history, though lesbians in one study felt it should only be recorded as an optional issue (Lucas, 1992). Many lesbian women experience discomfort surrounding the question of next of kin, for medical records (Caulfield & Platzner, 1998; Rankine, 1997) which may force disclosure and the potential thereafter for less than optimal health care.

Lesbians found very few opportunities given the heterosexist approach, to disclose their sexuality. In situations where disclosure occurred, few lesbians deemed the experience in a positive vein (Brooks, 1981; Hitchcock & Wilson, 1992; Robertson, 1992; Stevens, 1994; Trippet & Bain, 1992), often resulting in subsequent delays in further health seeking behaviour (Brogan, 1997).

Matthews (1998) engaged with 24 lesbian women utilising in-depth interviews and focus group meetings to research lesbians and cancer support in the US. Few of these lesbians felt that disclosure of sexual orientation was always required, and associated disclosure when warranted with stress and potential conflict. The fewer resources a lesbian woman had at her disposal the greater the problems associated with disclosure. It is probably reasonable to connect lower resourced women with the number of times they are removed from that measurement of the societal norm as being directly proportional to each other.

Lucas (1992) utilised a descriptive study to investigate the health care preferences of 178 self-identified lesbian women in the US. These women identified holistic counselling, health maintenance and disease prevention as main priorities. These lesbians defined health care as health oriented rather than medicine or cure oriented. Furthermore female health care providers were deemed to be preferable. Several other studies identify the preference for female health providers (Robertson, 1992; Trippet & Bain, 1992). Sexual classification held priority over the sexual orientation of the provider, with lesbian women feeling increased levels of comfort along with reduced levels of vulnerability with a female practitioner (Brogan, 1997).

Lesbians are more likely to engage in alternative diets, meditation and relaxation techniques, mental health therapy and counselling, and holistic care (Buenting, 1992; Trippet & Bain, 1992). They are less likely to seek gynaecological care resulting in a reduction of regular cervical screening (Buenting, 1992; Saphira & Glover, 1999). In part this may be associated with the belief that cervical screening is only relevant for women who have a history of penile-vaginal intercourse.

PROFESSIONAL ATTITUDES EXPOSED

The reaction to homosexual health professionals from within their own professions may be a useful gauge to illuminate the extent of the situation. Rose (1993) surveyed lesbian nurses in the UK, 25% of who reported homophobic attitudes directed at patients. All participants reported their colleagues resorting to derogatory terms such as 'pervert' or 'queer' when referring to lesbian patients. Most reported their colleagues as defining lesbianism as an illness, deviancy, and sinful. Twenty five percent reported having witnessed refusal to care for lesbian women from their peers.

Rose (1994) interviewed twenty gay and eight straight doctors to assess the strength of homophobia observed in colleague's behaviour and whether this caused extra stress to gay doctors in the AIDS era. The study found that "doctors who are supposed to be guided by an ethical code, are influenced by ideology and the values of their culture. In many instances they are blatantly homophobic: some even deny help to or find it difficult to treat some patients with AIDS" (p.587).

While the non-gay portion of the study considered that prejudice in the profession had worsened since the advent of AIDS the gay doctors reported only minimal worsening to an already embedded negativity towards homosexuality. Tinmouth and Hamwi (1994) report that many medical students encounter a heterosexist or overtly homophobic atmosphere within the profession. Robinson (1996) states that the advent of AIDS has given rise to a focus in medical schools on some aspects of gay male sexual behaviour. The emphasis is invariably directed on the potentially negative aspects, serving to overshadow any and all other significant health issues. Lesbian women it would seem continue to be rendered invisible in the majority of medical school curricula.

A study examining nursing texts used in Australia between 1967- 1986 found that generally the said texts did not acknowledge lesbianism or even contain the word lesbian. In the only text to acknowledge homosexuality it was described as a disorder, treatable by means of behavioural therapy and psychotherapy, along with a nurse-patient relationship that would re-instigate the natural sex role of the patient, thus promoting security and pride in womanhood (Jackson, 1995). Implicit here is the notion that, a lesbian woman is neither secure, nor proud, rendering a good example of the insidious patriarchal message contained within such texts.

Nursing theories and textbooks that present families as consisting of a male and female heterosexual couple and their children, or that delete mention of same-sex relationships, are heterosexist and serve to sustain heterosexual privilege by assuming that heterosexuality is the exclusive way of being in the world (Gray et al., 1996, p.206).

Information surrounding sexual orientation is conspicuous by its absence within nursing textbooks and curricula, with little or no content evident, reflected in the knowledge levels of such health care workers (Misener, Sowell, Phillips & Harris, 1997).

Muller and White (1997) examined a US medical curriculum on homosexuality to determine its efficacy to generate more positive attitudes of medical students towards gay men and lesbian women. Interestingly the curriculum was not proven to cause dramatic improvement in already held attitudes. Instead those students self-identified as religious, more consistently scored in the homophobic range than did those who did not identify with religion. Personally knowing gay or lesbian people was equated with positive gay friendly attitudes, and women repeatedly scored more 'gay- friendly' than men.

In a United States study with 187 participants Berkman and Zinberg (1997) report that 10% of social workers are homophobic and that the majority demonstrate heterosexism. They further illuminated an association between religious affiliation and higher levels of heterosexism and homophobia.

O'Hare, Williams and Ezoviski (1996) involved 175 US liberal arts college students in a

survey questionnaire to explore a potential connection between fear of AIDS and homophobia. Findings included that men were less accepting of homosexuality generally, displayed a greater fear of AIDS and were more homophobic than women. They found homophobia to be commonplace in the college and despite the availability of AIDS related information students exhibited negativity towards gay people and irrational fears of contracting AIDS.

Olsen and Mann (1997) conducted a US survey to explore the relationship between having a gay or lesbian acquaintance, levels of knowledge regarding homosexuality and attitudes about gay men and lesbian women held by medical students. They found that female medical students were more positive than males regarding homosexuality. Furthermore they associated greater knowledge levels with more positive attitudes.

NURSING ATTITUDES TOWARD LESBIAN WOMEN

Research in this area is, not surprisingly, sparse despite the fact that any nurse involved in the care of women, will necessarily encounter lesbian women. From the findings of the few available reports, which explored lesbian phobia in both nursing students and nursing educators, it is patently obvious that nurses are not free of the prejudicial attitudes towards lesbians demonstrated by society at large. Morrissey (1996) comments that the majority of nurses appear to hold deeply seated negative attitudes towards same sex attractions attributable to the socialisation process. This prejudice operates in both clinical practice and nursing education.

In an attitudinal study of 250 psychiatric nurses in the US Smith (1993) reported neutral to mildly positive scores related to attitudes about gay and lesbian people. Of significance though was the discovery that 77% of nurses were shown to be exhibiting moderate to severe homophobia. Thus despite a cognitive acceptance of lesbian women and gay men it was mediated by negatively held feelings towards these groups. The product of such a disparity may well be problematic delivery of appropriate nursing care to lesbian women. According to Ott and Eilers (1997) nurses refute the claim that negative attitudes held by them affect clinical behaviours. Conversely Hayter (1996) considers that the areas of sexuality and sexual orientation particularly reflect negative nurses attitudes which do affect the clinical behaviour.

Nursing students demonstrated a high level of lesbian phobia, many believing that lesbian lifestyles are unacceptable and that laws should be in place to guard against such sexual behaviour (Eliason & Randall, 1991). A significant number of nursing students identified lesbians as a high-risk group for AIDS often despite specific education to the contrary (Eliason & Randall, 1991; Eliason, Donelan & Randall, 1993).

Another study found that education types made no significant difference to female nursing students, who described lesbian seduction of heterosexual women, "boasting" and the "masculine aura" of lesbians. They also noted that lesbians were a bad influence on children, and described lesbian women who discussed their lifestyles (in a similar manner to their heterosexual co-workers) as "too pushy". Many respondents strongly objected to lesbians discussing their lifestyles, but liberal tolerance was somewhat evident if lesbians were silent and invisible (Eliason, Donelan & Randall, 1993).

Lesbian lifestyles are stereotypically defined by sexual activity alone, yet homosexual sex is not a legitimate topic of conversation or practice. Clearly if one is engaged in such activity both silence and invisibility are demanded by the wider world (Gray et al., 1996).

Nursing educators displayed heterosexism when surveyed many believing that lesbianism is not a natural expression of human sexuality. Common strains of thought were that lesbians were wrong, immoral, perverted and disgusting. Almost a fifth maintained that lesbians would molest children and a slightly smaller number would object if a nurse who was lesbian was caring for their child. Again a significant number of those surveyed believed that lesbians are a common source of AIDS transmission (Randall, 1989). The erroneous public assumption that lesbians are a high-risk group for AIDS persists (Friedman & Downey, 1994). It is crucial to note that negative attitudes towards homosexual people predates the advent of AIDS (Morrissey, 1996).

It is problematic that nurse educators display and disseminate either wittingly or unwittingly, such judgmental, negative and inaccurate knowledge and views towards a marginalised societal group. It would seem reasonable to assert that the caring profession cannot preclude the pervasive nature of societal constructs. Furthermore the

identity association regarding the transmission of AIDS may promote a reasonable argument for distancing lesbian women from gay men. This may encourage appropriate research into lesbian issues and concerns, rather than generalising across from the experiences of gay men. " To equate lesbian existence with male homosexuality because each is stigmatised is to deny and erase female reality once again" (Rich, 1980,p. 649).

I include a single piece of research, which though dealing specifically with nurses attitudes toward homosexual men found interesting changes following a workshop day. Half of those exhibiting negative feelings such as repulsive, disgusting, pity and sorrow expressed a more positive feeling toward these men, following participation in this workshop. An atmosphere was fostered whereby nurses could safely express issues concerning human sexuality and subsequently explore how such issues might impact on quality of care delivered to patients (Young, 1988).

SUMMARY

This chapter has provided a platform and foundation for this study. The small quantity of research literature repeatedly uncovers problematic health care encounters for lesbian women. Given that the majority of available literature is from outside New Zealand it is still unclear (given the dearth of specific research) whether the situation in New Zealand is comparable. Chapter five is reserved to address the identification of both similarity and difference between New Zealand lesbian women and the experiences informed by the available literature as discussed within this chapter.

The next chapter deals with the research design. This includes the qualitative approach, the critical social paradigm and the feminist process, which underpins this work. The participatory method, ethical issues, data collection and analysis are also contained within this section.

CHAPTER THREE

INTRODUCTION

This third chapter details the qualitative approach, the critical social paradigm and the feminist process, which underpins this work affording it both shape and structure. Within the early part of this chapter I position myself clearly articulating my rationale and bias for engaging with this topic. The participatory research method is explored followed by the means employed to gain participants. A brief overview provides salient information about the participants and the process for consent is outlined. The method of data collection is articulated followed by a section exploring issues relevant to the proposed focus group for the second interview. Finally a section outlining the thematic method of data analysis is offered.

QUALITATIVE APPROACH

A qualitative approach underpins this work. Such an approach implies a contextualised stance employed towards understanding meanings, which individual people, attach to their lived experience within their natural world. This unique meaning of experience is known by the individual person and subjectively articulated in order for the purpose of description and interpretation (Burnard & Morrison, 1994; Lo-Biondo Wood & Haber, 1994; Wilson, 1993). Both the person and their experience are privileged since only they can match the verbal account with the reality of the lived experience while sharing it by means of a common language (Allen & Hardin, 1998). Irrespective of the context women's issues and problems are both complex and numerous and consequently many approaches invoking qualitative research are necessary (Olesen, 1994). Qualitative research is particularly well placed to effect an exploration of new topics (Eichler, 1997).

Qualitative research can be defined as

Involving broadly stated questions about human experiences and realities, studied through sustained contact with persons in their natural environment, and producing rich, descriptive data that helps us to understand those persons' experiences. The emphasis is on achieving understanding that will, in turn, open

up new options for action and new perspectives that can change people's worlds (Munhall & Oiler Boyd, 1993, p.69-70).

Both a qualitative approach and an emancipatory paradigm allows for the biases, values, beliefs of the researcher to be described (Henderson, 1995; Janesick, 1994), thus maintaining a position that research cannot be conducted in societal/ cultural isolation. There exists a tension here to resist reductionism, as it is difficult to satisfy the demand of situating the self as a researcher without invoking reductionist labels. I have therefore employed labels, which illuminate certain aspects of my social/ cultural position while also endeavouring to describe their relationship to this work.

I position myself within this work as a woman, a lesbian woman, a registered nurse and a feminist. I have had occasion to experience both professionally and personally negative responses from colleagues, peers, family, and friends as a direct result of my sexuality. It is always difficult to be on the receiving end of negative responses and reactions to who I am as an individual (invariably in such circumstances all other parts of me are stripped away with the exception of being a lesbian). I have personally lived with the fear of being discovered as 'different' for much of my life and currently appreciate the reality of that fear for other people who find themselves in the unenviable position of being perceived as 'guilty by association'.

For the purpose of this work then the negative responses from professional health care personnel, both as a colleague and recipient of health care are expressly noted. This fulfils the requirement of exposing my values, biases and social situation, congruent with the philosophical position of this work.

The stated objectives of the research were twofold. Firstly to determine factors which either hinder or facilitate lesbian women's sense of safety when accessing health care. Secondly to provide relevant information to nursing and other health professions in order that it can be used as a tool to better judge the appropriateness or not of the care delivery currently provided to this group.

For knowledge to have value to nursing it must offer explanation or illumination of the human experience in ways which allow growing reflection on the quality and applicability of our practice (Carryer, 1995, p. 180-181).

Health professionals may not immediately appreciate the potential differences from heterosexual clients, which lesbianism invokes. Such difference may include the absence of role models, the absence of legal or social recognition towards their relationships, absence of traditional gender roles, the greater parity of power and control between same sex partners, and the particular role of extended and origin families (MacEwan & Kinder, 1992).

It is essential to determine who owns particular knowledge in order to judge who is most precisely positioned to define that reality. There is a need to see the world from where a particular group of women is situated (Lather, 1988). Farganis (1994) describes women as a minority group of outsiders who do not view the world as insiders do. Until a quarter of a century ago and the emergence of feminist research, men were taken to represent the universal norm, and consequently very little was known about women (Eichler, 1997).

Therefore it is congruent to instigate research with lesbian women given their invisible societal standing coupled with their historical exclusion from health research (Platzer, 1998; Simkin, 1998; Tinmouth & Hamwi, 1994; Wagner, 1998; Zeidenstein, 1990), in order to gain an appreciation of their lived reality. This in turn informs an understanding of potential differences from mainstream society leading to the potential for change to occur.

By listening to women speak, understanding women's membership in particular social systems, and establishing the distribution of phenomena accessible only through sensitive interviewing, feminist interview researchers have uncovered previously neglected or misunderstood worlds of experience (Reinharz, 1992, p.44).

EMANCIPATORY PARADIGM

This research is located within an emancipatory paradigm drawing on both critical social and feminist processes. Given the androcentric notions of much contemporary research where the male was viewed as the 'norm' (Altekruise & Rosser, 1992), coupled with an "enduring societal value on traditional heterosexuality" (Stevens, 1994, p. 218), women especially, those women in marginalised groups, have until recently, had little or no voice regarding researched health care issues relevant to them. Located within this paradigm is the potential for explanation, creating understanding, in a shared manner, in order to contrive the foundation for change. Emphasis therefore is placed upon understanding as opposed to objective results (Lumby, 1991).

There are striking similarities between feminist frameworks and emancipatory inquiries. A feminist stance is concerned with exposing oppression, challenging the traditional status quo, in order to effect social change (Hall & Stevens, 1991). Emancipatory inquiries have as their ideological origins a mandate to understand societal oppression, and from this understanding alter it. Therefore both critical social theory and feminist theory fit comfortably within an emancipatory paradigm (Henderson, 1995). Central to each of these positions is the perception that society contains groups whose levels of power and resources are not comparable with the dominant cultural group. Furthermore each position holds that knowledge is socially constructed, historically situated and based upon values. The sociocultural and historical contextual influences ensure that scientific research is neither value free, objective nor neutral (Henderson, 1995).

FEMINIST PROCESS

Awareness of the insufficient degree to which mainstream research has created useful knowledge about women's health has drawn many researchers to feminist methodologies. Such approaches tend to privilege qualitative designs, emancipatory objectives, and cooperative strategies. They challenge the notions of expert power, the appropriation of voice, and ownership of the research products (Thorne & Varcoe, 1998, p.481).

There exists no clear definition of the quintessence of feminist methods of research (DeVault, 1996; Maynard & Purvis, 1994). Feminism alone then is not considered to be

a research method, rather a perspective which can underpin a congruent method. The result of this grafting is that the research boasts two diverse sets of principles, those of the method and those of feminism being satisfied (Reinharz, 1992).

Three major principles underpin feminist research. The produced knowledge should be of value to the participants, the method of research should not be harmful or oppressive, and reflexivity is a constant process throughout all aspects of the study (Acker Barry & Esseveld, 1983; DeVault, 1996). An egalitarian partnership should develop between the researcher and those participating in the research, the research should be for women, and those participating should have as much potential gain from the work as the researcher (Carryer, 1995; Hall & Stevens, 1991).

Feminist research allows freedom and creativity in forging a research partnership with participants to generate knowledge which sheds light on human experience (Carryer, 1995, p.186).

The social construction of gender is central to all feminist inquiry, the ideological goal being to correct the invisibility and distortion of female experience in ways relevant to ending women's unequal social position. Feminist research exposes the centrality of male power within the social construction of knowledge (Maguire, 1996). Current structures must be challenged and alternatives posed (Grosz, 1990). A critical feminist analysis demonstrates deficiencies of alternative explanations about women's situations (Acker et al., 1983; Olesen, 1994; Sigsworth, 1995). Any feminist inquiry devoid of such recognition and critique is guilty of perpetuating the decontextualised, fractured worldview of the dominant culture.

Simply focusing upon experience neglects to offer explanations regarding how that experience has been both societally and culturally shaped. Should an unquestioning trust be placed on experience oppressive systems are merely being perpetuated rather than exposed and critiqued (Olesen, 1994). It is crucial for feminist researchers to offer critique, the potential for action to alter oppressive circumstances and transparency within their work to evade collusion by perpetuating the previously accepted silences (Fine, 1992).

Bhavnani (1997) when discussing feminist objectivity illuminates the connection of personal experience and objective knowledge. Therefore it is my personal experience (of invisibility, marginality, constant vigilance, and the potential for disaster) which informed by my objective knowledge, creates the ability for me to categorise such experience as injustice. This experience prompted an intellectual commitment to explore the causation of such injustice, ergo experience and objective knowledge co-operatively exist and are mutually informing.

I enter this research focusing on lesbian women, explicitly carrying both my objectivity and subjectivity in the knowledge that I cannot as a researcher be removed from either, they both form and inform my social/ cultural position and consequently my beliefs and actions. Put another way I resist the notion that subjective reality is the *single acceptable truth* to inform research invoking a feminist/ critical social process, while yet affording it primacy within such a stated position (Thorne & Varcoe, 1998).

PARTICIPATORY RESEARCH

The chosen method for this work is participatory research, which arises from both critical social and feminist theory and creates links between research, education and political action. Not surprisingly there are echoes of the principles of feminist research contained within the distinguishing qualities of conducting research from this position.

The researcher, and those participants involved in the research, engage in a partnership so that effectively research is performed 'with' others. Value is placed on experiential and popular knowledge, as legitimate ways of knowing. From the understandings of life particular to those engaged in the research comes the generation of theory. A strong focus exists on empowerment and power relations along with consciousness raising. Outcomes should be beneficial to those participating and are linked to the goal of participatory research. Benefits are seen to occur with the potential through political and social action for change to power inequities in society (Henderson, 1995).

Participation however involves more than simply taking part in a research project, by its nature it embraces active involvement, choice, and the potential for choice to be realised (Cornwell & Jewkes, 1995). Quintessentially participatory research involves a ground

up approach, which commences with identification of the phenomena to be researched, and those participating are involved in all subsequent decisions related to shaping and structuring the research project.

The highest attainable degree of participatory research requires the participants to effect a decisive role in the planning, implementation and evaluation (Rifkin, 1990). Cornwell and Jewkes (1995) note that predominately research which falls under the remit of participatory, translates to little more than an invitation to gain local knowledge and experience in projects, which are completely researcher controlled. A critique of participatory practice by these authors revealed that the theoretical level of collegiality required for method authenticity was rarely attained.

Due to the constraints of this particular research project a limitation is that the participatory nature of the work is only partially fulfilled. Given the time constraints and the student status of the researcher it was not possible to commence with a group of participants eager to identify a phenomena and work in partnership from that juncture. Byrne (1997) in her thesis work with lesbian women also identified the difficulties associated with collaborative research given the individualistic nature of an academic thesis.

The balance is somewhat redressed by the very recently released Lesbian Health Survey in this country by Saphira and Glover (1999). Within their recommendations they advocate for qualitative research to investigate barriers to accessing health care encountered by lesbian women. Furthermore

One key to success in knowledge development with diverse populations is to invite marginalized people to talk at length about the health problems they face, the obstacles that block their access to health care and other resources, and what they believe is needed to remedy their situations. While this seems almost too simple to be efficacious, the truth is that it is rarely done in research or practice in any discipline (Hall, Stevens & Meleis, 1994, p.35).

Participants were invited to comment upon any facet of the process at any time during the research. This invitation included written, telephoned or taped input and a memo returned with the first transcripts acted as a reminder of this open invitation. Furthermore participants did seek the opportunity to alter part of this research and a structural component was supplanted with an alternative of their collective choosing as a result. (This is covered in more detail under the section dealing with focus groups).

ACCESSING PARTICIPANTS

Following full ethical approval flyers requesting participants were placed at every conceivable location where lesbian women might gather or visit. This included the local Woman's Health Collective building, the local gay and lesbian club venue, the women's space at Massey University (I also left the information sheet at each of these venues to increase the information available to lesbian women considering participating in the research) and an advertisement in the Massey University weekly newsletter. Self identified lesbian women aged thirty-five years and over with between three to five hours to spare over the next six months were asked to phone.

I resisted proffered informal snowballing, which would specifically identify lesbian women who were well educated, articulated, white and middle-class. Research to date concerned with lesbian health has almost exclusively focused on American, white middle-class, and well educated lesbians in the twenty to forty age bracket (Thompson, 1998). Such categories represent the visible tip of the iceberg while concomitantly failing to appreciate the traditionally ignored bulk beneath that which is visible on the surface.

Lesbian identity contains plurality of race, class, ethnic grouping, disability, and religions (Wolfe & Penelope, 1993). Older, less well off, rural, disabled and lesbians of colour are considered to be almost invisible even within lesbian research. The difficulty of accessing these traditionally under represented groups within the larger group known as lesbian, has been identified as problematic by other researchers in this area (Ellis & Collings, 1997; Stevens, 1994; Trippet & Bain, 1992; Zeidenstein, 1990).

There is a need to bridge knowledge about health care experiences of women, persons of colour, and low-income clients with knowledge about health care experiences of lesbians (Stevens, 1994, p.218).

The response from this initial advertising was a single participant. Despite informal snowballing no further participants emerged with an interest in taking part in this study. Consequently an advertisement was placed on the Internet on a lesbian and gay friendly bulletin board site. The response to this was silence.

Following a return to the ethics committee permission was gained to place a journalistic piece in the Evening Standard outlining the study and requesting interested women to contact me by telephoning my provided mobile number. The response to this was silence also.

During a several day period at Massey University for formal study a number of my student peers came forward and offered to informally snowball in their geographical areas utilising the flyers and information sheets. Although cost constraint was my rationale for focusing on the city within closest proximity to me I realised that this geographical widening was crucial to the continuation of this work.

Resulting from this informal snowballing several participants resident in the North Island were gained who enthusiastically wished to participate in the study. While I experienced a sense of losing control over the process at this point as potential participants were co-opted into the study by community assistance, it nonetheless felt more congruent with a participatory process. I also felt a relief at shedding a portion of that control considered antithetical to a feminist process and relief at having participants.

THE PARTICIPANTS

Seven lesbian women participated in this research study. Geographically the participants lived in two distinct cities, though half lived far enough out on the fringes of cities to be classed as a rural setting. All women were aged above thirty-five, the youngest being thirty-eight while the oldest was fifty-seven. Two of the participants had

professional qualifications, one had no formal education while the remaining lesbians had attended high school for a varied length of time. Five were in paid employment while two were living on a State funded benefit.

The majority held health insurance and two participants had their partners covered through their work scheme insurance subsidies. This according to other research in this area is unusual (Walpin, 1997). The majority of participants had no defined chronic health conditions however one mentioned asthma and depression, along with high blood pressure, which was also mentioned by another participant. Five of the participants had children, for the most part adults themselves with a single participant raising a young child. All of the participants identified as of European descent.

It is crucial to point out that this small sample cannot be deemed as representative of the wider lesbian world. These lesbian women are not the representative voice of all other lesbian women (Byrne, 1997). Olesen (1994) states "qualitative feminist research is not homogenous but highly differentiated and complex" (p.168).

The recent emergence of Queer theory has raised objections to feminist theories of lesbianism critiquing the assumptions of lesbian feminists regarding the coherence, stability and permanence of sexual identity. This is further compounded by the assumption that all lesbians share common worlds and that this common ground translates into a community (Stacey, 1997).

While it is attractive to confine the use of the label lesbian to those who self identify as such it still fails to involve those who may wish to identify as lesbian but do not do so. There exists no narrow, reduced, single sentence, with which to encompass a definition of elements essential to being lesbian (Brown, 1997). A lesbian identity invokes a plurality of diverse meanings and cannot be defined solely upon sexual acts. If sexual experience with another woman is held as central to lesbian identity then the experience of a woman who identifies as lesbian in the absence of that experience is excluded. Conversely there are women who engage in sexual relationships with other women who would not invoke for themselves the label of lesbian. Alternatively attractions may exist and yet not be acted upon (Wolfe & Penelope, 1993).

ETHICAL ISSUES

Written information was sent by post detailing the purpose and intent of the study, and outlining the time commitment and other expectations of participating to each potential participant who had signalled interest in becoming involved. During the initial meeting between each potential participant and myself I specifically asked woman if they had read the information sheet. From this juncture there was an opportunity to discuss and ask questions about the study. No one posed any questions at this point. The written consent form was jointly read and each point carefully illuminated, specifically the points regarding posing questions at any time, withdrawing from the study or declining to answer any particular question, agreement to the interview being audio-taped and the right to have the audio-tape turned off at any time during the interview. Each participant signed the written consent form prior to the study commencement.

The participants were asked to choose a pseudonym by which they would be known throughout the study to preserve their anonymity. All transcripts were sent by post to the participants for verification and clarification, which included the right to change their mind regarding what they had said and make necessary alterations. This is particularly crucial to feminist analysis supporting some restoration of power and control to the participants regarding the research process. Potentially identifying information was subsequently removed from the transcripts in-keeping with the ethical requirement of anonymity. The opportunity to delete any material which following reflection, these participants felt might aid in their identification further supported the tenets of confidentiality/ anonymity, adding to the participants sense of safety regarding this research process (Platzer & James, 1997). This issue of confidentiality/ anonymity will be explored further within chapter seven.

METHOD OF DATA COLLECTION

Ethical approval had been gained to meet with participants on three occasions. However this was reduced to two face to face meetings simply for practicality. The initial meeting had been structured to provide the opportunity to outline the study, gather demographic information and make suitable (directed by the participants) arrangements for the setting of the subsequent meetings. This was incorporated within the first interview meeting

timeframe at the request of the participants themselves. All interviewing took place in participants homes again this was their choice of a comfortable and safe venue.

Once the written consent form had been signed the interview meeting began. This was a semi-structured, open-ended interview enabling the participants to engage in depth with the personal experiences of accessing health care. Participants were invited to share their stories uninterrupted following an initial open-ended question. *Tell me what it's been like for you getting health care.* This afforded participants the opportunity to speak unimpeded choosing their own style of language deemed critical to reflexive involvement (Hall, Stevens, & Meleis, 1994).

While my specific area of interest surrounded issues, which held relevancy to health care, safety and access I aimed to steer clear of narrowly structuring the interviews. Such restriction would be tantamount to seeking to fill gaps in already determined (by me as the researcher) concepts. The strategy of inviting the participants to determine the direction of the interviews held relevance on a number of counts. It is in keeping with the participatory nature, the philosophical underpinnings of the work being much closer to a consensual arrangement aimed at partnership than an autocratic one. It also afforded the opportunity for a marginalised group to potentially share meanings previously unarticulated and as such be creatively informing.

The method of data collection as unstructured reflexive interviews allows incorporation of feelings, exchange of information and knowledge and leaves space for emancipatory outcomes (Carryer, 1995, p.182).

Minority and disempowered voices are best heard in story form. Such a mode of articulation may empower invisible people who have traditionally been marginalised by race, class, gender and/or sexual orientation (Martin-Mc Donald, 1999). The interviews were recorded in full. A small number of participants stated their preference to be interviewed as a couple as opposed to individually and this was readily accommodated. Following the initial storied account some focused questions and probes were posed to encourage further exploration and clarification.

This involved sharing portions of my own story both with the intent of highlighting commonalities and outlining differences to our experiences as lesbian women. Feminists have argued for a real rapport between the researcher and participants to foster a non-exploitive relationship. Research becomes a means of sharing information which rather than bias the personal involvement of the interviewer is an important criteria in the building of trust, and enhances the opportunity for good information (Maynard & Purvis, 1994).

Mindful of the negative responses of participants upon reading their own spoken word I spent some time following the formal interviewing explaining the reality of verbatim transcription, (the lack of punctuation evident in spoken word, the colloquialisms employed by most of us unwittingly along with slang). This verbatim account often makes for difficult reading particularly when the voice being read is our own. By sharing some of the strategies and responses other research has recounted (Byrne, 1997; Carryer, 1995), I had the hope of minimising such negative introspective responses from these women. The effectiveness or not of this strategy is discussed within chapter seven.

Transcription of the first three interviews were performed by myself, a labour intensive process involving listening to small segments of the tape, pausing the tape recorder, and typing directly onto the word processor on the computer. Despite being a very time consuming exercise it provided an invaluable insight into the process of interviewing. Tolich and Davidson (1999) advise that the researcher initially transcribe the data in order to gain a sense of the effectiveness of the interviewing skills employed, support this. This allows for reflection upon the process.

A typist having signed a declaration of confidentiality transcribed the remaining transcripts. I chose this particular typist both for her expertise in transcribing data from audio-tapes (as a medical typist) and the knowledge that she would be both comfortable and treat with confidentiality the subject matter of my thesis. Despite my request for transcription to occur verbatim, this typist proudly informed me of the helpful tidying up she had done to enhance the grammar and speech of the participants. As a result the editing process was more time consuming than I had originally planned for with each

transcript being read while simultaneously listening to the audio tape to more appropriately realign the two to ensure meaning was not altered or lost.

This is important as silenced, marginalised people can not necessarily indulge in the dominant mode of speech, and consequentially it is absolutely essential to listen and hear their alternate ways of shattering silences. Within the silence other forms of expression will be created and used (Hall, Stevens & Meleis, 1994). To do otherwise is to fail to improve the oppressive societal conditions experienced by women. This necessitates both recognition and critique of the locus of dominant societal structures, in this instance language.

Most research which engages in this process of transcription neglects to identify problem areas specifically when typists are employed to perform the transcribing (Lane, 1996). It is crucial to explicitly inform the typist of the requirement of every verbal sound being transcribed verbatim should this be a requirement of the study. As Lane (1996) discovered

The omissions and changes were mostly the typist's well-intended efforts to 'tidy up' our untidy women's talk, in keeping with society's norms of good grammar and speech (p. 161).

Aware of the felt discomfort surrounding taping of conversations I employed an external microphone. This both captured with ease the voices of participants while also allowing us both (the participant and myself) to forget about the audio taping, in the shared knowledge that this extra piece of equipment was capturing the evolving story. It allowed for sitting back and relaxing rather than straining over a little taping machine, thus it quickly became a forgotten accessory.

On a cautionary note however it is still essential to check the workings of equipment prior to each individual interview. While this may seem to be unnecessary advice in the cold light of day, it is very different when the stresses of fieldwork coupled with efforts to downplay the non-comfort of taping a conversation for participants are taken into consideration. I speak from personal experience regarding this matter. The stress of being in the field, coupled with an arduous day of interviewing several of the

participants sequentially, my efforts to minimise the drama associated with taping conversations, along with my growing sense of confidence with my equipment conspired to be my undoing. Although all of my equipment seemed to be in superb working order and all the indicators were correctly displaying their particular function, a small unnoticed failure in my external microphone resulted in several second interviews not being captured on audio-tape.

The result of this was a return to those participants affected, with their full consent, following an explanatory telephone conversation to highlight my failure. While I couched this disaster in very careful language to minimise felt coercion by these participants I am fully aware that a level of compulsion undoubtedly existed for these women. Factoring in the growing relationship between us, their desire to speak about their lives and their unreserved desire to assist me is relevant to this situation. However each participant was in no doubt about granting the opportunity for my return and all commented that they easily appreciated the humanness of my error and welcomed the opportunity for a further (third) meeting. I thank them for their understanding once again.

INSIDER POSITION

A number of lesbian researchers have discussed an 'insider' research position, specifically that they as lesbian women undertook research within lesbian communities of which the researchers were also members (Byrne, 1997; McCauley, 1996). Although it may appear obvious that this research was also undertaken from this position some crucial differences need to be illuminated.

Although aware of the lesbian community within my geographical region and a member of the relevant association I have only participated in its activities on a very small number of occasions. If insider research equates to research within my own community then it is perhaps doubtful that this perspective can be attributed to this work. I would suggest that reserving an insider position solely for those researchers engaged in research within their own communities is limiting. This is not to suggest that this type of insider position is not relevant for uncovering highly crucial and much needed

information. My point is that there must be more than a single interpretation of an insider research position.

To only include lesbian communities (who presumably hold a level of commonality by virtue of their community status) denies the existence of, and consequently perpetuates the silence of such women who are situated beyond such defined communities. This may include those sections of lesbian women deemed invisible even within lesbian research for example older and rural lesbian women. Furthermore given a sole community driven approach to research for marginalised groups the risk is heightened of commonality being moulded into stereotypical patterns, which precludes a plurality of diverse voices that resist reduction and classification.

This research was undertaken from an insider position by virtue of my self-identification as a lesbian woman engaged in research relevant to other lesbian women. I imagine that an outsider position would be difficult and sought consensus on this question from the participants on the final interview. This is discussed in more detail within chapter seven.

Atmore (1990) discusses the insider position, which she says result in the role of the researcher and community member (read participant) becoming obscure. The participatory process holds sacred the notion of egalitarian, participative involvement inducing an intimate co-operative relationship between the knower and that, which can be known. Engagement in open, respectful dialogue with people resulting in collaborative relationships can aid the discovery of how people experience themselves, their health and the environment in which they live. This is the foundation for a partnership built upon trust and honesty (Ots, 1997).

PROPOSED FOCUS GROUP FOR SECOND INTERVIEW

I initially structured this study to include a focus group, which I scheduled to occur at the end of the transcribed/ verified individual data collection. Pugsley (1996) suggests that focus groups can be effectively used when exploring phenomena surrounding sensitive topics. Furthermore group participation affords the opportunity for previously silenced voices to be clearly heard. The focus group produces the opportunity for a

collective account of health care, while increasing credibility and consistency by producing a second source of data (Stevens, 1994). Bowser and Sieber (1992) observed that this focus group method enhances the role of participants as consultants rather than respondents.

The focus group would co-operatively give the participants the opportunity to engage in reciprocal dialogue, as collective interpretations were voiced. By this means the research would potentially be directly beneficial to the participants both by validating their personal experiences and facilitating the possibility that they can later share these findings and any new understandings with other similarly positioned lesbian women.

It transpired however that the overwhelming majority of participants were extremely uncomfortable with the proposed focus group interview. This was the single topic of discussion aired during the period of clarifying the study. Given the participatory nature of this research process the focus group strategy was replaced with a second individual interview with each participant thus maintaining both comfort and a sense of control over the proceedings. It also provided the opportunity for reflection on the probability that the initial lack of participants may in fact be linked to the proposed focus group strategy.

DATA ANALYSIS

The initial data analysis was conducted utilising thematic content analysis as a method (Burnard, 1991). Burnard (1995) considers thematic content analysis to most honestly represent participant's thoughts, utterances, feelings and beliefs in an organised and systematic way. At the outset the aim is to become immersed in the data and this is achieved by reading of the transcripts and making notes of general themes. On second reading headings are made which reflect the content otherwise known as open coding. The list of categories is then surveyed by the researcher and grouped together employing headings. The process contains the facility for continuing to collapse repeated and similar categories until a final list is produced.

The transcripts are again read to ascertain that the categories cover all aspects of the interviews. Each transcript is then worked through and coded according to the category

list and colour coding is advocated. The coded sections are then collated under the appropriate heading and subheading while maintaining context. Naturally complete transcripts are also maintained along with the taped account for reference purposes during data analysis (Burnard, 1991).

It is crucial at this juncture to clearly state that there is a sense of reductionism in regard to a textual method of data analysis. The researcher is placed in the position of having to make decisions regarding what stays in and what is omitted from the interview data consequently decontextualising and reducing it. The alternative is to present the transcript interviews in their raw form affording the reader the opportunity to illicit meaning for themselves (Burnard, 1995).

It is absolutely possible that given the complexity of data and the multitudes of potential meanings in any interaction that alternate readings and elicited meanings could be gained from this data. Sandelowski (1993) comments that given the same qualitative task no two researchers will arrive at the same result. I acknowledge clearly this reductionism while concomitantly stating that this analysis is by no means the single truth or reality of either the data or the position of the participants. However all views are indeed valuable with no one view holding primacy over others and as a result the explored interview texts still afford insight to be gained.

I acknowledge that the analysis is necessarily from my own interpretations of the texts, along with assistance from the participants in the study. This assistance with interpretation was one of two aims of the second interview. Participants were asked to work with the researcher to refine and enhance emergent themes as elicited from the first round of interviews. The overall emergent themes were presented in a report while each interview explored these in relation to the particular voice of the participant being used to gauge validity regarding category formation. The second purpose of this meeting was to seek guidance given the participatory nature of this work regarding dissemination of the findings of the research. Both of these purposes were outlined in a memo to participants, which accompanied the report sent to them. These elements will be discussed further within chapter seven.

Following initial data analysis a report containing details of emerging themes and possible meanings was typed up and sent by post to all participants along with a memo. Although I reflected the meanings attached to the transcripts I did not include actual voices at this juncture in order to preserve anonymity. Given the resistance to the proposed focus group by these women I was concerned that inclusion of their voice in a report to all participants may have appeared very similar.

Hall Stevens and Meleis (1994) highlight that, a conventional approach to preserving safety and confidentiality of participants may be inadequate for marginalised groups. They advocate the design of further protective strategies, which can be integrated into all stages of the research process. This is also in keeping with a flexible and reflexive approach to the evolving work and the unique problems which individual work may encounter. At such times it is crucial that as a researcher strategies can be utilised beyond that which is known specifically to preserve the ethical considerations of a work. Given work with hidden populations it is essential not to breach a delicate sense of trust and rapport. Each report was then discussed within the second interview utilising that participant's voice to illuminate and seek consensus and validity on the emerging themes.

Themes are usually organised around two structures, frequency and saliency. The former are those concepts which are repeated often while the latter captures those concepts which are noted either for their importance or because they stood out (Allen & Hardin, 1998). I sought both similarity and difference in the accounts of the participants and did not seek to give one primacy over the other. This is again in keeping with my stated feminist objective position where attention to differences is necessary (Bhavnani, 1994).

To merely seek similar positions is to plaster over the fissures, where dissenting, diverse and alternate voices may reside. If for example researchers seek to highlight only shared interpretations, differences between individual participants and participant researcher differences will be lost. These tensions within a research project are highly relevant especially should the researchers be involved in writing a text attempting disruption of societally held constructed beliefs (Opie, 1995).

Furthermore by not making explicit those differing voices, maintenance of a false sense of homogeneity and the potential for casting stereotypes is perpetuated as opposed to exploring, edifying and valuing diversity. Opie (1995) challenges researchers to attend to the paradoxical, contradictory and marginal elements which may seem insignificant but their very presence may offer a challenge to previously held interpretations or meanings. Consequently consensus and non- consensus were carefully listened for in the voice accounts of the participants.

Connections were also made between the analytic framework related to the concept of marginalisation, derived by Hall, Stevens and Meleis (1994) and the themes uncovered by this work.

SUMMARY

This chapter presented the foundations of the research outlining the particular approach, paradigm, and process both structural and philosophical and the rationale for such choices involved in moulding this work. Difficulties experienced on the research journey have been expressly noted. The participatory process was proven an attractive methodology well suited to the requirements of nursing research promoting egalitarian partnership and affording the opportunity for structural alteration to increase the comfort/safety of those participating.

Chapter four furnishes the opportunity to engage with the participants as they share and illuminate portions of their worlds to foster understanding.

CHAPTER FOUR

INTRODUCTION

This and the two subsequent chapters present the interpretation of the data, uncovered from the semi structured, in depth interviews with seven women who as part of their identity are lesbians. This work is not a journey of discovery as these women and their beliefs already existed albeit perhaps in silence and lacking visibility with regard to certain aspects of their selves. Therefore I choose to employ the term uncovering as opposed to discovering to imply that this data previously concealed has been revealed.

Few of the participants involved in this study had engaged at any length with the secondary or tertiary health care environments. Some may consider this a weakness of this work, and while in the beginning I might have concurred I now judge it advantageous. Had these women had specific experiences with health care interactions these may have skewed the work in a particular direction. This bias may have negated the opportunity to gain an understanding of the interconnectedness between daily living and social conditions and health related behaviours (Oakley, 1993). It is highly relevant to uncover what women who have not had such experiences believe as this more readily identifies the issues without bias.

Several major themes surfaced from this work. These themes do not exist independently from one another rather as a multiple inter-linked cohesive collection. For the purposes of clarity I have, to the best of my ability, extrapolated them from each other. I have frequently incorporated extracts from the interview transcripts to further assist with this process.

This chapter presents a cultural exploration of the meaning attached to claiming lesbian as part of a total identity package. This is relevant to maintain a contextualised approach towards health, necessarily incorporating physical, emotional, political and social contexts of everyday life. There is little in the way of "research that locates the concerns of women's health within the material and social context of their ordinary lives" (Oakley, 1993, p.340), and even less which connects cultural expression and lesbian

women. Therefore it has consistently been difficult to make strong links to literature within this chapter.

The research mandate to provide information for nurses implicitly demands a cultural exploration, which exposes differences from both heterosexual expression and experience. This fundamental insight of what it means to be lesbian is needed also in order to ensure the facilitation and fostering of a sensitive and supportive health environment for lesbians (Thompson, 1998), by nurses (and other health professionals).

SPEAKING FOR OURSELVES

I have titled this opening section speaking for ourselves, as it is crucial to afford these women a place to articulate their understanding of both themselves and the world in which they reside. As Louise noted:

...I think if you are going to be honest with people you need to explain and you know what the, being lesbian... what the impact it actually has on you as a person (Louise, Int.2. p.26).

Attention is given to issues, which separate this group from the heterosexual world in which they reside. Absence of role models, absence of legal and social recognition of relationships, absence of traditional gender roles, parity of power between partners as noted by MacEwan and Kinder (1992) have been placed within this chapter.

Several of these participants reacted with felt surprise that they were deemed to have something of importance to say. Some participants openly acknowledged that it felt wonderful to have somebody asking their opinion and saw this as validation of their life experiences. Louise said:

You know there are not many opportunities for lesbians to sit down and say what they think, and actually have someone or something sit back and listen, yea (Louise, Int.2. p.27).

JUST ME

To commence it seems valid to offer the participants the opportunity to define themselves. Although all of the participants readily acknowledged that they did indeed identify as lesbian this was far from the only adjective employed to define themselves and was rarely their starting point. As Louise commented:

I am also a sister, an auntie, and a friend... My sexual orientation is sort of my personal point of view it does actually affect the way and the choices that I make but it is not my 'life'. There is a lot more to life than being lesbian and I hope that that will continue to be the case. Its not like it is 'the' important factor in my life all the time... there are often a lot of other important or more important things going on (Louise, Int.1. p.12).

Conversely it was one of many terms utilised to define themselves as complete people, though several rated their lesbian identity as closely interrelated with the way they subsequently relate to the world. As Kate stated:

Oh yes I'm not Kate the lesbian. Yea, Kate the animal lover, and lesbian and mother and computer tinkerer yea. Um, but having said that I think that my lesbianism does colour the way that I look at the world (Kate, Int.2. p.11).

Not every woman felt comfort with the term lesbian being utilised as the sole or primary identifying term. As Meg noted:

Yes I am a lesbian woman, I don't like, I don't like having to be or having to define myself in those terms (Meg, Int.2. p.10).

Although prepared to utilise the term lesbian if required to do so Rae stated:

I am just me. I don't go and say I am a lesbian... No I haven't actually ever gone and said I am a lesbian. I have never done that to anybody. I don't feel as though I need to. I mean I would if it became an issue for something that I had to declare it (Rae, Int.1. p.10).

Several participants stated that 'it is me they are dealing with not a lesbian' clearly indicating that they are more than the sum of their sexual orientation. Pat expressed this:

So I don't mind being labelled a lesbian for some things if that's being put into categories I don't mind being put into categories. But the whole of me doesn't go in that category.... I've never really come out because I think its part of you that, part of the ongoing process of being a person (Pat, Int.1. p.17).

McCauley (1996) while granting the lesbian women in her study the opportunity to define what being lesbian meant for themselves closely correlates with this position. The majority of women involved in this 1996 study said that being lesbian 'is just being myself' (p.51). These women do not see the category lesbian, as having a pivotal position in their lives rather it is simply another piece of the composition of themselves. They do not engage in a reductionist definition of their lives rather strive to resist this approach. The potential consequences of such imposed reduction are discussed further in this chapter and also in chapter six.

OFF CENTRE STAGE, DANCING IN THE WINGS

Two participants talked about how they felt different from other women all their lives. This ranged from actually feeling physically different to feeling uncomfortable in feminine clothing. As Rae said:

...I never felt comfortable, isn't it funny I always felt as though I was in drag in high-heeled shoes (Rae, Int.1. p.14).

Issues around gender identity from a retrospective perspective are highly illuminative. Several participants employed the term 'tomboy' to describe their early years. This provides an excellent example of the depth of gendered language and its consequent (intentional) failure to represent individuals outside the sanctioned gender normative behaviour. It does little save reinforce the gender divisions again enforcing the one or other binary of masculine/ feminine.

Even at this age the pervasiveness of the culturally appropriate way of being is evident while having a sense that they are somehow contravening (crossing those delineated

borders) that correct manifestation. Terms such as 'tomboy' and 'sissy' (juvenile forms of dyke and faggot) are employed to direct those considered to be straying from the normative gender performance back to the prescribed side of the stage of life. Those who subsequently fail to remain thus positioned (as actors failing to correctly interpret the intended script) are banished to the shadowy wings out of sight.

Several participants talked about correct ways of being, acting, dressing and behaving as part of a lesbian identity. Ussher (1997) discusses this eloquently as both material and discursive expressions of 'doing lesbian' (p.151). The material reality of clothes and ways of talking or behaving is evident while there is also a representative significance attached to these expressions and interpretations of what it means to be lesbian. For the most part this behaviour was in the past a number of years ago. Ussher (1997) closely correlates this past positioning within her work finding that the women in her study used this older version of self, as a place to support comparison between the past and present representations of self. As Kate noted:

So you see the seventeen-year old woman walking down the street and you wouldn't have a clue what her sexuality was. ...they really don't dress and act like I felt I needed to when I first came out (Kate, Int.1. p.23).

On moving from the dominant culture at this time it was obviously considered essential to highlight this separation outwardly both by dress style and actions. This expression of identity would ensure visibility for other members of this subculture (Lukes & Land 1990), while reducing the potential for the assumption of heterosexuality (Ussher, 1997). Thus perhaps acting as an indicator of the potential to grow beyond the enforced monoculture, while reducing the sense of isolation when visible representations are more readily evident.

Contained within this next extract are clues to the difficulties of existing in two different cultures. Having moved to a subculture this participant reflects on the continued tension between attempting to resist the dominant culture (from whence we all commence) and finding regardless of this effort there seems to be no easy alternative to that dominant mode of defining our relationships to one another along the well-established masculine/feminine binary. As Kate commented:

...even though politically you weren't allowed to be butch or femme, you did actually sit on one side of the fence or the other. I don't know whether that defined me or I was already defined (Kate, Int.1. p.24).

This representation along the accepted binary division is misinterpreted by the dominant culture as an attempt to imitate as opposed to express difference thus the subculture is deemed to be shadow dancing with their dominant counterparts. I raised this issue of the male/female binary and the sense that lesbian women had a masculine aura about them or acted out an imitation of the heterosexual relationship alliance. None of the participants saw their relationships divided along these lines, although several admitted that this was how others saw them. Conversely these women made connections to the fluid nature of their relationships where decision making is a mutual activity and the stronger at any given particular time assists the other. Skills are attributable to one or the other partner without invoking the masculine/feminine binary rather which one of them is best positioned to do the job.

This amplifies the inability of the centre to pose alternative meanings beyond their narrow interpretations, thus imposing ill fitting explanations in the unitary mode of dominant language. It demonstrates effectively that oppressed people are adept at resisting, redefining, creating and utilising forms of expression which will be misinterpreted by those who given their rigidity are unable to engage in such flexibility (Hall, Stevens & Meleis, 1994).

Contained within this perceived imitation along the masculine/feminine binary, the lesbian stereotype, is invoked (as discussed earlier in this work) to provide a narrow and erroneous image. As Louise said:

...they did assume that because I was a lesbian that I was attracted to all women, ...I think they all had impressions that lesbians you know had short hair and um fairly butch sort of in appearance, but I don't know, don't know where they actually got those images and stuff from (Louise, Int.2. p. 8).

The perceived stereotype was enough to send Pat back to the ill fitting 'correct' side of the stage, having viewed the stereotyped image and not wanting any part of it. She said:

Because I was in a (lesbian) relationship when he came along and I didn't like the scene at that stage. I didn't want to be underground, I didn't want to be drinking myself to death and I wanted to get out into life and he showed a broader lifestyle that was what I wanted. So I kind of went into denial and it was a great risk actually to my mental health but he was good and I denied it for a long time (Pat, Int.1. p.1).

This demonstrates the effectiveness of the negative stereotype to patrol the borders. Strategies invoked to visibly announce differences are perhaps an effort to situate ourselves clearly beyond the heterosexual boundary (McCauley, 1996), yet are narrowly represented through the heterosexual worldview. From the conversations of these women it would seem that they believe the situation to have changed and evolved to afford a less rigid and fixed way of being lesbian today. Also there may be more obvious diversity in the lesbian identity. As Kate noted:

So I think that is one thing that you find amongst lesbians I think is that they do celebrate their differences now but I think there used to be a uniform. ...It helped the sisterhood (Kate, Int.2. p.25).

However Louise mitigates this when discussing the problems she encountered from within her lesbian community, when involved in a relationship with a bisexual woman. She said:

Actually one of the worst patches that I ever experienced was actually um when (name) and I were going out, we, because (name) is bisexual and I'm lesbian and the lesbian community gave (name) hell about being bisexual-being a fence sitter and all that sort of rubbish. A lot of gay people have little or no tolerance for bisexuality as an orientation separate from homosexuality and infer that bisexuals are in transition and dating a bisexual somehow dilutes my homosexuality (Louise, Int.2. p.17-18).

This readily demonstrates the difficulties encountered between marginal groups; the notion that there are correct ways of being even when residing on the margins. Despite situating ourselves beyond the heterosexual boundary should we have a thirst for

inclusion within these borders attempts to demonstrate 'normality' may be required (McCauley, 1996). These displays of 'normality' may be at the expense of those groups perceived to be even more deviant (from the central position) than lesbian women. Such polarising denies the complexity of life patterns, rather perpetuating the rigid monocultural divisive borders between those perceived to be 'other'. In reality these borderlines are much more blurred and many residents will hold multicultural status. As Kate noted:

It is never a good look amongst a minority, ... when they are seen to be fighting themselves you know a lot of um rednecks for want of a better word are gleeful. You know they can't get it together so we have got nothing to fear from them. It's perhaps a dishonest thing, ... but I think that with lesbianism um there needs to be a united front (Kate, Int.2. p.26).

This unified front may in itself be problematic as it once again serves to deny diversity and may result in further silencing and negating individuals who either do not fit or do not wish to fit within the chosen mode of community articulation. Louise expressed this:

... you have got people who are actually living um quite happily you know with partners or by themselves. Outside of the community... Who have been through the mill and actually don't want to get involved.... But would also, you know really like to you know get newsletters and that sort of stuff (Louise, Int.2. p.22).

It is important to avoid placing lesbians into a narrowly defined community where they do not feel they fit comfortably. One participant talked about how she had more in common with mothers than lesbian women following the birth of a child. There is some available literature, which would support this statement (Hare, 1994). Furthermore this participant expressed that having a young child compromised everything. As a consequence she has toned down as a result of concern for how she will impact upon his peers. Again Hare (1994) identified this, as a primary theme within her study where anticipation of their children being stigmatised by sexual orientation was a noted concern.

This motherhood role was different for those caught within the heterosexual paradigm. For those who had a choice (due to adoption) between male and female babies it would seem that the choice for these women was male, specifically to side step the gender normative role expected between a mother and daughter where the performance would be carefully repeated. These women did not feel 'right' in this feminine role and felt that a female child would do little save compound this narrow expectation of performance.

Lesbians are arguably always resisting or rejecting the archetypal feminine script in 'doing lesbian', as the rules of femininity are framed within a heterosexual matrix. Thus there is an awareness of performance and of the negotiation of roles and rules which is not present to the same degree in the talk of young heterosexual women, for whom femininity (and heterosexuality) is so familiar and ingrained that it is taken for granted (Ussher, 1997, p. 150).

All of these women believed that a male child would allow them to express themselves beyond this narrow role which for them was stifling. As Pat said:

...I didn't want a girl following me around wanting me, to teach her to sew and things like that (Pat, Int. 2. p.22).

Again there is evidence of the either/ or category within this and the following category. If the circumstances are not female by definition then they must be male. Both Pat and Rae expressed this:

I always identified with the men because they were my mates and I wanted to talk to them because they didn't talk trivia so much... (Pat, Int.2. p.22).

No, no, me neither and that's why I have ended up with the job I have got because it put me on the workshop floor... You know that kind of job which is nothing feminine about it (Rae, Int.2. p.22).

Women who resist their 'female role' in society while noting that the 'male' side of the border has for them more interesting choices are sanctioned even very early on in life by

societal structures. Later on this oscillation towards the more interesting will be misinterpreted along the male/ female binary of oppositional attractions as Rae noted:

And I tried to play rugby at school and got hauled up before the headmaster, 'don't you go down to that football field anymore' (laughter). I just wanted to play with the football not boys (laughter) (Rae, Int.2. p.23).

The oppositional binary further invokes the imitation mode. Kate said:

I mean like a lot of women in the olden days wore a suit and tie. I know I went through a stage where I wore men's trousers, you know not walk shorts but men's obviously men's trousers and yea of course I got accused of trying to be like a man. You try to do the reverse but you are doing exactly what they are doing because its, how I don't know, it is natural to do (Kate, Int.2. p.19).

A simple explanation for purchasing men's clothes is their practicality, durability and contrary to popular held belief has nothing to do with wanting to be a man! As Louise noted:

...it's just the bloody flimsy material that they make girl's clothes out of. ...for durability and that sort of stuff like men's clothing, men's T-shirts, men's gear lasts longer with, you know if you're into doing stuff, you know tom boyish stuff as a kid (Louise, Int.2. p.10).

Alternate explanations exist beyond those contained within the myth and stereotype invoked by the heterosexual world. The misinformation and misinterpretation of lesbian lives is directly attributable (in part) to an absence of a sanctioned gender role. The binary of masculine/feminine does little in this instance save continue to commit lesbian women to a deviant marginal position. That their cultural expression remains poorly understood amplifies the dominance of the heterosexual imperative. Viewing the world from these women's perspective affords the opportunity to forge alternate (from the dominant view) forms of cultural expression thus expanding informational options.

OMNIPOTENT MIRRORS

Definitive figures are not readily accessible due to the invisible nature of lesbian women however it is well accepted that approximately 10% of the population is non heterosexual (Brooks, 1981; Heart, 1994; MacEwan & Kinder, 1992). This is a sizeable marginal group, considering that approximately one in ten women may be non heterosexual and yet there is virtually a representational and informational vacuum concerning all aspects of life including health and wellness.

This next section addresses the difficulties associated with negotiating paths of daily living when encountering a void with regard to visual representations of the self. There are few available positive examples of lesbian representation (Hall, Stevens & Meleis, 1994; Marshment, 1997), so the available choice it would seem is a fluctuation between being invisible or negative imagery.

The heterosexual imperative contained within all facets of life has evolved to be taken (by most) as the common sense (hegemonic) way of the world. Homosexuality only has relevant meaning in a social and cultural environment where heterosexuality is hegemonic and where the preservation of this heterosexual norm is covertly subsumed within the mechanisms of state power (Butler, 1993). Three women talked about always knowing they were lesbian, but denying it, not listening to their own voices. Instead alternate voices were granted primacy. Meg expressed this:

Its always been there in the back of my mind but I tried not to listen to my mind and go ahead with what everybody else does, or what everybody is supposed to do if you like (Meg, Int.1. p.3).

It is questionable whether these were truly their own voices or realistically the voices of the dominant culture acting to steer individuals in the predetermined, correct and normal direction presented in this next extract within a published medium founded upon a heterosexist imperative. It is clearly evident that various interpretations of constructions mediated by society at large are also implicitly contained in much of this speak. As Pat stated:

And I actually reasoned, and they sounded like rational arguments to me at the time and so I turned my back on you know, I didn't let myself go along there, yeah. It was a shame in some ways I knew too much I wish I hadn't. If I'd just followed my nose and hadn't read so many books and things like that yeah. I might not have been in denial for so long (Pat, Int.1. p.3).

This extract also leads fluidly into the difficulties associated when role models or representations of self are denied to a group. Should there be diverse pathways of accepted and expected behaviours it is possible that some representations available to these women would have prevented this denial.

Given that such representations are not readily apparent this denial and endeavour to remain contained within the correct way of being in the world is not at all surprising. As discussed earlier within the introductory chapter this is often the sole recourse available to individuals when faced with a dominant and predatory culture (Bornstein, 1994; Brown, 1997). Compounding the vacuum of alternatives beyond the dominant cultural expression is the employment of negative imagery, which is discussed, in the introductory chapter as a form of social control endorsed by the centre. As Pat noted:

Although if I'd listened to my voice as a younger person everybody seemed to know but me. (laughs) My uncle that I'd spent a year with, my uncle and auntie when I was in standard six, it was the time when the two lesbians, the murder (reference to the Parker & Hulme case in Christchurch in 1954) yeah, I was told I was going to end up like that. So people (laughs) everybody knew, but me sort of thing and I was married twice (Pat, Int.1.p.1).

This represents a good example of negative sensationalist media being utilised as a mechanism to steer individuals in the correct direction. Following the murder of Honora Parker “a sensational court case followed, with extensive local and international media coverage and a resulting association of lesbianism with ‘evil’, ‘insanity’ and murder” (Glamuzina & Laurie, 1991, p.18). The correlation here is that if you are lesbian, you will turn out bad (in this case a murderer). As a consequence some women may turn from a more comfortable self-representation to remain camouflaged within the dominant group denying a part of their being even to themselves.

Several women discussed the issue of being drawn toward negative or sensationalist images of lesbians such is their thirst for visibility in the world in which they live. Any image is better than no image at all, again a good measure of the in availability of role models or imagery. Rae and Pat (being interviewed together) had this to say about a recent media reported situation which, reflected negatively upon lesbians

G And, and the way they portrayed that as some sort of...

R Lesbian cult sort of thing...

G So it was the lesbianism that was being blamed,

P But didn't we do much the same thing? Didn't I think oh bugger, you have let the side down (Int.2. p.42).

This final comment demonstrates the difficulties associated with negative representations and the tension of desiring positive images (forged from good behaviour) of lesbian women in order for normality and acceptance to be promoted (McCauley, 1996).

OPAQUE MIRRORS

This representational and informational vacuum poses difficulties regarding visibility and seeking images, which are similar to one's own reflection in the mirror. Rae having endured a highly painful and extensive personal reflection talked about her efforts to find others like herself

That didn't happen immediately I waited three years before I rang up. ...I rang the Citizen's Advice Bureau and the guy on the phone said, "I don't know why you women all phone here"? (Laughter). He gave me the name of the man from the AIDS Foundation and another women in town who I eventually rang. But it was just his attitude (Rae, Int.1. p.14).

This discussion continued following my comment that she was just a citizen looking for some assistance.

Exactly, but the AIDS Foundation? He gave me the number of the AIDS Foundation. That was actually horrendous... It was quite startling his attitude. I just couldn't get over (Rae, Int.1. p.15).

The next extract speaks very much for itself demonstrating the value and importance of viewing yourself by means of mirror images in the world thus reducing the perception of isolation (Lukes & Land, 1990; Hall, Stevens & Meleis, 1994). So frequently the refrain 'I thought I was the only one' is employed when people previously dislocated (for whatever reason) from the mainstream representations of the world uncover people like themselves. As Rae noted:

It is an amazing feeling to put ones boots on and go to town though and dance with the girls, that was the thing that was I found quite an awesome experience. ...When I got up there and there were all these women and I thought oh okay and I sat and talked most of the night... It was really quite an amazing experience because I didn't realise there were so many of us out there (Rae, Int.1. p.28).

THE OTHER SIDE OF THE MIRROR

All but two of the participants were in long term enduring relationships and felt that this made a difference to how they interacted with the wider world. The length of these relationships lent strength, coupled with a growing sense of comfort with their own identity as lesbian women. This may in part be due to having some constant visible representation of the self, viewed through a partner. Jen and Gay noted:

And because we've been together so long. We're strong we're very strong ...but a few years ago we probably would have you know, scared stiff to fill in a form like that and write that you were partners (Jen & Gay, Int.1.p.8).

Reflecting back to earlier times these women related a different level of being in and interaction with the world, which possibly demonstrates that experience is not static, rather fluid and evolving over time. Within her work Ussher (1997) determined that

“*doing or being* lesbian was a multi-layered performance, which shifted and changed both across time and across situations” (p. 150-151). It may be an indication of the changing world in which we all live, where culture and society is ever shifting and evolving.

Two participants related that several years before their current levels of comfort and strength they would have felt frightened and cowed down in health care encounters. A sense of self-comfort presently against younger feelings of embarrassment and being less inclined to take a stand was another response. Another participant commented that less security in her own sense of identity might have in the past resulted in a reactionary stance. Another participant mentioned the sense of not having problems going to the doctor now, whereas when younger she simply did not go. In past years a sense of real reluctance, non-comfort, feeling cornered, or threatened to the point where a surgical procedure might not have taken place, was yet another held view. Again this participant deemed the length of a relationship responsible for the current level of increased comfort.

Throughout the interview process, at various junctures every participant made comments pertinent to their sense of invisibility. Comments such as ‘we don’t register’, ‘we are invisible’ were evident. Invisibility was strongly linked to both absence of legal and social recognition, the absence of role models and perhaps most strikingly the stripping away of all other identifying features save that lesbian label. Thus this sense of invisibility was synonymous with the lesbian portion of their identity as opposed to their entire sense of self. This issue proved to be most problematic for some of these participants, this being reduced to a sexual orientation and its perceived interpretation. As Meg said:

I don't know? I mean we are invisible I know that, but I hate the connotation of being reduced to my sexuality because I am so much more than my sexuality. I hate that.... I really do think that we do resist having all those other aspects of our lives just being stripped away and just left a, a stalk if you like. It is like stripping away leaves off of a, off a tree and all that remains is a tiny little branch and yet the tree is so much more than just that little branch (Meg, Int. 2.p.9).

It also served to be another form of control, with lesbian women having to work extra hard to avoid the pitfall of having every minor event revolve around the reduced self. Should this prove to be the foundation of interaction with the legal system for example where a mother is a lesbian mother (note the 'othering' from the perceived heterosexual representation of a mother). Louise expressed this:

...I think once or twice been used against her by the father who, like they still haven't sorted out the custody entirely and it has been used in court a couple of times. That the kids are put at risk you know, just normal kid injuries and that's like, she has, she has to seek medical help for the kids but in doing so um puts her mothering skills at um on display (Louise, Int.2. p.2).

On coming out with lesbian as part of an identity several of these participants comment on their sense of moving from the place they previously inhabited to another environment. As Gay said:

Well when we first started out it was sort of like, I think you could call yourself a pioneer it was like going into a complete foreign land with no support. That's what it felt like (Gay, Int.2.p.7).

Not having contact for a variety of reasons, with those deemed to represent the cultural expression was likened to an exile by Kate:

...for me the time is never going to be right where there is no such thing as um going specifically somewhere for a lesbian thing because I miss it. I miss it a great deal and it was like self-imposed exile (Kate, Int.2 .p.1).

Living in a land which is foreign to a personal cultural expression it is evident that a crucially required element is contact with other members of the culture.

MIRRORS OF NONENTITY (OR LESBIAN NON-REFLECTIVE)

None of the women felt that they could readily identify role models and this was based across the past present spectrum. This question raised commentary on the vast array of

media and the overwhelming attitude that any form of media would be bought, read, watched or listened to should there be a hint of lesbian imagery incorporated within. These women talked about thirsting for images of their world. Most considered this role model void to be both critically important and still problematic in the present. Kate linked the need for role models to self-validation:

... I was watching a movie the other night and I said to my friend we don't get any validation... it is so shocking we watch any little part that may be vaguely lesbian for validation... 'Grease', Max (son) wanted to watch it and I remember thinking, ...back when I was a teenager please just something, because there was one character on there that could have been vaguely lesbian if you pushed hard. Please, something, anything you know I'm hungry and as a teenager I needed that validation. And it wasn't there.... It's stupid and it's awful I mean as a grown woman I feel stupid, at thirsting for validation, not that I need it for me personally, but wouldn't it just be lovely. And um, yea it is validation it is not having to swim upstream all the time (Kate, Int.2. p.12).

Louise noted the degree of felt difference between her heterosexual siblings and herself during adolescence when struggling through relationship difficulties. Here falling out with girlfriends was not afforded the same importance as any romantic connection was unknown. She said:

As often those teen relationships are quite clandestine, almost secret affairs, and when they fall to bits support from family and peers is not forthcoming as they didn't know the relationship existed. Maybe this is why a lot of gay people are not good at amicable separations (Louise, Int.2. p.4).

Some felt that certain types of role models were more easily viewed in the present (mostly within the music, sports and arts worlds) time. Hall Stevens and Meleis (1994) note that creativity is often sought by the dominant culture in minority spaces, which would suggest that if one is creatively serving the needs of the centre then any differences may be relegated to a less problematic positioning. Primarily the medium employed in those few available visible representations hailing from the centre is sexual

imagery. These participants considered ordinary 'normal' (meaning non-sexual) representations of themselves to be absent. As Meg noted:

I guess it probably is an issue because there aren't very many um out lesbians out there that you can model yourself on. I mean they are there and they're becoming more obvious and um but growing up for younger people I don't think there have been many role models. Unless you actually know somebody who is in your family or you know a close friend of the family then I don't think there are role models. I do think that that is an issue. Because it says you are not acceptable (Meg, Int.2. p.19).

Even within those few available film representations, which a number of participants mentioned, problems were discussed. This leads again to a central belief that the lesbian subculture is in imitation mode (Maynard & Winn, 1997), while those within the subculture criticise these actors playing lesbian roles. A difficulty articulating the nuance is obvious, but what is equally obvious is that the heterosexual world cannot represent lesbian imagery effectively to the lesbian culture. And so while it might be considered easy for lesbians to present themselves in a bicultural manner and pass unnoticed within the heterosexual world, these women are suggesting that the reverse is not possible. Those existing along the margins are considered by Hall Stevens and Meleis (1994) to have a significant wealth of knowledge pertaining to the centre whereas the opposite is seldom true. Pat and Rae stated:

P *It doesn't do it for me when they put ordinary women in, heterosexual women in, movie roles*

R *Portraying lesbians, it doesn't work does it, because... Yea well it doesn't come across as being authentic*

P *whatever it is it's different (Int.2. p.32).*

Given such paucity of role models several of these women talked about seeking out strong women to serve in this void as being the next best thing. These women do not

have to be lesbian once again removing the need to a level other than merely sexual identity. As Kate said:

...in terms of ah yea looking for role models when I was growing up, I looked to strong women and their sexuality I mean if they had been lesbians it would have been absolutely lovely.... so I had to just accept strong women that strove forth no matter what their sexuality, yea (Kate, Int.2. p.13).

The annual Hero parade held in Auckland was seen to be non-representational and this is worthy of some exploration. These are the very lesbian and gay people who are readily evident to the dominant culture, while concomitantly being non-representative of (at least) these lesbian lives. Kate stated:

K You know sort of like the Hero parades, I mean shit how many of us live like that? And it is unfortunate that they have to stand up and fight your sisters and brothers as it were and say tone down your act. Um, because we don't live like that but then how, how, how gay would a parade be with either you or I walking down the street?

G Not very gay. No.

K No. No it wouldn't be extreme in any way (Int.2. p.17).

Realistically though this and other such events are a celebration (and thus those participating are perhaps in extravagant party mode) they are likely to further invoke the stereotypical imagery leading to a tension between extreme and good (read normal) behaviour. In this sense extreme behaviour is that which is overt and obvious to the dominant centre while good behaviour favours efforts to behave in a 'normal' ordinary fashion and is thus covert and invisible to those at the centre, leaving such minority groups between a rock and a hard place. This dilemma can be heard in the above extract, the tension obvious between requiring extreme behaviour to be noticed and the felt need to take an oppositional position with your cultural brethren and suggest they tone it down.

A positive from such overt displays is contained within this next extract from Louise:

...like with Mardi Gras and that sort of stuff seeing that parents, parents of lesbian and gay marching you know with their banner and that sort of stuff would make some parents and also some gay people think and both either in a very positive way or in a quite a negative way (Louise, Int.2. p.7).

Hall Stevens and Meleis (1994) would consign this extract to maintenance of connection between the boundaries. Solidarity between families (irrespective of sexual orientation) blurs the borders affording a conduit of connection between the margins and the centre.

FOOTPRINTS AND CLUES

This section presents the issue of not feeling invisible or silent but rather having this invisibility and silence imposed from external sources. While these women may not engage in using the term lesbian in a verbal sense they believe that people know about this part of their lives. Rather than these women being invisible, central society is so wrapped up in its own self-identity that it is blind to such non-linguistic overtures. It is impossible to gain meaning from something, which is portrayed in an unfamiliar mode of communication. Contained within the imposed silence of those marginalised will be alternate modes of expression (Hall, Stevens, & Meleis, 1994). If shared meaning is ignored the blame can hardly be laid at the feet of those attempting to divulge the information.

JUST KNOWING (AS OPPOSED TO PASSING)

A number of articles in literature talk about the ability of lesbian women to camouflage themselves within the larger group of women and as a result pass as straight women if they wish to. Hitchcock and Wilson (1992) named this passing as heterosexual as active non-disclosure within the findings of their study. These participants frequently stated that they would not hesitate to disclose (given relevant circumstances) and this coupled with the numerous statements of these participants about people just knowing that they are lesbians needs careful consideration.

The majority of these women shared examples where they believed that certain people (mostly health providers within this context) knew they were lesbian despite having never being specifically told. Without naming it verbally it would seem that these women might choose to leave clues and signposts in their interactions with some people. Hitchcock and Wilson (1992) identified this non-verbal clue providing as passive disclosure. Stevens and Hall (1988) named this finding as 'identifiability' within their study, defining it as "the belief that one is known to others as lesbian without a verbal disclosure" (p.71).

In this study, probable examples of these clues include referring to partner by first name when relevant in conversations, not wearing rings on fingers, not using a title, a firm handshake, physical appearance, or a particular physical stance. The knowledge that you have gay friends or knowing you before you entered a lesbian relationship (therefore would notice the changes) increases this sense of probable knowing.

With regard to passing, few of the participants viewed themselves as indulging in this activity. Several commented that they could pass easily and adapt to any given situation. There was a sense that for non-important issues passing was acceptable but for important areas of life and interactions with others then passing was not an activity which these participants related to. As Meg said:

the chap that rung um assumed that she was my sister... it's irrelevant for me... to point out that she's not my sister that she's my partner (Meg, Int.2. p.15).

Passing in this next context may simply being culturally aware of the customs of the heterosexual world which is being visited coupled with a felt respect for those people residing within this world. Kate commented:

I haven't for many years, I can't remember the last time I would have gone out of my way to pass as a straight woman. ... but like I want to say out of respect for my parents... but if I was meeting one of their friends I probably wouldn't, nah I wouldn't even try and pass. I would just be me, I would just be Kate the daughter. But I would watch my P's and Q's if you like. As I would with other circumstances I wouldn't swear in front of certain people. But yea, if they, if

they said are you lesbian? There is no way I would deny it you know, yea that would be the closest to come to pass (Kate, Int.2. p.10).

If these women are not engaged in the act of 'passing' as heterosexual, it is feasible that a combination of not wanting to fall into the melting pot (resisting the label) along with a blinkered view by society to only see what it wants (read accepts) that contributes to the continued lack of visibility.

Hall, Stevens and Meleis (1994) consider that marginalised people are often believed to have broken ranks with the centre (dominant group) and view passing as a routine means of secrecy. This affords the opportunity to maintain a hidden identity. This group refutes the notion of passing. Should the lesbian identity be only a portion of all that is employed to assemble a self-identity this view is evidence of falling into the dominant reductionist representation of lesbians.

THE NEED TO SPEAK

There are times when several of these women feel compelled to speak and do so without hesitation. Examples of this are dealing with derogatory remarks, prejudiced talk, even to the extent of actively disclosing their lesbian identity. As Pat said:

And I have said to people, they say 'oh I don't know any lesbian people', I say 'well you do now you know' (Pat, Int.1. p.8).

While there is a need to address derogatory remarks the desire is to achieve a non-threatening position. I gained a sense of the rationale for this stance from Pat and Rae who seemed to be resisting the repetition of inflicting their beliefs, opinions and values upon others.

P ...we have to be careful we don't um do what, don't impose our view anymore than we want them to impose

R Theirs

P Theirs as well, so and I suppose we all come to our own truth eventually

R *Yea, I think we do*

P *And I also think that we have got to be careful and it took me a little while to think that um, not, not to scorn the knowledge I learnt in the heterosexual world (Int.2. p.19).*

These women make autonomous choices to invoke the lesbian portion of their identity depending upon the unfolding situation. Undoubtedly it becomes taxing to continually correct the heterosexual assumption and so this may only occur for certain encounters as opposed to every single interaction. This is quite distinct from the concept of passing or maintaining a hidden identity. The often hidden nature of a lesbian culture acts as a protective strategy providing a fortification against the prevailing dominant cultures prowess at reducing lives to aspects of their complete identity.

REFLECTIONS IN HEALTH CARE SETTINGS

The non representational status of these women resulting in an informational vacuum extends from the wider world to that of the health care environment. Several participants felt that this was an important area, though some admitted having never consciously thought about it before. This suggests that for these women negotiating their way through the world without imagery, to reflect their sense of self, is so routine as to be commonly accepted and therefore not easily articulated. Furthermore it demonstrates the hegemonic grip of those at the centre. Hall Stevens and Meleis (1994) consider that cultural institutions may be beyond the remit of influence of those residing outside the centre and consequently they may be poorly positioned to make their perspective known. As Kate said:

You, you would feel like somebody has put their hand up and said we count. Yea. We are actually part of this whole deal. I mean quite often when things are invisible you don't see them. You don't think of them. I have never thought of my, my medical practise as being ah particularly homophobic but then not, well I mean my doctor and the nurses are (not homophobic). But the actual centre, physical centre because I, if I saw a lesbian poster I would be thinking ah shit

that's what's been missing but never having seen it you never know what you are missing (Kate, Int.2. p.5).

Both Hall (1994) and Robertson (1992) illuminated the persuasiveness of the heterosexual culture leading to ignorance of issues relevant to lesbian women as barriers to developing trusting relationships with health care professionals. Trippet and Bain (1992) noted both a lack of respect and poor communication while Matthews (1998) and Rankine (1997) discuss the gapping void regarding sensitivity and knowledge. Stevens (1995) notes that written forms, brochures, and posters are all replete with heterosexist bias. As Meg noted:

I remember sitting there thinking and I actually picked out some of the pamphlets and had a look and there was no mention of, both for lesbian or gay men. There was none, no mention about for them, you know what sort of provisions may be there or what they should be looking for ... (Meg, Int.1. p.17).

A single participant noted that the mission statement indicated inclusiveness of all lifestyles and felt that this spoke a clear message to her. Beyond that however none of the participants saw reflections of themselves as lesbian women in their health care settings. As Louise said:

I interestingly enough do actually read the notice boards but I have never actually found anything relevant to my being gay at all. I wouldn't like to see support group contacts and that sort of stuff because I actually think that's quite negative in the way that being gay is considered to be curable or a health issue (Louise, Int.1. p.11).

This opposition to support group contact information in the wider health care environment, which might add to the notion that being a lesbian, was deemed problematic by this participant. However Kate held this opinion:

Even a lesbian support group pamphlet of, of your local group. ...you might be struggling to come to terms with lesbianism, if you are young or you are just

coming out and yea. It belongs in doctor's surgery a contact point for lesbian line... (Kate, Int.2. p.7).

Having direct lesbian data would be useful, especially clear and positive messages, which would inform lesbian women of issues relevant to them. Matthews (1998) study identified the need for gay positive literature to be displayed as a precursor to safe disclosure occurring. This is echoed by many of the participants in this work as being a factor enhancing felt safety. As Meg said:

...even if it had something, even if it pertained to gay men you know like HIV/AIDS. ... And you'd feel more comfortable much more. You wouldn't be quite so frightened to disclose your sexuality in that environment. You would, there would be an assumption an underlying assumption that you could actually do it and not have any fear of discrimination (Meg, Int.1. p.18).

This strategy would require a move by those at the centre to visually represent lesbian women, which is currently unlikely. This lack of visible reflection serves to dislocate these women from the centre by essentially rendering them invisible while delivering the strong message that they are not part of the 'normal worldview'. Those hidden invisible groups may only have the negative stereotypical images dispatched from the centre, with which to compare themselves consequently inner turmoil may result (Hall Stevens & Meleis, 1994). Meg noted:

It makes you feel like you're invisible you're not part of the mainstream if you like... It probably makes you feel a bit unsafe about going there and disclosing a private part of you because I mean its not there's no welcoming there (Meg, Int.1. p.18).

This is an example of power as defined by Hall Stevens and Meleis (1994) with regard to marginalisation. The dominant group in this case heterosexual people reside in the centre of society. Their power however is dependent on their authority being almost undisputed. A substantial challenge arises when a marginalised population is afforded visibility. Therefore it is in the interests of the heterosexual world to prevent such visibility occurring.

Nobody mentioned specifically the possibility of having lesbian imagery available in the health care environment. Instead links to AIDS Foundation material, Alcohol and Drug resources were suggested as possible strategies. This suggests the depth of invisibility surrounding lesbian women, while implying that gay men are more visible. Gay offered this opinion regarding this disparity between visibility of gay men and invisibility of lesbian women.

I think it is more male orientated. They have got more power. And we are always that, that lower level (Gay, Int.2. p.12)

The heightened visibility towards gay men occurred in the wake of the AIDS crisis and such imagery from the AIDS Foundation acts to confirm the stereotypically held image by those residing within the centre. Within the article by Tinmouth and Hamwi (1994) students aired frustration regarding the limited inclusion of gay and lesbian health concerns, with commentary, which suggested that HIV related illnesses overshadowed 'normal' (read, experienced by the mainstream) issues such as myocardial infarction.

SUMMARY

The above discussion illuminates the world where these women reside. The depth of lesbian invisibility is well judged by virtue of the smallest signal speaking volumes to these women. This provides the best indicator of their non-reflective status in society. A sense of safety in health care environments was closely linked with the presence of gay specific information, currently conspicuous by its absence. It is from this silenced, non-representative void that these women must negotiate interactions with the heterosexual worldview. For most this will include at some point an engagement with the health care environment. This cultural platform is useful in order to appreciate the unique perspective of these lesbian women along with several of the difficulties inherent with this cultural identity. When attended to, the voices of these women serve to disrupt the dominant reductionist account of their lives offering instead their own truth.

Chapter five focuses on specific issues relevant to health care for lesbian women as informed by the literature review. This overseas research provides the reference point with which to begin to gauge the New Zealand situation.

CHAPTER FIVE

INTRODUCTION

This chapter uncovers issues concerning health care guided by the review of literature as being salient to lesbian women. I have attempted to identify both difference and commonality between the overseas research and the situation in this country, determined by the accounts of these participants. Choice and preference of health care providers, cervical screening, and HIV/AIDS are discussed. The Issue of HIV/AIDS will be further explored to demonstrate and illuminate the problems encountered once a reductionist definition of lesbian has been invoked. This is followed by sections covering the use of alternatives and finally specific issues for lesbian women and their comments on what health care providers can do towards increasing comfort levels.

CHOOSING A HEALTH CARE PROVIDER

A good amount of literature surrounding women's health issues discusses the issue of choosing a health care provider. This often specifically refers to the possibility of effecting a choice between a male and female provider (Lucas, 1992; Robertson, 1992; Trippet & Bain, 1992), usually a GP as the majority of primary health care is currently provided by this group. Saphira and Glover (1999) found that many of the lesbian respondents to their survey choose female doctors however travel had to be incurred by those rurally situated in order to effect this choice.

For several of the participants in this study the notion of choosing a health care professional was euphemistic. In many instances choice was in fact not an issue, rather it was mitigated by available client space in a surgery or the availability of a female doctor in the local area. This was especially relevant to rural as opposed to urban areas. Jen talked about choosing a female doctor when she became available by setting up practice in the area, indicating that until then a choice could not be effected:

...years ago growing up there was always just male doctors and I used to hate going to the doctor myself. And even having babies I had a really good doctor but I mean I still didn't always feel one hundred percent comfortable. And so

when the opportunity came up of a woman doctor I just changed over straight away. Not because of being gay or anything but because I felt more comfortable talking to another woman (Jen, Int.1. p.11).

Two of the participants were simply handed over to new male doctors following retirement or moving away from the area by their original GPs which neither woman considered problematic. Certainly the concept of choice is absent in such circumstances conversely being passed along as if part of the furnishings. As Pat said:

My long-term family doctor moved off and I was passed over to Dr (provides name of doctor) here (Pat, Int.1. p.1).

Rae talked about accidentally getting a female doctor upon moving, however her principal concern at the time was to secure the services of a doctor. She had made several unsuccessful attempts prior to being accepted onto the books of her present doctor. Again choice was not an issue here, rather access. She said:

I don't have any real problems about having a woman doctor or a male one. It was just who turned up at the time when I was ringing around for a doctor (Rae, Int.1. p.1).

I have previously noted some anecdotal evidence of casting around to find an appropriate health care provider and often seeking advice from other lesbian women within a community setting. This was not particularly noted in this work however Kate recalls getting assistance from an older lesbian woman to find a lesbian friendly male doctor. She said:

...there was a lesbian woman around here... And she said to me, the kind of health care that you're getting from your GP is not good enough. And she rang around and she found this doctor, who happens to be a male... (Kate, Int.1. p.1).

Only Louise was in a position to actively choose a female provider. From the extract it is obvious that there was much more involved beyond the sex of the provider. She said:

I've selected a GP that I sort of feel comfortable with which is a woman. A straight talking sort of GP. Someone that had a good knowledge base and a known reputation for that and it wasn't really from a lesbian angle at all, it was more from a 'woman' angle really. Someone who is actually going to treat me without fobbing me off (Louise, Int.1. p.1).

Two participants on reflection stated that if choosing again they would opt for a female doctor. The first resided in a city large enough to support choice while the second was currently in the process of moving closer to a city from a rural setting where choice of a female doctor is simply not a reality. As Kate noted:

If I was choosing again I would probably go for a woman doctor. Not necessarily a lesbian but probably gay friendly I guess. Yeah I would go for a woman doctor because like sometimes with my male doctor I just hold back a little bit (Kate, Int.1. p.18).

HEALTH CARE PROVIDER PREFERENCE

Much of the available research surrounding lesbian women reports a strong preference for a female health care provider (Hitchcock & Wilson, 1992; Lucas, 1992; Robertson, 1992). Three participants had a stated preference for a female provider. I speculated given that doctors are immersed in the same educative process whether there are real differences in the approach between men and women as doctors, or whether this is a false perception. The available literature on this issue is interesting. Brogan (1997) considers that lesbian women feel less vulnerable in health care encounters, with a woman provider due to a perception of increased openness on their part. More pertinent is that women are reported in a number of studies to be less homophobic, more positive towards homosexual people and more gay friendly than their male counterparts (O'Hare et al., 1996; Olsen & Mann, 1997; Muller & White, 1997).

These women did not find it easy to articulate the rationale behind this preference for a female provider. The term 'more comfortable' arose predominantly, and was linked to increased levels of comfort when communicating with the provider. As Louise said:

For some reason I just felt more comfortable with a woman doctor (Louise, Int.1. p.1).

Participants also stated that women communicate differently, that they talk an ordinary language and the explanation from these participants does not as a result have to be dressed up in pseudo-medical terms, they can just say it straight. As Gay noted:

Yeah You always hedge around the problem because you can't, it's hard to say straight up where if it was a woman doctor you'd just tell her what's happening and yeah...Because she's a woman yeah. And you do, you do talk the same language no matter whether you're gay or heterosexual whatever when you sit down and talk with women eh? (Gay, Int.1. p.13).

Pat volunteered the following point of view:

Always being suspicious. Whatever you say you know that its either coming from a woman's point of view or a males point of view and I'm not sure which is best or which is worse (Pat, Int.1. p.21).

It is possible that any such positive (or indeed negative) attitude would be received in subtle fashion offering a greater sense of comfort. Deevey (1990) suggests that lesbian women who encounter on a daily basis a range of environments from hostile to friendly are adept at picking up subtleties in actions and speech which act as signposts of either danger or safety. Stevens (1994) concurs with this concept of perceptiveness with regard to words and deeds. As Gay stated:

You can see it (prejudice or judgement) in their eyes or you can see it in their movements it's easy to pick-up (Gay, Int.2. p.26).

Three participants were unconcerned whether their provider was female or male. It is probably reasonable to suggest that if choice between a male or female provider has never been a reality that it may not even have been considered as an issue. As Pat said:

Yeah, so really to me it doesn't really make a difference who or what it is as long as they know what they're doing and yeah. (Pat, Int.1. p.13).

Kate moved between both the male GP and the female practice nurse depending upon the nature of the visit:

and I like the nurse's station at the practice, that's approachable, no appointments necessary and its far more casual. I can just go down there for a smear when I pluck up enough courage I just pop off and do that (Kate, Int.1. p.21).

Two participants had a stated preference for a male provider specifically for cervical screening purposes. One felt that her doctor was more professional than the female provider she had experienced was. Pat felt more self-conscious with a female provider. She said:

I'll tell you something that I find interesting and I'm the only person I've ever known, that's ever thought this or has ever admitted to thinking of it when it comes to an internal examination I'd rather have a man than a woman and they always said the opposite. Because I couldn't care less what they think but I'm more self-conscious with a woman taking a smear from me that the male doctor.... But if I was going to feel embarrassed and you know have a red face it would be for a woman doing it not a man who is totally irrelevant you know (Pat, Int.1. p.12).

In New Zealand we have seen the movement towards provision of female providers for cervical screening linked closely with the cultural safety awakening in the 1990s. In part this was a response to expressed cultural risk specifically connected to race relations, resulting in lost opportunities in service delivery (Ramsden, 1995). It is important to note that this may not be the preference for each and every woman. Furthermore how easy will it be to ensure that such a choice is a free one given the persuasive message coupled with the perceived political correctness of the choice. It is conceivable that the majority of women will opt for female providers despite a number of these having a

preference for a male provider, simply because it is difficult to swim against the perceived politically correct current.

CERVICAL SCREENING

The literature identifies cervical screening as a problematic area for lesbian women. Many lesbian women fail to have screening done regularly due to feeling vulnerable in health settings (Buenting, 1992). The 1999 survey on lesbian health in New Zealand concurs with this difficulty (Saphira & Glover, 1999). Rae provided this:

...the worse thing that I ever have to go through now is my smear test. They have big problems trying to do it... and it was so embarrassing because the doctor couldn't do it properly so the nurse came and had a try and she couldn't do it so another doctor came in. They were like miners they had these sights on me. (laughs) Okay I can laugh about it now but at the time I have never been so embarrassed in all my life with my legs stretched out there. They put them up in stirrups in the end. It was just horrendous and I have always had problems with that ever since (Rae, Int.1. p.1).

With the exception of a single participant who no longer requires screening all of the participants in this study are involved with regular cervical screening. Though none enjoy or relish the process they all deem it necessary and important as part of their health check.

However two of the participants acknowledged that previously they had believed that this regular attendance to cervical screening was unnecessary for them as lesbian women. One participant had been informed of the need for checks following a birthing experience. Saphira and Glover (1999) consider that some anecdotal evidence exists to suggest that women may find it easier to front up for this procedure having previously given birth and felt that there was some evidence within their study to lend further credence to this. Furthermore lesbians with children may interact more often with health care providers and both the opportunity for getting a reminder and the opportunity to have a screen may be heightened as a result.

Louise ended up requiring treatment for a serious condition after a six-year gap between screens. She firmly believed that she did not require cervical screens because of her lesbian identity. She clearly remembered being told this 'fact' but could not remember the status of the person who imparted the information. She said:

I didn't because I didn't think I needed to and I got a reminder to go and get my cervical screening done and that was still on the fridge when the next one come and the next one come and the next one come and six years had passed...

Anyway I eventually went after six years and I actually had CIN2 (cervical intraepithelial neoplasia) and got the fright of my life. I have probably had more smears in the last four years than I have had in the rest of my life. Yeah I do have very regular smears and that is one thing that I do recommend for all women. I honestly thought I was a very low risk (Louise, Int.1. p.9).

Lesbian women who have never engaged in heterosexual sexual activity are very much in the minority in this study. A larger study by Ussher (1997) strongly concurs with this. However these may be the very lesbian women at most risk of believing that they do not need regular screens. Marrazzo et al (1998) reports that women, who have sex with women exclusively, received less frequent routine screening.

Within the chapter reserved for the literature review Lehmann et al (1998) considered the risk of cervical dysplasia to be negligible among women, who engage sexually, exclusively with other women, citing the association of the human papillomavirus infection with penile-vaginal intercourse.

Yet Marrazzo et al (1998) determined from their research that the human papillomavirus among women exclusively engaging sexually with women has the potential to be sexually transmitted. They call for investigation employing a larger number of women in order to be placed appropriately to disseminate messages regarding risk of cervical cancer, linked to the need for screening and advocating protective sexual practices.

In a social environment where heterosexuality is considered to be the compulsory form of relationship expression (Rich, 1980), it would not be surprising to find that the majority of individuals residing on the lesbian (or gay) continuum had at some point in

their lives engaged in sexual relationships or sexual acts with the opposite sex. For those who consequently invoke a lesbian identity this may be explained by an endeavour to fit into the accepted mode of cultural expression compounded by peer pressure (Ussher, 1997). However as demonstrated to a degree in the above section and more so in the following one, the available stereotype perpetuated by those residing in the centre serves to muddy the waters, with potential deleterious consequences to health for lesbian women.

AIDS AS AN ISSUE

The majority, though not all of the participants believe HIV to be an issue for lesbian women. A small number more readily made the connection to gay men. This is a point worthy of some discussion as from a media perspective the distinction between lesbian women and gay men is not drawn thus lesbians are deemed to be a high risk category (Lampon, 1995). Brogan (1997) suggests that from the perspective of the heterosexual world lesbian women and gay men are considered homogenous. This filters into society as was outlined earlier when discussing nursing students beliefs that lesbian women were a high risk group for HIV/AIDS (Eliason & Randall, 1991; Eliason, Donelon & Randall, 1993; Friedman & Downey, 1994).

There are contradictions embedded in the dissemination of information regarding HIV/AIDS. Consigning lesbians to a low risk group may carry the potential of increased risk as women consider themselves almost immune by virtue of having a lesbian identity as part of their being. Being a low risk group may lessen the relevance of risk behaviours. Lesbian women may also believe that if not specifically targeted for educational information that they are not at risk.

Yet the construction of lesbians as a homogenous 'low- risk' group by those providing HIV/AIDS education materials is in stark contrast to their emphasis in considering the rest of the population in terms of 'risk-behaviours rather than as 'risk-groups' (Lampon, 1995, p.171).

The construction of a lesbian woman as a woman who engages exclusively in sex with other women as already noted is problematic and erroneous for many such identified women. This construction is reductionist in that it only pertains to that sexual activity

which stereotypically lesbians are thought to engage in. Furthermore sexual identity and sexual practices are not necessarily concomitant and derived assumptions founded upon sexual orientation alone may result in potential risk behaviours remaining obscured (Chiu, Conti, Schable & Diaz, 1994).

Raiteri, Fora and Sinicco (1994) conducted a research study to determine HIV transmission through lesbian sex. Their results supported a non-existent risk of transmission between lesbian women however the study had only duration of six months in total.

Some lesbian women consider women who claim a lesbian identity and also engage in heterosexual activity contradictory. This was illuminated within the previous chapter when noting the reaction to a participant's relationship with a bisexual woman. It is possible that this tension may reduce the honest reporting of heterosexual activity thus increasing risks of contracting diseases. This situation is further compounded by the fact that dental dams were noted by two participants, to be problematic for women. As Kate noted:

Well its been my opinion, in recent years that lesbians are doing more and more risky sexual activity, yeah it seems to be increasing. And nobody I've ever met has ever used a dental dam. They're at the club, freely available... (Kate, Int. 1. p.17).

Meg commented about many of the other sexually transmissible diseases noting that they were much more readily transmitted. She said:

Probably more likely to catch a hepatitis than you are, or many other sexually transmitted diseases than you are HIV or AIDS (Meg, Int. 1. p.16).

Donor insemination may also prove problematic for lesbian women given the potential for donor semen to be infected with the HIV virus (Zeidenstein, 1990). Engaging in heterosexual activity for money and as noted above the possibility of rape also need consideration. These positions however disrupt the narrow and reductionist worldview held by those in the centre. Ill conceived research studies, misinformation, contradictory

information and lack of information relevant to these women threatens safe and timely access to health care.

ALTERNATIVES

The overseas research indicates that lesbian women report the utilisation of a broad range of alternatives often in preference to more conventional health care (Buenting, 1992; Trippet & Bain, 1992).

The vast majority of participants in this research do and would engage in a range of strategies prior to making an appointment to visit their doctors. However this was dependent upon the actual problem or concern. The range of alternatives used included vitamin and mineral supplements, massage, reading up on the issue, finding out what you can do yourself and using your own initiative. Jen and Gay said:

We don't go to the doctor's unless we have too eh? But we try, yeah we try vitamins and things before we go to the doctor, or read up on things don't we?
(Jen & Gay, *Int.1.* p.29).

This use of alternatives did not extend beyond the women themselves and dependant children engaged with the doctor for any treatment required. As Kate noted:

For me I would do other things for the child its to the doctor... For me I'd go to the health shop and get a few things (Kate, *Int.1.* p.16).

I did not at any time gain a sense that these women would prolong the period before making an appointment to see their health care provider due to perceived barriers by virtue of having lesbian as part of their identity. Due to having clear differences between the participants and the overseas literature on a number of issues I included specific questions within the second interviews to be certain of this interpretation of the participants dialogue. Specifically there was a noted departure from the literature with regard to delaying seeking health care (along with fear to disclose which is discussed within the next chapter).

These concepts were clearly rejected by these participants, holding little veracity for their lives. A number of these women suggested that the pioneering spirit legendary among New Zealand women might be responsible for this noted difference. Many of these participants were older women, having journeyed from the heterosexual world where their health seeking habits may well have been shaped and consequently adhered to. As previously discussed only a single participant acknowledged any form of delaying health care interaction, which was in the form of cervical screening.

SPECIFIC ISSUES FOR LESBIANS

From a health perspective all of the participants identified similar health needs, all concerning physical health care. Cervical screening was important as was mammography and general health checks. A number of participants held strong beliefs regarding where responsibility lay for ensuring that appropriate health care was accessed, stating that such responsibility lay with women who identify as lesbian. Whether this is a strategy to ensure wellness in a social world which to date has ignored these women I am uncertain. Rae expressed this:

A lot of them think that because they are lesbians they don't need cervical smears and they probably don't need mammograms done. I think that is very foolish to go along with that way of thinking because I think they do need it. ... I would like to think there is something positive about that (providing specific information), which says just because you are a lesbian you still need to be responsible for your health and to get these things done. Yes I do. Yes they certainly should have and they should encourage it rather than say well you are a lesbian so you don't need it as if to say, well (Rae, Int.1. p.7-9).

One participant suggested that lesbian specific health care issues beyond routine women's issues needed to be addressed, as opposed to lesbians having to be proactive due to the void of specific information. These women may be implying that the responsibility falls to them by default. What appears problematic is how women who identify as lesbian interpret health care initiatives, which are exclusively heterosexual in their presentation as being of relevance to them especially when compounded by associated myths.

There was a sense from several of the participants that the physical body did not differ between a lesbian and a heterosexual woman and so those health needs are alike. Matthews (1998) study identified a similar viewpoint with many biological issues considered relevant to both heterosexual and non-heterosexual women. At these interactions then these women may not worry about the assumption of heterosexuality, as they may simply be attending to their physical body (telling would be irrelevant, which is discussed in more detail within the following chapter).

As a result the differences in health care needs for lesbian women may be other than physical in nature. Factually these differences are closely connected with the cultural position of women who as part of their identity are lesbian. This cultural position was discussed within the previous chapter. The absence of legal and social sanctions is probably most directly relevant to the health care environment, compounded by the underlying assumption of heterosexuality. Louise stated:

I think legally recognising the relationships that these women are in will have a flow-on effect within the health care system, but, like they do have, the relationships that we are actually in do have a large bearing on the way that we actually feel about ourselves. And health is all about you know your body's response to what's going on isn't it? ...Like it is important that people feel comfortable and have their ah significant others treated as simply that as our significant people. ...Well I think yea your ability to recuperate from things um whether they be physical or psychological does depend on um your sense of security. And support really, so you need to have access or you need to be able to have the people that can give you that support around and you don't need the conflict of having your next of kin questioned or that sort of stuff, like you don't need the conflict of legal problems (Louise, Int.2. p.33-34).

Caution needs to be employed however to appreciate that the complete cultural world of these participants impacts upon health and wellness. Should health care providers represent as agents of holistic care delivery it is crucial that they embrace the social, economic and historical framework of the person to whom such service is offered. Both individual and collective personal histories are critical to this process (Ramsden, 1995).

A number of participants talked about their discomfort/dislike at having to hedge around the truth, resulting in being less honest than they wished to be and guarding what they were saying and how they would say it. This contains strong links to the assumption that everyone is heterosexual and it's reflection in many of the New Zealand's Government statutes and state structures, which fail to reflect other than oppositional couple relationships (Auckland Lesbian and Gay Lawyers Group, 1994; Bear Reader, 1997). As Louise noted:

... there is that lifelong one... enquiring after your marital status...the impact that has... closeted behaviour (Louise, Int.1. p.8).

Several participants talked of the need to appreciate and recognise their relationships with other women. If the female partner is viewed merely as a friend the emotional impact of illness, death, separation, isolation (to name a few issues) may be given less attention than it would be should the partnership be recognised for what it is. As Meg said:

I don't think there is a difference between a heterosexual woman and a lesbian woman at all physically. But I think the emotional um if you are not totally out and people don't know then the emotional side of it is a lot harder to express because you know if somebody dies, if your partner dies or you break-up, it's, it's hard to express that (Meg, Int.2. p.18).

Even should the relationship be readily evident the degree of impact may not be equitable to a heterosexual relationship

... I would like to think it would be, but my suspicions, my thoughts would be no it wouldn't be. It wouldn't be seen as to the same degree.... It was a passing fad (Meg, Int.2. p.18).

SUMMARY

The previous chapter provided insight into the worlds in which lesbian women find themselves and the difficulties associated with navigating through them. From that juncture using the literature review as a guide, health care issues have been presented

highlighting both similarity and difference from the available literature. The deleterious consequence to lesbian women's health once a reductionist definition of a lesbian identity is employed has been demonstrated. These women accept a significant responsibility for working out for themselves what they need to know about their health care. Even with the best intention important information may not be recognised either by the woman herself or the health care professional.

The informational void specific to lesbian health coupled with the reductionistic approach fostered by the stereotyped lesbian image is unquestionably a hindering factor regarding safety. The additional layer for these women to navigate through given the relevant informational vacuum can not be considered equitable health care.

Ramsden (1995) clearly states that the removal of barriers to improve health care is not the responsibility of those made powerless by (among many other named disadvantages) sexual orientation, rather the responsibility of the service provider. Lee (1998) acknowledging the power difference between provider and client considers it crucial that the provider prove a respectful attitude.

The next chapter addresses the difficulties surrounding informational decisions to disclose this aspect of identity and the perceived consequences of such disclosure decisions.

CHAPTER SIX

INTRODUCTION

This final interpretative chapter presents the themes connected with the difficulties for these women regarding informing health care providers of their sexual identity and the perceived response to such disclosure. A negative reaction from a health care provider is only the beginning of the potential problematic encounter for these women. As this theme unfolds the complexity surrounding this issue of disclosure becomes palpable.

The rationale for non-disclosure speaks clearly to this issue of felt safety which cannot be taken as a given for these women.

A number of participants shared past experiences, which occurred prior to their accepting and consequently embracing lesbian as part of their identity and these experiences may have added to the perception that a negative reaction was indeed possible when interacting with health care professionals simply by virtue of being female.

Most have a sense that they could experience a negative reaction should they tell that they are lesbian in a health care encounter. This might take the form of displeasure at the notion of two women being a couple, to a pregnant pause while regrouping happened or not showing respect particularly for a partner.

Meg had a difficult time with staff while her partner was hospitalised as is quite convinced that this was as a direct consequence of her relationship being unidentifiable to them. She said:

She never considered that, I don't think, that I might be her partner.

Oh god. I don't really know. I guess she saw this nurse saw me as, it was unusual that a, yeah unusual that another woman would be there when somebody is coming back from theatre ... (Meg, Int. 1. p.6).

This proved to be a situation where stress was increased by the inability of staff to think beyond the traditionally accepted composition of a family

she kept saying things like that I shouldn't be there because you know a friend shouldn't be there and what time did I think it was to come visiting. I mean she's just got back from theatre and I shouldn't be visiting her and that sort of thing. And I found that a bit difficult, that was really difficult (Meg, Int.1. p.2).

The following day proved no better by which point this participant believed that she was being treated differently to the traditional representation of a couple

And then I came home and I tried to ring the hospital about nine o'clock to see if (names partner) was all right and I got a really nasty reception from them for ringing up at that hour of the night. And that wasn't very nice and I don't think they would have done that had it have been a straight couple ... (Meg, Int.1. p.2).

SHARING AND NAMING A FURTHER PIECE OF MYSELF

These women call on many different things to assist in their identification beyond being lesbian. When asked to define themselves most stated easily that they are just themselves (as discussed in chapter four). While they do not separate themselves from their lesbian identity they are much more than that unitary identity. As Meg commented:

No I don't need to tell them. I mean what does it have to do with my treatment... Normal society if you like to call it normal you don't walk around saying hey I'm heterosexual or I'm straight so why should I have to because I'm lesbian tell them? (Meg, Int.1. p.11).

Several women indicated that should the topic come up, they would tell. The fact that the overwhelming majority of these women had not informed their primary health care provider would indicate that the issue does not readily present itself as a topic of conversation. Brogan considers the assumption of heterosexuality to be so strong that the appropriate question is rarely asked. Further to this Hall (1994) links reduced trust between health care providers and lesbian women when closed heterosexual questions

are posed. These reveal a knowledge deficit with regard to sexual orientation on the part of the provider.

INTO THE MELTING POT (REDUCTION)

Two participants had previous experience of having someone else telling others (generally as opposed to health care environment) about them being a lesbian. This drew the response that the information *is for me to tell and share* and not for others to do so for me. Meg expressed this:

...she inadvertently outed me or almost outed me at work in front of everybody and while I was not totally uncomfortable or terrified or, I didn't feel particularly comfortable either. ...I don't like being forced into a corner to actually be outed. If I want to say something then I want to say it on my terms and not on somebody else's terms (Meg, Int.1. p.10).

Connections can be drawn between this knowledge being the prerogative of the woman to share and the subsequent problematic issue of confidentiality and having sexual orientation incorporated within medical notes. Despite being a relevant aspect of a health history sexual orientation should perhaps be recorded as an optional issue (Gentry, 1992; Lucas, 1992).

When discussing health care environments these women perceive difficulties in response to being labelled as lesbian. As Rae noted:

You don't want a label that says you are anything, you don't want to be labelled anything. You just want to be you who you are (Rae, Int.1. p.27).

Overseas research suggests that mature lesbian women resist and dislike labels (Deevey, 1990), and one participant clearly stated that she would not want lesbian stamped on her medical file. However more than a dislike of labels is evident here. These women are trying to resist having all other aspects of their lives stripped away, which would leave them only a lesbian identity. As Pat said:

...it's not so much that I don't want to be labelled a lesbian it's that I don't terribly want to be labelled anything. I don't belong to a political party but I have quite strong political views (Pat, Int.1. p.16).

INVOKING THE CLOSET HANGER

Labelling is only the beginning of a potentially problematic encounter. There is a belief that having a handy 'hanger' (as a direct consequence of the invoked label) to place cause of illness upon may reduce the urge to investigate effectively. Lee (1998) concurs with this position noting that an all too ready assumption will be that it is the sexual orientation that needs intervention as opposed to the presenting problem which will then be relegated to second place, if not dismissed entirely (as symptoms of an underlying pathology). Stevens (1994) study also correlates with this position with the participants sensing that upon disclosure the potential for being mistreated, misdiagnosed or ignored would be amplified. The result may be that things would not be taken to their natural conclusion having been diverted by the issue of being lesbian. Pat expressed this:

More worried about what I would be excluded from as opposed to included as... (Pat, Int.1. p.17).

From this particular perspective there is a very sound rationale for opting to refrain from sharing and naming this portion of identity. As Louise said:

I think there is comfort in being an unknown entity really at times. I think there is less risk of people pigeon holing or excusing or maybe sort of not exploring further. Like health issues, especially when it comes to mental health, I am not sure whether I'd be as open to actually disclosing my sexual orientation until I actually felt reasonably safe or that I was sure that they were going to maybe delve deeply and not just fob it off as a lesbian problem. Well you know it's the assumptions the majority of lesbians are depressed or whatever and make generalised assumptions and therefore it's all right that I am depressed when in fact there is probably a good reason that is not at all related to my sexual orientation. I think there are a lot of people have the view that it is quite difficult being lesbian and therefore you have got to have had some deep psychological trauma or deep reasoning for being gay. Or some problem going on that is not

making you a functioning, integrated, vivacious person. It can be lost that curiosity I think can be lost when you disclose too early (Louise, Int.1. p.12).

Both Rae and Meg specifically expressed the difference in telling (disclosing to) health care professionals as opposed to routine disclosing in the context of their ordinary lives readily making connections between both the potential personal consequences.

There is a huge amount at risk. There is your own self respect for a start and how you feel about yourself and the worst thing to do would be to come out of that office feeling like nothing. Coming out of the surgery. Feeling like that's it. I have blown it. It is never going to be the same when I go in there again and that sort of thing. I really wouldn't like that (Rae, Int.1. p.25).

and that perception of the pathologising of the lesbian portion of their identity.

...there is that convenient hanger. That patient is a lesbian that's the reason why she's like this, or she has these problems... (Meg, Int.2. p.14).

TO TELL OR NOT TO TELL THAT IS THE QUESTION

The above section provides the backdrop against which these women have to determine the relevancy or not of disclosing this piece of themselves to health care providers. To do this effectively the unfolding health care encounter has to be monitored, and responses may have to be guarded to preserve the option to disclose should it become necessary. This signifies an additional burden beyond the presenting health concern for these women.

NO NEED TO TELL

Most agreed that for minor interactions within a health care environment it would be unnecessary to tell, the information would be non essential, thus the staff would not need to know. As Kate said:

Only if my partner was there and she needed to be there, and I wanted her to be there. ...But if I'm just sailing through A&E with a broken leg and its simple, they're just going to plaster me, nobody needs to sigh a hell of a lot it wouldn't be necessary. Be nice to think of going through there in a wheelchair saying 'by the way I'm a lesbian', you know but that would be showcasing, (laugh) giving them unnecessary information (Kate, Int.1. p.22).

For more complex interactions especially involving staying in overnight the decision to tell or not is less straightforward. Neither does it occur quickly as the women are monitoring the evolving health care interaction to determine the necessity or not to disclose. Stevens found similarity within her 1994 study, uncovering an intently watchful stance in health care environments. As Rae noted:

It would depend on the circumstances and whether I was going to be in overnight and whether it is going to be necessary to let anybody know and that person I would want to be able to come and visit me if anything happened or if I needed anything, that she would be free to come and go because she was my partner (Rae, Int.1. p.19).

Many indicated that if it came up or should it be relevant then they would tell the health care provider as previously noted. In their study Hitchcock and Wilson (1992) reported that relevancy that is having a logical reason to disclose was pertinent. Stevens (1994) also reported in her study that lesbian women judged the relevancy of disclosure given the particular situation. Meg said:

I might be more I suppose likely to tell this other doctor if it ever came up or I needed to (Meg, Int.1. p.1).

JUST IN CASE

Three of the participants had gone to the extent of drawing up power of attorney for their partners with issues relevant to health specifically in mind. Hitchcock and Wilson interpret this as an anticipatory stage where cognitive strategies are invoked linking it to the basic social process of personal risking. As Gay noted:

...because yeah when I was going into hospital... they said because you need to have that as well (Gay, Int.1. p.2).

These women expressed their concern that in times of ill health families of origin may well take a differing position to that desired by the woman herself and as a natural extension of that her partner. This power of attorney was also seen to give a partner decision making authority to prevent argument between the partner and the family of origin. Meg expressed this:

So she'd have some clout yeah I suppose it is so that she wouldn't be undermined by medical professionals or by my family yeah (Meg, Int.1. p.14).

The issue of rest home care in older age was raised by Jen and Gay who again expressed this period as being a time when families of origin may intervene and hold primacy over partners without the added clout of a power of attorney. Gay said:

Yeah when you get really old that's another time when your family moves in and starts deciding what's going to happen to you (Gay, Int.1. p.18).

A number of participants briefly mentioned the positive difference it made to their lives having support from their origin families. For many of these participants this related directly to having support from their own adult children. One participant noted that she would extend primacy to a partner over her family of origin should it be an issue. Yet another participant discussed the fact that positive support from origin families was not a given and in reality was heavily dependant upon the belief and value system of the origin family. The operational value system could equally deny a positive response in favour of a negative reaction. As Jen noted:

No but I mean it could always happen (speaking about a potential negative response) I probably do think about, that's probably why I talked about doing the power of attorney just as another stronghold for us (Jen, Int.1. p.14).

Many lesbian women have discovered that their rights with regard to health care require legal preparation, to ensure that their wishes are met (Auckland lesbian and Gay Lawyers Group, 1994). It is a strategy invoked out of necessity following observation and experience of the dominant cultural expression. This strategy of adding legal validity to relationships is perhaps an effort towards parity between the centre and those at the edges (Hall, Stevens & Meleis, 1994) trying to equalise the power differential. Factually this strategy conspires to formalise lesbian relationships by means of legal validity.

GOT TO TELL

In their past experiences two of the participants had in fact disclosed within mental health settings believing that this facet of their lives might have some bearing on the presenting issues. Pat expressed this:

Because I had such a sort of torrid upbringing and had this sort of lesbian thing inside me all the time I thought well they're be a lot here that I could get off my chest you know. I'd known psychologists and about psychology forever and I didn't really think it would do me much good but I did know I had a background that nobody ever really listened to before. So they don't want to hear about it and nobody had ever known me as a child (Pat, Int.1. p.2).

Hitchcock and Wilson (1992) found in their study that active disclosure almost always occurred in psychological settings being viewed as necessary information for the health care provider to know. Both of the participants stated that the issue of being lesbian was purposefully ignored, not clearly spoken about, denied and not taken as an issue. This is not to say that these women believed that being lesbian was problematic for them, rather that the effects of making their way through the heterosexual world may have had an impact. As Pat said:

He was good, he was a very nice, gentle, patient man but he tiptoed round it. 'Now your friend (name)' he would say 'is she all right to speak to?' That was about as close as he got 'can you tell her things'? He didn't want, seem to want to take it as an issue that meant anything through my life, yeah (Pat, Int.1. p.2).

MADE TO TELL

A different type of disclosure classed as reactive disclosure (Hitchcock & Wilson, 1992) potentially occurs when the lesbian woman feels coerced into sharing this part of her identity as opposed to sharing this part of an identity willingly. Meg stated:

I guess we were cornered if you like. So you're forced into having to make a statement. I don't suppose that I really wanted to tell them cos I was forced into laying my cards on the table if you like (Meg, Int.1. p.8).

ALTRUISTIC TELLING

Decisions to disclose by this group were overwhelmingly in the realm of putting their partner first. Should they be hospitalised they felt that in order for their partner to have access to visit, to be granted respect as the most important person in their lives, to fill information gaps should they themselves be unable, and to be involved in the care then telling may become necessary. Kate said:

Only if my partner was there and she needed to be there, and I wanted her to be there. I probably wouldn't bother telling them. But if it was my partner I probably would because there may be certain screened off areas that friends can't go to that partners can. Yeah so if that became necessary or she had to sign a form, or give me some general cos I'm too banged around to answer any questions, that's when they need to know (Kate, Int.1. p.22).

Rae stated that a diagnosis of a communicable health problem, which would potentially affect her partner, would be a relevant cause for disclosing. She said:

If she had to watch out... I would have to ask the question just to be sure that she wasn't infected or something like that.... So I would have to I would certainly have to say something and that wouldn't bother me at all (Rae, Int.1. p.10).

FEAR OF TELLING

Within the literature there is evidence of fearing discrimination from health professionals on disclosure (Trippet & Bain, 1992). There was a noted departure from

the literature with regard to fear of disclosure in health care settings from these participants. They almost without exception responded that they did not feel fear with regard to disclosure. Although there have been times for these women when they choose not to disclose they did not readily relate this to felt fear. However Pat made the following observation:

...I think there might be a shade um to be honest at the time because you know you are vulnerable instinctively you will try and protect yourself. By making it look, making yourself look as favourable as possible in the, in the caregivers eyes.... But just in subtle little things like having, perhaps having to take you to the toilet and things like that um you would just not want it to be an issue, you would just want to perhaps, be just like anybody else and that probably is rooted in, in fear (Pat, Int.2. p.59).

This is a poignant example of adopting the persona of the agency or dominant culture when in vulnerable settings to gain a measure of felt safety. Being unable to articulate a perspective from a marginalised position (Hall, Stevens & Meleis, 1994) makes it necessary to adopt the mantle of the environment or agency. This directly contravenes the essence of cultural safety where individuals are treated fully respectful of their differences from the persona of the agency (including personnel).

ALWAYS TELL

Two participants stated that they would now always tell. However as the conversation evolved it appears that this telling takes the form of having such personal knowledge about each other that it could only be recognised as the prerogative of an intimate couple. These participants firmly believe that their health provider is aware of their relationship without having invoked the verbal cue.

WHAT CAN PROVIDERS DO?

A friendly, genuine, respectful and open approach is favoured by many of these women. An obvious effort on the part of health care professionals to put the woman at ease and make her comfortable is suggested. Not making any assumptions which, included not assuming the preference of a provider without asking the woman herself. Accepting and

not reacting with surprise to any information being given was another response and would more likely occur if staff were exposed to in-service on sexuality issues. As Pat noted:

They're taught, trained not to be prejudiced... And you're never quite sure whether you're getting their personal reaction, but probably not because they're professional people and they're trained to smile and say that's okay. And sometimes they go overboard to try and make you feel okay and you think hey that's not normal (Pat, Int.1. p.18).

Keeping all questions asexual in nature, thus allowing for as much or as little to be told depending upon the circumstances. Treating anyone accompanying the woman with respect even if partner status unknown was deemed crucial. Much of this echoes Stevens (1995) when she suggests the employment of non-sexist language, written and verbal inquiring without underlying assumptions. This would afford the opportunity for opening and sharing of health concerns without preconception of need. These issues as outlined by the participants, are categorised as the factors which would facilitate lesbian women to feel safe in health care environments and encounters. Attention to these issues would foster such an environment.

SUMMARY

While the term safety was not overtly invoked by these women the complex decision making required regarding disclosure of this identifying aspect implicitly places them in an environment which does not readily invoke images of felt safety. Rather this decision- making requirement readily disadvantages them from the covert levels of safety experienced by heterosexual individuals engaging with the health care environment. It is this, perception of negativity from health care professionals that is most telling. The assumption of heterosexuality, labelling and reduction to sexual identity must be consigned as factors, which hinder safety in health care access.

Chapter seven presents the participatory research journey followed by the discussion, research recommendations and conclusion of the work.

CHAPTER SEVEN

INTRODUCTION

This final chapter presents the participatory research experience and contains commentary from the participants regarding benefit of involvement, invisibility imposed by anonymity, the insider position and their advice regarding the dissemination of the findings. From this juncture a discussion follows making connection between the findings of this work, nursing, and future research recommendations.

BENEFIT OF INVOLVEMENT

Without exception all of the participants viewed involvement in this study as being of value to them. Despite close questioning none offered any negative experiences from such involvement even when reviewing painful and difficult experiences. Several ad hoc comments pertaining to the difficulty reading the transcribed voice were made however, and these despite the advance warning given following the initial interview. I have no way of knowing whether I drew attention to this issue or diluted it by virtue of this warning.

All of the participants were easily and readily able to see themselves reflected from the pages of the report sent to them. Involvement in the research was described as being good, fun, fascinating, and giving food for thought. One participant noted that it was good to talk to somebody who understood her. Another two commented upon the fact that it gets easier each time issues are voiced and consequently strength is gained. Several women commented upon their interest to read opinions other than their own and found they came across issues previously not personally considered. Holding individual opinions whilst concomitantly having a sense of belonging to a group was also deemed positive.

One participant did afford a critique of the initial report as the sections she was particularly interested in were placed somewhere in the middle and she commented that she would have been bored by the time she found them.

Although I have reviewed a significant number of articles which illuminate the perceived benefits of research to participants there seems to be little specifically written about the actual benefits. An exception to this is an article by Hutchinson, Wilson and Wilson (1994) which outlines the many positives of being involved in a study underpinned by an in-depth interview strategy. Between them the participants in this work echo many of those benefits as stated.

INVISIBILITY IMPOSED

Kate early on in the second round of interviews stated clearly that by not using her real name within the study another layer of invisibility was being cast upon her. She said:

Lesbian women exist but we can't really tell you their names. Not a lot of people are going to understand the ethics of that, that they may see that we won't identify because we are too scared.... I understand what, why it has to be that way um but because the subject is lesbian. ...We have been talking about how people see right through us you know around us they don't see us and there's another thing that says it is a study about lesbians and, and we don't give names, you know. I have shrunk to, not, not quite a statistic, I, I am, I am a story yea, yea (Kate, Int.2. p.37).

This issue had been in the back of my mind throughout the process and I was indeed grateful for it being brought to the surface without being actively sought. I put this comment forward during all the subsequent second interviews and found the responses to be both of significance and telling.

Three participants agreed with the perspective of the participant who raised this issue, while acknowledging that they appreciated the ethical decision making behind the use of pseudonyms. Two of the other participants felt that there was not really an issue believing that the utilisation of a pseudonym did not render them invisible. The final participant did not have a personal problem with the invisibility issue while acknowledging that identifying her within the work may prove problematic for her partner.

To probe a little deeper I asked the participants what (if there was a choice available) they would opt for within the study. Several commented that it would be difficult to see clearly in the future and anticipate what might occur following the finalised work. Two stated that should they elect to use their real names that they would have to read the final document right through properly to avoid any potential backlash to their children. Pat and Rae (along with the participant who raised this issue) would choose to employ their real names within the work without hesitation. However they continued (speaking as a couple) reflecting on this issue and further on in the interview Pat stated:

...we can be smug because we are coming from a comfortable place.

Where um well, in my case anyway it's not going to affect employment or.

And we have got our own place you know sort of thing so I am not terribly at risk. So I mean what that tells you I don't know (Pat, Int.2. p.70).

Collectively these comments depict a level of the persuasive silence and invisibility imposed from the heterosexual world. These women cannot be certain that following their identification, nothing untoward would occur, a stark insight to the vigilance required by virtue of the place they hold within the dominant world.

There are no easy answers to this issue, however future participatory research studies may opt to afford informed choice and subsequently acknowledge those participants whose real names were employed within research should that be their choice from the initial stage of the study's structural moulding. Though not within the remit of this work to solve the complexity of this issue (especially with groups previously silenced within society) it should not be, consigned irresolvable.

INSIDER POSITION

McCauley (1996) considered it would be unlikely that a heterosexual would be trusted to engage in research within a lesbian community, citing membership of a dominant group and the resulting power imbalance as partial reasons for this position. Due to the earlier discussion contained within chapter three regarding, insider privilege with regard to research I sought commentary from these participants on this issue. I asked whether

they would have talked to a non-lesbian researcher attempting the same research project. The responses varied to a degree. As Rae said:

Yea I wouldn't have been as relaxed and as open and said the things I did... the fact of acknowledging that I was lesbian and things like that might have been a whole lot more difficult for me (Rae, Int.2. p.56).

Here perhaps is the evidence to support the concept of plurality of truth, as that which would have been provided to a non-lesbian researcher would have been different. Pat noted:

I don't know how I would have reacted, I am sure it would have been different but maybe in the opposite way, I might have been out to um prove a point. Shocking (Pat, Int.2. p.56).

Another participant felt that there was an added level of comfort to the proceedings by virtue of my identity. A further two felt that my identity placed me as 'sort of like family', increasing levels of trust, and thought they might not have been so open with a non-lesbian researcher. Both of these participants though felt that it was too narrow to suggest that only lesbian women should be doing research with lesbians and thought that in order that lesbians become more visible and thus educate the public towards acceptance it was important to talk about the way they live.

Kate also talked about educating and illuminates another reason for her participation in research, while placing restrictions upon what would have transpired. She said:

I love questionnaires, so perhaps I would have entered into it... I would have educated you...if you were a heterosexual women doing something on lesbians the first question I would say what the hell are you doing? And why are you doing it? You know I would have been suspicious. Anyhow had you come out with the right answer, like there is nobody else to do it and I am really genuinely into this, yea, but you would have got a different honesty. I could not have sat here and talked to you about um the things that are left in the closet for us (Kate, Int.2. p.24).

Comments contained within these extracts such as a different honesty, and tempering answers differently clearly refute the notion of a single reality or truth. Conversely truth and reality are mitigated by the unfolding interaction and found circumstances. From these responses I ascertained that most of the participants in this study would engage with a heterosexual researcher albeit with an altered and more vigilant approach.

WHAT TO DO WITH THE FINDINGS

Finally I sought advice congruent with the participatory nature of this work on what messages should be afforded primacy, to whom and how I should disseminate these findings. I outlined my professional intentions regarding the findings of this research and from this juncture, sought advice. Most of these women were passionate regarding women such as themselves being able to read about this work, in an ordinary common garden language and had several good strategies for effecting this. The emphasis was on getting this work out to anywhere it could be accessed by lesbian women. Written in a serious manner (academic style) was seen to be useless to these women.

A number of popular New Zealand magazines were suggested, the Internet, and also the seasonal weekly television programme *Queer Nation* (mentioned by many participants as the sole thirty minutes exclusively for them). Several participants believed that it was necessary to get the studies findings to both health care professionals and lesbian community groups. As Meg said:

So just getting it out there is really important and sometimes if it is written in such a way that make people think or "oh god, I never thought about it from that, that point of view" you know. It sparks people to change their practise or change the way they do things, or the way they think (Meg, Int.2. p.23).

DISCUSSION

This research sought to uncover factors both hindering and facilitating lesbian women's sense of safety regarding health care. Given the often hidden nature of these women a cultural perspective was considered essential to promote contextualised understanding. In turn the uncovered information would afford nurses a yardstick to measure current service delivery against.

The work presented a world where lesbian women reside devoid of imagery in any form with which to guide, validate, represent or measure their lives. From this position the tension between 'normal' and 'extreme' behaviour became evident. The heterosexual world demands silence and invisibility of those non-dominant residents should they desire to be perceived as 'normal'. It is no accident that those 'extreme' representations perpetuate the negative stereotype. The heterosexual imperative in its many manifestations is consigned to the archetypal hindering factor for these women as it informs all contained within its boundaries, including the health care environment. Little exists independently from this worldview.

The predominantly heterosexual world cleverly disguises the informational void for lesbian woman employing distracting tactics of negative stereotypes and myths to both camouflage the void itself and confound the wider issue. The processes of labelling and reducing to mere sexual orientation purchase, by covert intimidation, a worthwhile degree of silence. To illustrate this point the predominant view from the heterosexual world was that I must be lesbian to be engaging with this work, a normal person (read heterosexual) would not even contemplate engaging in research with lesbian women. In seeking to disrupt the vacuum I have disclosed an additional cultural affiliation, on each occasion I have mentioned my research simply by naming the topic, no more was ever required. This assumption (though accurate) may be partially responsible for the very limited research (read silence) in areas of sexuality and other sensitive topics.

It becomes obvious reading through the accounts that these women have negotiated their way through a maze of inter- locking worlds effectively managing to both gain and sustain a sense of self. They incorporate the lesbian adjunct without affording it primacy in their lives, however the harsh reality of being defined merely as a lesbian (with all other identifying factors removed) is also acknowledged. They are resident in two worlds engaging in a complex style of living to meet the demands of their bi-tribal status. These lesbian women refute the narrowly held stereotypical view of hetero-imitation made possible by sanctioned gender performances. They voiced the invisibility of this aspect of their cultural identity, expressing the difficulties of residing in a world lacking in any form of reflected imagery.

The stark absence of both representation and specific information in the health care environment requires that these women interpret their health needs through a heterosexual medium. Undoubtedly for some this will mean less than adequate care as demonstrated in chapter five by the participant who presented with a significant health risk following a lengthy gap in cervical screening. The additional burden of accessing health care within an informational vacuum coupled with determining health needs through an inappropriate medium is a significant barrier to promoting safe and equitable access of service delivery.

Mindful of their historical interaction with health care and the world at large, it is highly reasonable that lesbian women have a level of anticipation of potential negative reactions from this source (Ramsden, 1995). The felt degree of uncertainty regarding health care (despite none of these lesbian women having had multiple encounters with these agencies) should disclosure occur is most illuminating. The fact that many of these women perceive a negative response to disclosure is a telling indictment. More troubling is the perceived consequence of such disclosure to a level of sub-standard care following being labelled as lesbian and subsequent reduction to merely a sexual orientation.

The historical baggage can only be relegated to a historical footing by informing, altering, reshaping and realigning practice to mitigate the perceived problems these women identified within this work. Having lesbian as a partial identifying feature should in no way serve to minimise or pathologise presenting concerns from this group. This 'hanger' needs to be clearly hung in the historical closet and replaced with open, honest and positive appreciation of the difficulties associated with negotiating life through a cultural position so narrowly representative that it abjectly fails this group.

That these women neither delay or fear health care encounters is somewhat reassuring however neither have the majority had the opportunity present to share this portion of their identity with their primary health provider. Given the heterosexually assumed worldview, it is not surprising that many of the problems associated with, interactions between health professionals and lesbian women will be nullified, if this assumption is removed from the encounter. Inclusive language and open-ended questions will avoid

the implicit assumption of heterosexuality, reducing the associated internal debate regarding disclosure, and enhancing both respect and good communication.

This in turn will encourage health-seeking encounters perceived as safer. Images, which mirror lesbian women's experience, should be produced and incorporated within health institutions, clinics or other venues. These can be in the form of posters, perhaps simply, depicting two women, brochures and pamphlets with relevant information and data targeted toward lesbian women. These strategies will increase the levels of felt safety for such women.

NURSING RELEVANCE

Health care encounters, which are comprehensive and equal in both access and quality for all only exist should all health care encounters be positively perceived by all who use the service (Stevens, 1992). It is crucial to grasp that the sole individual positioned to determine safe care is the individual intending to utilise the service (Ramsden, 1995). Health professionals therefore need to be in a position to appreciate the cultural differences from heterosexual clients, which lesbianism invokes, to ensure felt safety couched in equitable access for this group. The following statement is by the New Zealand Nurse's Organisation regarding gay and lesbians

Nurses/midwives in clinical practice need to ensure that they never intentionally behave in a way, which marginalises this client group. They must examine their behaviour towards clients to ensure that it cannot be considered prejudicial, actively seek to raise awareness of the problem amongst colleagues and discourage unhelpful responses, and explore all possible ways of supporting and assisting lesbian women and gay men using their health service (NZNO, 1997, p. 13).

While this statement provides a starting point much more is required of nurses than merely examining their behaviour in a clinical setting. This will encourage at most a level of tolerance, without effectively engaging with the underlying causation of discrimination towards lesbian women. Such positions neglect to appreciate the socio political environment and its relationship to health in the wider sense. The statement

fails to recognise the societal marginalisation processes, which these women (and men) encounter on a daily basis. Furthermore it is crucial to explore and examine the unintentional mechanisms of marginalisation, so deeply embedded that they will be covertly present as opposed to overtly recognisable.

It is erroneous to presume that health care professionals are immune and detached from the societally held beliefs related to lesbian women. Rather it is vital to recognise the pervasive forces, which shape the deeply held attitudes towards lesbian women that growing up in a heterosexist and homophobic society produce. The attitudes of both nurses and doctors (within the literature review) towards members of their own profession who are lesbian or gay is a stark insight into the embedded attitudes held. Such attitudes must translate to homosexual persons in their care. The power of culturally held beliefs and attitudes related to homosexuality are crucial to an understanding of health care professionals response to homosexuality (Hartman & Laird, 1998).

It should not be lesbian women alone who negotiate the path towards equitable health service delivery attempting to extricate their specific needs and requirements from a health environment simply non-representative. Rather health care professionals (and here I strongly promote nurses) need to deliver the message through real actions that health care services are appropriate for this group. Positive change requires inclusion and involvement for maximum effect. Lesbians have a lengthy history of negotiating their way through treacherous worlds and will prove enthusiastic and active partners in any such endeavour towards parity in health care encounters.

This will necessitate a concerted drive to include appropriate education within the nursing curriculum. A discussion paper on graduate education in nursing, in light of the health care reforms states "Nurses have the chance to make graduate nursing education more responsive to the actual health needs of the populace and more relevant for practice in communities" (Hall & Stevens, 1995, p.332). Several strategies are advocated for, including taking a partisan stand with vulnerable groups and applying an understanding of the broader environmental context of health (Hall & Stevens, 1995).

Health professionals need to be prepared to affirm lesbian women who disclose their sexuality, and this can only occur if they themselves have been suitably prepared at graduate level. Sexuality needs to be incorporated into the nursing (and other health professional) curriculum. Educators have a huge influence at this level as students have a tendency to absorb whatever values are prevailing (Randall, 1989), from their educators. Nursing needs to continually evolve to ensure that they provide education, which realistically measures up to their statutory body's guidelines.

If we neglect issues such as diversity in cultural identity and sexual expression, within our education we are in no position to calmly lay claim to such attributes as culturally competent care, partnership, advocacy, caring or the uniqueness of the individual, as being inherent to our practice. It is simply not congruent to claim such attributes, while we potentially, ignore and neglect 10% of women in this country (and an equal number of men). An enlightened nursing practice would facilitate the following notion and embody the spirit of the Treaty of Waitangi.

Caring for women occurs in the context of an egalitarian and collaborative relationship. This implies that the relationship is structured so that the professional power of the nurse is balanced with the power of the woman seeking health care. Mutual recognition of one another's expertise, sharing of information, and defining goals in collaboration are central elements of the process. Women are regarded as experts about their own bodies and self-care, and nurses are regarded as experts in the health problems populations of women experience and the processes that can be used to facilitate health (Woods, 1995, p.135).

Creative innovative and informed nurses have proved their ability to take up this cultural challenge (against the dominant ingrained ideology) with regard to culturally safety and congruent care provision for the Tangata Whenua (indigenous people) of this country.

Nursing's traditional role of patient advocacy can be greatly enhanced by a nursing workforce that is continually working to develop cultural competence (Misener et al., 1997, p. 180).

In 1996 the Nursing Council of New Zealand expanded the concept of cultural safety to incorporate sexual orientation (along with several other categories) within the guidelines. It remains then to translate from the grand theoretical notion into concrete application.

This is truly where nursing as a profession will excel promoting partisan partnership with such groups. Thus proving itself a lead profession as we commence charting the waters of a new millennium. While this journey will likely be a considerable and often treacherous one the reward of knowing that groups are continually being brought in from the margins will be provocation enough for this profession to take those first tentative steps and journey forth. The end results of, which will be affordable, accessible and culturally congruent, care to all peoples. To achieve this positive future for all people nurses and nursing must construct an environment where they continually challenge their own beliefs and assertions.

Nursing is to be congratulated on the journey it has made and the courage and determination it has shown to work with the issues. There will be an ongoing process of self examination towards the expansion of practice in the search for excellence in the service offered and given to those fellow human beings who differ, fully regardful of their difference and of the realities of those people who are nurses or midwives (Ramsden, 1995, p.12).

RESEARCH RECOMMENDATIONS

Given the limitations of a single study it would be appropriate to recommend further nursing research, with lesbian women in the New Zealand context. Further research of a similar nature specifically aiming to uncover health and safety issues for lesbian women in the more rural and isolated regions is essential. It would be of interest to engage with the South Island of New Zealand, as it is perceived to be considerably more conservative than the North Island. For any person considering such a project but uncertain of a suitable commencement point the recommendations contained within the Saphira and Glover (1999) report provide an excellent starting place.

The New Zealand Nurses Organisation states

Nurses/midwives undertaking research need to develop studies of lesbian women's and gay men's actual and perceived health care experiences and should establish how nurses/midwives can best meet the needs of their lesbian and gay patients (NZNO, 1997,p.13).

To facilitate the above statement it becomes crucial to forge a partnership approach between lesbian women and nurses. Therefore it becomes essential to engage in research which seeks to uncover held attitudes concerning homosexuality by nurses in this country. Such research to expose attitudes towards homosexuality and homophobia in health care workers is limited (Saphira & Glover, 1999; Smith, 1993). Given that nurses (and other health care professionals) do not grow up in a vacuum, removed from the social forces, they will have internalised societal myths, taboos and stereotypes resulting in the development of negative attitudes founded in misconception and misinformation towards lesbian women (Smith, 1993). It may be naïve to state with any degree of certainty that professional, ethical or conduct codes act as non-penetrable shields deflecting such attitudes and beliefs, while paving the way for non-judgemental care to flourish (Rose, 1994).

Responsibility rests with health care professionals to engage in explorations of the concepts of heterosexism and homophobia both outside and within the environs of health care delivery (which necessarily includes health care professionals themselves). It would be edifying to engage in research, which strove to uncover nursing attitudes towards lesbian women from the perspective of both lesbian and non-lesbian nurses. This would be well informed by seeking to uncover the hidden nature of lesbian nurses within their own profession.

Seeking held attitudes by members of the nursing profession regarding lesbian nurses promotes transparency to assist with an assessment of the depth of relevant issues. Professional introspective research of this nature coupled with further research with lesbian women is the setting for the subsequent forging of a partisan partnership between nursing and this marginalised group. From this research foundation can an assured level of appropriate health care access, delivered by nurses who are culturally safe become reality for lesbian women.

CONCLUDING STATEMENT

This work has provided the opportunity for previously ignored women to share portions of their life journey incorporating lesbian as part of their identity. I would take this opportunity to sincerely thank them for their energy, enthusiasm, hospitality, time and most importantly their sharing of their lives and experiences in such a stunningly honest way.

I have gained personal strength from the knowledge that these women grace 'my world' and hope that their involvement in this work in part reciprocated this. These women have comprehensively illuminated their cultural world within this work and the relationship to health. Issues pertaining to the informational vacuum, the potential for labelling and subsequent reduction to their sexual identity, which these women encounter, have been shared as being both relevant and problematic.

It is my hope that nurses will work to gain an appreciation of the 'other' world, in which lesbian women find themselves residing. Though I acknowledge my bias (being both a nurse and a lesbian woman) such gained appreciation will serve to afford nurses the opportunity to gauge current practice towards this group and move toward a service which would truly speak of equity.

Differences between the overseas literature and the experiences of these women have been expressly noted. Specifically delaying seeking health care, fear, and non-engagement with the cervical screening programme varied significantly from the predominantly American literature. While this is positive I once again point out that this group of participants varied also from those to date considered representational of lesbian women by virtue of age and educational preparation.

Finally it clearly needs to be reiterated that this work in no way speaks for lesbian women as a whole. It represents the experiences of the seven participants and the interpretation of that experience by me as the researcher. Undoubtedly significantly diverse experiences from other lesbian women exist and remain as yet to be uncovered.

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INFORMATION SHEET

My name is Geraldine Clear and I am currently undertaking a Master of Arts (nursing) degree at Massey University, Palmerston North. This research study is a requirement of this degree. I am a registered nurse and am currently employed as a graduate assistant in the School of Health Sciences at Massey University in a part time capacity.

My supervisor for this study is Dr. Jenny Carryer who is also a nurse.

I invite you to consider being a participant in the study described below. You are free to ask questions before reaching your decision and are under no obligation to participate.

STUDY OUTLINE:

In this study I wish to look at factors which influence a sense of safety for lesbian women seeking health care. Most health care organisations relate to women believing them to be 'straight' and information from these organisations for the most part mirrors this 'straight' image. I am keen to explore what factors hinder and help lesbian women to feel safe when seeking health care. I am interested in lesbian women particularly as I believe there are unique issues for lesbian women, which are not understood within the health care environment.

YOUR PARTICIPATION:

Should you agree to participate in this study, your involvement will consist of 3 meetings. An initial meeting to discuss the study and gain your consent. Following on from this there will be an individual meeting which will last for about an hour, and later a group interview with other participants will be arranged, lasting about 2-3 hours. With your consent both of these interviews will be audio-taped and these tapes will be transcribed onto paper. In the first interview you will be invited to share your experiences of health care after which some questions will be asked.

Before the group interview I will return a copy of the first interview to you to ensure that I have recorded correctly our discussion. You may delete any portion of your discussion, which you are unhappy with at this time. There will also be an opportunity for you to clarify any particular point and add anything you may wish. You have the right to decline to participate at any stage of the interviews or you may refuse to answer any question asked.

The group will give you the opportunity to explore together what it is like to be lesbian women seeking health care. Again your consent will be asked for prior to this group interview.

CONFIDENTIALITY:

At the first interview I will ask you to choose a pseudonym by which you will be known throughout the study. At no time will your real name(s) or any other information be used which would enable you to be identified. With your approval as a participant, selected excerpts will be printed verbatim (as you stated it) in the thesis (study) document. However the use of a pseudonym and deletion of any identifying features will protect your anonymity. You should be aware that because a focus group meeting is part of this research that other participants would know your identity. However, there will be protocols in place for the focus group meeting to ensure the on-going protection of your identity.

Once the audiotapes have been transcribed (typed onto paper) they will be kept locked until the thesis has been marked. You will then be offered your tapes to keep. If you do not wish to keep these, they will be erased. Only myself, Dr. Jenny Carryer, my supervisor and the transcriber (typist) who will be required to sign a confidentiality agreement read the transcripts. At all other times these transcripts will be kept securely locked in my home office.

CONSENT FORM:

- ❖ Before the study commences I will ask you to sign a written consent form which states that you have agreed to participate, and fully understand what is required of you by your participation in this study.
- ❖ It will also state that you have the right to withdraw from this study at any stage without fear of coercion or disapproval.
- ❖ You may also refuse to answer any particular question at any time throughout the study.

Should you agree to participate I will endeavour to keep you fully informed throughout the course of the study and at the conclusion, a summary of the research findings will be available to you. I will also keep you informed on how I intend to publish the research findings. You will be able to contact either myself or my supervisor at any time throughout this research study.

Geraldine Clear 021 2106736

Dr. Jenny Carryer 06) 3569099 School of Health Sciences, Massey University.

Thank you for considering participating in this research project which aims to look at lesbian women's sense of safety when accessing health care.



LESBIAN WOMEN'S SENSE OF SAFETY WHEN ACCESSING HEALTH CARE.

CONSENT FORM

I have read the information sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I understand I have the right to withdraw from the study at any time and to decline to answer any particular question.

I agree to provide information to the researcher on the understanding that my name will not be used without my permission.

(The information will be used only for this research and publications arising from this research project).

I agree/ do not agree to the interview being audio-taped.

I also understand that I have the right to ask for the audio-tape to be turned off at any time during the interview.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signed:

Name:

Date:

LESBIAN WOMEN'S SENSE OF SAFETY WHEN ACCESSING HEALTH CARE.

CONFIDENTIALITY AGREEMENT

I _____ of _____
have agreed to transcribe *ad verbatim* Geraldine Clear's research data from the
audiotapes into a written form. I agree to maintain complete confidentiality in regard to
anything I may hear or read in connection with this research.

All tapes, computer discs, and paper copy of this information will be kept in a secure
place while I have it for the purposes of transcription. All the aforementioned material
will be returned to Geraldine Clear on completion of each transcription and any
information on the computer hard drive will be erased.

I understand this agreement is binding both now and in the future.

Signed _____ (Typist)

Signed _____ (Researcher)

Date _____