

**Voices from the Hinterland: Lesbian Women's
Experience of Irish Health Care**

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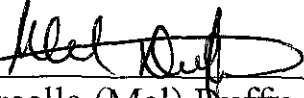
***A thesis presented to Dublin City University for the degree of
Doctor of Philosophy***

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I hereby certify that this material, which I now submit for assessment on the programme of study leading to the award of Doctor of Philosophy is entirely my own work, that I have exercised reasonable care to ensure that the work is original, and does not to the best of my knowledge breach any law of copyright, and has not been taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of my work.

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Glossary of Acronyms

| | |
|------|--|
| AOH | Ancient Order of Hibernia |
| APP | American Psychiatric Association |
| GCN | Gay Community News |
| GLBT | Gay, Lesbian, Bisexual and Transgender |
| GLEN | Gay and Lesbian Equality Network |
| HSE | Health Service Executive |
| ICCL | Irish Council for Civil Liberties |
| ICSP | Irish Cervical Screening Programme |
| ILGA | International Lesbian and Gay Association |
| ILGO | Lesbian and Gay Organisation |
| LEA | Lesbian Education and Awareness |
| NCNM | National Council for the Professional Development of Nurses and Midwifery |
| NOW | New Opportunities for Women |
| RCN | Royal College of Nursing |
| RSE | Relationship and Sexuality Education |
| STI | Sexually Transmitted Illness |
| WHO | World Health Organisation |

Abstract

There is a lack of knowledge about lesbian women's lives and social experiences in Irish society. Lesbian women's invisibility is reinforced and permeated in all social institutions in society such as religion, education and the family. This thesis deals with the nature of being-in-the-world of health care: the nature of being lesbian women both as service users and nurses working in the health care environment. In their day to day living, lesbian women know how to act, react and behave to exist within society. However, these taken-for-granted ways of understanding of being-in-the-world are brought to the forefront when lesbian women seek health care. For lesbian nurses, being-in-the-world of health care is to know that world both as health care professional and as lesbian women.

The method for this study derives from the philosophical tradition of phenomenology utilising Heidegger and Sartre. The findings from this study suggest that some lesbian women go to great efforts to conceal their sexual identity. They curtail their behaviour, set up barriers to communication utilising protective devices to protect the self from exposure to Others. Lesbian nurses recall being set apart with their difference exposed for them to see as well as the tactics they utilise to negate the effect of being Othered. They remain hidden, fearing the consequences of being discovered, which leads to feelings of isolation, loneliness and sadness.

Chapter 1: *Setting the Scene*

1.1 Introduction

This study is centered on the stories that lesbian women as services users and as professionals in Irish health care tell of their experiences of being lesbian. Frank (1995:3) argues that “*storytellers have learned formal structures of narrative, conventional metaphors and imagery, and standards of what is and is not appropriate to tell*”. These are shaped by the cultural context within which the storytelling occurs. Some of the imagery that lesbian women who participated in this study use to describe their understanding of the situation they found themselves in include: using two cloaks, being a nobody or the images of being other than who they are, that is, a heterosexual woman. Frost (1996:1127) offers the reader a helpful image to understand lesbian women’s experience of Irish health care.

The Road Not Taken (Robert Frost)

Two roads diverged in a yellow wood,
And sorry I could not travel both
And be one traveller, long I stood
And looked down one as far as I could
To where it bent in the undergrowth;

Then took the other, as just as fair,
And having perhaps the better claim,
Because it was grassy and wanted wear;
Though as for that the passing there
Had worn them really about the same,

And both that morning equally lay
In leave no step had trodden back.
Oh, I kept the first for another day!
Yet knowing how way leads on to way,
I doubted if I should ever come back.

I shall be telling this with a sigh
Somewhere ages and ages hence:
Two roads diverged in a wood, and I –

I took the one less travelled by,
And that has made all the difference.

The Road Not Taken may be interpreted as Frost illuminating what it is like to be at the cross roads of life. Which path should I follow? The one that is beaten down and well trodden upon, which I can interpret as the one that Others have taken. On this road I can obtain guidance on the way. This can be viewed as the most travelled heterosexual path. As it will be shown it is the norm of society. Or the one least travelled? This one is a mystery to us; we do not know those who have gone before as there is no sign. This illustrates the position that some women find themselves in, in their path of discovery of their lesbianism. However this path is fraught with cultural meanings of what a lesbian woman is as Moane (1995:86) succinctly puts it: "*The 'label' lesbian has been used as a weapon to silence and intimidate women who speak out assertively or defiantly*".

In Irish academia there is a paucity of knowledge about lesbianism, particularly in the literature on health care. This study derives out of my interest in inequality in health care, and how texts on inequality in Irish health care make little or no reference to lesbian women. While lecturing on the subject of lesbian women in health care I had to turn to studies abroad to reveal what was happening, and perhaps could be happening in Ireland. The inadequacies of available literature are based upon the assumption that all Irish women are heterosexual with no allowance for difference. In addition, I was also drawn to the topic as a lesbian woman and from my own personal experiences of health care. Out of this, derived my interest in developing a thesis on lesbian women's experiences of health care.

1.2 Aims and objectives

This study aims to investigate lesbian women's experiences of Irish health care both as service users and as services providers in their capacity as nurses. The objectives of the present research are to:

1. Explore the lived experience of health care of lesbian women;
2. Investigate the meaning(s) that lesbian women construct of that experience;
3. Investigate the lived experience of lesbian nurses working in the health care environment;
4. Investigate the meaning(s) that lesbian nurses construct of that experience.

These objectives are particularly significant, as one of the intended results of the women's health policy document, *A Plan for Women's Health, 1997-1999* (Government of Ireland, 1997), was the provision of a woman-friendly health service. This document was produced in "*response to a growing concern that women's health needs were not always being met by the health services*" (Government of Ireland, 1997:4). The policy document stipulated that all women should be treated equally within the health services, recognising groups that are marginalized. It is stated that the "*health services should not further marginalise women who are already marginalised*" (Government of Ireland, 1997:54).

In the chapter entitled "Women with Special Needs", the various groups of women that are marginalised within the health service are identified: 'women who are socially and economically disadvantaged'; 'young women'; 'women as parents'; 'traveller women'; 'women with disabilities'; 'women as carers'; 'older women'; 'women in prison'; 'women in prostitution'; 'women and drug users'

and 'lesbian women'. The document recognises that many of the health problems encountered by women are common to all regardless of the social groups they belong to. In identifying the groups mentioned above, it is acknowledged that "*certain groups of women experience particular challenges which undermine their health*" (Government of Ireland, 1997:54). It is further indicated, that the health services should be flexible in meeting the needs of these women

In relation to "lesbian women", it is stated that:

The most serious health issue identified by lesbian women during the consultative process was the attitude which they encountered when seeking care from the health services. Lesbian women are also more prone to stress and depression associated with their sexual identity, particularly during adolescence. The difficulties which lesbian women face in health services arise partly as a result of lack of knowledge on the part of professionals about the health risks associated with a lesbian life style and partly because of deep seated attitudes to homosexuality generally. There is clearly an onus on health personnel to be informed about lesbian health issues and to ensure that sexual orientation is not a barrier in accessing services (Government of Ireland, 1997:64).

While the strategy recognised that health care professionals are not immune to societal attitudes towards lesbian women, an action plan was laid out in the women's health policy document to enable lesbian women to obtain non-prejudicial health care. Consequently, this study will examine whether on the one hand a woman-friendly health service has been created for lesbian women and on the other if there is awareness and respect for diverse sexual orientations in the health services.

Primary data will come from obtaining and then analysing the lived experiences of lesbian women as services users and those who work as nurses within health

care. Two sets of research questions arise. The first deals with lesbian women's experiences as consumers of health care.

1. How do lesbian women experience being lesbian in health care?
2. How do lesbian women describe their experience?
3. How do lesbian women interpret that experience?
4. What meanings do lesbian women give to their experience?

The questions relating to lesbian nurses are:

1. How do lesbian nurses experience being lesbian within the health care setting?
2. How do lesbian nurses describe their experience of working within health care?
3. How do lesbian nurses interpret their experience?
4. What meanings do lesbian nurses give to that experience?

In addition, both sets of research questions deal with the nature of being-in-the-world: the nature of being lesbian in the world as consumers of health care and the nature of being a lesbian nurse in the world of the health care environment. Health care is just one area in which lesbian women experience being-in-the-world as that of the outsider, where they are exposed to the attitudes and judgments of professionals (Marrazzo, Coffey and Bingham, 2005; McDonald, McIntyre and Anderson, 2003).

1.3 Exploring experiences

The methodological framework for this study derives out of the qualitative tradition utilising hermeneutic phenomenology. Van Manen (1990:6) informs us

that this type of phenomenology "is a human science which studies persons".

He further states that

We might say that hermeneutic phenomenology is a philosophy of the personal, the individual, which we pursue against the background of an understanding of the evasive character of the logos of other, the whole, the communal, or the social (Van Manen, 1990:7).

In this context, it is the personal and individual experiences of lesbian women, of being either service users or providers of health care, that is being explored. In considering the questions above and others that arose during the study, van Manen's (1990) methodical structure¹ guides my research.

A method for understanding the lived experience is found in van Manen's (1990:30-31) articulation of the elements this method entails. These include:

1. *turning to a phenomenon which seriously interests us and commits us to the world,*
 2. *investigating experience as we live it rather than as we conceptualize it,*
 3. *reflecting on the essential themes which characterize the phenomenon,*
 4. *describing through the art of writing and rewriting,*
 5. *maintaining a strong and oriented pedagogical relation to the phenomenon,*
 6. *balancing the research context by considering parts and whole.*
- (Van Manen, 1990:30-31).

However this process is not a step by step guide in how to carry out a hermeneutic phenomenological research, rather a guide of what it entails during the process.

1.4 Turning towards the phenomena

The phenomenon that interests me and commits me to the world is that of lesbian experiences as both consumers and as nursing practitioners in the world of health

¹ Robertson-Malt (1999:293) suggests that van Manen's methodical structure "promotes freedom and initiative in the researcher's involvement with the dynamic process of hermeneutical phenomenological inquiry"

care environment. To obtain an understanding of lesbian women's experiences in Irish health care it is necessary to ground it in an understanding of lesbianism in Irish society. Chapter Two seeks to understand women's sexuality in the context of Irish culture. It reviews the part social institutions play in the construction of women's sexuality, and how lesbian women find a voice in this. It points to the invisibility of lesbian women in social institutions such as family, religion and education (see Chapter Two)

Chapter Three seeks to review lesbian women's health care issues; it presents lesbian women's experience of health care from Britain, New Zealand and the United States of America, as these countries have begun to deal with the issues of lesbian women's health and health care. In contrast, there is a lack of available literature on lesbian women's health or health care in Ireland. However, the Irish government in the 1997 women's health policy has pointed to the need for the recognition of lesbianism in health care. While literature on lesbian nurses is scant, it does point to the problems they face within a health service that assumes heterosexuality for all women (Kavanagh, 2006), both as service users and service providers. Lesbian women, find their sexuality makes the difference in their treatment in health care (Bonvicini and Perlin, 2003; Westerståhl, Segesten and Björkelund, 2002; Stevens, 1996).

1.5 Investigating the lived experience

To investigate the lived experience, it is necessary to site it within an epistemological frame of reference, so Chapter Four explores the philosophical roots of phenomenology. It overviews the traditional frameworks for the

production of knowledge within the field of sociology, suggesting that the positivist perspective of bias-free production of knowledge, leads to the negation of an individual's understanding of experiences of the world. The epistemological framework stays within the tradition of interpretative sociology.

The philosophy of Heidegger (1962), which was developed further by Sartre (1969), underpins this study. Heidegger's (1962) concern with being *in* the world, offers a theoretical framework whereby lesbian women can be seen as active participants in the world, creating understanding and meaning to their existence. Sartre (1969) offers us a lens through which we can examine how lesbian women experience the self, as either service users or providers of health care. It is this capturing of life as it is lived, that frames the articulation of understanding and meanings that lesbian women derive from the situations they find themselves in, in this study health care.

1.6 Methodology

Chapter five explores the methods chosen to undertake this study, giving a detailed descriptive account of the research process. The telling of stories necessitates an atmosphere of trust and confidentiality, and this chapter describes how this was achieved. Through the data gathering process lesbian women participated in the telling of their story. Dinkins (2005) informs us that the quality of the data obtained is a reflection upon the ability of the researcher to facilitate participants to recall and reflect upon their experiences. For some service users their stories were old, and for others their stories were relevantly recent. In this way, lesbian women told stories relating to their experiences of the

road they had taken. This chapter also explores the process of writing and the technique used to develop the themes that are explored in chapters six and seven (service users), and chapters eight and nine (nurses).

1.7 Hermeneutic circle

Ironside (2005) suggests that during the process of doing a hermeneutic phenomenological piece of research, the researcher cannot step in or out of the study or circle of the study. However they can go back and forward. In this way, chapters six, seven, eight and nine are the interpretations of the data. They represent the balancing between the parts and whole of the study. They keep in mind the questions: "*What is it? What is this phenomenon in its whatness?*" (van Manen, 1990:33). In addition, these chapters are not divorced from what arrived prior to them, but represent the balancing of the parts into a whole. The concluding chapter brings together the main findings, incorporating suggestions for further research.

Chapter 2: *Women's Sexuality in Ireland*

2.1 Introduction

This chapter reviews the literature on women's sexuality from the foundation of the Irish State to the present day, suggesting it has been a contentious subject. There are many institutions that have attempted to shape women's sexuality, in particular, the State and the Catholic Church. The twinning of Catholicism with Irish identity and the struggle for independence, facilitated an Irish sexual morality based on Catholicism (Smyth, 1995). Catholicism and Irish identity was further secured through legislation such as the Censorship of Publication Act, 1929 and the Criminal Law (Amendment Act), 1935, after the foundation of the Irish State, and reinforced through the institutions of family and education (Smyth, 1995; Fahey, 1992).

This chapter is divided into five sections. the first seeks to answer the question 'who are lesbian women?'; the second deals with the influences of the Irish State and the Catholic Church on the sexuality of Irish women from 1922-1960; the third examines social change in Irish society from 1960 to the present day; the fourth addresses the development of sexuality as a curriculum topic in Irish schools; and finally, the fifth deals with lesbian women and their position in society.

Women's sexuality in Ireland has been researched from diverse perspectives, such as: the sociological paradigm on women's quest to control their fertility (Murphy-Lawless and McCarthy, 1999; Mahon, Conlon and Dillon, 1998); the feminist perspective of women's changing role in society (Connolly, 2002; Beale 1986);

and the socio-historical analysis of women's changing status in Irish society (Inglis, 1998; O'Connor, 1998; Kenny, 1997). However, lesbianism in Ireland has a history of invisibility, although some researchers have attempted to shed light on the subject (Moane, 1999, 1996, 1995; Crone, 1995; O'Carroll and Collins, 1995; Rose, 1994).

2.2 Who are lesbian women?

Defining 'lesbian' or 'lesbianism' is not an easy task (Stein, 1998). There are many paradigms that have dealt with the meaning or attempted to define lesbianism. These have included the religious (lesbianism is seen as immoral), criminality (lesbianism is seen as a crime/ deviant behaviour), medical (lesbianism is seen as pathology/sick) or consumerist (lesbianism is seen as a lifestyle/social role) (Wilton, 1995). The lesbian then, is seen as abnormal (sick, deviant and immoral) pitted against the normal (healthy, law-abiding and moral) and labelled deviant. The practice of labelling homosexuality as deviant can be viewed, according to McIntosh (1998:69), as having two functions: one being social control; the other being the maintenance of normative heterosexuality and institutions that:

keeps the bulk of society pure in rather the same way that similar treatment of some kinds of criminal helps keep the rest of society law abiding.

Stein's (1998:558) definition is the following: "*Lesbians [are] were biological women who [do] did not sleep with men and who embrace the lesbian label*". This definition is considered reductionist; it negates other aspects of lesbian life as it defines lesbianism only in relation to sexual activity (Moonwoman-Baird, 2000). As Kelly (1972:474) indicates:

For most people, especially for most men, a lesbian relationship is defined in terms of what happens in bed rather than as a total, revolutionary way of communicating with, enjoying, supporting, and loving another person.

However the label 'lesbian' enables women to construct an identity that assists them in creating meanings of their own existence and that of others (Wilton, 1995). In so doing, a lesbian woman builds a coherent world-view, "understanding, evaluating, and constructing accounts of experience" (Linde, 1993 quoted in Moonwoman-Baird, 2000:350).

Without this meaning, lesbian women would find their existence 'meaningless', with no purpose. Weber (1962:33) indicates:

all processes or conditions remain "meaningless" if they cannot be related to a meaningful purpose: this regardless of whether they are inanimate, human or inhuman.

An individual learns meanings through socialization. She not only becomes a subject but also, in order to co-habitate in society with others, she must become an inter-subject, thus seeing herself as others see her. In so doing, she integrates the values, belief systems and norms of her particular society, enabling her to occupy a position within that society. Mead (1934:265) indicates that "until one can respond to her[him]self as a community responds to her [him], s/[he] does not genuinely belong to the community". However, those meanings are cast in doubt when a woman identifies as a lesbian as this identity may not co-exist with the values, norms and belief systems of her earlier socialisation as this thesis will show.

Nevertheless, as Rust (1993:52) points out, women who are "raised to assume heterosexual identities" do assume lesbian identities and "shape [her] image to fit

in” (Lemon and Patton, 1997:118) to a lesbian community. Equally, Lemon and Patton (1997) echo Mead’s (1934) assertion in relation to the community, as “*failure to conform may mean failure to resolve identity, or a lack of acceptance by those people with whom a lesbian identity does not assume stigmatised status*” (Lemon and Patton, 1997:119). Therefore, while a lesbian may find that she does not ‘fit’ the heterosexual community, there is also an element of conformity in ‘fitting’ a lesbian community. She must therefore learn the norms, values and belief system of the community she wishes to join.

Meanings arise from both the lesbian’s subjective and inter-subjective interpretations, that is, the meanings imputed by others, which may be reinterpreted or modified by her, to interact with others. The ‘lesbian label’ provides a starting point from which such meanings and interpretations can develop. It also provides a “*feeling of biographical continuity which she is able to grasp reflexively and, to a greater or lesser degree communicate with others*” (Giddens, 1991:54). Stevens and Hall (1988:70) indicate that it is the taken-for-granted views of the world that lesbians cannot have.

Lesbians cannot take for granted that they share the world with others who hold congruent values, interpretations and behaviors, nor can they assume that they will be evaluated according to their own personal qualities

In a heterosexual world, a woman may not identify with the label ‘lesbian’. Rather she may call herself a woman who loves women, a woman whose primary relationships are with women or a woman who only has relationships with women.

Younger women may embrace the term lesbian while older women may not. Claassen (2005:223) in her study on older lesbian women states.

Throughout this project, I have been struck by the number of narrators who said that they knew no words, had no words, used no words, gave no words to their loving of women, to their lovers, to their friends and family, to themselves.

Older lesbian women had an inability to name who they were to themselves or others. This derived out of their fears: losing their jobs, family or lovers if their relationships were named (Claassen, 2005) (see Chapter Three).

O'Carroll and Collins (1995:30) asked Mary Dorcey (an openly lesbian woman in Irish society) in their interview with her what 'lesbian' meant to her. Her reply takes into account not only sexual desire but also social and political elements:

It seems to me, to put it at its most simple (which is not always easy), that I am a lesbian because I love women more than men. It is not a matter only or even primarily of sexual desire, but rather of erotic love. . . I think erotic love is not so much a matter of lust as of who and what inspires the imagination, awakens psychic passion. A lesbian is a pioneer, a woman who has escaped from the controlling grasp of masculine heterosexuality, a visionary, a free spirit, an adventurer, a self-creator.

This gives us a greater and complete definition of a lesbian woman, taking into account the social, emotional, physical and political facets of a lesbian woman's life. From an Irish perspective, Dorcey's (O'Carroll and Collins, 1995) description of what a lesbian woman is, takes into account the negation of heterosexuality, but also her impression of heterosexuality as being male centered rather than a joint creation by women and men. Therefore, lesbianism is created without male influences, and as such it has none of the trappings of heterosexual masculinity. But lesbian women also "have to contend with the attitudes and practices of a heterosexist society" (LOT, 2000:9). When Dorcey is asked, "what

kind of women become lesbian?" she replies *"all kinds, every physical type, every personality type, every class, every culture, all age groups"* (O'Carroll and Collins, 1995:31). From this, we can see that for Dorcey there is no stereotype of a lesbian woman and a lesbian can be found across cultures. As such, she may not be readily identified.

"Lesbians are not strange, extraordinary or exotic women We are ordinary women" (Crone, 1995:61). Crone (1995) points out, that lesbian women are brought up in a heterosexual environment and socialised in the same way as all women. The problem of 'who a lesbian is' lies in the role-stereotyping of women, namely the roles associated with family relationships, such as mother and carer, which can be considered as woman's "core roles" (Connolly, 2002; Wilton, 1995, Beale, 1986). Crone (1995:61) suggests that to come to the point of knowing that she is lesbian, a woman must undo all her social conditioning, that is, being *"socialized into a mothering role as helpers, assistants and carers"*. However, this view may negate the experiences of lesbian women, who occupy roles; as mothers and carers of their partner, children or parents. They do not embrace the traditional concept, which is that all mothers are heterosexual, a perspective that is examined in the following section.

2.3 Historical overview of Irish women's sexuality from 1922-1960

Ireland emerged as an independent state in 1922 (Lee, 1989). The Catholic Church had a privileged role in relation to the new state, which was similar to that in other European countries such as Spain (Payne, 1984) and Portugal (Gallagher, 1996). However, it must be highlighted that:

the nature of Catholicism has clearly been moulded by socio-economic, political, and ideological factors internal to individual countries which have given rise to distinctive national Catholic mentalities (Conway, 1996:6).

Consequently, the distinctiveness of Irish Catholicism has influenced the perception of what it is to be a 'woman' in Irish society. Up to the 1960s the Irish State vindicated the Catholic Church's social teachings on women and women's sexuality, by enacting legislation reflecting their principles. From the 1960s the Catholic Church's position of power began to be eroded, which is discussed in the section on social change (section 2.4).

2.3.1 The rise in dominance of the Catholic Church

Nic Ghiolla Phádraig (1986) argues, that the legacy of colonialism in Ireland is a Church that has been viewed as traditionally working for the underprivileged. This led to a Church being rewarded with uncritical loyalty by the people (Nic Ghiolla Phádraig, 1986). Independent Ireland did not create a Catholic State, rather the Church consolidated its position after independence, through legislation and the support of politicians (who were nearly all Catholic), such as Cosgrave and De Valera (Keogh and O'Driscoll, 1996; Fahey, 1992; Nic Ghiolla Phádraig, 1986).

Breen et al (1990) suggest that with the foundation of the State and the civil war that ensued, there was a need for cohesion and legitimisation, which led to the non-separation of Church and state with some considering it a natural alliance: "*the Church offered the state continuity and stability and in return sought its support for continuity and stability of its own work*" (Nic Ghiolla Phádraig, 1995:609). Not only did the Catholic Church offer stability and continuity, but

crucially it supported the Free State during the civil war, even though “*the British inspired 1922 constitution was not particularly a Catholic document*” (Keogh and O’Driscoll, 1996). Since the members of the government were nearly all Catholic, early legislation reflected a Catholic ethos. Thus, an “Irish-Catholic” state identity emerged, which was different from that obtained in Poland for example; both the Polish First Republic (1791) and Second Republic (1918) had a clear separation of Church and State (Grabowska, 1992:289). Upon the foundation of the Irish State the majority (93%) of its people were Catholic (Hug, 1999) while in contrast, Poland in 1918 found itself with a diversity of nationalities and denominations with only two-thirds of its population identified as Catholic (Grabowska, 1992), though this diversity disappeared after World War II.

The rise to dominance of the Catholic Church in the new Irish State has been attributed to the isolationist policy of the Irish government, its non-participation in World War II, and the shared values of both Church and State (Smyth 1995). These values were conservative in nature and rooted in rural, social and economic life, as the aspiration for its people (Lee, 1989) Three elements have been identified in the implementation of Catholic Church power in Ireland:

(i) through the ideological power (the power of belief system), (ii) through the control of resources (land, property, health and education systems) and, it is increasingly being revealed, (iii) through coercive physical power (usually described today as ‘abuse’) (Tovey and Share, 2003:397).

Fahey (1992) considers the relationship between the Catholic Church, the Irish State and nation as symbiotic for much of the twentieth century, whereas in Poland the Church and state have been at odds with each other. This, for him, has

resulted from two very different political histories in the last century. Ireland's neutrality in World War II and relative political stability, contrast with Poland's involuntary participation in that war, which led to German occupation and afterwards the development of a communist system (Fahey, 1992; Grabowska, 1992), where diversity disappeared under the unity of communist society proposed by communist ideology.

2.3.2 Moral authority

Women's position in Irish society has been characterised by relegation to the private domestic sphere, for at least four decades from the foundation of the state (Kenny, 1997; Beale, 1986). It has been argued (Hug, 1999; Inglis, 1998a) that once independence had been secured, the Catholic Church had no enemy to galvanise the people. As such, it was in danger of losing its position in society. Since the enemy was not outside the state, the antagonist had to be within. Thus, sexual immorality became one of the new adversaries. For instance, 1934 has been identified as a significant year in Spain for the consolidation of the Catholic Church's position in its endeavour to establish "*moral reform of the nation*", locating it in the domestic sphere (Vincent, 1996:98). Through article 41 in the Irish Constitution of 1937, the Catholic Church had its view of the family, the rights of women and sexuality enshrined, equating womanhood with motherhood (Hilliard, 1992). This ensured its position in Irish society as the moral authority.

Nic Ghiolla Phádraig (1995) argues that through the Marian cult² a domestic, silent role for women was espoused. Women were encouraged to emulate the

² The Marian cult derived out of the devotion to the Virgin Mary in the Catholic Church whereby all women were encouraged to emulate her

Virgin Mary as their role model, which was a universal vision for Catholic women (Tippett-Spirtou, 2000; Vincent, 1996). The sexual morality of the Catholic Church was/is that sexual expression should take place within marriage, and its purpose should be procreation, not pleasure (Inglis, 1998a; Kenny, 1997). Thus in general terms unmarried women were either deemed virgins (waiting to have sexual relations within marriage, for procreation), or whores³ (having relations outside marriage, for pleasure) by virtue of the fact they either “played by the rules”, or they did not.

As well as complying with the moral authority of the Church, Ireland has a history of enacting legislation which prohibited the sale, publication or distribution of materials encouraging the use of birth control. This legislation reflects Catholic social teachings. The Censorship of Publication Act, 1929 and the Criminal Law (Amendment Act) 1935 banned the importation and sale of contraceptives (O'Connor, 1998; Beale, 1986). The trends in Europe were similar. In France for example, contraception was illegal in the 1930s and until the 1960s (Tippett-Spirtou, 2000) Things changed dramatically in Europe in the 1960s in terms of contraception and its availability; but not in Ireland. For instance, open sale of condoms in chemist shops or pharmacies only occurred in 1992. In Ireland the implementation of the legislation has been viewed as a clear link between Roman Catholic stance on morality (Inglis, 1997), particularly sexual morality, and the State's willingness to enshrine Catholic morality in law (Kenny, 1997; Lee, 1989).

³ The use of the word 'virgin' in relation to women has had a positive connotation for women while the word 'whore' represents a negative image but more importantly is embedded with moral judgements

2.3.3 Normative heterosexuality

Women's position in Ireland is further highlighted by Byrne's (1997) work on the lives of '*never married single women*' in the early twentieth century. The role of women focused on marriage and the family, the assumption being that if a woman did not fall into this category, then life held no meaning for her. Single women were deemed to be "*marginal, unimportant and largely leading miserable lives*" (Byrne, 1997:415). Meaning for women could only be obtained through marriage, thus enforcing heterosexuality as the norm, that is, procreation. It also implies that it was not socially acceptable for women to have sexual relationships outside marriage. With the inference being that women were either married or celibate (Byrne 1997), nowhere is there any suggestion or understanding that there were any other forms of intimate relationships available to them, such as a lesbian one.

Milotte's (1997:30) study on Irish babies who were put up for foreign adoption⁴, reveals the extent to which engaging in sexual relations outside marriage within Irish society, was socially unacceptable for both women and men. The norm for women and men was to be either married or celibates, but for women who were sexually active and became pregnant outside marriage:

The stigma attached to their condition [pregnancy outside marriage] meant their objective was to hide the fact that they had had a child at all, a process that involved concealment, deception and denial, with unknown consequences in terms of long-term psychological damage.

This has had long-term consequences in Irish society, and exemplifies the secrecy and silence, with which non-normative behaviour was dealt with in society. Such

⁴ Milotte (1997:199) indicates that "the Department" of Foreign Affairs "only kept records from the end of 1950 onwards" thus it is almost impossible to state when the practice began as "there is no record whatever of 'illegitimate' Irish children who were adopted".

stigma can still be experienced today, particularly in relation to abortion (Oaks, 2002; Mahon, Conlon and Dillon, 1998). The stigma attached to unmarried motherhood was not unique to Ireland; Beadman (2002:56) suggests that Spanish women sought illegal abortions “to preserve themselves and their families from the powerful social stigma that attached itself to sex outside marriage”. He documents how the procurement of illegal abortions led to the imprisonment of women who sought them, and their facilitators (Beadman, 2002).

Irish single women who were pregnant were removed from their families and communities, and some emigrated to conceal their pregnancy (Murphy-Lawless and McCarthy, 1999). Others were sent to Magdalene⁵ homes. This practice began during the 1800s (Luddy 1995:97), as a response to the problem of prostitution whereby “male and female philanthropists .. were concerned with problems relating to sexual morality”. John Charles McQuaid, the Catholic Archbishop of Dublin and Primate of Ireland from 1940-1962, established himself according to Cooney (1999:277) as the “arbiter of public morality in all spheres of human behaviour, particularly sexual conduct” thus reinforcing the use of Magdalene homes:

Unmarried mothers were sent away or placed in ‘Magdalene Penitentiaries’, where they were forced by nuns to engage in slave-labour as laundry workers and cleaning women (Cooney, 1999:278)

The women had to atone for their sin of having a child outside marriage, by learning to discipline the body, which in turn led to the saving of the soul (Raftery and O’Sullivan, 1999; Cooney, 1999), rgis process reflects Foucault’s (1973) thesis on the disciplining of the body.

⁵ Nic Ghiolla Phádraig (1995:600) indicated that Magdalene Homes were used for women who had a baby outside marriage “often resulted in young women being placed for life” providing “free labour and lived in prison-like conditions”.

The virgin/whore images of women are exposed, when the consequences for women having children outside marriage are explored. This can be viewed from the perspective of patriarchy, and colonialism, whereby the systems of domination have unequal power consequences for men and women (Moane, 1996) but in very different ways. In the 1990s, the practices in institutions such as the 'Magdalene Penitentiaries' began to be scrutinised; prior to this development there seemed to be a silent acceptance of the need for such institutions to exist (Nic Ghiolla Phádraig, 1995). Thus 'the norm' of heterosexual behaviour was reinforced by removing non-conformity from view; equally lesbian behaviour was absent from the discourse.

Attitudes towards single women who are pregnant can be found in Hyde's (1997) study of single mothers in a large Dublin maternity hospital in the 1990s, which highlights continuities with the past. She suggests that normative judgments were made by the medical profession, about "*pregnancies that threaten the social order*", particularly about whether or not the woman intended to keep her child (Hyde, 1997:124). Single women were forced by medical professionals to see a social worker and questioned about childcare arrangements. Hyde (1997) reports that these issues were never raised in relation to married couples regardless of their potential need to avail of assistance.

Part of the problem in dealing with single mothers in Irish society, is that single motherhood was viewed from the perspective of social problems and a breakdown of social order (Mahon, Conlon and Dillon 1998; Hyde, 1997). However, Hug

(1999:3) points out that it is more than just a breakdown in social order.

Unmarried motherhood signals the:

corruption of society at large because they undermine the family, the institution on which moral order is built, the basic unit of society whose main function is to maintain order.

As we have seen, marital motherhood was enshrined in the Irish constitution. The medical profession in Ireland reinforces the “*standard for how social reproduction should be organised (a family unit with two married parents)*” (Hyde, 1997: 122). Thus a third domain began to reinforce the Catholic Church’s stance on procreation, expression of sexuality as well as excluding diversity in relationships such as lesbian ones (see chapter three, section 3.4 for a further discussion of this).

2.3.4 Non-normative heterosexuality

Byrne’s (1997) study raises an interesting question: were “women looking for husbands” between the 1900-1960s? In light of studies carried out (Raftery and O’Sullivan, 1999; Cooney, 1999; Milotte, 1997), it would appear that some women were not looking for husbands. Rather, they were banished from Irish society because of non-normative behaviour. A woman’s individuality was expressed through who her father was, and later her husband, and without either she was a ‘nobody’ (Byrne, 1997). Vincent (1996) indicates that women in Spain were also subservient, first to their fathers prior to marriage, and then their husbands. There is a dearth of literature on lesbianism in the early to mid twentieth century, which does not mean that lesbianism did not exist in Ireland. Indeed, the early to mid twentieth century Ireland, anyone that participated in non-

normative behaviour became invisible in society and shrouded in secrecy (Cooney 1999, Milotte 1997).

Those who could not or did not reform, the unmarried mother, the homosexual, the lesbian, the fornicating bachelor farmer, were excluded from society and put into convents, homes and asylums (Inglis, 1997:5).

There was another way, as Inglis (1997:21) indicates: "*Sex could be private and silent as long as one was not caught*". However, while sexuality became private, a personal affair, it carried with it sanctions if the practices were non-normative (Weeks, 1999).

Secrecy can then be viewed on two levels: on one level the silence around the disappearance of women who were pregnant outside marriage, and on the other the silence of those engaged in non-normative behaviour that were never "caught". However O'Connor (1998:14) suggests that Irish women faced double standards when it comes to expressing their sexuality.

Among young women the persistence of sexual double standards and the culturally created difficulty of treading a line between being too sexually available and not sufficiently sexually available are important elements in patriarchal control.

O'Connor (1998) implies that within Irish society, women are constructed and reconstructed in relation to men. This reinforces De Beauvoir's (1949:295) earlier assertions, "*One is not born, rather becomes, a woman*", thus suggesting that the set of sex organs one is born with, does not inevitably lead to one being-a-woman, rather, that society creates and constructs woman, indeed as it does 'man'. However, unlike 'man', who is both a negative and positive construct, 'woman' is negative (Evans, 1995). Evans (1995:4) suggests the idea that, "... *men are the*

standard, that 'man' indicates and defines 'human', is entrenched". Consequently for Evans, it is against this that all women and their behaviour is measured.

2.4 Social change – 1960s to present day

The 1960s and the following decades are viewed by many as the turning point of social change in Ireland. Change was influenced by Vatican Council II and Irish economic growth (Tovey and Share, 2003; Fahey, 1992; Beale, 1986). Vatican Council II has been considered the most significant event in twentieth century Catholicism; it was initiated by Pope John XXIII, to examine the problems faced by the Church in the modern world (Tippett-Spirtou, 2000). In particular, the Church was influenced by global events such as World Wars I and II, and the consequences of scientific development (Dillon, 1999). Irish women were seeking to achieve, "*full personal agency in law – access to contraception, access to information about abortion and the legalization of divorce*" (Murphy-Lawless and McCarthy, 1999:71). The trend of women seeking full personal agency was not unique to Ireland, but was also an issue in other countries such as France (Tippett-Spirtou, 2000) and the United States of America (Dillon, 1999)

In relation to family planning, there were many innovations to subvert the 1929 and 1935 legislation in Ireland, with, for example, the opening in 1969 of the first family planning clinic in Dublin (Mahon, Conlon and Dillon, 1998). The family planning clinic could not sell contraceptives; clients were asked to give a donation (Beale, 1986) In France however, contraception was legalised two years earlier (Tippett-Spirtou, 2000). The Health (Family Planning) Act (Department of Health, 1979) made contraception legal, but only in certain circumstances:

contraceptives were available on prescription for medical reasons and bona fide family planning (Murphy-Lawless and McCarthy, 1999). In addition, “*a further major limitation of the Act was that it allowed doctors, nurses and chemists to opt out of the scheme if they held conscientious objections to contraception*” (Beale, 1986:107). Thus, the medical profession became a powerful agent in regulating ‘the norm’ of heterosexuality, rather than recognising diversity in sexual behaviour and orientation. The Act allowed for married women only to avail of contraception for medical reasons, making it almost impossible for single women to obtain them; in rural areas, married women had to find both a sympathetic doctor and/or chemist (Barry, 1986; Nic Ghiolla Phádraig, 1985).

In 1985, the sale of non-medical contraception was legalised for people over eighteen years, regardless of marital status, from a range of named outlets (Hilliard, 1992; Barry, 1986; Beale, 1986). In 1992, the sale of condoms was deregulated as a direct result of HIV/AIDS and the global safer sex campaigns (Mahon, Conlon and Dillon, 1998). The Health (Family Planning) (Amendment) Act (Department of Health, 1992) legally required the provision of family planning services by Health Boards (Mahon, Conlon and Dillon, 1998).

Part of the problem of dealing with family planning in Ireland, was the “*rigorous moral training which helped in the subordination of individual interests to those of family and community*” (Inglis, 1998a: 179). Inglis (1998a) clarifies this point, by explaining that it was through the hold of the Catholic Church on the “Irish mother” that delayed marriages, migration or emigration were sanctioned. Irish mothers were expected to keep a tight reign on their children’s sexual desires.

But they were not alone in doing this. The local Catholic priest, who sanctioned their social position by his mere presence, helped them. It was the priest who had the power to take or give the mother a reputation as either a good or bad mother. The good mother had children, be they young or adults, who were virtuous and the bad mother had offspring who strayed from the path of righteousness (Inglis, 1998a). Vincent (1996) argues that in Spain, the role of mother was important to women considering their subservient status. Through the role of the mother as envisaged by the Church, they were able to extend their power into the home. Inglis' analysis suggests that all Irish mothers became agents of the Catholic Church.

Nevertheless, such an analysis cannot account for the emergence, development and consolidation of a women's movement in Ireland as analysed by Connolly (2000). Nor does it allow for what Beadman (2002) calls, "*an alternative pragmatic morality of ordinary people*" which, as he indicates, developed in Spain even in the face of severe prohibition by both Church and State when dealing with issues of sexual morality. Equally, the negotiating patterns of groups that are stigmatised by the Catholic Church, such as pro-choice adherents or lesbians who transgress the moral teaching (Dillon, 1999), cannot be accommodated in Inglis' argument. Dillon (1999:4) argues that by articulating difference within the Church, transgressors of Catholic principles can "*constitute a source of change and redefinition of the larger community*".

While the 1960s have been viewed as the defining moment for social change in Ireland, the 1990s can be seen as the crossroads for the Catholic Church's

privileged position, particularly in relation to sexual morality. Nic Ghiolla Phádraig (1986:142) captures the privileged position that the Church held in Irish society up to the 1990s. "*Church intervention in matters of family care and sexual morality is regarded as legitimate, and guidance in such matters is not only accepted but sought by a large section of the Catholic population*". The legitimacy of the Catholic Church's teachings on sexual morality began to be questioned in the 1990s, when various scandals began to emerge, such as the fathering of children by Bishop Casey and Fr Cleary, both high profile clerics. However, more important was the uncovering of clerical child sex abuse scandals, for example the case of Brendan Smyth in 1992, which caused the fall of the government of the day, and the publication of the *Ferns Report* (2005) which detailed clerical child sex abuse over a forty year period in the Ferns diocese. As Inglis (1997:6) succinctly puts it:

We now know that alongside the religious discourse emphasizing celibacy, purity, innocence, virginity, humility and piety, there existed practices of child abuse, incest, paedophilia, rape, abortion and infanticide.

Consequently, the Church hid diversity within its own population, while stigmatising lesbianism and homosexual practices which did not involve abuse.

Nic Ghiolla Phádraig's (1986:153) suggestion, that the Catholic clergy were a vulnerable body who "*on a single important issue could jeopardise the persistence of commitment among a majority of their flock*" seems prophetic, in light of the revelations of the 1990s. The role of the religious, in particular priests, as listeners to the people's "confession" in private, has moved to the public "confessional" of T.V. and radio chat shows through 'phone-ins' and 'letters' (Inglis, 1997). Through the media and the courts, the actions of bishops,

priests, brothers and nuns are being investigated. O'Connor (1998) suggests that the media facilitated women in articulating the diversity of their thoughts and feelings, in relation to their sexuality and abuses of their sexuality, by challenging the unity and power of the patriarchal voice of the Church, state, lawyers and doctors.

2.5 Influences of the educational institution on the construction of sexuality

Education is an important institution in the process of learning about sexuality. Through education, normative heterosexuality is encouraged, and issues pertaining to lesbians are excluded from the curriculum. This situation reflects the secrecy/silence of alternative sexualities to that of marital heterosexual coupling. It would appear that those who embrace difference and diversity are at best tolerated, if hidden from view (Lodge and Lynch, 2003; Inglis, 1997), and at worst discriminated against, even to the point of being physically violated (Gay and Lesbian Equality Network [GLEN] and Nexus, 1995). However, Lodge and Lynch's (2003, 2002, 1999) work shows that the system of segregated education based upon issues such as religion, gender and membership of an ethnic community, has led to inexperience on the part of students in dealing with diversity. Equally, the silence around sexual orientation within the educational system, has led to a vocabulary deficit in dealing with non-normative sexuality.

Education in Ireland takes place in a multitude of environments. First level education takes place in either coeducational or single-sex settings. Some single-sex girls' schools at first level are also coeducational for the first three years while, single-sex boys are not. However, boys move to different schools after this

period (Lodge and Flynn, 2001). Second level education was characterised traditionally by single-sex schools, changing in the 1960s and 1970s with the development of coeducational settings. There are different types of coeducational school settings at second level; for example, secondary, vocational and community/comprehensive schools (Tovey and Share, 2003).

2.5.1 Socialisation

Hilliard (1992) points out, that education is an important part of the child/adolescent socialisation process, as it inculcates the *“values and roles, which will be crucial to their self-perception, aspirations and achievements, not only in their educational careers, but in their future lives in society”* (Hilliard, 1992:251).

Lodge and Flynn's (2001) study of gender identity in the primary school sector illustrates how children recreate social norms through play. When girls and boys play separately, they play games that reinforce the traditional stereotypes of femininity and masculinity (Lodge and Flynn, 2001). They also find that when girls and boys played together their games *“often involved games and behaviours with romantic overtones that reinforced hierarchical, heterosexual relations”* (Lodge and Flynn, 2001:190) When this happened these forms of play were hidden from adults, thus illustrating awareness that knowledge of sexual issues was not only unacceptable by adults, but also *“taboo”* (Lodge and Flynn, 2001). Through play, girls and boys consolidate their socialisation as *“the child creates and reproduces the same social meanings, rituals and structures”* (Lodge and Flynn, 2001:175) of their culture.

Studies have found that there was a difference in emphasis on education in single-sex girls' schools compared with single-sex boys' schools (Lynch and Lodge, 2002; Drudy and Lynch, 1993). In girls' schools, emphasis was placed on "*caaring for others, sincerity, gentleness, refinement and self-control*" (Lynch, 1989 quoted in Drudy and Lynch, 1993:183). Areas of achievement, physical prowess and motor skills were emphasised more in single-sex boys' schools. Lynch and Lodge (1999:232) report that while "*competitive individualism*" was a value in girls' schools; "*traditional feminine characteristics of nurture and artistic expressions*" were encouraged but subordinated in the hierarchy of values. While academic achievement was highly valued, they also found that:

assertive or challenging behaviour was sanctioned ... While nurturing and traditional feminine behaviour (defined unspecifically as 'ladylike') was identified as the school's ideal ... The traditional nurturing role of women (as primary carers in society) was represented as the ideal one for women in their school. ... Many girls felt that their personal lives and their bodies were being 'policed' in the school" (Lynch and Lodge, 1999:232).

Consequently, through education, adolescent girls are taught a dual-role approach to being a woman in society. On the one hand, the for women to be in the workforce, necessitates a competitive spirit to survive in contrast to the more traditional role, which perceives women as the primary care-givers and nurturers in society. There was a notable change in the education of girls from that of nurturer and carer to that of achiever, with the dominant definition of femininity being portrayed as "*diligence, deference, and self-monitoring*" (Lynch and Lodge, 2002:106).

2.5.2 Management of sexual orientation

Ryan (1997) explores the nature of sexual attraction and how sexuality is constructed through gender discourses in Irish second level schools in the 1990s. She illustrates how young girls are encouraged into normative roles for women, and how discourses on sexuality between boys and girls demand normative behaviour rather than exploration of diversity. The literature on the Irish educational system acknowledges that normative heterosexuality is reinforced (Lynch and Lodge, 1999; Lynch and Drudy, 1993), and very little is done to deal with the subject of other types of sexual orientation (Tovey and Share, 2000). This silence around the subject of lesbian and gay sexuality arose from the criminalisation of homosexuality in Ireland, and as we have explored, the dominance of Catholic sexual morality (see section 2.3.2 Moral authority).

Homosexuality was decriminalised in 1993. Senator David Norris articulated in his Senate speech on June 29th 1993 that by decriminalising homosexuality:

Young people will no longer have to grow up in the shadow of the taint of criminality which had blighted the vulnerable youth of so many of our citizens with terror and shame (reproduced in O'Carroll and Connell, 1995:23)

The State was innovative in the law reform of 1993, as it ignored the Catholic Church's notion of sin, removed the criminal aspect and in the process equalised the age of consent, for both heterosexuality and homosexuality. Rose (1994:58) suggests decriminalisation revealed, that "[a]s a society we had faced up to our fear of sexuality, especially a different sexuality". However there is still evidence of both denial and silence on the subject of sexual orientation in the educational system (Lynch and Lodge, 2002). Lynch and Lodge (2002) report, for example, that students did not have a language to describe their feelings, and boys felt

comfortable expressing hostility and derision towards gay men. This has led to lesbian and gay students experiencing “*institutional invisibility .. reinforced by the lack of a vocabulary to name and discuss sexual difference*” (Lodge and Lynch, 2003:21), even though:

Most studies confirm that self-realisation of one’s sexual identity occurs in the adolescent years, the period when most young adults attend secondary school. Our study found that the majority (70%) of respondents realised they were lesbian or gay before the age of nineteen years (GLEN and Nexus, 1995:45).

A report focusing on the issue of sexual orientation in education, was commissioned by LEA/NOW3 (Lesbian Education Awareness New Opportunities for Women 3rd programme) for submission to the Department of Education and Science RSE (Relationship and Sexuality Education) team (O’Carroll and Szalacha, 2000). There was a high level of resistance to implementing the RSE programme from schools, teachers and parents, with the result that no second-level school had completed the module on sexual orientation included in the *Relationship and Sexuality* programme in 1999 (O’Carroll and Szalacha, 2000). This points to the difficulty in delivering programmes on sexuality, even when based on heterosexuality, in the Irish educational system. Equally, it points to an inability to recognise diversity of experience within heterosexuality. This being the case, it may appear understandable, but not acceptable, that issues relating to lesbian and gay reality were not present in RSE programmes or in their implementation.

O’Carroll and Szalacha (2000:45) suggest that their research “*highlighted the need to take seriously the right of lesbian and gay students within Irish schools to a safe learning environment*”. A safe learning environment may not be easily achieved,

as most students have negative attitudes towards lesbians and gay men. Lodge and Lynch (2003:21) in their study found that students indicated that lesbian and gay students should either be excluded from the school system or openly advocated violence as the following examples illustrate:

'Set all fags on fire: (A second year student in Ballinroe [single-sex boys' school]).

and

Gays should not be allowed to be educated. They have a perverted problem (A third year student in St. David's [single-sex boys' fee paying]).

Though the first national survey on Irish sexual health and relationships suggested that attitudes towards homosexuality in Ireland have "considerably softened in recent decades" (Layte et al, 2006:101), Lodge and Lynch's (2003) study establishes that this has not filtered into the education system.

While, Norman, Galvin and McNamara's study (2006:100) found less violent language it equally indicates that lesbian and gay students would have a 'hard time' in school.

Gay students would probably get a hard time around here. A few people would have problems with it, because it is different, not normal. People are 'slaggèd' if they're not into football or P.E., and because of the music they like. Calling someone faggot is if they are not like a guy (Student 4, Male, 16, School A).

Stereotypes such as those quoted above feed into what it is to be a gay adolescent such as choice of music and not looking like a 'guy'. Other gay male stereotypes found in the study ranged from good shoppers, and style conscious, to guiding heterosexual adolescent girls on relationships with boys (Norman, Galvin and McNamara, 2006). However, one of the drawbacks with Norman, Galvin and McNamara's (2006) work is the lack of gay or lesbian students' voices, in this

study on homophobic bullying in second level education. Homophobic bullying, is viewed from the gaze of the heterosexual student's impression of what it might be like, to be a lesbian or gay student. For example, the respondents in Norman, Galvin and McNamara's (2006) study state "*gay students would probably*" which renders it a hypothetical statement rather than one embedded in fact, thus negating the experience of lesbian and gay students who remain silent and voiceless in a discussion on an issue, homophobia, which is directly related to them.

Lodge and Lynch (2003) indicate that for 55% of respondents discovering that their friend was either lesbian or gay, was sufficient grounds for termination of that friendship. Some lesbian and gay students have experienced this:

My two best friends deserted me and as a result I suffered from very bad depression and needed to repeat my Leaving⁶ (GLEN and Nexus, 1995:45).

Nevertheless, Lodge and Lynch (2003) report that two out of the twelve schools who participated in their research, had created space through the educational programme to discuss lesbian and gay issues, indicating that this enabled all students to express their feelings and fears. Norman, Galvin and McNamara (2006) established that out of 226 second levels schools participating in their study, 37% (84) schools had references to lesbian and gay issues in their RSE school policy. Table 2.1 illustrates the break-down by school type:

Table 2.1: Reference to lesbian and gay issues in RSE by school type:
(Norman, Galvin and McNamara, 2006:65)

| | Single-sex boys | Single-sex girls | Co-educational | All |
|-----|-----------------|------------------|----------------|-----|
| Yes | 53% | 25% | 37% | 37% |
| No | 47% | 75% | 63% | 63% |
| All | 100 | 100 | 100 | 100 |

⁶ The Leaving Certificate is the final examination at second level, which is undertaken at the age of 17/18, the results of which are used for entrance into third level education and the employment market.

While single-sex boys' schools were more willing to deal with gay issues, single-sex girls' schools were less inclined to raise the subject of lesbianism. Lynch and Lodge (2002:145) state that an inability to speak about sexuality is not just a product of peer culture, rather:

It is played out within an education system which, for a long period of time, has been characterised by segregation and a lack of recognition for difference and diversity, in its institutional processes and structure.

Thus in general the Irish educational system has been based upon sameness, rather than diversity which accommodate lesbian and gay experience.

2.5.3 Influence of the Catholic Church

While second level educational establishments are highly sexualised locations, Tovey and Share (2000:175) observe that sexuality is an area that “*is notable by its absence*” in Irish educational research. Within Irish society, sexuality has moved away from the morality of the Catholic Church as suggested by Inglis (1998a). However, Norman, Galvin and McNamara (2006:30) indicate that in the educational system, the Catholic Church is still a strong force in dictating sexual morality in the school curricula, pointing out that there are:

over 400 Catholic voluntary schools catering for 185,563 students, which account for 56% of the total school enrolment of this age group. Another 15% of students attend 90 Community/Comprehensive schools, in which, for the most part, a Catholic Diocese or Religious Order act as co-trustees. The remaining 29% of the second level population attend the 247 Vocational schools and Community Colleges, which while multi-denominational in theory, most commonly have a majority of Catholic students, parents and teachers and often representation on their boards of management from the local Catholic Diocese.

Therefore the Catholic Church can influence the curricula in Irish schools, both directly and indirectly thereby maintaining a Catholic ethos. Norman, Galvin and

McNamara (2006) point out that through the role of patrons or trustees of schools the Catholic Church's teachings are still influential in what is taught.

However, there are other factors at play in schools such as the stereotypes of what a girl or young woman is, and the language that young people use to regulate each other in schools (Ryan, 1997). Firstly, Ryan (1997:26) found that adolescent girls who did not express an interest in boys risked being labelled "*frigid*", "*stuck up*" or "*lesbian*". Secondly, if young girls display too much interest in boys they risked their reputations with labels such as "*tart*", "*slapper*", "*tramp*" or "*slut*" (Ryan, 1997:26), and this can also be seen as a form of homophobic bullying (Norman, Galvin and McNamara, 2006). The use of derogatory labels is a successful aspect of informal regulation, which can be as efficient as formal sanctions if not more, so as:

we must recognise the changing forms of social regulation, informal and formal, from the operations of Churches and state to the forms of popular morality (Weeks, 1985:179).

It is "*popular morality*" as taught and learnt that can be more effective in curtailing the diversity of experience and orientation such as lesbianism.

2.5.4 Lesbian and gay adolescent experiences

Goffman (1963) illustrates the effects and characteristics that labelling entails and the process is detailed by Garfinkel (1956)⁷. Some meaning can be found in

⁷ Symbolic-interactionists suggest that the behaviour of an individual can be judged as good or bad through the reactions of others. Thus behaviour can be labelled, forcing the individual labelled to conform to the norms and values of society. Homosexuality was one such behaviour that was previously labelled as deviant. However, today it has shifted, thus pointing to the fluidity of what is thought of as non-conformist behaviour. However, the ability to label reflects the construct of power within society. For Goffman (1963) an individual can embark on a deviant career by taking on the label or labels that other(s) impute on her/him, thus becoming that label. Garfinkel (1956) implies that a community can become involved in the labelling of an individual,

GLEN and Nexus' (1995:45) work as they explore the experiences of Irish lesbian and gay adolescents of education, reporting that it can lead to "*loneliness, depression and/or extreme self-criticism*". It equally leads to social isolation as illustrated in the following quote:

I was paranoid about lack of acceptance and that other people would find out (GLEN and Nexus, 1995:45).

In his study of ex-mental patients Goffman (1963:28) discussed stigma which has a relevant application here, as the lesbian student must "*face unwilling acceptance of her[him]self by individuals who are prejudiced against persons of the kind s/[he] can be revealed to be*". Therefore, a lesbian student must maintain the performance of being heterosexual, but crucially they must prevent a "*discovery*" of their true sexual identity that would discredit them.

Wherever s/[he] goes her [his] behaviour will falsely confirm for the other that they are in the company of what in effect they demand but may discover they haven't obtained namely, a heterosexual [mentally untainted] person like themselves (Goffman, 1963:58).

The use of the label 'gay' also acts as a social control mechanism, by students in relation to their peers perceived background and physique (Lynch and Lodge, 2002). Teasing and bullying on the school premises, particularly amongst adolescent boys, at times focused on the labelling of the target as 'gay' (Lodge and Lynch, 2003) and girls 'lesbian' (Ryan, 1997). Ryan (1997) does not probe into the effect of the labels, used by both adolescent females and males to control the sexual expressions of their peers. She does not examine how the label 'lesbian' affects the development of female students, both as individuals within a community or as sexual individuals (Ryan, 1997).

through what he called a degradation ceremony In this way a negative label is applied to the individual

While student adolescents act as social controllers in relation to sexuality through the use of language, teachers can also participate in the regulation process by providing legitimacy to student attitudes and actions:

As social actors, teachers reflect to their students whatever definitions they have constructed out of their own social relations and in doing so can reproduce the status quo (Norman, Galvin and McNamara, 2006:13).

This can result in lesbian or gay adolescent students obtaining no support in the educational system. A teacher who participated in Norman, Galvin and McNamara's (2006:82) study, indicated that she witnessed teachers' inability to deal with homophobic bullying but fall short of condoning it:

I've seen situations where teachers practically fell just short of encouraging homophobic bullying (a former teacher; Female, 8 June 2004).

Norman, Galvin and McNamara (2006:77) point out that there are other factors at play which hinder teachers from helping or working on gay or lesbian students' issues such as "*disapproval from other teachers, student disapproval and the possible disapproval of their board of management*". This is illustrated in the following quote by a former student:

I was constantly harassed by students in secondary school (at one point attacked) I was also harassed by teaching staff (GLEN and Nexus, 1995:46).

The consequence of this is, students conceal their sexual orientation while in second level education (Norman, Galvin and McNamara, 2006) as student says:

I was alienated by my classmates, snide comments passed at every opportunity. The teacher gave me a hard time (GLEN and Nexus, 1995:46)

Tovey and Share (2000) point out that sexual harassment or other abuses are not managed in Irish schools, and male and female stereotypes are reinforced. Lodge

and Lynch (2003:18) found that only 1% of teachers in their study, cited sexual orientation as a contributor factor in educational equality. This suggests that teachers perceive their students as 'all the same', which inevitably leads to the negation of the existence of diversity. Equally, the vocabulary of inequality was not part of a student's lexicon; therefore it was not identified while, "sexist behaviour was considered 'normal'" (Lynch and Lodge, 1999:236). While Povey and Share (2000) and Lynch and Lodge (2003) find that issues of inequality are not dealt with in Irish schools, the Equality Authority, utilising equality legislation has made recommendations to schools requiring, that policies be established that recognise equality of opportunity for all students, regardless of sexual orientation (Norman, Galvin and McNamara, 2006). The following table illustrates the equal opportunity policy in Irish second level schools:

Table 2.2: Equal opportunities policy by school sex type: (Norman, Galvin and McNamara, 2006:69)

| | Single-sex boys | Single-sex girls | Co-educational | All |
|-----|-----------------|------------------|----------------|-----|
| Yes | 40% | 26% | 38% | 36% |
| No | 60% | 74% | 62% | 64% |
| All | 100 | 100 | 100 | 100 |

Norman, Galvin and McNamara (2006) find that 64% of Irish second level educational establishments do not have an equal opportunity policy, most notably in single-sex girls' schools, thus negating the existence of lesbianism.

2.5.5 Heteronormativity⁸

Smyth and Hannan (1997) suggest that coeducation leads to pressure being put on girls by boys to conform to traditional gender stereotypes, that is, heteronormativity. Inglis (1998b) indicates that through education adolescents are “*learning about sexuality .. learning about what was right and wrong, good and bad, appropriate and inappropriate sexual behaviour*” (Inglis, 1998b:8). Inglis (1998b: 27) further states, that “*learning about sex was based on the regulation and control of desire*”. Within an Irish context, control and regulation of desire are based upon Catholic morality, framed in a heterosexual domain, (Cooney, 1999; Nic Ghiolla Phádraig, 1995; Beale, 1986), resulting in girls/women not only being responsible for their own desires, but encouraged to take responsibility for male desire also (Tovey and Share, 2000). However, Segal (1997:185) suggests that normative notions of sexuality are always being contested, making sexuality a “*troublesome affair*”. Epstein (1996:147) makes a pertinent point in relation to sexuality, which can be applied to Irish society, namely:

a domain of elaborate and nuanced behaviour, potent and highly charged belief systems, and thickly woven connections with other arenas of social life – was deeply embedded in systems of meaning and was shaped by social institutions.

Adolescents have the power to regulate social behaviour, in particular the sexual behaviour of their peers, and more precisely their female peers: male to female and female to female (Ryan, 1997). Girls don't always need a male gaze, but

⁸ The word heteronormativity was coined by Michael Warner in 1993 (Chambers, 2007) However, at that time he did not give a definition Berlant and Warner (2000 312) stated. “By heteronormativity we mean the institutions, structures of understanding, and practical orientation that make heterosexuality seem not only coherent – that is, organized as a sexuality – but also privileged Its coherence is always provisional, and its privilege can take several (sometimes contradictory) forms, unmarked, as the basic idiom of the personal and the social; or marked as a natural state, or projected as an ideal or moral accomplishment”.

young girls and adolescents regulate themselves as “*sexual lives are never merely a private affair*”, (Segal quoted in Epstein, 1997:188).

Same sex peer regulation can easily be achieved in single-sex schools. There is an element of high romance, as females want to impress on their peers, their likes and dislikes in relation to boys. This is achieved through pop culture and posters of the stars they find attractive. In these settings there is the physical absence of male peers, which can be applied to single-sex boys' schools with the physical absence of female peers. However, Lynch and Lodge (2002) point out that the exercise of control and sanction by students takes many diverse forms, from exclusion and teasing, to verbal abuse which Norman, Galvin and McNamara (2006) name as expressions of homophobia. In single-sex female schools there more emphasis was placed on control and regulation (Lynch and Lodge, 2002). As Scott and Jackson (2000.172) inform us:

The social and cultural shaping of sexuality happens not simply through prohibiting, restricting or repressing sexual practices, but more telling through permitting, promoting and organising particular forms of eroticism.

Consequently, amongst adolescents and teachers, expression of lesbian or gay inclination are neither ‘promoted’ nor ‘permitted’ within the environs of second level education.

2.6 Irish lesbian women

In Ireland there is limited knowledge about lesbian women's lives and social experiences, thus rendering lesbian women invisible and constructing them as a mystery, if not a group shrouded in myth. Lesbian women's invisibility permeates social interaction; they are also indistinguishable within the social

structures and institutions of society (Lemon and Patton, 1997), which include education, religion and family. O'Connor (1998:1) began her work on women in Ireland with the words:

Any discussion of changes in the position of women in Irish society over the past thirty years tends to elicit two views. that it has changed completely, and that it has not changed at all.

This could easily apply to lesbian women. Although there have been enormous changes in Irish society, such as the decriminalisation of homosexuality in 1993, the Employment Equality Act, 1997 and the Equal Status Act, 2000, lesbian women remain invisible. Moane (1995:70) points out that "*a fundamental feature of lesbian existence is invisibility*"; therefore they are not only invisible in literature but also in populations, mass media, and their lives are absent from cultural representations. This leads to inequality and social exclusion as Byrne and Leonard (1997:1) succinctly state: "*Inequality is not a natural state, but a social product*".

The Offences Against the Person Act (1861) and the La Bouchere Amendment (1885) began to be examined in the 1980s. Senator David Norris took a High Court action which did not succeed; there was an unsuccessful redress in the Supreme Court case leading to the European Court of Human Rights, which recognised the need for the Irish legalisation to be redressed. The legislation was reformed in 1993, resulting in the decriminalisation of male homosexuality (Hug, 1999. Rose, 1994). The 1861 and 1885 laws emanated from the legislature of the British colonialist (Norris in O'Carroll and Connell, 1995), which was not examined by the new state and were meant to curb homosexual activity between men (Weeks, 1989). Scott and Jackson (2000:181) argue that the criminalisation

of male homosexuality can be interpreted as the "*construction of sex as something that men do and women consent to*". Laws were shaped in relation to heterosexuality, namely male heterosexuality, as women were not seen as active participants, but rather passive recipients of male heterosexuality. Female sexuality was defined in relation to men (Weeks, 1996). In addition, the laws of 1861 and 1885 were effective in curbing academic theorising of the subject (Inglis 1997). Thus, it would seem that what was neither spoken nor written about may not exist in Irish society.

By this effective silence on the subject, no young woman except, through self-awareness, would know of the existence of lesbianism or young man of gayism, rendering it the "love that hath no name":

One of the major issues when researching aspects relevant to lesbian identity and culture has been the dearth of adequate, specific information that deals with lesbian experience as separate and distinct from that of gay men (Lemon and Patton, 1997:114).

There are two stereotypes that feed into a definition of homosexuality in Ireland, namely homosexuals are male and they are a "*homogenous minority; affluent, organized*" (GLEN and Nexus, 1995:3). In contrast, lesbians are invisible if not non-existent because they are not homogenous, or perceived to be affluent. However GLEN and Nexus' (1995) account negates this stereotype as it reveals the diversity amongst the gay and lesbian population. There has been a proliferation of literature on lesbianism outside of Ireland from Cavin's (1985) cross-cultural analysis of the origins of lesbianism, to historical analysis (Jivani, 1997; Faderman, 1992; Benstock 1989).

The first Irish study on sexual health and relationships was published in 2006. From the findings it is clear that there has been a change in public attitude towards lesbian women and gay men, with 53% indicating that sex between same-sex couples was 'never wrong' (Layte et al, 2006). Sexual identification was explored by gender. The following table illustrates the findings:

Table 2.3: Sexual identification by gender: (Layte et al, 2006:127)

| | Men (%) | Women (%) |
|-----------------------------|---------|-----------|
| Heterosexual | 96.5 | 98.6 |
| Homosexual (gay or lesbian) | 1.6 | 0.4 |
| Bisexual | 1.1 | 0.8 |

Layte et al (2006) suggest that the history of stigmatisation of homosexuality in Irish society may distort these figures.

Though the level of stigma associated with homosexuality has decreased in recent decades, it is still pronounced in Irish society. This means that all estimates of same-sex attraction, experience and identity based upon self-reports should be seen as under-estimate (Layte et al, 2006:127).

This would seem to be a contradiction in that attitudes have changed towards homosexuality. However, the results of this study would point to the fact that lesbian, gay or bisexual individuals must experience stigmatisation if they do not feel secure enough to identify themselves in a confidential questionnaire. However there was a distinction between sexual attraction and practice amongst the respondents in Layte et al (2006) study. Table 2.4 reflects these findings:

Table 2.4: Sexual attraction by gender: (Layte et al, 2006:128)

| | Men (%) | Women (%) |
|----------------------------------|---------|-----------|
| Only heterosexual | 94.3 | 94.0 |
| Mostly heterosexual | 3.6 | 5.0 |
| Both heterosexual and homosexual | 0.2 | 0.5 |
| Mostly homosexual | 0.8 | 0.2 |
| Only homosexual | 0.8 | 0.1 |

There is a difference between people's perception of 'sexual identification' and 'sexual attraction'. For instance 1.1% of men identify themselves as bisexual but 0.2% of men in the 'sexual attraction' category.

2.6.1 Coming out

For lesbians to get to the point of knowing who they are, they go through a process known as 'coming out', which has no comparable process for heterosexual women (Bradford, Ryan and Rothblum, 1997). Rust (1993:25) indicates it is "a process of describing one's social location within a changing social context". Chirrey (2003:24) suggests that 'coming out' is that "moment of recognizing and asserting their gayness". A lesbian woman has not only to 'come out' to herself but also to her family, friends or co-workers. For most lesbian women, 'coming out' is a life-long process, facilitating the need for self-affirmation, validation, the acceptance of others and the need to meet potential partners (Chirrey, 2003; Tiemann, Kennedy and Haga, 1998). As Rust (1993:25) puts it, "coming out is not a linear, goal-oriented, developmental process". It is not a process that has a neat beginning and end, but one that continues throughout the life cycle. It may begin as early as thirteen years of age, or as late as the thirties or forties depending on the availability of knowledge, that is, if lesbianism is spoken about or literature available within a community and society (Rust, 1993).

However, this process may be misrepresented in society; heterosexuals may hold negative attitudes and connotations of 'coming out', seeing it as "flaunting sexual activity, imposing on the sensitivities of others, or revealing personal information

inappropriately” (Johnson and Guenther, 1987:234). Heterosexuals do not have to declare their sexuality, as it is the norm. It would appear that in order to ‘come out’ as lesbian, a woman must undo all her understanding of the structures of society. She must create a new way of being within a dominant heterosexual culture.

The invisibility of lesbians can be seen as the “editing out” of the reality of their existence, and of different types of existence for women. This leads to a situation where there is a perception that there is no difference between women, as they (lesbians) are encouraged to conform for fear of judgments, thus negating the existence of diversity. Invisibility in itself can lead to the assumption of the non-existence of lesbianism; as Peel (1999) points out, there are more negative stereotypes of gay males than lesbians in Australian society, precisely because of gay males detectability. Lemon and Patton (1997), in their study of women’s experience of ‘coming out’ in a lesbian community in Brisbane, found that the stereotypes of lesbians, were embedded in societal institutions such as religion and education, and reinforced by the family. Lesbian women in this study, indicated that they internalised some of these stereotypes. Gottschalk’s (2003:223) findings reinforce this in her study of lesbian experiences of becoming lesbian in the Australian state of Victoria which were influenced by “*social/cultural values, attitudes and beliefs about homosexuality in terms of their experiences during the process of becoming lesbian*” Gottschalk (2003) indicates that societal values and ideas about the causes of homosexuality prevail in the manner in which lesbians identify themselves as such.

Both of these studies contradict Peel's (1999) argument that greater visibility in Australian society leads to more stereotypes. Visibility in itself, can and does lead to prejudicial actions, but invisibility in and of itself, does not negate prejudice. Prejudicial judgments are: "*stabilized deception of perception*" which leads to "*selective reality – the narrow spectrum of reality that human beings choose to perceive and/or what their culture selects for them to see*" (Anzaldúa, 1990/1998:533). Tong's (1989) observation may point us in the direction of why this may be the case, not only for Australian society, but also for other societies including Ireland. "*If success in a woman's public life depends upon discretion about her private life, it makes no sense for her to be vocal about her lesbianism*" (Tong, 1989:124). However, this suggestion in itself feeds into the continued invisibility of lesbian women, as it would seem that to be visible leads to discrimination in 'public life', while discretion on the other hand leads to obscuring of the reality of lesbianism. Therefore, it can be concluded from Tong's (1989) perspective that being visible may lead to discrimination.

2.6.2 Emerging public voice and the law

As we have seen, there were many institutions in Irish society including the Church, family and education, which effectively silenced the subject of lesbianism. The subject was broken on national TV in 1980 on the popular talk show the *Late Late Show*. Crone (1995) deals with the effects of being the first woman to declare her lesbianism to the Irish nation, indicating that she received negative reactions from both family and friends. Moane (1995:86) insinuates "*the word 'lesbian' is powerful, it arouses strong emotions within a whole system of prohibition*". The reason Crone (1995:67) gave for going on the show was to:

dispel the ignorance and fear about lesbian sexuality. At the time, lesbianism was considered a taboo subject, suitable only for secret, scandalous and private conversation

While Crone's (1995) intention in 1980 was to remove the 'taboo' status, in 1994 "countless lesbians and gay men were intimidated by the news that two activists, Suzy Byrne and Junior Larkin, had been physically assaulted" (Moane, 1995:86). It would appear that even though Crone wanted to dispel the mystery of lesbianism in 1980, by 1994 some sections of society were still not ready to deal with the reality of the existence of lesbian women and gay men.

While the law may have changed, social attitudes take longer and the fear and loathing of not only the word, but also the individuals that embrace the lifestyle, still exist (Moane, 1995; GLEN and Nexus, 1995). Layte et al (2006:123) suggest that:

Sexual orientation, identity and expression do not occur in a neutral environment where sexual identity is a simple matter of individual choice. Quite the opposite, homosexuality is still widely stigmatized and homosexual identity can come at great personal cost to individuals.

It has been suggested (Bradford, Ryan and Rothblum, 1997), that there are institutions, such as the Church, that sustain heterosexuality that are not open to lesbian women. The debates that began in 2002 on the elevation of an openly gay minister to the role of bishop in the Anglican Church, which continues today adequately illustrate this exclusion.

There is no legal recognition in Ireland of same-sex relationships, which can lead to economic difficulties in relation to pensions and/or inheritance in the case of the death of a partner (Mee and Ronayne, 2000; Moane, 1995; Irish Council for Civil Liberties, 1990) Mee and Ronayne (2000:5) suggest that "a wide range of

legal privileges and obligations are triggered by the status of marriage” which are not available to same-sex couples. The most recent voices have been those of Canadian married couple, Ann Louise Gilligan and Katherine Zappone, who took a high court action in 2006, to have their marriage recognised in Ireland. However, they lost the case and are currently seeking redress in the Supreme Court. Nevertheless, the Labour party introduced a Civil Union Bill in 2006 into Dáil Éireann⁹ which was voted down and reintroduced it again in 2007. Both were rejected but the government has promised a Bill by March 2008. Thus, it would appear that the legal situation with regard to same-sex couples will change in the near future but will fall short of marriage as it is proposed to introduce civil partnership.

While Ireland awaits some legal recognition of same-sex couples, Belgium and the Netherlands have gay marriage, according the same rights as enjoyed by heterosexual married couples to gay cou[les]. Other European countries such as Denmark, France and Germany implemented civil partnership with varying degrees of rights accorded to lesbian (and gay) couples (ILGA-Europe¹⁰, 2007). Ireland’s closest neighbour, the United Kingdom, introduced civil partnerships for lesbian (and gay) couples in December 2005, affording same sex couples similar rights to married heterosexual couples in areas such as tax, pensions and inheritance (Government of United Kingdom, 2007). This enables same sex couples in other European jurisdiction, to live their lives as equal citizens and have their rights protected through legislation.

⁹ Dáil Éireann is the Irish house of parliament

¹⁰ ILGA (International Lesbian and Gay Association) Europe through its website (<http://www.ilga-europe.org>) reviews same-sex marriage and partnership rights throughout Europe

2.6.3 Economic independence

In the economic sphere, Inglis (1998b:99) argues that when women become economically independent from men, regardless of sexual orientation, they will be free *“from the image they have of themselves as constructed by men. In this process they overcome the way they have been symbolically and politically dominated”*. It could be argued, that lesbian women are already freeing themselves *‘from the image they have of themselves as constructed by men’*, as they do not fall into the dominant role for women (Crone, 1995; Dennerstein, 1995). Economic independence can lead to the reconstruction of image (Inglis, 1998b). Lesbian women had no choice but to become economically independent, as they did not have the traditional partner of the male provider. Therefore, it could be argued, that lesbian women are already engaged in the process of image reconstruction. However, an economic system that has pay rates based on equality of the work being carried out rather than gender, would lead to greater independence for all women. Abbott (2000) indicates that in the world of position, the traditional role expectations of men and women still exist, including the notion of the male breadwinner. This influences employers in relation to the opportunities available to both women and men in the work place.

The primacy of heterosexuality is reinforced in society where privileges are incurred through laws that regulate marriage, social security and work (Scott and Jackson, 2000). It takes more than economic independence to cast off the shackles of the male construction of women. It also necessitates a change in institutional structures and the attitudes that prevail in these institutions. Research results have indicated that even though lesbian women were well educated (some

holding primary and secondary degrees) (Rust, 1993), they did not have the income comparable to their education (Esterberg, 1997; Stevens and Hall, 1988). GLEN and Nexus' (1995:xiv) study reinforces this point in the Irish context, indicating that their respondents revealed:

job opportunities were severely narrowed because they avoided work for which they were qualified (21%) or categories of work (39%) through fear of discrimination, both of which can lead to downward mobility.

While the focus here is on economic independence, it can be argued that the socialisation process of society also creates emotional dependence as, according to current norms, to be emotionally fulfilled, a woman "needs" a man. Lesbian women not only become economically but also emotionally independent, in a society that views heterosexuality as the norm (Claassen, 2005; Clunis et al, 2005). This does not imply that all women who are economically independent are necessarily lesbian, insofar as there are economically independent women who have emotionally fulfilling relationships with men, both within and outside the normative heterosexual marital domain (Oakley, 2005).

2.7 Concluding remarks

This literature review suggests that knowledge about lesbian women's lives and social experiences is severely limited in Ireland, so that the findings of this thesis will shed light on one aspect of their lives, that is, their experiences of health care as either consumers or providers. The ability of the Catholic Church to gain power and authority, and the willingness of the Irish State to enshrine their morality into the legislature, led to the subservient status of women. It also led to the creation of an identity for women based on Catholic ideology and social teachings. However, it was hoped the deregulation of homosexuality in Ireland,

would lead to a destigmatised status in all areas of life. While the legislation has changed, attitudes are much harder to alter. However, deregulation of homosexuality, related to gay men only, as lesbianism was given no recognition in the regulation.

The lack of acknowledgment of the existence of lesbian women through the legal system, reinforced the invisibility of lesbian women in Irish society. This invisibility permeates all social institutions in society such as religion, education and the family, thus not acknowledging lesbian women as part of the diversity of the nation. It has been argued that lesbian women in the educational sector experience "*institutional invisibility*" which is "*reinforced by the lack of a vocabulary to name and discuss difference*" (Lodge and Lynch, 2003:21). It is argued that 'institutional invisibility' may extend into the health services resulting in a vocabulary deficit when discussing lesbian health. It is these attitudes, perceived or real, that need to be explored. Specifically we need to see how they affect lesbian women as they access the health services and lesbian women who are part of the nursing profession. The following chapter seeks to explore this.

Chapter 3: *Lesbian Women's Health Care*

3.1 Introduction

This chapter reviews the literature on lesbian women's health care, particularly in relation to the experiences of lesbian women. Lesbian women and gay men internalise the negative attitudes of the dominant culture towards them; equally heterosexuals internalise the norms, values and belief systems of cultural socialisation, whether they be negative or positive. Nurses and doctors are products of their culture. Consequently, it may be difficult for them to shed their former socialisation, although the acculturation process of becoming a nurse or doctor, could enable them to reconsider their norms, values and belief systems to incorporate diversity. However, research in Australia has shown that where nurses or doctors regularly participate in religious practices, regardless of denomination, they exhibit negative attitudes towards lesbian women and gay men, identifying themselves as right wing politically (McKelvey et al, 1999).

The chapter is divided into four sections: the first deals with the medicalisation of homosexuality; the second addresses the provision of health care to lesbians, and reviews the outcomes for lesbian women when they disclose their sexual orientation in a health care encounter; the third addresses the providers' attitudes towards providing lesbian health care; and finally, nurses' perceptions of lesbian women are examined.

Research suggests that lesbian women attend health care providers less often than heterosexual women (Fields and Scout, 2001). Some researches suggest that this may arise out of ambivalence, and/or lesbian women may not consider themselves

to be exposed to the same risk factors for illness and infections as heterosexual women. The American Medical Association, Council on Scientific Affairs (1996) reiterates these concerns, implying that lesbian women may not feel that health issues such as smear tests, are of concern to them. Other issues at play are "*isolation, fear, violence and the requisites of day-to-day survival*" (Gochras and Bidwell, 1996:20). Isolation and fear may be factors to consider when lesbian women are seeking health care. Fear may emanate out of past experiences of health care, or of the related experiences of other lesbian women.

3.2 Medicalisation of Homosexuality

The traditional model of understanding homosexuality within the health care profession, derived from the causes and treatments paradigm (discussed below), thus rendering homosexuality in need of psychiatric care. Conrad (1975:12) views medicalisation of every day life as "*defining behaviour as a medical problem or illness and mandating the medical profession to provide some treatment for it*". He further suggests that the process of medicalisation begins with a definition "*in medical terms, using medical language to describe the problem, adopting a medical framework to understand a problem, or using a medical intervention to "treat" it*" (Conrad, 1992:211). Defining homosexuality from a medical standpoint led to a new medical model of homosexuality¹¹, rather than a criminal or immoral model, giving new meaning to 'deviant' behaviour, and turning homosexuality into an illness/disease that can be treated and cured.

¹¹ Rosario (1997) identifies the emergence of a Euro-American medical exploration and definition of homosexuality as beginning in the late nineteenth century.

Conrad and Schneider (1980) view imposed medical treatments as a new form of punishment and social control. Martin (1993) indicates that the medical profession was influential in defining identity and sexuality, which permeated cultural norms (see Foucault, 1978). Thus the medical profession became a powerful force in constructing the identity of the homosexual and creating homosexuality as a social problem, best dealt with by the medical profession as they had the 'treatments' and 'cure'. Martin (1993) analysed medical discourse on lesbian women and gay men, suggesting that this may be the roots of the stereotypes that persist to the present day. "*Lesbians were not only failed heterosexuals but failed women Gay men were not just homosexual but, more important, were not masculine*" (Martin, 1993:254). Studying a phenomenon in society from a scientific approach, is based upon non-biased exploration and expansion of our knowledge (Marmor, 1998). The use of science to explore homosexuality enabled doctors to become powerful social persuaders on societal norms (Marmor, 1993), thus producing a biased exploration and explanation. From Foucault's point of view, this can be described as the power of the medical profession to produce "*the truths we live by*" whereby, truth is a "*product of science or scientific 'methods'*" (McHoul and Grace, 1993:58). Thus, the medical profession produced the 'truthful' knowledge on human sexuality, in particular what constituted socially acceptable human sexuality. Homosexuality was a deviation of that 'truth' about human sexuality.

The varieties of medical interventions to 'treat' and 'cure' homosexuality ranged from "*hypnotism through to chemical experimentation and in the 1960s to aversion therapy*" (Weeks, 1996:51). Aversion therapy was mainly used for gay

males, where they “were shown erotic pictures of men, at the same time an electric shock was applied to their genitals or they were induced to vomit” (Marcus 1993:13). While there is no medical model to explain heterosexuality, Freud had indicated that an understanding of heterosexuality was also in need of examination (Wilton, 2000). Freud’s view of homosexuality can be elicited from a letter he wrote to a mother regarding her concerns for her son: “*Homosexuality is assuredly no advantage but it is nothing to be ashamed of, no vice, no degradation, it cannot be classified as an illness*” (Freud, quoted in Conrad and Schneider, 1980:186). From this then, Freud neither viewed homosexuality as an illness or deviance; rather, he categorised it as a different sexual behaviour.

Why did the Euro-American medical profession continue to view homosexuality as an illness/disease? The answer may lie in Marmor’s observation, that treating homosexuality as a mental illness enabled society to justify “*aggressive interventions into the lives of individuals*” (Marmor, quoted in Scasta, 1998:13) and particularly the homosexual life. In other words, homosexuality was just one avenue by which the medical profession gained an entrance into people’s lives, enabling doctors to make diagnoses about personal behaviour:

When an institution (e.g. the church, state, medical profession) gains the power and authority to define deviance, that is, to say what kind of a problem something is, the responsibility for dealing with the problem often comes to that institution (Conrad and Schneider, 1980:8).

This negates individuals’ responsibility in dealing with the ‘problem’ of homosexuality, rendering it the remit of powerful bodies such as the Church or the medical profession. Thus this ‘dis-ease’ of society can be both ‘treated’ and ‘cured’ by those professionals who know best. This is reflective of the position of unmarried mothers in Ireland (see chapter 2, section 2.3.4 for a discussion of

this), who were placed in 'Magdalene laundries' so that the 'dis-ease' of society was removed from view, through the sanction of the Catholic Church.

When sexual behaviour is categorised as "sin" (homosexuality is immoral), "deviant" (homosexuality is non-normative) and "sickness" (homosexuality is an illness) (Wilton, 1995), individuals or groups are alerted to the consequences of that behaviour. Labelling sexual behaviour removed the possibility of any discourse of lesbianism or gayism from society, both by academics and lesbian women and gay men. Chauncey, Duberman and Vicinus (1989:1) concisely put it:

Repression and marginalization have often been the lot of historians of homosexuality as well as of homosexuals themselves.

Repression shifts the reality of being a lesbian woman or a gay man to a medical or religious definition of that reality. The medical profession, particularly the psychiatric profession, became a powerful agent in defining lesbian reality. It can be argued that reality:

in this distinctively human world, is not a hard, immutable thing but is fragile and adjudicated – a thing to be debated, compromised and legislated. Those who most succeed in this world are those who are most persuasive and effective in having their interpretations ratified as true reality. Those who do not are relegated to the fringes of the human world, are executed as heretics or traitors, ridiculed as crackpots or locked up as lunatics (McCall and Simmons, 1966:42).

For most of the 20th century, the medical profession was to the forefront in its interpretations of the reality of lesbianism, which became culturally accepted.

(See chapter 2 for a discussion of lesbianism and who lesbian women are.)

Berger and Luckmann (1967:1) view reality as a "social construction".

The medical profession was a powerful agent in its contribution to the social construction of lesbianism. This contributed to the marginalisation of lesbianism to the periphery of society, with the outcomes described by McCall and Simmons (1966) sanctioned. The history of lesbian women and gay men is replete with discrimination and laws introduced to curb their existence (Miller, 1995; Marcus 1992; Duberman, Vicinus and Chauncey, 1989). One of the most extreme enactments was the attempted eradication of lesbian women and gay men as one group amongst others during the Holocaust (Miller, 1995; Haeberle, 1989). Another example of curbing the existence of lesbian women and gay men was during the McCarthy era in the United States of America. Lesbian women and gay men as well as Communists were targeted as risking national security (Miller, 1995), resulting in them being dismissed from positions in the federal government, army and leading to imprisonment or incarceration in psychiatric hospitals.

In 1973, the American Psychiatric Association (APA) removed homosexuality from its list of mental illnesses. When doing this, the APA stated: "*homosexuality per se implies no impairment in judgment, stability, reliability or general social or vocational capabilities*" (Boyer, 1981 quoted in ICCL [Irish Council for Civil Liberties], 1990:7). Almost twenty years later (1991), homosexuality was removed from the World Health Organisation (WHO) publication *International Classifications of Diseases* (King, 2003; Frank and Mceneaney, 1999). The consequences of this delay in deleting homosexuality from its list of mental illnesses, resulted in its stigmatisation within the health care profession.

However, King (2003:685) indicates that sexual orientation is still included in the *International Classifications of Diseases*¹²:

'F66.1 Egodystonic sexual orientation' to indicate when a person's 'gender identity or sexual preference is not in doubt but the individual wishes it were different because of psychological and behavioural disorders and may seek treatment in order to change'.

F66.1 Egodystonic sexual orientation therefore, offers lesbian women and gay men treatment to change orientation. No such directive exists for heterosexuals enabling them to seek treatment if they wish to change their orientation. As King (2003:685) indicates, "*Clinicians never see heterosexuals who are seeking treatment to become lesbian or gay*".

Nevertheless, the problem with this directive is the suggestion that sexual orientation can be treated, and that it is somewhat abnormal (Hinchliff, Gott and Galena, 2005; King, 2003; Marmor, 1998). The idea of treatment may lead to further stigmatisation in society, as lesbian women and gay men can seek medical intervention for their 'condition'. Therefore, the lesbian woman or gay man becomes responsible for not 'wishing' to change:

If a person believes that people choose or learn to be homosexual, it follows that they can also believe that homosexual people are responsible for their actions, a belief that may trigger anger towards them. If a person believes homosexuality to be congenital, there is no blame (Röndahl, Innals and Carlsson, 2004:390).

It is the internalisation of stigmatisation of lesbian women and gay men in society, that may necessitate the interventions of mental health services, rather than the fact of being a lesbian woman or gay man (King, 2003; Welch, Collings and Howden-Chapman, 2000).

¹² International Classification of Diseases (ICD) 10 came into effect for WHO Member States in 1994. There has been eleven updates since its endorsement by the World Health Assembly since 1994. However, F66.1 is a mental health category which remains unchanged [version 2007]. (<http://www.who.int/classifications/icd/en/>) Visited: 4th February 2008

However, specific areas of mental health needs have been identified. Some lesbian women participate in substance abuse, suicidal behaviour, or are affected by eating disorders, with some being survivors of sexual abuse (Gibbons et al, 2007; Welch, Collings and Howden-Chapman, 2000; Bradford, Ryan and Rothblum, 1997). Hershberger, Pilkington and D'Augelli (1996), suggest that suicide behaviour in the lesbian or gay adolescents, points to particular stressors in their lives that are not comparable to those of heterosexual adolescents. Examples of these stressors are family rejection, physical abuse or fear of the consequences of disclosure of their sexual orientation. These researchers also suggest, that the more open adolescents are about their sexual orientation, the more they become exposed to victimisation, which results in "*extremely victimized and socially rejected youths*" (Hershberger, Pilkington and D'Augelli, 1996:56). While some mental health issues, are directly related to being a lesbian woman or gay man, others are not directly related to one's sexual orientation, and are present in other members of society.

Mental health professionals are advised, when dealing with lesbian women or gay male clients, that:

The focus in such cases, no less than similar feelings in religious or ethnic minorities, should not be on their minority status per se but rather on the nature of the prejudice and discrimination to which they are exposed (Marmor, 1998.26-27).

Lesbian women may not be as readily observable as other minority groups, as they can blend into the heterosexual community (King, 2003). It may be the reality of living a dual existence that brings them into contact with the mental health profession. Beals and Peplau (2005) support this by suggesting that when one's identity (being a lesbian) has both social support and understanding, it leads

to higher self-esteem and psychological well-being, while the lack of both may lead to negative feelings and thus to seeking treatment from the mental health profession.

3.3 Provision of health care to lesbian women

Over the last twenty-five years, research has been carried out on lesbian women's experience or perceived experiences of health care provision by health care providers. The problems facing lesbian women are twofold: "*those that face women in general with dealing with the medical profession and those specific to being lesbian*" (Regan, 1981:21). However the "*most significant medical risk for lesbians and gays is the avoidance of routine health care*" (Bonvicini and Perlin, 2003:115). Routine health care include pap smears and breast checks. It can be inferred that if health care providers are not aware of that lesbian women could be part of their client group, or that it is not part of their social reality, they may not be able to provide the best possible health care. Equally, if lesbian women avoid health care professionals then they cannot receive the best possible health care.

Cochran and May (1988) suggest that it is lesbian women's responsibility to obtain the best possible health care provision, which may necessitate informing health care providers of their sexual orientation. Taking responsibility for one's own health care is reflected in the Irish Government's health care policy. The stated aim is "*to encourage people to take responsibility for their own health and to provide the environmental support necessary to achieve this*" (Government of Ireland, 1995b:1). This is not unique to Ireland; rather, it reflects developments in

health policies in other European countries as shown in WHO's (1985) strategy document (Bunton, 1998; Devlin, 1997; Ashton and Seymour, 1993).

3.3.1 Disclosure or non-disclosure of sexuality

Research studies (Cochran and Mays, 1988; Regan, 1981; Dardick and Grady, 1980) on whether lesbian women disclose their sexual orientation to health care providers, were initially carried out in the United States of America. Regan (1981:124) investigated the reasons why respondents had not disclosed their sexuality to their physicians, finding that "*lesbian subjects felt that professionals would be seldom positive (46%), usually curious (50%), usually anxious (40%) and likely to refer a lesbian to a psychologist (32%)*". Disclosure might lead women to experience health care that is both alienating and inappropriate (Cochran and Mays, 1988; Regan, 1981; Dardick and Grady, 1980). Equally, non-disclosure of sexual orientation can lead to inappropriate health care, particularly in relation to sexually transmitted illnesses (STIs) (Dardick and Grady, 1980), as partners may also need treatment.

'Coming out' is important, as it leads to the visibility of lesbian women but it is also "*vital for a health history*" (Enszer, 1996:5). The Council for Scientific Affairs [American Medical Association] (1996) maintains that responsibility for disclosure of sexuality lies not only with lesbian women, but also with health care professionals who should provide an environment that enables disclosure:

A physician who does not determine sexual orientation and sexual behaviour, tacitly assuming that the patient is heterosexual may deter the patient from openly confiding in the physician and may overlook risk factors (The Council for Scientific Affairs, 1996:1355).

Openness on the part of the health care provider is essential, and those who do not provide the space for lesbian women to 'come out', may not be providing the best possible health care. It has been argued that if a health care provider is not aware that her/his client is a lesbian woman, then they do not provide adequate health to their patient/client and in some cases, such as diagnoses of Sexually Transmitted Illnesses (STIs), which may have consequences for their partner(s) (Marrazzo and Stine, 2004; Bonvicini and Perlin, 2003; Stevens, 1996; Rankow, 1995; Dardick and Grady, 1980). In contrast, Stevens (1996:38) implies that positive experiences of health care have more far-reaching consequences, as clients "comply with treatment recommendations, return for services, refer others for care". Thus, confidence in the health care provider, results in positive outcomes for both the provider and the client (Saulnier 2002; White and Dull, 1998; Saddul, 1996).

3.3.2 Disclosure and discrimination

The concerns of Irish lesbian and bisexual women in relation to the health care professions, were discussed at a seminar on lesbian health organised by Lesbian Education and Awareness (LEA) and the Western Health Board in 1999. Eight concerns were identified:

1. *Reluctance to disclose sexual identity due to prejudice, oppression and internal homophobia amongst health professionals*
2. *Fear that disclosure may affect quality of care*
3. *Consequent withholding of personal details, which may have an impact on medical history and diagnosis*
4. *Fear that a lesbian partner will not be recognised as next of kin and not treated accordingly.*
5. *Fear that disclosure of sexual identity will not be treated confidentially, fear family members and others will have access to medical notes, charts etc*

- 6 *The invisibility of women's and lesbian issues in health services, lack of appropriate health promotion material targeted at lesbian and bisexual women.*
- 7 *The resistance of many health practitioners to developing more inclusive practices for fear of alienating the majority heterosexual population*
- 8 *The gender bias in gay health: an over-emphasis on AIDS and HIV issues (LEA and Western Health Board, 1999:3).*

Gibbons et al (2007:19) study on Lesbian Gay and Bisexual sexual identity in Irish health care service in the North Western Region reports the main themes were:

- ***Disclosure of sexual orientation*** *The disclosure, or not, of LGB sexual identity to service providers appeared to be a significant factor influencing health care for interviewees. Anxieties concerning confidentiality, homophobia and heterosexism emerged across all the services in this regard.*
- ***Recognition of partnerships/next of kin*** *Concerns with regards to partnership rights, particularly in relation to hospitalization and GP services*
- ***Parenthood*** *Arose primarily in relationship to GPs and maternity services*
- ***Mental Health.*** *Primarily arose in relation to GPs and other mental health professionals*
- ***Sexual/gynaecological health.*** *Arose mainly in relation to GPs and other sexual health professionals (emphasis in the original).*

Irish lesbian women have concerns around confidentiality, which they state may lead to discrimination if their sexuality is revealed (Gibbons et al, 2007; LEA and Western Health Board, 1999).

The issue of confidentiality "*is crucial for lesbians*" (Jones, 1988:49). She argues that "*sexuality should not be recorded on medical notes since its inclusion may leave patients open to negative attitudes from other staff in the future*" (Jones, 1988:49). From this one can infer that information about a patient's sexual orientation is not safe in the hands of health care providers, once again cloaking lesbianism in secrecy and relegating it to taboo status. It also implies that lesbian

women must come out to their health care provider, each time they need health care intervention. Jones (1988) recognises that homophobia, exists within the health care profession, yet she does not suggest ways of counteracting it. Rather, by suggesting the non-recording of sexual orientation, she appears to be reinforcing it. Instead of the non-recording of sexuality which Jones' (1988) appears to be advocating, others argue that nurses need a comprehensive knowledge of lesbianism, lesbian culture and lesbian concerns when interacting with health care professionals (Saddul, 1996; Stevens, 1995; Stevens and Hall, 1988).

It has been suggested that nurses have a:

burden of responsibility for nursing as a profession and for nurses as individual clinicians, educators and researchers to evaluate the adequacy of its knowledge base and reassess the quality of health care offered to lesbian women (Stevens and Hall, 1988:69)

It would seem that the conclusions reached in 1988 were not heeded, for in a later study, Stevens (1995:29) found that the idea that "*female clients would be other than heterosexual was seemingly so extraordinary that, in most cases, it was never anticipated, never mentioned, never addressed by health care providers*". Roberts and Sorensen (1995), indicate that lesbian women want non-judgemental health care, but they do not always receive it because of the assumption of heterosexuality rather than diversity.

Spinks, Andrews and Boyle (2000:137) suggest that nurses, "*as health care providers, [we] want to provide high-quality care, including culturally competent care, to every client*". While this may appear aspirational, it does suggest that it is irrelevant whether or not a lesbian woman's sexual orientation appeared on her

chart. It is acknowledged that lesbian women are a culturally diverse group who are not always readily recognisable, which creates the challenge to identify them and provide health care without stigmatisation or discrimination (Spinks, Andrews and Boyle, 2000). It is only through investigation of lesbian women's experiences of Irish health care, that we will be able to uncover whether they experience stigmatisation or discrimination.

Lesbians are divided on the subject of whether their sexual orientation should appear on a history chart (Saulnier, 2002). The division is based upon the issues of trust, confidentiality and the need to prevent unrelated questions such as use of contraception re-emerging. Lesbian women want a say in whether their sexual orientation is recorded on their charts or not (Saulnier, 2002). In this way, they can decide whether they believe the health care provider is trustworthy. As Denenberg (1995:84) highlights, "*trust and truthfulness are the cornerstones of provider-client relationships*". Trust in the context of health care has been described as a voluntary action whereby an individual has expectations about how they will be treated by another, both now and in the future (Gilson, 2003). If the experiences of lesbian women of health care have been negative in the past, then it will be difficult for them to expect anything other than a negative result in the future (Stevens, 1998). As Thiede (2005:1456) indicates, "*trust is always rooted in experience*" which leads to both "*emotional and cultural security*".

In circumstances where trust may not be established, between the lesbian patient and her health care provider she must place some trust in the health care professional's competence to provide care. If some form of trust is not

established, whether on a voluntary or involuntary basis, it may then be impossible to achieve a successful outcome. If the patient cannot trust the health care provider, then the individual may not trust the provider's competence to provide the best care, as trust relies on the "*reliability of the other within a given context*" (Thiede, 2005:1456). Lack of trust may result in non-compliance with prescribed medical regimes and the patient seeking further health care interventions (Denenberg, 1995). Trust and confidentiality relate to Jones' (1988) question regarding where the information on sexual orientation goes and who has access to it. White and Dull (1997) indicate that trust can be built through good communication, leading to the lesbian client feeling at ease with her health care provider. However, the building of trust requires the health care provider to acknowledge that some of her/his women clients could be lesbian (Gibbons et al, 2007; Saddul, 1996). The problem is that some health care providers appear to have an inability to acknowledge that lesbian women also make up the client group (Tiemann, Kennedy and Haga, 1998).

3.3.3 Disclosure and outcome

Stevens (1996) interviewed 45 women in the United States of America on their experience of power dynamics in health care, in particular focusing on when they seek a consultation with physicians. She explored power relations, recognising that physicians are the knowledge brokers while women are vulnerable, and in need of their expertise. Respondents reported both positive and negative experiences of health care. The positive experiences included being made part of the diagnoses and treatment, being treated with both compassion and competence and an overall trust in the medical provider. The negative experiences ranged

from lesbian women being talked down to, in some cases their concerns being dismissed, the use of sexist language and in other cases the health care provider either prescribed a higher estrogen pill to enable the women to 'look more like a woman' or offered 'breast reduction' neither of which the lesbian women involved wanted (Stevens, 1996). Stevens (1996:37) concluded that, regardless of whether or not lesbian women had come out to their health care provider, they:

not only risk verbal intrusion on their dignity, denigration of their intellect, and dismissal of their concerns but also risk loss of control over bodily appearance and reproductive functioning, violation of bodily safety, and sexualization.

Saulnier (2002) reported similar results, suggesting that respondents received a multitude of reactions upon disclosure of their sexual orientation. Five categories of responses to disclosure were identified: "(1) homophobia, (2) heterosexism, (3) tolerance, (4) lesbian sensitivity and (5) lesbian affirmation" (Saulnier, 2002:359). However, she suggested that tolerance from others was more an aspiration on the part of lesbian women than a lived experience.

A particular barrier identified by lesbian women when seeking health care, is the fear of judgments being made about their sexual identity and sexuality (Gibbons et al, 2007; Marrazzo, Coffey and Bingham, 2005) and the dread for some of the physical reality of a gynecological examination, which pertains not only to lesbian women (Stevens, 1998; Robertson, 1992). This fear emanates out of lesbian women's own experiences and the related experiences of their friends such as discussed above: judgments about sexual identity and practices as well as age-related assumptions (discussed below), that is, at what age would a woman know she is lesbian or the consideration of lesbian sexuality in older women.

Fear of judgments leads to 'distrust' on the part of lesbian women, which may have consequences for later health care needs.

Lesbian women's experiences of negative outcome in Stevens' (1996, 1998) and Scherzer's (2000) studies validate Regan's (1981) participants' reasons for non-disclosure. Scherzer (2000:93) indicates that

the most prominent barrier to seeking care was the expectation - based on prior experiences - of practitioners' ignorance and insensitivity about their sexuality, especially because the women did not conform to dominant notions of 'appropriate' behaviour, identity, or appearance.

Lesbian women who disclose their sexual orientation to their health care practitioner are also being proactive in seeking out both best medical care and preventative care (Diamant, Schuster and Lever, 2000; White and Dull, 1998). This is a positive step as it both reflects the changing attitudes amongst providers, but also societal attitudes towards lesbianism. White and Dull (1998) reported a high rate of disclosure of sexual orientation in their study, suggesting that lesbian community-based health education, coupled with media visibility and changing societal attitudes, may have an impact on the decision to 'come out' to health care providers.

While there are reports of positive outcomes upon disclosure, some lesbian women report negative reactions from their provider when they question and participate in their health care. These negative reactions include the use of inaccessible language, dismissal of lesbian women's concerns to being told that they did not need certain treatments, precisely because they were lesbian women (Marrazzo and Stine, 2004; Scherzer, 2000). A U.K. study established that some physicians were uncomfortable with lesbian patients finding them "slightly

aggressive” and wondering whether they (lesbian women) were “*quite as scary as they say they are*” (Hinchliff, Gott and Galena, 2005:348). However, Hinchliff, Gott and Galena (2005) reported that the majority of the physicians, found it difficult to discuss sexual health with lesbian and gay patients, as they did not understand diversity (see chapter two in relation to the understanding of diversity in Ireland). Equally, they found that some viewed lesbian sexual practices from the standpoint of heterosexuality, therefore judging it as non-normative.

3.3.4 Disclosure and age

Another issue of concern in the context of lesbian women and health care is that of age. Scherzer (2000) reveals that providers have age-related assumptions of when an individual should know whether they are lesbian or not:

You can't be gay! You're too young! (Anna, age 19 as reported to Scherzer, 2000.93).

Such a reaction renders young lesbian women uncomfortable in revealing their sexuality to future health care providers, and further illustrates that the health care provision based on heterosexuality, reinforcing the societal norm (Saddul, 1996; Robertson, 1992). It can prevent young lesbian women from seeking further health care, and may lead to their delaying health care in the future, with serious consequences (Fields and Scout, 2001; Shelby, 1999). Keighley (2002) suggests that adolescence is the period when sexuality is questioned, with some women identifying as lesbian (see chapter two, section 2.5.4 for a discussion of lesbian and gay adolescent experiences in the Irish educational sector). However, it may take the young lesbian woman longer to accept her sexual orientation in the face of societal stereotypes.

Keighley (2002) argues that health care providers working with adolescents should be aware and secure in their own sexuality before they can assist others, particularly if the sexuality expressed is different to their own. While some practitioners may overtly state their surprise, others relate this attitude through facial expressions, intonations and body language, both implicit and explicit (Stevens, 1998; Dardick and Grady, 1980). Lesbian women pick up cues of negative or positive attitudes and can tell when a health care provider is uncomfortable. This reinforces Blumer's (1969:2) three premises of symbolic interactionism namely:

1. . *human beings act towards things on the basis of the meanings that the things have for them.*
2. . *the meanings of such things are derived from, or arise out of, the social interaction that one has with one's fellows.*
3. . . *these meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he encounters.*

The young lesbian woman has learnt the cues of both negativity and positivity through the socialisation process, and she interprets and puts meanings on the actions, both verbal and non-verbal, of those around her.

This is equally the case when she is in a medical encounter. When lesbian women were asked what they would say to health care professionals, one participant indicated she would put forward the question:

Have you ever felt uncomfortable around lesbians? If your answer is yes, do you think they didn't know that? (participant in Stevens', 1998:84).

Lesbian women participate in everyday life and are aware of societal attitudes and prejudice towards them. They bring this awareness into the health care setting utilising it to prevent further discrimination where possible. Saulnier (2000) reported that regardless of age, lesbian women wanted reassurance that health

care providers are aware that lesbian women are consumers of their practice. Both young and older lesbian women are aware of, or fear, discriminatory practices on the part of some health care providers. Both are conscious that a number of health care professionals practise from a heterosexist standpoint.

Just as there may be assumptions about young lesbian women in the health care setting, there are also assumptions about older lesbian women (Hinchliff, Gott and Galena, 2005; Harrison, 2001). In some cases there is no recognition that older women (those aged over 60) could be lesbian (Wojciechowski, 1998). Older lesbian women experience an increase in substandard care where their sexual orientation is revealed due to prejudice of the nursing care team (Wilson, 1999). Lesbian women are simply ignored in research on health care needs of older women (Wilson, 1999; Wojciechowski, 1998). Wilson (1999:17) suggests that one of the major issues for older lesbian women in health care is their invisibility, resulting in them dealing with:

“stereotypes, specific issues surrounding next-of-kin and consent; acceptance of self and others by patients, visitors and staff, patient privacy and interpersonal respect”.

Wilson (1999) and Wojciechowski (1998) argue that it is the environmental factors in health care that can become problematic for older lesbian women, impacting on the health care they receive and on their health. However, it could be argued that it precisely the lack of research in this area that contributes to the invisibility of older lesbian women in health care.

Older lesbian women appear to be “*distant*” or “*difficult to nurse*”, which may be a direct consequence of internalised homophobia (Wilson, 1999). Labelling a

patient as 'difficult', provides the nurse with an escape route for not providing the best possible care rather than examining why the patient is being difficult (Wilson, 1999). Heath (2002) suggests that there are myths, usually negative, around sexuality and sexual expression in older people. Heath (2002:149) argues that nurses can play a pivotal role in "*helping older people, particularly those with illness or disability, to express themselves in the way which they would choose*". It must be remembered that older lesbian women are the cohort who lived in silence, experiencing on a day-to-day basis society's institutions' pronouncements on sexuality, as discussed in chapter two.

3.3.5 Disclosure and colour

Cochran and Mays' (1988) study of black women in the United States of America, found that 45% of lesbian women in their sample and 66% of bisexual women had not informed their physician of their sexual orientation. While Regan (1981) reported perceived reactions to disclosure of sexuality, Stevens and Hall (1988:72) found that 72% of the participants in their study reported experiencing negative reactions to disclosure, describing "*ostracism, invasive personal questioning, shock, embarrassment, unfriendliness, pity, condescension and fear*". While white lesbian women faced discrimination because of their sexual orientation, black lesbian women faced discrimination not only because of their sexual orientation, but also because of their colour (Dardick and Grady, 1980; Cochran and Mays, 1988).

Stevens' (1998) study reiterates these points, reporting that stereotypes of black women prevail within the health care system. The key stereotype that they are

confronted with is of over-active heterosexuals in need of birth control. For some black lesbian women physicians and nurses did not know how to respond to a black woman when she revealed her lesbianism. This results in being treated through silence and/or the lesbian woman being the object of curiosity, bringing other nurses around to see what a lesbian woman looks like: "*when she came back in, this other person was peering in at me from behind the door*" (Stevens, 1998:85). While there were concerns that non-disclosure would lead to inappropriate health care (Cochran and Mays, 1988; Regan, 1981 and Dardick and Grady, 1980), disclosure in and of itself did not lead to appropriate health care. Rather, the stereotypes that both physicians and nurses held regarding women in general and women of colour led to inappropriate health care (Steven, 1998).

3.4 Assumption of heterosexuality

Studies have indicated that the invisibility of lesbian women in health care, arises from the fact that the "*traditional health care system has based its care and treatment of women on the assumption of heterosexuality*" (Robertson, 1992:155). Brogan (1997) supports this assertion, and Robertson (1992:155) argues that it is "*the invisibility of lesbians in society that lends to the continued negative experiences lesbians relate*". The assumption of heterosexuality can lead to alienating health care, particularly when discussing birth control (Regan, 1981). The experiences of lesbian women will reveal whether or not they perceive Irish health care, is based upon the assumption of heterosexuality. This is in part inevitable as no other sexuality has been recognised, since heterosexuality is the norm. There are strongly-held views within society regarding what is 'normal'

and 'natural' sexuality, and these permeate the health care professions (Bonvicini and Perlin, 2003; Fields and Scout 2001; Taylor, 1999). As previously stated in chapter two, this not only applies to the health care profession, but also to the other institutions and structures of society.

The use of heterosexual language such as being asked for their spouses name, silences lesbian women, as they find no opening to 'come out' to their provider. Thus, they are alienated from the health care system. Lesbianism does not exist and the health care provider becomes a powerful agent of this negation. When this assumption is voiced by the provider, it leads to lesbian women being both vulnerable and rendered with an inability to challenge the heterosexual ideology of health care provision for women (McDonald, McIntyre and Anderson, 2003). Equally, it reinforces Stevens' (1996) and Scherzer's (2000) suggestion of the power relations that permeate health care consultations, in which the health care provider is a knowledge broker and the lesbian woman, becomes a consumer of this knowledge. More importantly, she is constructed as a clueless consumer. This removes lesbian women's knowledge of their own bodies, but more significantly, it removes the potential for partnership between the lesbian woman and her health care provider in dealing with her health issues and care.

3.4.1 Assumption of heterosexuality and effect on attitude

Lehmann, Lehmann and Kelly (1998) found that 70% of participants in their study had never been asked about their sexual orientation, with 31% believing that to 'come out' to a health care provider would result in negative outcomes. Not seeking to find out the sexual orientation of clients or lesbian women's fear

of 'coming out', militate against health care providers' ability to provide appropriate health care. Lehmann, Lehmann and Kelly (1998:386) argue: "*Any health care provider who provides care to women is likely to have lesbians among his or her patients*". The problem is that there are health care providers who practices from the "*standpoint of prejudicial stereotypes, attributing immorality, promiscuity, instability, danger, or disease to lesbian women*" (Stevens, 1995:29). This results from the general "*assumptions about the universality of heterosexuality [which] were linked to these denigrating assumptions about lesbians*" (Stevens, 1995:29). It has been suggested that "*Any person who represents or symbolizes a different image risks discrimination, oppression, dismissal or erasure*" (Ponticelli, 1998:1). The assumption of heterosexuality leads to the exclusion of lesbianism, creating the potential for discrimination on disclosure.

It would appear that best practice would be to assume that all women could be potentially lesbian if not otherwise stated. However, it was also reported that health care providers did not ask the sexual orientation of their client, because they were afraid that they would 'insult' heterosexual women (Westerståhl, Segesten and Bjorkelund, 2002). Saddul (1996) acknowledges that offending heterosexuals may be an outcome of asking a person's sexual orientation, but views this as an opportunity for the health care provider, to dispel fears and stereotypes that patients may have of lesbian women or gay men.

A participant in Hinchliff, Gott and Galena's (2005:349) study of GPs' experience of treating the sexual health needs of lesbian women and gay male

patients indicated: “*it’s not people’s fault because they are not used to working that stuff, but we need to move it on so that people are comfortable*” (Female 44213, age 50 years). The problem arises in assuming that non-heterosexual patients are new, or ‘working that stuff’ is new. The history of lesbian women and gay men points to the existence of non-heterosexuals through the ages (Padgug, 1999; Faderman, 1991, 1979/1997; Gowing, 1997; Ben, 1992; Cavin, 1985). Equally, the history of the regulation of sexuality by institutions such as the church and the legal system (United States of America, United Kingdom, and Ireland to name just a few), would point to the existence of lesbian women and gay men (Harrison, 2001; Marmor, 1998; Martin, 1993). The history of 20th century medical research points to a rich anthology of literature indicating the existence of lesbianism (Scasta, 1998; Denenberg, 1995). It would appear that some of the respondents in Hinchliff, Gott and Galena’s (2005) study were not familiar with either medical literature or social history.

3.4.2 Assumption of heterosexuality and effect on treatment

GP’s, question the relevancy of sexual orientation when caring for the lesbian patients (Westerståhl, Segesten and Björkelund, 2002). This study reveals that some GPs consider that lesbianism is not an issue in their practice as:

I work as a GP and not as a psychiatrist or a psychologist (Westerståhl, Segesten and Björkelund, 2002:205).

or

I cannot think of any disease that is related to whether you are lesbian or not (Westerståhl, Segesten and Björkelund, 2002:205).

The second quote is an understandable perspective, as it illustrates an attempt at equality if not diversity. While some physicians may practice from this

standpoint, other studies have pointed out that lesbian women have specific STI health needs of which physicians need to be aware (Marrazzo, Coffey and Bingham, 2005; Spinks, Andrews and Boyle, 2000). Studies have also pointed to the health risk behaviours of lesbian women such as unsafe sex, which could lead to STIs and in some cases HIV (White and Dull, 1998; Rankow, 1995).

Spinks, Andrews and Boyle (2000) point to the transmission of infection through vaginal fluid, in particular when sex-toys are shared. It has been found that *“monilial and bacterial vaginitis are common in lesbian women”* (Spinks, Andrews and Boyle, 2000:140). Part of the problem in dealing with woman-to-woman sexually transmitted illnesses, is the belief by lesbian women that they are not relevant. This is in part rooted in the original perception that HIV/AIDS was a gay man’s disease (Altman, 1986; Patton, 1985), and later seen as predominately a heterosexual disease. These studies counteract the idea that all women are the same and therefore can be treated the same.

However, while it is recognised that all medical recommendations for women apply to lesbian women; it is an understanding of the similarities and differences between lesbian and heterosexual women that will create better health care (Dibble, Roberts and Nussey, 2004; Rankow, 1995; Roberts and Sorensen, 1995). It is not necessarily relevant whether a woman is a lesbian or a heterosexual, but simply being a woman can put one at risk for certain conditions such as breast cancer (Dibble, Roberts and Nussey, 2004; Boehmer, 2002; Spinks, Andrews and Boyle, 2000). The respondent’s announcement that they (doctors) are not a *‘psychiatrist or a psychologist’* (Westerståhl, Segesten and Björkelund,

2002:205), fits into the old medical definition of lesbianism being in need of mental health facilities. While homosexuality has been removed as a medical category of mental illness, it has not been deleted from the psychics of all physicians.

3.5 Inclusive language

While lesbianism was hidden, individuals had to deal with the subject, regardless of profession. This may point to the real problem. Today, lesbian women are no longer speechless or invisible. Consequently, visibility in and of itself creates problems for those whose assumptions are rooted in heterosexuality. One GP indicated that in his practice:

we have in our declaration that we treat people of all sexual orientation as well as colours, so people have it in black and white that they shouldn't be discriminated against when they come here (Male 4313c, age 42 years quoted in Hinchliff, Gott and Galena, 2005:350).

It would appear that some clinicians need updating of their communication skills, particularly when others are already practising from an inclusive stance. Hinchliff, Gott and Galena (2005) also report that experiential learning¹³ was a preferred option for some of the participants in their study. This could put lesbian women and gay male patients in a precarious situation and make them vulnerable to discrimination as not all health care professionals may be open to discussing lesbian and gay life.

This calls into question whether lesbian women and gay male patients should also act as educators for health care providers (that is, educate health care professionals on the culture of lesbianism) and not only be recipients of health

¹³ By experiential learning Hinchliff, Gott and Galena (2005) mean learning from experience that is learning about lesbian or gay life by meeting and conversing with a lesbian or gay man.

care. Some studies have found that lesbian women do become educators for health care providers, which has led to both positive and negative health care outcomes (Saulnier, 2002). It has also been suggested that access to health care is more inclusive when heterosexual language is removed from routine questions and history-taking, and replaced it with gender-neutral language. Thus, terms such as 'life partner', 'significant other' or 'domestic partner' could facilitate lesbian women in disclosing their sexuality (Bonvicini and Perlin, 2003; Saulnier, 2002; Taylor, 1999; Walpin, 1997).

Richmond and McKenna (1998) suggest that homophobia is an inappropriate concept to be utilising in a nursing perspective, as it does not have the same outcomes as other phobias in the medical profession, such as haematophobia (fear of blood) or alogophobia (fear of pain), have particular physiological sequelae. While homophobia does not have this clinical characteristic, Richmond and McKenna (1998) suggest that it is an experience that some heterosexuals have, resulting from societal attitudes towards homosexuals. These attitudes range from fear to hatred, leading to social isolation and discrimination of lesbian women. Lesbian women's health care has been influenced by cultural assumptions about homosexuality whether they are based on religious, legal or normative grounds (O'Hanlan et al, 2004; Bonvicini and Perlin, 2003; Giddings and Smith, 2001; Diamant, Schuster and Lever, 2000; Richmond and McKenna, 1998) as discussed in chapter two.

Young (1990) suggests that while equality legislation exists in most societies, it is hard to eradicate homophobia. Straight identity is destabilised by the existence of

lesbian women and gay men, as it implies that anyone at all could turn out to be a lesbian woman or a gay man. Saulnier (2002) indicates that homophobia has a clinical psychological root that categorises it as a mental illness. Such a categorisation renders the homophobe non-responsible for their actions, as they cannot help it. Through the medicalisation of homophobia, a medical 'condition' was created providing society with a loophole for not dealing with the social consequences of the phenomenon. One of which is the non-acknowledgment of diversity.

3.6 Training for sensitivity to diversity

Awareness and good communication can lead to both satisfactory care and compliance of patients with medical advice (Kiss, 2004; Taylor, 1999; White and Dull, 1998). Johnson and Guenther (1987) had argued earlier that good communication and compliance with medical regimes necessitate lesbian women's 'coming out' to their health care provider. They further contend: "*a gay person will have difficulty in developing an honest relationship with any individual unless sexual orientation is revealed*" (Johnson and Guenther, 1987:1234). However, having an honest relationship is a reciprocal process: a lesbian woman can only feel safe in disclosing her sexuality when the knowledge of doing so will lead to a non-compromising health care outcome. Where there are lesbian-friendly health services¹⁴, the uptake on preventative health care is higher (Bonvicini and Perlin, 2003; Diamant, Schuster and Lever, 2000). In other

¹⁴ The Women's Community Clinic in San Francisco is one such clinic that offers lesbian friendly health care services. Their mission is to improve the health and well-being of all women. Another is The Gay, Lesbian, Bisexual, and Transgender (GLBT) Health Access Project which is a community-based effort in the Massachusetts Department of Public Health. The GLBT Health Access Project works with GLBT populations. They provide training, technical assistance and materials to agencies across the state to help service providers learn more about the health care needs of GLBT populations and create welcoming environments for staff and clients.

words, it is easier to look after one's health if there is no fear of discrimination or prejudice. King (2003:687) suggests that the:

instances of failure stem from simple ignorance on the part of professionals about human sexuality, sexual orientation and lesbian and gay development throughout the lifecycle, and the subculture of gay and lesbian communities.

He further indicates that this can be remedied through "*education and training*" as this facilitates the "*lack of experience and knowledge*" (King, 2003:687). Clinicians should be trained and educated in developing communication skills, gender-neutral language and attain a non-judgmental attitude (Kiss, 2004; Marrazzo and Stine, 2004; Bonvicini and Perlin, 2003) which can accommodate diversity.

When seeking health care it has been found that lesbian women request information on the providers' level of training, understanding and experience of providing health care to a lesbian women client group (Saulnier, 2002). Equally they seek health care providers who "*listen*" and are "*knowledgeable, competent understanding and sensitive to lesbian issues*" (Robertson, 1992:161). While the recommendations by Kiss (2004), Marrazzo and Stine (2004) and Bonvicini and Perlin (2003) appear to be specific to lesbian women and gay men, all client groups, regardless of age, socio-economic status, ethnic background or sexual orientation would benefit from health care professionals who have these skills (Thiede, 2005) for interaction with a diverse client population.

3.7 Nurses' perceptions of lesbian women

Bradshaw (1998) suggests that the training of nurses from a traditional vocational to a third level academic model, has moved the nursing profession to a social

science model of caring rather than a scientific model like medicine¹⁵. A social science model of caring suggests that nursing practice take cognizance of the identity and social experience of the patient, which informs the outcome of the nurse-patient relationship. In this way the patient::

not just as the object of clinical practice and administrative procedure, but also as an experiencing subject, has exerted a powerful set of forces on interactions that take place between individual nurses and their patients (May and Pukis, 1995:286)

Bégat and Severinsson (2001) agree with this, indicating that this shift has taken place and arguing that nursing care has progressed from task-centered to patient-centered care.

Three categories of barriers to nursing care have been identified: “*human barriers, barriers created by the culture of nursing and administrative barriers*” (Yam and Rossiter, 2000:297). The first two barriers are pertinent to this study. ‘Human barriers’ are created by nurses themselves and are threefold: firstly, in relation to nurses, “*lacking knowledge, experience, confidence and autonomy in care, negative attitudes and personality*”; secondly, their colleagues’ “*attitudes and peer pressure*” and thirdly, their patients’ “*attitudes and expectations*” (Yam and Rossiter, 2000:297). The nurse-patient relationship is a two-way process where the nurses’ and patients’ attitudes influence the quality of care. Caring has been described as a “*complex human process in which there is a relationship between carer and cared for*” (Buchanan and Ross: 1995:4). The nature of caring involves a relationship between two or more people; it is the nature of this relationship that will influence the quality of the care provided. The literature on

¹⁵ This model of nursing training has also taken place in Irish nurse education. Fealy (2006) provides a detailed historical account of the history of nurse training in Ireland. It has moved from a “*religious-pastoral*” model to the modern “*secular-professional*” model of today

nursing care has identified two elements involved in nursing care, namely instrumental care and expressive care.

Instrumental care refers to what practitioners do, and their predetermined actions which may objectify patients, expressive caring includes emotional elements, which reflects a commitment to values of respect for the individual, their identity and specific needs (Mackintosh, 2000:323).

While the identity of the individual must be respected, the cultural definition of woman based upon heterosexuality creates difficulty for lesbian women (Rich, 1999).

3.7.1 Nurse-patient relationship

Nursing research has identified three dimensions of nurse-patient relationships. Firstly, "*knowledge of the patient as an actor participating in a social world*" (Bégat and Severinsson, 2001:71). Nurses no longer view the patient as a set of medical definitions that need nursing care for recovery, but rather see that the patient is an active participant in their social world, including the medical world, and therefore in their nursing care. Patients as active participants bring with them their own interpretations and meanings of illness. They will impute meanings on their recovery and in so doing patients actively participate in both medical and nursing interventions. When patients are removed through hospitalisation from the social world in which they belong, know how to act, behave and fit in, the patient is forced to renegotiate their surroundings. To be an active participant in a new social setting, patients must recreate and interpret their social world, which is that of the hospital with its own rules and regulations. It is through the nurse-patient relationship that a new definition of the situation can be established. It can be argued that most individuals will have an experience of the hospital setting as

visitors, but it is a different reality to be a patient. As a visitor, the individual can move in and out of the situation, but as a patient the individual is forced to renegotiate the reality. It is the experience of this reality, that may differ for lesbian women compared with other women patients, which will be examined through their experiences detailed in chapter six.

The second element of the nurse-patient relationship is "*reciprocity in which both nurse and patient communicate with each other*" (Bégat and Severinsson, 2001:71). For a relationship to exist, at least two actors, who willingly participate in its formation, are needed. It is the nature of this communication that creates the interactive order and defines the nature of the nurse-patient relationship. May and Pukin (1995:287) indicate that the positioning of the interaction is set up prior to any communication taking place, suggesting that positioning itself "*involves negotiating terms for engaging in particular kinds of relationships and determining the agendas and boundaries of the encounter*". Thus, the nurse, through positioning, has power within the relationship as s/he determines the boundaries and the terms of engagement. This power has two facets: firstly the nurse holds knowledge about the patient's medical condition, and secondly s/he determines how communication takes place. The third aspect of the nurse-patient relationship identified, entails nurses needing managerial skills to carry out "*specific objectives of nursing care*" (Bégat and Severinsson, 2001:71).

Nursing care has moved from the patient being treated as "*a biological object whose body was observed. the nurse was part of the machinery of surveillance which described and thereby objectified the body it monitored*" (Armstrong,

1983:458). The nurse-patient relationship is no longer one of objectivity (in the Foucauldian sense), but one of subject-object, whereby the patient becomes an active participant rather than a passive recipient of nursing care. The patient must become an inter-subject, thus seeing herself as others, in this case nurses, see her. This has obvious implications for the lesbian patient, insofar as if the nurse's view of lesbian women is negative, then the lesbian patient may view herself negatively. This will affect her response to nursing care and ultimately her recovery. Similarly, if the nurse's attitude is positive, the lesbian patient will have positive feelings towards herself and towards the nursing care she receives, thus rendering the nurse-patient relationship a successful encounter.

3.7.2 Nursing students

Research has shown that nurses "*often fear that lesbian patients will try to 'make a pass'*" (Jones, 1988:48). Brogan (1997) also found this to be a dominant theme in her study of nursing students' attitudes towards lesbian women. In particular nurses fear or think that they [lesbian women] like to seduce heterosexual women. Student nurses "*recommended 'keeping a distance' from all lesbians to 'protect' themselves from 'overly friendly' lesbians who will 'make eyes at you'*" (Brogan, 1997:40). The implication is that no matter how ill a lesbian woman may be, she still has enough energy to make a 'pass'. This results in stereotyping lesbian women as sexual fiends with insatiable sexual appetites from whom no heterosexual woman is safe. As a result, one can legitimately pose the following questions: Do nursing students feel threatened by male patients? Do male patients 'make eyes' at them? Do male patients 'like to seduce' nurses or make a

'pass' at them? Through the socialisation process prior to entering the nursing profession, they have been equipped with the skills of the heterosexual dance.

White (2002) indicates that there are also concerns around inappropriate heterosexual sexual contact in the nurse-patient relationships. Touch is central to the physical aspect of nursing care, and it is the interpretations of touch that can lead to inappropriate behaviour on the part of both patients and nurses (White, 2002). She points to research on the sexual harassment of nurses by male patients, suggesting that nurses should be aware of the sexualisation of nursing as a profession. While such advances may be inappropriate, they point to the reality that heterosexuality is the norm, so nurses should be aware of unwanted advances. Faced with lesbianism, student nurses revert to societal prejudices and stereotypes when dealing with lesbian patients. This points to a socialisation process within society that lacks the ability for the subject of diverse sexualities to be explored, for instance, through the curriculum in nursing studies.

Mackintosh (2000) indicates that the values and beliefs student nurses bring with them into the nursing profession, may be added to and transformed by the socialisation process they undergo through training, and later, as practitioners. Through the socialisation process, the student nurse will learn the cultural norms and beliefs of nursing, how to fit into that culture and incorporate such knowledge into practice.

Socialisation processes have a fundamental impact on the nature of care, for whether care is regarded as an innate human trait, a moral or spiritual imperative or part of a reciprocal relationship, and regardless of its physical or expressive nature, the care which nurses provide is shaped by the socialisation nurses experience (Mackintosh, 2000:323).

The socialisation process will not only reflect the norms, values and belief systems of the society in which nursing resides, but those of the nursing profession.. Lesbian nurses, wherever they go as members of the nursing profession they must be recognised as such by their fellow professionals and society as a whole. *“Perhaps the most important effect of professional socialization is its function as a process, by which disparate actors learn things in the same way”* (May and Purkis, 1995:285). Thus, Irish cultural norms, values and beliefs (see chapter two) may well be reflected in the nurse-lesbian relationship.

Spinks, Andrews and Boyle (2000) suggest that providing competent health care to lesbian women starts before they become patients. Keighley, 2002 and Spinks, Andrews and Boyle, 2000 have argued that nurses should be aware of their own attitudes towards lesbianism, and take steps to rectify the situation if it is warranted. However, nurses were ill-prepared in the past to provide care for lesbian women patients (White, 2002; Morrissey and Rivers, 1998). When lesbian women’s health care is introduced as a topic, negative results have been reported (Harrison, 2001). One such study by Harrison (2001) reflects these attitudes. She indicates that when students on her postgraduate course in gerontology were introduced to lesbian women’s care it provoked comments such as:

But it’s none of my business (Harrison, 2001:143).

or

It’s only their needs that matter, just treat people the same, don’t ask or think about sexuality (Harrison, 2001:143).

If we do not know about people’s sexuality then we do not have to deal with it.

Based on the findings of the above-mentioned studies it is clear that there is resistance from both undergraduate and postgraduate students in dealing with the issue of lesbian women's health care. Whether it portrays itself as covert or overt prejudice, it would appear easier for students not to be confronted with diverse sexualities. Formerly nurses were ill-prepared. When attempts are made at postgraduate level to introduce the topic, it can elicit negative responses from students. Some may absent themselves for that particular class, or overtly reject the need for any education on the topic (Harrison, 2001; McKelvey et al, 1999). As in chapter two, Lynch and Lodge (2002) indicate that in the Irish educational system, there was institutional invisibility of lesbian women and gay men. Young girls and boys are socialised into heterosexuality. They learn the rules and negotiating skills around opposite sex relationships, which does not exist for young lesbian women (Lynch and Lodge, 2003; Lynch and Lodge, 2002; Inglis 1998b; Ryan, 1997). Invisibility leads to fear and stereotyping (Lynch and Lodge, 2003; Lynch and Lodge, 2002), and lack of diversity socialisation in nursing, leads to an inability by nurses to care appropriately for lesbian women who are patients (Stevens, 1998).

In contrast to the Irish situation, Røndahl, Innala and Carlsson (2004) report positive attitudes in their study on Swedish nursing attitudes towards lesbian patients. They found that registered nurses are more positive than assistant nursing students. The perceived 'cause' of homosexuality reflects the attitudes of nurses. When nurses perceive it to be congenital then a positive attitude ensues, whereas if nurses believed the cause of homosexuality to be acquired then negative attitudes result. However, Røndahl, Innala and Carlsson (2004:390)

postulate that "*life experiences and education*", may explain why registered nurses are (Röndahl, Innala and Carlsson, 2004:390). McKelvey et al (1999) utilise a questionnaire suggesting one of the problems with using questionnaires, is that the research did not establish whether negative attitudes translated into negative patient care outcomes. We have seen that studies that utilise a qualitative approach prove this may be the case (Marrazzo, Coffey and Bingham, 2005; Scherzer, 2000; Steven, 1998; Robertson, 1992). This reinforces King's (2003) assertion that education and training of health care professionals can facilitate an understanding of diverse sexuality in health care, but it begs the question whether education alone can change attitudes.

Wilson (1999) argues that nurse education centres may not be the best environments to dispel stereotypes and prejudice, as these educational centres may unwittingly facilitate such attitudes. Walpin (1997:130) suggests that what is really needed, is for nurses "*to become aware of their biases because negative attitudes may prevent gay and lesbian individuals from seeking appropriate medical care*". In fact Morrissey and Rivers (1998:490) suggest that the "*Mims-Swenson Sexual Health Model*" should be employed in nurse education. This model developed from an exploration of student nurses' own attitudes and belief systems about sexual orientation to the provision of health care. If these suggestions were incorporated in nurse education, then there would be no need for lesbian women to feel that when their sexuality was disclosed it would lead to substandard nursing care.

However, it is also recognised that education in and of itself may not change deeply held attitudes (Morrissey and Rivers, 1998), but it may enable nurses to practise from a non-biased position. Morrissey and Rivers (1998) further suggest that if student nurses can explore their own sexuality norms in a non-judgmental manner, this may translate into practice as they have experienced non-judgment and therefore can put this experience into practice. It may lead to positive outcomes, whereby nurses can utilise their professional position as role models in the health care setting, to demonstrate acceptance of lesbianism and challenge those who do not (Spinks, Andrews and Boyle, 2000; Shelby, 1999). There is also the suggestion that nurses can challenge the stereotypes that abound in the profession (Spinks, Andrews and Boyle, 2000; Shelby, 1999; Morrissey and Rivers, 1998).

In addition, nurses are responsible for ensuring that nursing standards are not lessened because of a person's sexual orientation (Wojciechowski, 1998; Morrissey and Rivers, 1998). Wilson (1999:18) has recommended that nurses should practice from the standpoint of "*Open-mindedness, acceptance and tolerance*", as these are the underpinning principles for caring for those who "*do not share one's own values, beliefs, attitudes and behaviours*". The onus for providing good health care is on the nurse, and s/he is responsible in dealing with her/his fears and prejudices in relation to lesbianism, rather than it being the lesbian woman's responsibility to assure nurses of their personal 'safety'.

3.7.3 Lesbian nurses

While most studies focus on lesbian women's experience of health care, only a few deal with lesbian women's experiences of being nurses in the health care system (Giddings and Smith, 2001), or with their contribution to nursing care (White, 2002). Giddings and Smith's (2001) study in the United States of America suggests that lesbian nurses do not 'come out' at work, as they are aware that the nursing environment can be homophobic.

Jane is not out to her patients and considers hospitals an unsafe place for persons who want to be open about their sexuality (Giddings and Smith, 2001:15).

Another respondent informed them that she chooses when and where to disclose her sexuality.

Maggie chooses when to be 'out' in her job because she is aware that 'society and equally the health care environment, especially nursing, is homophobic' (Giddings and Smith, 2001:16).

This study reflects the experiences of patients: if lesbian nurses feel 'unsafe' in disclosing their sexuality in the workplace for fear of prejudice then what environment will lesbian patients, vulnerable through illness, be subjected to?

While lesbianism is very visible in the nursing work environment through jokes, stereotypes and gossip, invisibility exists through either self-imposed or socially-imposed closeting (Giddings and Smith, 2001). This may be explained from the

viewpoint that "*Few lesbians are able to escape the social stigma of having a sexual identity at odds with current mainstream cultural values*" (Beals and

Peplau, 2005:146). Closeted lesbian nurses can collude with other health care

professionals through participating in rituals that lead to stereotyping in order to

keep their secret, thus conforming to the expectations of the dominant group

(Giddings and Smith, 2001), and thereby avoiding stigmatisation because of their

lesbian identity. While they are avoiding overt discrimination by collusion, they are experiencing direct discrimination by being forced to remain closeted.

For lesbian nurses to 'come out' in the work environment requires basic trust, namely, trust in:

one's world and especially in the persons who are its interpreters is crucial to one's sense of identity. It is for such reasons as these that shame may be said to go deeper than guilt; it is worse to be inferior and isolated than to be wrong, to be outcast in one's own eyes than to be condemned by society (Lynd, 1958:207).

Through the internalisation of society's fears and anxieties about lesbianism, the lesbian woman may succumb to a feeling of shame, as Sartre (1969:222) puts it, "*I am ashamed of myself as I appear to the Other*". Shame is internalised and can be dealt with by the self; guilt on the other hand can be sanctioned by society and penalised. Guilt finishes as it is the price paid for wrongdoing. In contrast, shame can arise out of an 'if-others-knew' syndrome, that is, "*we always imagine and in imagining share the judgments of the other mind*" (Cooley, 1968:90). Through gossip and jokes the imagined judgments of the 'other mind' become a reality.

Lesbian nurses are aware that they lack the social support and understanding from their work colleagues, which is necessary for the maintenance of self-esteem (Beals and Peplau, 2005). It has been suggested that, "*identification with the majority culture does not preclude identification with the minority culture, and vice versa*" (Fingerhut, Peplau and Ghavami, 2005:130). Therefore, one may act in a social situation in a way that leads to the best outcome for the individual. By presenting oneself as an acceptable member of the majority culture, the lesbian

woman is risking the outcome of a disclosure. Plummer (1975), in his interactionist study of gay men's life in England, reinforces this point:

Through interaction he builds up commitments, perspectives, 'world-taken-for-granted views' and a stable self-conception, all of which lend a precarious stability to his social world (Plummer, 1975:40).

If a lesbian nurse carries out her performances in work effectively, other nurses will not question her validity. But through the stereotypes, jokes and gossip the lesbian nurse faces "*unwilling acceptance of her [him]self by individuals who are prejudiced against persons of the kind s/[he] can be revealed to be*" (Goffman, 1963:58) Therefore the lesbian nurse tends to remain closeted and silent.

Shelby (1999) suggests that lesbian nurses should 'come out', arguing that while disclosure can be fraught, the health benefits are greater. Equally, she indicates that if 'reputable' nurses 'come out', this would lead to other nurses questioning their biases. This however, is problematic: who decides who is 'reputable'? Moreover, there is no evidence that people question their biases based on new information (Harrison, 2001; Wilson, 1999). In 39 states of the United States of America, lesbian women and/or gay men can be discriminated against in recruitment to employment based on their sexual orientation (O'Hanlan et al, 2004). It would appear that the lesbian nurses in Giddings and Smith's (2001) study, had good reason to remain in the closet and pass themselves off as heterosexuals. Most lesbians have had a lifetime experience of passing as heterosexuals, beginning from the moment they recognised their sexuality (Harrison, 2001; Shelby, 1999; Wilson, 1999). However, this has been described as lesbians living a 'dual-identity', participating both in heterosexual and lesbian worlds (Fingerhut, Peplau and Ghavami, 2005). Dual-identity has also been

perceived as living “*two lives*”, one that derives out of economic necessity, and the other in which lesbian women are socially connected with other lesbian women or others who affirm lesbian women’s existence (Bradford, Ryan and Rothblum, 1997).

Some lesbian nurses have argued that lesbian nurse lecturers/teachers should be visible to their students (Giddings and Smith, 2001). While participants in Giddings and Smith’s (2001) study talked about the necessity to ‘take care’ of themselves in their work environment because of both overt and covert discrimination, whether they were out or closeted, it is somewhat disingenuous to suggest that those working in schools of nursing would be any safer from discrimination. It was also noted that:

As with other forms of social injustice within nursing, it is not the sole responsibility of the marginalized group to educate and raise the consciousness of the dominant mainstream culture (Giddings and Smith, 2001:14).

Stereotypes reinforce heterosexuality and the language used to construct negative images of lesbian women such as ‘men-haters’, ‘feminists’ or ‘wanting to be men’ reinforces the norm (Giddings and Smith, 2001).

“Woman reinforces a covert belief in the unification of ‘woman’, of all women as the same” (McDonald, McIntyre and Anderson, 2003:699). Diversity amongst women, whether based upon ethnicity, socio-economic circumstances or sexual orientation, is negated. “Any person who represents or symbolizes a different image risks discrimination, oppression, dismissal or erasure” (Ponticelli, 1998:1). The language of ‘de-womaning’ lesbian women, serves as an effective mechanism in alienating them from heterosexual women. Relying on the educational system

alone may not counteract this situation as change also needs to happen in the wider cultural arena. The positive results from Swedish research (Röndahl, Innala and Carlsson, 2004), reflects laws that prohibit discrimination based upon sexual orientation. Ireland has also introduced laws to combat discrimination in the Equal Status Act, 2000. This research will indicate if Irish equality legislation has had a positive influence on lesbian health care outcomes, and whether they create safe working environments for lesbian nurses.

3.8 Concluding remarks

Brogan (1997) and Robertson (1992) indicate that the invisibility of lesbians in health care arises out of the assumption that all women are heterosexual. This is reflective of the findings in chapter two whereby lesbian women were invisible in institutions of society such as religion and education. Societal views on what is “normal” and “natural” sexuality” are reflected in the health care profession (Taylor, 1999). While other countries such as Britain, the United States of America and New Zealand have begun to grapple with the issue of lesbian women’s health and health care, *a knowledge gap still exists in Ireland, and this is reflected in health care on the ground.*

Research indicates that health care professionals hold and express judgemental attitudes about the sexuality of their patients/clients; assumption of heterosexuality, lesbianism as being non-normative (Tiemann, Kennedy and Haga, 1998; Roberts and Sorensen, 1995; Stevens, 1995). Health care professionals also make judgments on sexual identity and sexuality [sexual practice] (Marrazzo, Coffey and Bingham, 2005) and age-related assumptions

about a woman's awareness of her sexual orientation. This affects the perceptions of the lesbian women accessing their services (Fields and Scout, 2001; Gruskin, 1999).

This study examines whether the findings in this literature review are reflected in the lived experiences of lesbian women of health care in Ireland. Equally it investigates the lived experiences of lesbian nurses as health care professionals. The following chapters will analyse the epistemological framework and methodologies that underpin this study.

Chapter 4: *Research Theory*

4.1 Introduction

I argue that different research methods answer different research questions and use different research perspectives and different types of data according to the question asked. These choices determine the kinds of research outcome so that one's research methods should be made cautiously and consciously from a broad range of methodological options within the context of the nature of the type of results desired or knowledge sought (Morse, 1999:393-394).

The research method I have chosen to fully answer all aspects of the research questions is taken from the phenomenological perspective, particularly the hermeneutical or interpretative phenomenology. This enables me, as Morse (1999) indicates, to obtain the knowledge that I require, that is, knowledge of the lived experience of lesbian women as consumers of health care and lesbian nurses' experiences as providers of health care.

Prior to discussing how I will carry out this research, it is necessary to place it within the epistemological (theories of knowing) and methodological (theories of doing) traditions I intend to use. Within the field of sociology there are two distinct traditions that make claims about the status of knowledge, the positivist and the interpretative.

4.2 Positivist tradition

Positivism claims that there are appropriate methods whereby the researcher can produce knowledge that is objective and value-free. Positivism also claims that research from this perspective is bias-free and unaffected by the world-view of the researcher (Taylor, 2001). Knowledge obtained can be generalised and universal and other researchers can reproduce the same results. As O'Brien (1993:7) states,

positivism is "a view of sociology as a progressive, cumulative, explanatory 'scientific' project". Thus, positivism in sociology is associated with the physical sciences and was expounded by Durkheim and Comte. Jones (2003:32) suggests that Durkheim "wanted to create a science of society to generate knowledge necessary to show how this could be done". A scientific positivist guiding principle is that if something exists in nature, then it is caused by something else in nature. Equally for Durkheim society consists of 'social facts', that are external to and constraining upon the individual (Ritzer, 2000). - We do not create society, rather society creates us, and our ideas and actions are products of social forces.

Society is more than the individuals who compose it; society has a life of its own that stretches beyond our personal experiences. Society was here long before we are born; it shapes us while we live, and it will remain long after we are gone (Macdonis, 2005:107).

A Durkheimian approach is interested in the collective; there is no place for the individual lived experience of the world. Durkheim's view of the individual in society can be seen as deterministic. If society shapes us then we have no control over our own destinies.

Durkheim's project was to create a scientific study of society, which would be achieved through choosing methods that lead to objectivity. These methods were borrowed from the natural sciences, utilising their language such as control of variables, causal relationships and correlations that were quantifiable (O'Connell Davidson and Layder, 1994). Positivists proposed, that by following the methods of the natural sciences they could expose external truth(s) about the social world.

4.3 Interpretative tradition

The second tradition of inquiry is interpretative, which emanates from the work of Weber (1971). Interpretative researchers look “*for culturally derived and historically situated interpretations of the social world*” (Crotty, 2005:67). They reject the idea that external truths can be revealed; rather, they seek to understand “*what meaning and what significance the social world has for people who live in it*” (O’Brien, 1993:7). Unlike the positivists who thought that society already existed and individuals ‘fitted’ into society, the interpretative tradition believes that individuals create and recreate the social world around them. Individuals in society act in a certain way because it holds meaning for them, creating a meaningful world around them, thus creating their own social reality (Haralambos and Holborn, 1995).

‘Society’ does not act, persons do. Actions have the essential property of meaning. What is being done, by whom and with what purpose are all matters which persons, ‘social actors’, make sense of in producing their own actions and in responding to the actions of others. From this point of view, then, meaning and understanding are not incidental to social life, they create or constitute it (Cuff, Sharrock and Francis, 1990:141)

The interpretative tradition stipulates that a sociological analysis of society must begin with the individual, their understanding of and place within the social situation (O’Brien, 1993; Cuff, Sharrock and Francis, 1990; Coser, 1971). An action cannot be a social action, unless an individual thinks about it and considers the reactions of others.

Therefore, from Weber’s perspective, an action can only be considered social if it goes through a process of consciousness, and is reflected upon in relation to others (Haralambos and Holborn, 1995).

Action is social in so far as, by virtue of the subjective meaning attached to it by the acting individual (or individuals) it takes account of the behaviour of others and is thereby oriented in its course (Weber 1971:128).

Weber postulated that individuals are thinking, reasoning human beings who attach meaning to their actions (Marsh and Keating, 2000). “*Meanings do not have an independent existence, a reality of their own which is somehow separate from social actors*” (Haralambos and Holborn, 1995:815). Meanings are not imputed by external forces such as religion or current ideologies, but are created and recreated by individuals acting within society. The researcher has to try to understand the beliefs that people hold and the meanings that people attach to actions.

Weber put forward his concept of *Verstehen*, to achieve a mechanism for interpreting social actions and the meanings of those actions. *Verstehen* involves understanding social action from the perspective of the social actor, the meanings that resulted in the action, which can only be achieved if the researcher can empathise with the situation:

We can understand (verstehen) human action by penetrating to the subjective meanings that actors attach to their own behaviour and to the behaviour of others (Coser, 1971:220).

Ritizer (2000) points out that there are debates about whether Weber meant *Verstehen* to be understood on the micro or macro-level of analysis. He concluded that Weber utilised it in both ways. *Verstehen* leads the researcher to be concerned with the inner subjective world of human beings rather than the collective. Weber regarded *Verstehen* as “*doing systematic and rigorous research rather than simply getting a “feeling” for a text or social phenomenon*”; it is a “*rational procedure for study*” (Ritizer, 2000:112).

Weber (1971:128) defines sociology as:

a science which attempts the interpretive understanding of social action in order thereby to arrive at a causal explanation of its course and effects.

He indicates that individual actions emanate from the meaning and understanding that individuals attributed to their actions. He views human action as intentional and rational with a means-end orientation (Swingewood, 1991), and the method(s) of social research must facilitate the relationship between meaning and action. Weber asserted that a methodology based upon a scientific explanation of social action was possible, thus generating 'laws' or causal explanations for social action. However Cuff, Sharrock and Francis (1990:142) suggest that this is impossible, as researchers whose:

emphasis on the centrality of meaning and understanding find major difficulties (some would say insurmountable difficulties) with the notion that sociological explanations should take the form of general laws.

Therefore, the meanings and understandings that individuals attribute to their actions are not generalisable.

4.4 Understanding the social world

Out of these two perspectives for understanding the social world emerged that of symbolic interactionism and that of phenomenology. Symbolic interactionism has its roots in George Herbert Mead and was further developed by his student Blumer. It is an American "*perspective on life, society and the world*" (Crotty, 2005:72). It rests on the investigation of the meaning of experiences as an exploration of culture. Ritzer (1992) indicates that symbolic interactionism derives from the philosophical position of pragmatism. He suggests that the following three points are central to symbolic interactionism:

1. *a focus on the interaction between the actor and the world,*
2. *a view of both the actor and the world as dynamic process and not static structures,*
3. *the great importance attributed to the actor's ability to interpret the social world (Ritzer, 1992:327).*

By interpreting the social world the individual gives meaning to social interaction.

Symbolic interactionism suggests that these meanings are not universal, but rather that individuals give meanings to things. Blumer (1969:4) suggests that symbolic interactionism sees:

meaning as arising in the process of interaction between people The meaning of a thing for a person grows out of the ways in which other persons act toward the person with regard to the thing.

The individual defines the thing rather than having the definition ascribed for her/him.

Meanings are social products, which are not created in isolation; they are products of interpretations of the actions through a process of reflecting on the actions. Individuals give meaning to the situation in which they find themselves in; this is informed by both cultural norms and expectations. Therefore, a similar interaction in a different culture may lead to different meanings. Blumer (1969) suggests that we use the meanings that we derive from past situations, to guide us in further actions in similar situations. If we want to investigate the meanings that people have towards things or situations, such as lesbian women's encounters in health care, we do so from the point of view of individuals.

However, this has been criticised as leading to a methodology that describes the meaning that individuals give to things. In other words researchers must be able

to put themselves in the other person's social world rather than critically analyse imputed meanings.

Methodologically, symbolic interactionism directs the investigator to take, to the best of his ability, the standpoint of those studied (Denzin quoted in Grotty, 2005:75).

Consequently, chapter three provides examples of how lesbian women behave when they are interacting with health care professionals. Past positive or negative experiences informs how they will act within their next encounter (Gilson, 2003; Saulnier, 2002; Stevens, 1996). The lesbian woman brings with her the meanings she derived from encounters, taking those meanings into the next encounter.

As we have seen, lesbian nurses are aware of how their colleagues perceive lesbianism and their interactions are predicated upon this (Fingerhut, Peplau and Ghavami, 2005; Giddings and Smith, 2001):

The individual takes not simply the attitudes of others towards him/her but seeks to integrate the 'whole social process' into individual experience (Swingewood, 1991:266).

Timasheff and Theodorson (1967:242) elaborate on this when they suggest that:

The social world is not self-ordered, and meaning is not inherent in behaviour, rather, the significance of a particular behavior is the meaning people attribute to it.

The method I will be adopting stays within this tradition of interpretative sociology. It is derived from the phenomenological approach, as I seek to understand the meanings that lesbian women generate from their experiences as services users and lesbian nurse's experiences of working in the environment of Irish health care.

4.5 Phenomenology

The phenomenological approach is primarily descriptive, seeking to illuminate issues in a radical, unprejudiced manner, paying close attention to the evidence that presents itself to our grasp or intuition (Moran, 2002:1, emphasis in the original).

Phenomenology seeks to understand a phenomenon as it presents itself to us as conscious human beings. Social experiences, things (inanimate objects) and events have no meaning in and of themselves; they only hold meaning because human beings confer them with meaning (Jones, 2003), (see chapter two for a discussion of this). This is why phenomenology has been described “as a human science, the purpose of which is to describe and understand particular phenomenon as lived experience” (Cutcliffe, Joyce and Cummins, 2004:308). “In other words a phenomenological study “describes the meaning of the lived experiences for several individuals about a concept or the phenomenon” (Creswell, 1998:51 emphasis in the original).

Phenomenology emphasises:

- *subjectivity (rather than objectivity)*
- *description (more than analysis)*
- *interpretation (rather than measurement)*
- *agency (rather than structure)* (Denscombe, 2003:96).

A phenomenological study is concerned with people’s “*perceptions or meanings, attitudes and beliefs, feelings and emotions*” (Denscombe, 2003:96). It is concerned with how individuals experience a phenomenon, how they describe, interpret and understand the phenomenon under investigation. Thus, the lived experience:

is the ‘originary’ way in which we perceive reality. As living persons, we have an awareness of things and ourselves which is immediate, direct, and nonabstractive. We ‘live through’ (erleben) life with an

intimate sense of its concrete, qualitative features and myriad patterns, meanings, values and relations (Ermarth quoted in Bergum, 1989:56).

Bergum (1989) indicates that the lived experience goes beyond the taken-for-granted characteristics of life. It is the interpretation and meanings that individuals give to everyday life experiences. We act towards things based on the interpretations and meanings we have given to previous experiences of similar situations. In this way, individuals create their own reality, which may be similar or different, to that of other individuals experiencing the same situation.

Benner suggests that to understand the lived experience we need to go beyond the taken-for-granted explanation and:

uncover meanings in everyday practice in such a way that they are not destroyed, distorted, decontextualized, trivialized or sentimentalized (Benner quoted in Bergum, 1989:57).

As Giorgi (2005:77) indicates, the *“goal of phenomenological analysis, more than anything else, is to clarify the meaning of all phenomena. It does not explain nor discover causes, but it clarifies”*. He further suggests that clarity of a lived state can lead to change, as there can be a discrepancy between what we think we live and/or how we experience life, and the reality of the actual living and/or the experience. *“A discovery of this difference and its correction can lead to more authentic living and interaction with others and thus a better world”* (Giorgi, 2005:77). In other words, a deeper understanding of the lived experience can change a person's reality and what it means to be a human being. A phenomenological study acknowledges that in any one culture multiple realities may exist, and that groups or communities share in these realities. Therefore, it allows for a number of meanings of the same experience to exist that may or may not be shared by others.

The roots of phenomenology lie in the philosophy of Husserl which was further developed by his student Heidegger. Phenomenology is seen as a descriptive study of phenomenon that presents itself to the consciousness, precisely in whatever way it presents itself (Sokolowski, 2000). Therefore, phenomenology is not a set of doctrines but a way of seeing things (Moran, 2000; Palmer, 1969).

4.6 Husserl

Husserl was concerned with epistemology, that is the nature and grounds of knowledge, (Grbich, 1999; Cohen and Omery, 1994; Ray, 1994) stating that the 'definitive basis for knowledge' was experience (Draucker, 1999). He insisted on the superiority of the lived experience as it is experienced over any other form, indicating that all human activities originate and begin with the lived world, and rejecting empirical science's claims that they are the 'only producers of truth' (LeVasseur, 2003; Johnson, 2000). He indicated that the empirical sciences, while objective in their research, could not uncover the phenomenon of the lived experience: "*Phenomenology aims to describe in all its complexity the manifold layers of the experience of objectivity as it emerges at the heart of subjectivity*" (Moran, 2002:1, emphasis in the original). Thus the phenomena of phenomenology include:

all forms of appearing, showing, manifesting, making evident or 'evidencing', bearing witness, truth-claiming, checking and verifying, including all forms of seeming, dissembling, occluding, obscuring, denying and falsifying (Moran, 2002:5).

The phenomena include all facts of the human lived experience, which in turn contain all that is already recognisable as well as what is *hidden* from us.

However, we can unearth that which is hidden through taking detours that will enable us, to uncover the meaning of the lived experience. In other words, the initial meaning of the lived experience can be the “taken-for-granted”¹⁶, but by unpacking it or stripping away the initial meaning, we can uncover that which is hidden (Sokolowski, 2000). Husserl implies that it is the character of the natural world that is hidden from us, because we view it from a natural attitude, which enables us to live in the world. The natural attitude constitutes our normal everyday life and the things in it. Though, Sokolowski (2000:167) indicates that the natural attitude does not give us the whole truth: if we knew everything there would be “*no hiddenness, no vagueness, obscurity, error and ignorance*”

4.6.1 Uncovering the phenomena

In order to approach the lived experience within a philosophical framework, Husserl suggested the use of “*phenomenological reduction, epoché, and bracketing*” to attain the phenomenological attitude (Stewart and Mickunas quoted in LeVasseur, 2003:411). Husserl did not use these three terms as three separate entities; rather, they are interchangeable, referring to “*change in attitude necessary for philosophical inquiry*” (Stewart and Mickunas quoted in LeVasseur, 2003:411). Husserl uses these terms to refer to the reflective process whereby once we put aside our understanding, opinion and prejudice of a phenomenon and go back directly to the experience of the phenomena, we will find new meanings of the phenomenon or at least enhance and validate the meaning we had given to the experience. This is bracketing, or “*phenomenological reduction proper*” (Cohen and Omery, 1994:138), the researcher must set aside their experience of a

¹⁶ The taken-for-granted is that which comes immediate to mind, we do not think or reflect upon it.

phenomenon, so that they will not prejudge or impute pre-conceived ideas about the meaning of a situation or experience (Johnson, 2000; Koch, 1996; Ray, 1994). Thus, one's own experience of a phenomenon will not colour the data. Husserl was looking for the essence of phenomena and indicated that if we were to uncover the true meaning, we had to purge the natural attitude and assumptions that are initially offered. Bracketing thus enables meaning to develop.

Ray (1994) suggests that Husserlian phenomenology was concerned with being *of* the world, and that through bracketing we have no historical or pre-conceived theories to explain the phenomenon under investigation. Rather, this will enable us to unearth the true meaning of the situation, by gaining a state of "*pure consciousness or ego*" (Grbich, 1999:168), which produces true reality, not the general taken-for-granted reality. Cohen and Omery (1994) suggest we often do not notice the common place, and take for granted much of our social experiences. Consequently, a lesbian woman's taken for granted views of the world may not be the reality in a health care setting (see chapter three for a discussion on this).

Cohen and Omery (1994:148) indicate the research methodology of this approach describes the meanings of experiences as they appear to us, which is called "*eidetic description*". The *eidetic* is the belief that "*there are essential structures to human experience*" (Draucker, 1999:361). Caelli (2000) points out that '*eidetic description*' is the pre-reflective experience as it has been lived, and this produces the real meaning of the phenomenon. The person experiencing it has not interpreted it; rather it is in its 'raw' state of experience. It is not coloured by tradition or informed by the culture where the experience takes place. In this way

the phenomenon can be studied objectively even though what is being studied are subjective experiences. Researchers bracket their presuppositions and describe the essential structures of the experiences being studied (Grbich, 1999; Cohen and Omery, 1994). The meaning of the eidetic description is “*fundamental and essential to the experience no matter which specific individual has that experience*” (Cohen and Omery, 1994:148).

Koch (1996:176) suggests that the “*critical issue of representation is precisely whether bracketing is possible and plausible*”. Can we negate our understanding of the world, and look at situations without any preconceived ideas? Heap and Roth (1973) suggest a Husserlian phenomenological approach cannot be utilised in a sociological study, as it cannot negate the world in which the phenomenon takes place. Sociology’s “*interests, problems, and solutions*” are found in the world and are not “*found in the realm of possibilities*” (Heap and Roth, 1973:357). LeVasseur (2003) argues that we do bracket things when we come to question them, and accept that we do not know or fully understand something that we thought we did. In other words, when we re-examine something, we are in fact suspending our prior meaning and understanding to come to new ones. However she does not indicate what happens if the individual, upon re-examining, comes to the same conclusion or meaning. The answer may lie in the assertion that “*our unreflective assumptions mask the thing itself until it falls silent and cannot call out with fresh and vital experience*” (LeVasseur, 2003:418).

Edwards and Titchen (2003) argue that a phenomenological sociology is possible. They use Schutz's (1967) development of Husserl in their investigation of patients' experiences of health care, suggesting that:

Phenomenological sociology fosters respect for the development of participants' own unique interpretations of their experience" (Edwards and Titchen, 2003:456).

In their study they state that the emphasis on bracketing is two-fold: that of the researcher and that of the participant, acknowledging that full bracketing of participants' interpretation of their experiences would not be totally possible (Edwards and Titchen, 2003). In addition, researchers experience themselves as human beings existing in the world. To know that other things exist in the world, the researcher must know that they exist both as human beings and researchers (Grbich, 1999). In other words the researcher cannot exist outside of the social world and as interpreter of data, inescapably the researcher:

brings certain background expectations and frames of meaning to bear in the act of understanding. These cannot be bracketed (Koch, 1996:176).

Koch (1996) argues that a Heideggerian framework allows both the acknowledgment of the researchers' lived experience in the world and that of the participants which Husserl does not provide. It is therefore to Heidegger we must now turn.

4.7 Heidegger

Heidegger was interested in ontology, which is concerned with the nature and relations of being (Grbich, 1999; Cohen and Omery, 1994; Ray, 1994; Macann, 1993). He was more concerned with being *in* the world, rejecting Husserl's being *of* the world. The essence of Heidegger's phenomenology is 'Dasein' which he

refers to as the human being in the world: "*The 'essence' of Dasein lies in its existence*" (Heidegger, 1962:67). Johnson (2000:136) suggests that Heidegger views the human being as "*always involved in the practical world of experience*" (Johnson, 2000:136). As Heidegger (1962:86) indicates "*Being-in-the-world is a basic state of Dasein*". Dasein exists within the world and not outside it and the 'world' for Heidegger:

is the interconnected context of involvements that give meaning to everything one encounters within one's individual world (Johnson, 2000:137)

Therefore, for lesbian nurses, being-in-the-world of health care is to know that world, both as a health care professional and as a lesbian woman. This differs from the being-in-the-world for lesbian women as service users, as their knowledge of the health care world is that of the outsider, rendering them vulnerable to the knowledgeable professionals.

A health service that is based upon heterosexuality (Saulnier, 2002; Stevens, 1995) renders lesbian women outsiders when they seek health care. Lesbian women's susceptibility has been well documented: judgments about sexual orientation (Marrazzo, Coffey and Bingham, 2005; Saulnier, 2002); age-related assumptions (Hinchliff, Gott and Galena, 2005; Harrison, 2001; Scherzer, 2000) and use of heterosexual language (McDonald, McIntyre and Anderson, 2003; Stevens, 1996). Lesbian women who are nurses on the other hand have an insider's knowledge of health care, as members of the profession. However, they are aware of the attitudes to lesbian women that prevail in the health care environment, as they encounter them in their working lives: homophobia (Giddings and Smith, 2001); lack of social support and understanding (Fingerhut,

Peplau and Ghavami, 2005) leading to non-disclosure of their own sexuality (O'Hanlan et al, 2004; Shelby, 1999), due to the covert or overt discrimination in the workplace.

Human beings do not encounter things in the world in a detached way; rather there is interconnectedness between the human being and the world around her/him (Lindseth and Norberg, 2004; Johnson, 2000; Koch, 1996). Human beings make decisions and understand phenomena through their lived experience of the world. However they interact without being consciously aware, or thinking through. They utilise what Draucker (1999:361) calls "*everyday skilful coping*". These are the skills for everyday living that an individual has developed over time, to enable her/him to live within her/his community or culture. Equally, they are the skills we take for granted, never questioning them as if they become second nature in the lived life.

According to Heidegger, we do not think of things outside of the world in which they take place (LeVasseur, 2003). The human being understands her/his own existence but also the being of other things such as a wall or chair (Gorner, 2002). Dasein, that is, the human being in the world, understands the existences of other things in the world beside her/his own existence (Johnson, 2000). In other words while I exist in the world, other people also exist, as well as non-human things. Heidegger indicates that we are not to suspend our preconceived ideas as to "*what constitutes the possibility of intelligibility or meaning*" (Ray, 1994:120). It is through our prior understanding and reflections that we can ask further questions.

Thus, while Husserl's phenomenology has been seen as descriptive, Heidegger's is viewed as interpretative (Crotty, 2005; LeVasseur, 2003; Williams and May, 1996) or existential phenomenology (Koch, 1996). Darbyshire, Diekelmann and Diekelmann (1999:23) suggest that the:

central task of interpretative phenomenology is to interpret everydayness as a pathway (method) that attempts neither to deny human agency nor to valorize it.

Heidegger rejects cultural meanings of a given phenomenon as the "dictatorial voice of *das Man* – the 'they', the anonymous One" (Crotty, 2005:97, emphasis in the original). He develops a phenomenology of the human being where:

The essence of human being lies in its existence - that is, in its possibilities to choose different ways of being. Human being is always oriented toward future possibilities of its own (Cohen and Omery, 1994:144).

Human beings by choosing possibilities in their lives are constantly becoming. In other words a human being may choose to become a teacher, but this is not the end of her/his 'becoming'; it is not indicative of her/his full potential as s/he has numerous possibilities of what s/he could become.

Johnson (2000:139) suggests there are three elements to Heidegger's concepts of meaning and human being:

(1) that prior to and apart from any awareness of this fact or any choice in this fact, humans ultimately are 'already' what they essentially are, (2) that because the essence of human being is finite, it is never complete, finished, or done. It is always in a process of 'becoming', and (3) that in order to consciously and personally be oneself one must affirm one's essence (emphasis in the original).

This would suggest that a human being must own her/his essence and become it. Furthermore, in order to be an authentic human being s/he must acknowledge or choose her/his essence. From a Heideggerian point of view, a lesbian woman

must embrace and acknowledge that she is a lesbian, thus attributing meaning to her situation through her essence. As Heidegger puts it:

Dasein is in each case essentially its own possibility, it can, in its very Being, 'choose' itself and win itself, it can also lose itself and never win itself; or only 'seem' to do so (Heidegger, 1962:68, emphasis in the original).

Therefore I am my own possibility, I can choose myself and thus win myself, yet, there is also the possibility that I can lose myself (Heidegger, 1962).

4.7.1 Being authentic

Can we say then that a lesbian woman can lose herself by not choosing her essence? Equally, the question is, can she be other than who she is? A lesbian woman who rejects or hides her true essence, is not her true self but rather “*only seems' to do so*”. However, Heidegger indicates that it is a choice: I can choose my possibility but I can also limit it. If I choose not to become my possibilities, can I be authentic? Heidegger (1962:68) goes further when he states:

But only in so far as it is essentially something which can be authentic – that is, something of its own – can it have lost itself and not yet won itself. As modes of Being, authenticity and inauthenticity are both grounded in the fact that any Dasein whatsoever is characterized by mineness (emphasis in the original).

By ‘mineness’ Heidegger means ‘I am’ or ‘you are’, it is mine or yours, it belongs to me or you and therefore it cannot be given to me or you. It could be suggested from this that a lesbian woman only can give herself her authentic self, by choosing her own possibility of being lesbian, in other words, by saying ‘I am a lesbian’. No other person can do this for her in a Heideggerian sense.

When a lesbian woman chooses not to embrace her lesbianism she is being inauthentic. Heidegger (1962:68) offers a way out as “*the inauthenticity of*

Dasein does not signify any 'less' Being or any 'lower' degree of Being". Heidegger (1962:68) offers examples of when this may occur: "*when busy, when excited, when interested, when ready for enjoyment*". This suggests that Dasein does not choose her/his inauthentic state; rather it happens upon her/him. However, in chapter 6 I argue that lesbian women choose their authenticity in relation to the situation they find themselves in. If they feel safe they may choose to 'come out' to their health care provider, and if they feel unsure of their safety, they may not. This applies equally to lesbian nurses in their workplace.

4.7.2 Hermeneutic phenomenology

Heidegger not only interprets the phenomenon but also describes it, moving into hermeneutical phenomenology:

Heidegger's hermeneutics starts with a phenomenological return to our being, which presents itself to us initially in a nebulous and undeveloped fashion, and then seeks to unfold that pre-understanding, make explicit what is implicit, and grasp the meaning of Being itself (Crotty, 2005.97).

Heidegger suggests that hermeneutic phenomenology is based upon the everyday understanding of phenomena. The hermeneutic circle entails the going back and forth in the questioning of our prior knowledge, in order to understand the deeper meaning of the lived experience. Koch (1996:176) indicates that Heidegger used the term hermeneutic circle as a metaphor "*to describe the experience of moving dialectically between the part and the whole*". Palmer (1969) suggests that the understanding of the parts and whole must be achieved simultaneously, and this is realised by taking a leap into the hermeneutical circle. In other words, we cannot understand the parts or the whole as separate entities but rather as one, the parts informing the whole and the whole informing the parts.

LeVasseur (2003:418) advises that the hermeneutic circle is another configuration of Husserl's bracketing as "*the ongoing project of reflective questioning keeps the possibility of new experience and understanding alive*". Robertson-Malt

(1999:292, quoting Gullickson) points out the methodology of hermeneutic phenomenology:

works to support a method to gain meaning from the pre-reflective lifeworld of the person in order to make visible to those standing outside of the experience what kind of knowing occurs when one is involved in the situation.

Consequently, within this study, I uncover the meanings that lesbian women and lesbian nurses give to their lived experiences in the world of health care. Hermeneutical phenomenology does not negate the situation in which the lived experience takes place (Robertson-Malt, 1999), as meaning resides within the context of the experience (Palmer, 1969). In this way a hermeneutical phenomenological method will enable me to uncover the meanings that lesbian women give to their experiences of health care, or lesbian nurses, of working in the health care environment, for both groups of lesbian women it is being-in-the-world of health care.

Overall, the goal of hermeneutic phenomenology is "*to increase understanding of the meaning of human experiences and practices*" (Draucker, 1999:361). Palmer (1969:68) suggests that:

A theory of understanding is most relevant to hermeneutics when it takes lived experience, the event of understanding, as its starting point. In this way, thinking is oriented to a fact, an event in all its concreteness, rather than an idea, it becomes a phenomenology of the event of understanding.

For lesbian women to have meaning in health care, they must understand the situation in which they find themselves, which will further provide them with meaning. Equally, the lesbian nurse understands what it means to be a nurse in health care. However, her understanding will provide further meanings that she derives out of her situation. This is a circular position: to have meaning, one must understand the situation, and also to understand the situation one must have meaning attributed to it, one enhances the other and *visa versa*.

Palmer (1969:131) indicates that Heidegger defines understanding as "*the power to grasp one's own possibilities for being, within the context of the lifeworld in which one exists*". Therefore, lesbian women have the power within themselves to understand the situation their possibilities in which they find themselves.

Heidegger implies that understanding is the basis for interpretation, and this is projected into the future. In other words, to interpret something such as a health care encounter, we have to understand it first, and it is this understanding that we take into our future experience(s), so that "*Interpretation is simply the rendering explicit of understanding*" (Palmer, 1969:134), it is a way of seeing something.

As we have seen in chapter three, lesbian women take with them their understanding of a past health care experience and themselves and their possibilities into the next one. They regulate information about the self, for example, whether they come out to their health care provider (Saulnier, 2002; Scherzer, 2000; Stevens, 1998). Through the interpretation of understanding of past experience(s), lesbian women project their meaning(s) into future health care experience(s). To undertake research from a Heideggerian tradition, the researcher must uncover what it means for the human being "*to be a person in the*

world" (Draucker, 1999:361). Johnson (2000:140) points out, it is in "*the actual living of our own stories individual events acquires significance within the whole to which they belong*" (emphasis in the original).

4.8 Existentialism

The majority of writers choose Gadamer (1975) or Merleau-Ponty (1958) in developing phenomenology. However, I am not interested in exploring language or psychological meanings of the lived experience (Moran, 2000). Rather I am interested in how lesbian women experience the self in health care, that is, being lesbian in the world of health care. Both Heidegger and Sartre enable me to develop this. Sartre and Merleau-Ponty developed existentialist phenomenology, viewing phenomenology as capturing "*life as it is lived*" (Moran, 2000:5).

Adler (1949:285) suggests that existentialism is principally concerned with "*problems of personality development and interhuman relations*". Dufrenne (1965) indicates that existentialism has its origins in Being, the being in-itself and the being for-itself. The in-itself is what it is, it is the essence which receives its meaning from for-itself which has consciousness (Moran, 2000; Dufrenne, 1965).

Beings-in-themselves are non-conscious things, which can be said to have essences, which exist independently of any observer and which constitute all the things in the world. Beings-for-themselves are conscious beings whose consciousness renders them entirely different from other things, in her/his relation both to themselves and to one another, and to those other things (Warnock 1969:ix).

Through their consciousness, lesbian women, either as service users or as providers of health care, may know their difference both on a personal level and in relation to Others.

4.8.1 Sartre

Sartre's focus is on the consciousness of being, where meaning comes from human beings' "meaning-giving" (Moran, 2000:357). Meaning is not outside the human being, but within.

Sartre was interested in the question of subjectivity, suggesting that it was free, not constrained by religion or any other controlling factors, as an individual is not a means to an end, but an end itself. The individual must create her/himself. This is similar to Heidegger's idea that the human being is not complete, but constantly becoming:

He needs the other, not only to live and make the species live, but also to assert himself, to get recognition, as the child by his parents or the artist by his public, and to enter into collaboration, since his freedom is finite and wants to be carried over to the freedom of others (Dufrenne, 1965:55).

Consequently the individual does not create her/his potential as an island; as Sartre indicates, the individual needs the other and seeks her/him out. The lesbian woman in health care needs the provider or other nursing colleagues, to create her potential.

If the individual needs the other for affirmation and collaboration as Dufrenne (1965) suggests, then a society has to exist, and as society cannot exist in a vacuum, so then culture must also exist. This is reinforced by Macionis (2005:89) when he suggests that society "refers to people who interact in a defined territory and share a culture". Tovey and Share (2000:281) suggest that culture "refers primarily to the way of life of a people, social groups or historical period". An individual exists within a culture with its values, norms and belief

systems, which enables the individual to live her/his life, even if there is disagreement with some cultural beliefs, values and norms. This, for example, is explored in Dillon's (1999) investigation of Catholic identity in the United States of America. She was particularly interested in those who dissented, from the teachings of the Catholic church, for example, lesbian women or women who are pro-choice yet remained committed to a church that viewed them as either immoral (women who are pro-choice) or sinful (lesbian women) (Dillon, 1999). Existentialism is concerned with how the individual negotiates her/his existence in the world that s/he finds her/himself. Earle (1969:83) reveals that to become oneself "*is to become oneself through others*", therefore we cannot become on our own. Sartre (1969) indicates that "*I can know myself only through the mediation of the other*". Human beings work on the project of life or living in conjunction with others.

The individual is a thinking human being, and in this thinking has awareness of her/his existence (Adler, 1949). Adler (1994) further implies that when an individual acts they are making choices, the choices carried out are made in complete freedom (Newman, 1966). Sartre signals that the human being is unique and her/his actions are unique to her/him. Thus, for Sartre, human beings are "*free to change the world*" (Newman, 1966:185). Moran (2002:358) suggests that for Sartre freedom resided in the intellect "*in autonomous thinking, rather than arising in action. One can be free and yet unable to act*". This would suggest that a prisoner could be free through her/his own thinking, even though captive, as s/he may not be able to act upon her/his thoughts. Thus, there is a distinction between intellectual freedom and physical freedom. The lesbian nurse

or service user, though constrained by the culture of the hospital, is still free to think of herself as a lesbian woman regardless of the categorized assigned to them (see chapter three for a discussion of this).

Adler (1949:289) points out that there is a universal feature of human beings which is:

the human conditions of having to make a choice without any basis for judging this choice as right or wrong but with full responsibility for all its consequences.

Human beings are free to make whatever choice(s) they wish and participate in whatever action(s) they want. However, they are responsible for the outcome of that choice(s) or action(s). In addition, human beings are only free in so far as they do not impinge on the freedom of others. Human beings do not act in isolation. They act within a normative culture of actions. If there are socially acceptable ways of acting, can we have any semblance of freely choosing to act? The answer may lie in the fact that we are free to act in a normative way, to act outside of the normative way, or not to act. In this way difference and diversity may emerge. However, if an individual perceives that her/his freedom is impinged by the other, this might lead to hostile relationships (Adler, 1949). However, it would appear from Moran's (2000) interpretation that hostility might not arise, if the individual does not act upon her/his thoughts. In other words we are free to choose to act and if we can foresee hostility then we may not act. This provides us with an explanation as to why lesbian women do not 'come out' to their health care professional or lesbian nurses their colleagues. If they perceive the situation as hostile they freely choose not to act, that is 'come out'.

Mead (1934) indicated that human beings develop in the eyes of the other and Adler (1949) suggests that Sartre agrees with this. Equally Sartre suggests that human beings are always limited by their “*facticity (her/his sex, height, economic position in society, and so on)*” (Moran, 2002:326). Just as human beings are limited by their situation, that is, the time or the historical period in which they live, human beings are also always creating themselves. Therefore, can we say that human beings are ever completely free if there are facticity and historical time constraints? It could be argued that to be of a higher socio-economic group, for example, may lead to greater freedom. However Luddy (1995) for example, portrayed how women, although wealthy in their own right, were constrained by the historical epoch of nineteenth-century Ireland. Consequently, the health care setting holds the possibility for a lesbian woman to create herself.

4.8.2 The self

Sartre points out that human beings can have negative attitudes about the self which turn inwards rather than outwards. As we have seen in chapter three, negative attitudes have been labelled homophobic (Young, 1990), and can have consequences for lesbian women’s health care as they can be internalised (O’Hanlan, Dibble, Hagan and Davids, 2004; Bonvicini and Perlin, 2003). Homophobia is the set of negative attitudes that others can have towards lesbian women and gay men, regardless of the basis for their foundation (Giddings and Smith, 2001; Diamant, Schuster and Lever, 2000). The inward turning of these attitudes, is when the lesbian woman turns the homophobic attitude(s) on the self; thus she internalises homophobic attitude(s) which may have consequences for the mental and physical health of the lesbian woman (Kerr and Emerson, 2003).

The attitude which Sartre discusses is “*bad faith*”, which he shows is associated with “*falsehood*”. “*We say indifferently of a person that he shows signs of bad faith or that he lied to himself*” (Sartre, 1969:48). Sartre suggests that a human being knows the truth of the situation, but s/he lies both to her/himself as well as others, thus avoiding the true reality of her/his essence:

The essence of the lie implies in fact that the liar actually is in complete possession of the truth which [s/]he is hiding. A [woman/]man does not lie about what [s/]he is ignorant of; [s/]he does not lie when [s/]he spreads an error of which [s/]he [her/]himself is the dupe; [s/]he does not lie when [s/] he is mistaken (Sartre, 1969:48).

Therefore the individual, when lying to the self, is aware of the situation. I suggest (see chapter 3) that a lesbian woman is in *bad faith* if she withholds the knowledge of her sexual orientation from her health care provider as this may have ramifications for her care.

Sartre indicates that the person who lies knowing the truth recognises their own existence and the existence of others in the world:

*It presupposes my existence, the existence of the **Other**, my existence for the Other, and the existence of the Other for me* (Sartre, 1969:49, emphasis in the original).

As we exist in relation to others, we lie in relation to others, we not only lie to the self but to the other in our presence, through verbalising the untruth of our situation. So we hide who we are from the other through lying, we become what Sartre (1969:49) calls “*hidden from the Other*”.

If the lesbian woman knows that the reaction of the health care provider could be negative she may not be in *bad faith*, but may be protecting herself. However, Sartre indicates that we are not only a being-for-itself, but we are also a being-for-

others. *“Upon any one of my conducts it is always possible to converge two looks, mine and that of the Other”* (Sartre, 1969:57). Therefore, we act in the situation from our own reality standpoint.

The equal dignity of being, possessed by my being-for-others and by my being-for-myself permits a perpetually disintegrating synthesis and a perpetual game of escape from the for-itself to the for-others and from the for-others to the for-itself (Sartre, 1969:58).

If I am both a being-for-myself and a being-for-others, I will tailor who I am in front of the other.

Therefore, the lesbian woman as service user or the lesbian nurse, acts through the knowledge of their situation which will entail whether or not they are open about their sexuality. *“We have to deal with human reality as a being which is what it is not and which is not what it is”* (Sartre, 1969:58). This can be applied to a health care service, based upon the assumption that all its female clients are heterosexual (Kavanagh, 2006; Scherzer, 2000; Stevens, 1998, 1996). A lesbian woman presents herself for care, but the assumption of heterosexuality means that a lesbian woman who does not identify herself as lesbian, is what she is not and which is not what she is. Therefore *“the one who practices bad faith is hiding a displeasing truth or presenting as truth a pleasing untruth”* (Sartre, 1969:49). The other then can influence how we behave in certain circumstances, and we present ourselves in a pleasing way towards others.

However, studies in lesbian health care (Enszer, 1996; Cochran and May, 1988; Regan, 1981; Dardick and Grady, 1980) suggest that lesbian women should ‘come out’ to their health provider to obtain appropriate health care. Other studies reveal health care providers should provide an environment whereby

'coming out' is facilitated (Marrazzo and Stine, 2004; Bonvicini and Perlin, 2003; Spinks, Andrews and Boyle, 2000; Stevens, 1996; Rankow, 1995). Therefore, it could be said that health care professionals may be in *bad faith* if they do not provide a safe health care environment for lesbian women. Equally, health care professionals are in *bad faith* by not recognising the reality that difference exists between women in society.

4.9 Concluding remarks

Two traditions have developed in studies that use phenomenology as a methodology: the European and the American. The European has developed from Husserl and Heidegger and the discussion above emanates from the European tradition of phenomenology (Caelli, 2000). The American tradition focuses on the meaning of experience within the cultural context in which it occurs. Caelli (2000:371) notes that:

Many contemporary phenomenological studies focus on the everyday understandings of experience rather than on the way the phenomena present themselves in original everyday experience and thus demonstrate a move away from traditional European phenomenology.

She further suggests that the American phenomenological approach:

focused on describing the participants' lived experiences of the phenomenon within the context of culture rather than searching for its universal or unchanging meaning outside the cultural context (Caelli, 2001:274).

Though, the American tradition has been developed from Heidegger's work to include the way in which the inherited and cultural experiences shape the phenomenon being investigated.

Lawler (1998) suggests that both the European and the American phenomenological traditions derive out of cultural ways of thinking. The uniqueness of American phenomenology lies in the attention it pays to “*subjectivity and individual meaning than on being itself or the thing(s) that beings are making sense of*” (Lawler, 1998:107). She indicates that this is reflective of the American culture of individualism. In contrast, the European tradition which emanates from German and French philosophy does not derive meaning from culture, but rather from the human being. Heidegger develops “*a phenomenology of human being*” (Crotty, 2005:97). The French philosophers Sartre and Merleau-Ponty incorporate a “*subtle shift towards embodiment, incarnate existence*” (Lawler, 1998:107).

Van Manen (1990:17) indicates that:

Human life needs knowledge, reflection, and thought to make itself knowable to itself, including its complex and ultimately mysterious nature.

This acknowledges that research participants have thought about and reflected on experiences prior to a researcher asking them about it. Research participants make sense of their experiences that are informed by the culture in which they take place. Therefore the culture in which a phenomenological study takes place informs the method that is chosen, and in this study it is the experience of lesbian women in an Irish health care context.

Chapter 5: *Applied Methodology*

5.1: Introduction

The purpose of this chapter is to provide an account and description of the research process in this study.

The methodology derives out of the qualitative tradition which has a multitude of ways to produce data (Dinkins, 2005). The methodology for data production and analysis employed in this study is hermeneutic phenomenology (see chapter four), which requires a particular kind of data to be produced. Phenomenological enquiry, particularly the hermeneutic tradition, claims to produce data that lends itself to the interpretation of the “*concealed meanings*” in the phenomena being studied (Dinkins, 2005:113).

The techniques chosen for the purpose of data collection were that of ‘insider’ researcher and unstructured informal interviews in the majority of cases, with some interviewees taking a more interventionist approach. The interview of both lesbian service users and lesbian nurses consisted of one question from which other questions or areas were explored as they arose. The analysis of the data is guided by Heidegger’s (1993) concept of dwelling, listening to the voices of lesbian women, moving forward in parts and taking refuge in other parts. Through writing and re-writing an interpretive text emerged.

5.2 Finding a Phenomenological Method

Prior to discussing the method I utilise, it is worth noting Hekman's (1980:341) four criteria for a methodology to be classified as having obtained social science rigour:

first, it must define the subject matter of the social sciences; second, it must explain how that subject matter is constituted, that is, how the "facts" of social science become facts; third, it must provide the social scientist with precisely defined conceptual tools and procedures; and, fourth, it must define the limits of social science activity (emphasis in original).

The subject matter of this study is the meaning(s) that lesbian women give to their experiences of health care, and the experiences lesbian women have as nurses working in the health care environment. Hekman's (1980) considerations derive from a positivist viewpoint, demanding a certain methodology for the production of knowledge. She indicates that a phenomenological study seeks to uncover the subjective while the positivists are concerned with objectivity: the "*starting-point of social scientific analysis must be the understanding of social action in the terms of social actors themselves*" (Hekman, 1980:342). Hekman (1980) claims that phenomenology meets the four criteria as she utilises Schutz's (1967) method.

Schutz's (1967) analysis derived mainly from the work of Husserl and Heidegger. Heidegger's intention was to develop a methodology to understand the actions of social actors. In particular, he rejected Weber's concept of 'meaningful action' and 'subjective meaning'. Schutz (1967) suggests that Weber's methodology is not explicit, and he consequently also aimed to develop a methodology that would enable him to explore meaning and subjectivity. While Schutz (1967) did develop a methodology for utilising phenomenology, I will not be using Schutz's

(1967) development as it advocates bracketing (see chapter 4 section 4.6.1 for a discussion on bracketing), which negates the lived experience in the world.

It has been suggested that bracketing is the suspension of judgments when researching phenomena:

What we put within brackets is our judgments about the factual, about what is the case, in order to become open to our experience and to the understandable meaning implicit in this experience (Lindseth and Norberg, 2004:148).

This is different to what Husserl originally suggested, in that judgments about phenomena imply reflection on the phenomena. Here Lindseth and Norberg (2004) appear to be suggesting that it is the researcher who should suspend judgment(s), rather than participants. In this way participants will speak freely about their experiences. They also indicate that their form of phenomenology takes into account meaning as:

something with which humans are familiar in the practices of life, and this familiarity has to be expressed through the way of living, through actions, through narratives and through reflection (Lindseth and Norberg, 2004:147).

In this way they allow for participants' prior judgments, reflections and future actions when experiencing a similar phenomenon.

Shaban (2005, citing Dowie, 1995) points out that the definition of judgment is "*the assessment of the alternative, the choosing between alternatives*". Shaban (2005) further argues that Dowie (1993) implies "*that judgments are always in some way an assessment of the future*". Future interaction is based on past experiences, which have been reflected upon. This fits well with the literature review on lesbian health care (see chapter three), where lesbian women point out

that they inform their provider of their sexual orientation if they had positive reactions in the past. Similarly, they do not inform them if they had negative reactions in the past (Marrazzo and Stein, 2004; Scherzer, 2000), or if their friendship group have had negative experiences (Stevens, 1996; Robertson, 1992). Equally, lesbian nurses do not inform their colleagues of their sexual orientation, as they experience both overt and covert discrimination in the workplace (Beals and Peplau, 2005; O'Hanlan et al, 2004; Giddings and Smith, 2001).

5.3 Methodological choice

The methodology I have chosen for this study is hermeneutical phenomenology, emanating from the philosophy of Heidegger and Sartre. Cutcliffe, Joyce and Cummins (2004:308) suggest that phenomenology is often referred to as a human science, "*the purpose of which is to describe and understand particular phenomena as lived experience*". In addition, we also need to embrace the rationality of the human science with its fundamental assumption that.

human life may be made intelligible, accessible to human logos or reason, in a broad or full embodied sense To be a rationalist is to believe in the power of thinking, insight and dialogue (Van Manen, 1990:16)

Van Manen (1990:17) further suggests that:

Human life needs knowledge, reflection, and thought to make itself knowable to itself, including its complex and ultimately mysterious nature.

Consequently, to understand the experiences of lesbian women of health care or lesbian nurses as providers of health care, we need to listen to their stories and make their experiences accessible to the wider community.

5.4 Obtaining the sample

One of the problems in undertaking a study of lesbian women in Irish society is their lack of visibility (Lodge and Lynch, 2003; GLEN & Nexus, 1995) and, when the research is sensitive (Lee, 1995), this has implications at every point in the research process as:

*The problems and issues that arise at each stage take a variety of forms
They may be methodological, technical, ethical, political or legal.
Sensitive research often has potential effects on the personal life, and
sometimes on the personal security, of the researcher (Lee, 1993:1).*

Lee (1993) further argues that threats to the person can come in the form of intrusion into an individual's life and social space; it can take many forms, from the perception of, to actual reality of, physical threat. These are considerations that lesbian women take into account when deciding whether to participate in a study, and in this study the lesbian women participants were self-selecting.

A mobile phone was purchased for the sole purpose of this study, as a mode of contact that no one else had access to. I had lengthy conversations with each participant when the initial contact was made. I answered all concerns that were voiced and rang each lesbian woman prior to meeting them for the interview even when time, dates and venues were set. This enabled me to establish my credibility as a researcher, and begin to develop a relationship based on trust and confidentiality. It also acted as a buffer zone for potential participants to remove themselves from the study if they so wished. A consent form was signed by each participant (appendix A), and a plain language statement of the study (appendix B), was given to each woman. Each participant retained a signed consent form, which clearly states that they can remove themselves from the study at any stage.

5.4.1 Lesbian service users

Following ethical approval from Dublin City University Ethics Committee, an advertisement (appendix C) seeking lesbian women who experienced health care was placed in the April 2006 issue of *Gay Community News* (GCN), which stimulated immediate response. GCN is a free community newspaper available nationwide through large bookstore outlets, or through direct mailing to individual homes for a small fee to cover postage and packaging. I decided to use this medium as I felt that it would be the best way to gain a sample consisting of lesbian women living in urban and rural areas. The advertisement did not specify what category of lesbian women I was looking for, such as, disabled lesbian women; lesbian women living with a particular illness, lesbian women by social class or ethnic background. As this is the first study on lesbian women's experience of health care in Ireland, I wanted to attract as broad a sample as possible, accepting whoever phoned as a potential participant.

I received text messages and phone calls from lesbian women responding to the GCN advertisement. The following are two examples of text messages I received:

(i) *Hello Mel, saw GCN. I'm interested in helping u out with your research. 30 gay, 6 operations, health service experiences good & bad.*

(ii) *Hi Mel, my name is X, my partner Y who I know contacted you about your study. I also would be interested in participating. I had negative experience when I was in (names hospital) with meningitis. I can be contacted on this mobile at any time, but will be out of the country after this week on business.*

The advertisement placed with GCN specifically stated I was seeking participants with experience of health care.

5.4.2 Lesbian nurses

I decided to develop two different advertisements for two different audiences. The GCN advertisement did not include an invitation to lesbian nurses to participate in the study. A lesbian nurse responded to the GCN advertisement stating:

liked the advertisement as it caught my eye and made me think about ringing to find out what the research was about and if I could help (telephone conversation with Grainne, a lesbian nurse).

In conversation with Grainne, I stated I was also interested in lesbian nurses' experiences of working in health care. She asked why I did not include lesbian nurses in the GCN advertisement. I explained the dual approach to advertising which meant separate advertisements for lesbian women service users and lesbian nurses. However, the GCN advertisement did obtain other lesbian nurses who responded as a service user:

Hi there Mel my name is X. I would be interested in participating in your study as a gay woman who both works and avails of Irish health care service How should I go about participating?

Text messages enabled me to obtain some of lesbian nurses sample. I discovered other respondents were nurses through the initial telephone conversations when they rang inquiring about the GCN advertisement.

An advertisement (appendix D) to obtain a sample of lesbian nurses was placed on the National Council for the Professional Development of Nurses and Midwifery (NCNM) website in March 2006. The advertisement was also placed in the NCNM magazine edition in June. Every registered nurse in Ireland receives the magazine. While the advertisement on the NCNM website elicited no

participants, the magazine advertisement did, validating the more informal method of contact which did not threaten a nurse's professional status.

The NCNM website advertisement did not have the sentence indicating I was a lesbian researcher. The gatekeeper of the website specified NCNM did not "*give out personal details on their website*". Although I did state that this was not something personal but rather a fact, it did not alter the gatekeeper's commitment to the personal security of all advertisers. This is discussed below.

5.5 Overt versus covert research

Byrne (2000:145) points out the pitfalls of being an insider.

it challenges the supposed objectivity of the researcher and the emphasis on maintaining distance from research subjects.

She further explains that being the insider challenges the traditional construct of the research relationship which is presented as:

objective, expert researcher [with] little in common with research participants and that this is desirable for the production of value-free, neutral, scientific research (Byrne: 2000:143).

However, being an insider researcher allows those who belong to a marginalised group to speak freely, without fear of judgments or preconceived ideas being made about their experiences.

I undertook overt research by stating that I was a lesbian researcher in the advertisement, signalling in this way my insider status to all potential participants. However, my insider status did not include belonging to the nursing profession, rather my knowledge of nursing emanates from my position of lecturer in a nursing school. Platzer and James (1997:627) suggest that researchers who

acknowledge their insider status may face the “*threat of stigma contagion*” . *particularly when taboo subjects are explored which relate to sexuality*”. A researcher may experience similar stigma to the group that they are studying. While both Platzner and James (1997) indicate they experienced stigma before, during and after their research, I have not experienced this from my colleagues or when I present papers at conferences.

Oakley (2005) and Reinharz (1992) suggest that feminists claim that if women’s lives are to be understood, “*it may be necessary for her to be interviewed by a woman*” (Reinharz, 1992:23). Reinharz (1992:24) further states:

A woman listening with care and caution enables another woman to develop ideas, construct meaning, and use words that say what she means.

I argue in a similar vein that for lesbian women to be understood in a research project, it may be necessary that a lesbian woman undertakes the interviews. This does not negate the fact that other researchers, who are not lesbian, can interview but rather that they may not be privy to the types of revelation(s) that are made available to an insider researcher. Participants must feel that they can trust, that they will not be judged (Claassen, 2005; Clunis et al, 2005) or that the researcher will not bring preconceived ideas about their situation to the interview (McDermott, 2004; Weston, 2004; Reinharz, 1992). For instance, Higgins and Glackin (2005) found it difficult to obtain a sample in their research on Irish lesbian, gay and bisexual experiences of bereavement. Even though Higgins and Glackin had advertised in GCN for participants there was little take up. They were informed (by contacts in the gay and lesbian community) that the marginalised group they wished to study, did not trust two ‘straight’ women

would be sensitive enough to their experiences (personal information from both researchers).

5.6 Data gathering and ethics

Each step of the sampling and data gathering requires the researcher to take steps to protect their participants. To disguise their identity, the pseudonyms I use are of old Celtic Irish origin, and I only assign urban or rural to the geographical area of residency. The following table gives the names of participants, which are in alphabetical order and do not reflect the order of interviews:

Table 5.1: Name and number of participants

| | Lesbian service users | Lesbian nurses |
|--------------|-----------------------|----------------|
| | Aibheann | Cellach |
| | Afric | Donnfhlaidh |
| | Barrfind | Finnsech |
| | Béinn | Gormlaith |
| | Caireann | Grian |
| | Ebhlin | Muirgel |
| | Folda | Saoirse |
| | Gormlaith | |
| | Laoise | |
| | Meadhbh | |
| | Narbflaith | |
| | Riognach | |
| Total | 12 | 7 |

Sixteen of the lesbian women who participated are Irish while two service users were from other European countries. They have been identified in chapter six as European¹⁷, as this identity informs their understanding and the meanings they give to their health care experiences. One lesbian woman, Gormlaith, participated in this study both as a service user and nurse, thus bringing to nineteen the total.

¹⁷ Ireland is a member of the European Union thus making all Irish citizens both Irish and European. However, for the purpose of this study, I make the distinction between those who are Irish and those who originate from other European countries, as this informs how lesbian women read the situation they find themselves in.

number of interviews. Fifteen lesbian women who had experience(s) of health care made contact, and twelve were interviewed. Nine lesbian nurses responded to the study and seven were interviewed. In total, nineteen interviews were carried out, and while all the women report to be lesbian, each of them has a very different story, demonstrating the diversity that exists amongst lesbian women. Through interviews, the voices of lesbian women can be heard, offering us an insight into their "*ideas, thoughts, and memories in their own words rather than in the words of the researcher*" (Reinharz, 1992:19). Interviews ranged in duration from twelve minutes and two hours, with the majority between forty to sixty minutes. Two interviews took place in the School of Nursing communication suite, DCU, one took place in my home, and the remainder took place in the participants' homes. At the end of each interview, I asked the participant if they would ask their friends to participate in the study, and in this way the study snowballed. This is a technique used by others who have researched lesbian and gay populations (Claassen, 2005; Weston, 2004; Phellas, 2000).

As I was always concerned that I was asking lesbian women to give their time, I made sure that I arrived early to their homes. All of the women were hospitable, offering tea or coffee, a glass of wine, and in some cases, we shared lunch. I was nervous about the interviews as I wondered whether I would be too intrusive, or whether I would gain data that would be useful. I constantly reminded myself that it was the women's stories I wanted to hear and that their experiences were real to them, therefore making the data important. However, I was reminded of Byrne and Lentin's (2000:7) identification of the practice of feminist research, as

“prioritising women’s lived experience of the social, telling this experience ‘in their own voice’” rendering my concerns less important, as it is the voices of lesbian women that need to be heard.

Dorothy and Smith have argued that those who research women:

must never lose sight of women as actively constructing as well as interpreting the social processes and realities that constitute their everyday lives (quoted in Byrne and Lentin, 2000:9).

Initially, I wondered about how much of myself I should give, but Letherby (2003) indicates it is the nature of research to give of the self. Wuest (1993) points out that some researchers find the detached relationships between researchers and researched problematic (cited in Im, 2000). However, Reinharz (1992:26) argues that *“every aspect of a researcher’s identity can impede or enhance empathy”*. The interview process is thus a social interaction situation, and the more open I became about my own identity the more relaxed and forthcoming the participants were. Phellas (2000:61) experienced similar outcomes in his research on men who have sex with men with the Cypriot community in London.

It seemed to me that the more I disclosed about my own sexual lifestyle, family background, coming out and personal relationships, the more safe they felt to open up to me.

What a lesbian woman says is happening in her world is happening as she experiences it and lives it: *“It is in the co-disclosure of the shared world that issues of voice, reflexivity, identity, and understanding reveal themselves”* (Kavanagh, 2006:252). It is through the voices of lesbian women that we can begin to understand their experiences of health care, and lesbian nurses’ experiences of working in the health care environment.

5.6.1 Concerns of participants

Prior to the interview, a lively debate was engaged on an individual basis with lesbian women who participated in this study, ranging from experiences of the gay/lesbian scene, relationships or political issues such as civil partnership. Participating in these debates led to ease of communication (Oakley, 2005), an appreciation of understanding lesbian life and my credibility as a researcher and member of the community was enforced. McDermott (2004:177) notes that “*studies have reported the willingness and eagerness with which participants tell their stories to lesbian and gay researchers*”, a situation, as previously mentioned (see page 137-8), that is not necessarily repeated with other researchers. Consequently, as an insider I have been able to gather data, as well as have unprecedented access to the lives of the women who agreed to be participants in this study.

Lee (1993) argues that research on sensitive topics could place threats on the integrity of the individual who participates or the researcher. In the data-gathering process I found that some lesbian women live in constant fear of being ‘discovered’. Lesbian women use well practiced “*everyday skilful coping*” (Draucker, 1999:361) in their daily lives; however, the constant anxiety of being exposed is a daily reality for some. They develop well tested mechanisms of survival, which can be threatened if they feel they will be exposed or revealed (Wojciechowski, 1998).

I found that in some cases this concern is so over-powering that it inhibits their participation, even when they make the initial contact and want to tell their

stories. In conversations I had with lesbian women prior to recording their experiences, these concerns were expressed. Some participants spoke about living in the areas in which they currently reside, and how they protect their sexual identity by not displaying signs such as the rainbow flag, pink triangle or overtly alerting their neighbours. Claassen (2005:20) illustrates this point when she writes that lesbian women:

have built numerous barriers and safeguards around themselves. They know exactly what dangers and pleasures their life story and current lifestyle can bring to them.

I was aware that, by inviting me to their homes, lesbian women were exposing themselves and leaving themselves vulnerable, as I knew where they lived. However, this also points to the level of trust they were willing to place in me, as I would not reveal their identity or place of residence.

5.6.2 Barriers to participation

In this study issues of trust and confidentiality acted as barriers to participation for lesbian women who have lived a lifetime in secrecy, even though they had initiated the contact. It was a conflict that for some lesbian women could not be overcome. Claassen (2005) has similar experiences in her research, whereby lesbian women would talk openly and frankly but would not allow a recorder or their informal conversations to be used. While some lesbian women indicated that they appreciated my openness and frankness with them, issues of trust were not directly related to me as a person but rather to where "*the information might end up*". I reassured participants, that my starting point was to give a voice to lesbian women in the area of health care. Even though five potential participants accepted this reassurance, they did not feel they could continue as they feared that

the material could not be disguised enough to protect their identity. It was suggested "*Ireland was a small place and X [names urban area where she resides] even smaller*".

Consequently, this problem of trust focuses on two important issues: why and for whom the research is being undertaken:

As qualitative social researchers reflexively exploring everyday lives, we must continually confront questions of the nature and assumptions of the knowledge we are producing, and who we are producing it for (Edwards and Ribbens, 1998:4).

Edwards and Ribbens (1998) argue against qualitative researchers having to justify their research. However, this argument does raise the issue of who we do research for. In other words, why did I choose this particular topic and methodology? My interest in the topic arose out of my own experience of health care, as well as numerous conversations I had with friends of their experiences of health care. Lively debates on issues such as: whether lesbian women needed a smear test; doctors informing lesbian women that they were not really sexually active, as they were not having sex with a man; and inappropriate or irrelevant health care leaflets; led me to develop the current project.

However, the salient question of 'where does the information end up', is most important for some of the lesbian women who participated in this study. Will their voices be lost in the transcribing of their interviews? Or, will the material be so insufficiently disguised that their safety will be in jeopardy? These are issues that every researcher who undertakes research, on sensitive topics or marginalised groups, confronts (Lee, 1993; Reinharz, 1992). The private and personal social world of lesbian women who participated in this study will be presented to an

academic audience, so bringing into public gaze, lives that have been hitherto hidden. These reasons dictate that the researcher must protect participants from identifiers. Consequently, there are ethical considerations to be taken into account at every juncture of the research process and Sorrell and Dinkins (2006:310) inform us that:

ethics is concerned with the suffering humans cause one another and the related capacity of humans to recognize and address this suffering through empathetic virtues of sympathy, compassion, and caring.

These ethical considerations have been into account during the data gathering process and interpretation of the data.

5.7 The interview

The interview schedule consisted of one statement, which invited the participant to reflect on her experience of health care, whether as a service user or as a member of the nursing profession:

- Lesbian women services users were asked to describe their experiences of health care.
- Lesbian nurses were asked to describe their experience of being a lesbian nurse in Irish health care.

As Dinkins (2005:111) points out, the researcher is the “‘*instrument*’ through which data is collected”. In this way, my abilities as a hermeneutical phenomenological researcher to enable participants to recall their experiences as lesbian nurses or service users and reflect upon them, had a direct impact “*on the quality of data obtained*” (Dinkins, 2005:111). During the initial enquiry from potential participants we spoke about what my study was about and what I would

like them to talk about. In this way they could think and reflect on their experiences in their own time and space, prior to the interview.

During the course of the interview, further questions arose from the information the interviewee imparted. When the interview consisted of a couple, of which there was five each lesbian woman reminded and clarified for each other what was being said. Thus, a dialogue was established between the women with very little intervention by me. In some cases I asked very little, as the lesbian woman began to tell her story speaking freely with no need for my intervention. When I did intervene, it was to seek clarification on statement(s) or issue(s) which arose that were left undeveloped or hung in the air inviting clarification. The majority of interviews were unstructured in format, allowing the participant to tell her story as she wished. In other cases a more interventionist approach was employed to aid participants who thought they had very little to offer, and were reticent during the interview process.

5.7.1 The interview process

The interview process consisted of one-to-one interviews with nine lesbian women. The majority of those who were in a relationship chose to be interviewed together. In total nineteen lesbian women were interviewed. Each couple was given the choice to be interviewed separately or together, with the majority choosing the latter. For example, my initial contact and appointment was with Caireann, and at the end of the interview I was informed that Afric would like to participate in the study. I undertook the interview with Afric on the same day when she arrived home from work, which was ten minutes after the interview

with Caireann, was completed. Finnsech was interviewed separately, as her partner Bébinn was not home from work when I arrived for the interview. However, when her partner arrived we had completed our interview and Finnsech remained for Bébinn's interview, thus adding to the conversation as it progressed. The following table shows the breakdown of those interviewed as a couple and those as single interviews.

Table 5.2: Interview type – Service users and nurses

| | Individual interviews | Couple interviews |
|--------------|------------------------------|--------------------------|
| | Aibheann | Barrfind and Folda |
| | Afric | Bébinn and Finnsech |
| | Caireann | Cellach and Gormlaith |
| | Donnfhlaith | Nárbflaith and Meadhbh |
| | Ébhlín | Ríognach and Laoise |
| | Finnsech | |
| | Grian | |
| | Muirgel | |
| | Saoirse | |
| Total | 9 | 10 |

Interviewing lesbian women as couples led to them sharing their experiences of particular incidents during their health care encounters with each other. The interview provided an occasion to talk about issues and feelings they may not have had an opportunity to discuss. One example where this arose was between Meadhbh and Nárbflaith. Nárbflaith was discussing one admission into hospital and Meadhbh began to speak about her feelings about the situation she found herself in.

You probably heard none of this before? (*Meadhbh*).

No! Yeah! No! I think we did have that discussion afterwards (*Nárbflaith*).

In this way the interviews were strengthened and facilitated a deeper understanding of what was taking place in health care encounters. It also led to

the enrichment of each participant's understanding of their lived experience. This is reflective of Giorgi's (2005:77) assertion that the interview process can lead to a discovery of "*difference leading to more authentic living and interaction with others and thus a better world*". This was not only reflected in the individual but also in couples it led to authentic conversation between them, thus revealing aspects of experiences that may not have been spoken about before.

The following is an example of where conversations resulted in insights from a partner; after Cellach had shared a very painful experience of being a lesbian nurse, Gormlaith remarked:

It's probably healing for you, am I right? – you mightn't know that now
(Gormlaith).

In other words, the effects of having opened up and talked about lived experience may not have an immediate effect, but rather a long-term one. This reinforces Giorgi's (2005) assertion of the power of a phenomenological study, as it can lead to authenticity.

5.8 Data analysis and phenomenology

A research method is only a way of investigating certain kinds of questions. The questions themselves and the way one understands the questions are the important starting point, not the method as such. But of course it is true as well that the way in which one articulates certain questions has something to do with the research method that one tends to identify with. (Van Manen, 1990:1:2).

Within the phenomenological movement there are numerous methods for undertaking a study. (Cutcliffe, Joyce and Cummins, 2004; Robertson-Malt, 1999). Equally, it has been stated that the method of phenomenology "*is that there is no method*". (Gadamer, 1975 and Rorty, 1979 cited in Van Manen,

1990:30). If this is the case, how can we undertake a phenomenological study?

The answer lies in Caelli's (2001:275) assertion that:

It is the task of each phenomenological researcher to navigate the abundant and conflicting literature in phenomenology and articulate an appropriate process or method for achieving the aims of a particular project.

She further states that this position is derived out of the uniqueness of phenomenology as it stems from philosophical positions (Caelli, 2001). What the researcher needs to do is understand the philosophical position being used while undertaking a phenomenological study. Rosenthal and Bourgeois (1977) earlier put forward the opposite to Caelli's (2000) argument, suggesting that if we illustrate understanding of the method then it signifies understanding of the philosophical position. The philosophical position derives from the question which the researcher wants to answer.

Van Manen (2002) titled his book on writing phenomenology: *Writing in the Dark*. This title in and of itself expresses adequately my experience of interpreting the data. Questions flooded my consciousness when it came to writing this part of the research. How was I to go about it? What did it mean to write? Would I get it right? Would I represent the voices of the lesbian women who participated in this study adequately? Dr. Christine Sorrell Dinkins at the Institute for Interpretive Phenomenology (2007) indicated that the hermeneutical circle begins the moment you choose your topic of study. In other words what has gone before and what comes after are both crucial parts of the circle. So I was in the hermeneutical circle without initially realising it. Van Manen (2002:2) states that "*the writing remains painful, difficult, disorienting*". Yet it is through this process of disorientation and difficulty that a text finally emerges.

Through writing, re-writing and re-writing, a text emerged. However, the question remains, how did the text happen? In addition, Ironside (2005) suggests that we cannot step in and out of the circle but must remain within it throughout the process, though we can go back and forth. Krell (1993:344) also suggests:

In poetry we are less disposed to manipulate things or reduce them to our own technical-scientific, quantitative frames of references; we are encouraged to let things be what they are and show their many-sidedness

In this sense we let poetry speak to us as it is voiced or written. We sit with it and allow it to seep into us. This is the approach I took with the data which was collected on an ipod, downloaded onto compact discs, and transcribed by a professional transcriber. I spent time with the data through the spoken word, listening to the lesbian women describe their experiences. When I had come to an understanding of what was being said, I then turned to the written word.

In a Heideggerian sense, I dwelled with the data.

When we speak of dwelling we usually think of an activity that man performs alongside many other activities. We work here and dwell there. We do not merely dwell – that would be virtual inactivity – we practice a profession, we do business, we travel and find shelter on the way, now here, now there (Heidegger, 1993:349).

Dwelling with the data, therefore, was not a passive activity. I was doing business with it, practicing a profession, traveling with the data but also finding shelter in the voices, staying put in parts and moving along in other areas. My activities were taking me places, even though I physically dwelled in one spot, namely my study. In other words, while I was dwelling with the material, my mind was moving from one part to the next, making links through and between the voices of the lesbian women. While I was dwelling, I was building meaning and understanding which was contained within the material, thus leading me to an

interpretation of the data. Through the returning to particular shelters, themes emerged that enabled me to adequately describe and interpret the data.

Describing how the interpretation of the data came into being is not an easy exercise as Smyth et al (2007) suggest that “*working with the data is an experience of thinking*”. It is a difficult task to unravel how the thinking happened. This study required the discipline of writing, reading, re-writing, rereading until a text materialised. The initial writing was the first superficial interpretation (Smythe et al, 2007) but through the process of rereading both the data and the philosophy other interpretations emerged. However this was not a linear process but one of going backwards and forwards until a text surfaces. As Van Manen (1990:79) indicates,

Making something of a text or of a lived experience by interpreting its meaning is more accurately a process of insightful invention, discovery or disclosure – grasping and formulating a thematic understanding is not a rule-bound process but a free act of ‘seeing’ meaning

Emergent themes were not necessarily similar for all participants but rather they represented “*an understanding that we have something that matters significantly, something that we wish to turn the reader towards*” (Smythe, 2007) It is something important that necessitates thinking about and gives an invitation to the reader to think further. Themes can be thought of in another way, they give “*control and order to our research and writing*” (Van Manen, 1990:79).

I was embedded in the study and at times did not know how something came to light; it just did. Yet there were many times when nothing came and I just left it and went for a walk. There were other times when the writing flowed and hours just seemed to pass. Part of the writing took place in a hospital, my niece was

very ill and I wrote while sitting with her. Without my knowing it at the time this experience embedded me further into health care as I was present for my niece's medical and nursing care interventions. This was a peaceful time and the period during which the interpretations were written. I would write as it came and when the interpretations reminded me of something I had previously read I would put the name of the philosopher or theorist in brackets with some thoughts to remind me to look it up later and revisit the section.

Smythe (2005.228) states:

Within the experience of thinking there are no subheadings to categorize or arrange thinking. Thinking lives in rich, multidimensional ebb and flow, circling and recircling. Nevertheless, the written account demands a breaking down, and an order.

In accordance with Smythe (2005) the data was arranged through the headings chosen. Through this process, the "*painful, difficult, disorienting*" aspects of writing that van Manen (2002.2) point to, are hidden from the reader. For instance in chapter 6 *To be or not to be*, I go from lesbian women's experiences of living their lives as out and open individuals within society, to that of their decision to come out or stay in the closet, while in a health care encounter. In chapter 8 *Never the twain shall meet. private lives, public silences*, I begin with lesbian nurses' experiences of being out and open in health care setting in Europe in contrast to their experiences in Irish health care environments.

Chapters 6 through to 9 are the interpretations of the data which are presented as embedded within the philosophical framework that underpinned this study. "*The choice to 'do it this way' is known as resonance, attunement, and a sense of 'goodness of fit'*" (Smythe et al, 2007).

5.9 Study limitations

Hermeneutic phenomenology claims, meanings and understanding of everyday life “*are bound by context*” (Esterfan, McAllister and Rowe, 2004:36). This study aims to explore the meanings and understanding that lesbian women generate as either health care service users or providers in the capacity as nurses. Therefore, the findings of this study, conducted in Ireland, in 2006 with a small number of participants, are not generalisable. As van Manen (2002:7) suggests hermeneutic phenomenology writing does “*not yield absolute truths, or objective observations*” rather, “*at best gains an occasional glimpse of the meaning of human experience*”. Van Manen (1990:31) also reminds us that a phenomenological study is always “*one interpretation*”. However, this does not exhaust the process of interpretation, as there is always the “*possibility of yet another complementary, or even potentially richer or deeper description*”. Thus what is presented here, is my interpretation of the experiences of lesbian women.

5.10 Concluding remarks

This chapter has given an explanation of the method used in this study. This account has outlined my choice of methodology, the choice of qualitative technique selected and the research design employed. The description contained in this chapter, details the characteristics peculiar to this study which have a bearing on the methodology. These include the difficulties in obtaining a sample of a hidden population in society, consideration of issues surrounding secrecy and sensitivity, and the ethical and practical consequence of being an ‘insider’ researcher. It also explains the methods chosen to obtain a sample, and the interview techniques utilised.

The next chapter develops the themes that emerged from interviews with lesbian service users of the experiences of health care. Their stories serve as text for interpretation, utilizing the epistemological framework of Heidegger and Sartre.

Chapter 6: *Setting the Scene: To Be or Not To Be*

6.1 Introduction

This chapter analyses a key theme that emerge from the interviews with lesbian women as health care service users. The dominant theme is ‘coming out’ in health care encounters; the process of ‘coming out’ for lesbian women is the point of knowing who they are (Rust, 1993), with no such comparable practice for heterosexuals in society (Bradford, Ryan and Rothblum, 1997). For most lesbian women, ‘coming out’ is a life-long process, facilitating the need for self-affirmation, validation and the acceptance by others (Chirrey, 2003). It involves making decisions on whether to disclose or not to disclose, based upon the lesbian woman’s comfortableness with the self, situations and in some cases upon the past experience(s) of disclosure(s). Research has shown that coming out in health care is important, resulting in the visibility of lesbian women (Enszer, 1996), provision of adequate health care (Marrazzo and Stine, 2004) and building trust relationships, with health care providers (White and Dull, 1997). All these issues emerge in the interviews as they are linked to ‘coming out’.

This chapter is divided into four sections: the first deals with being lesbian in Irish society; the second reviews the experiences of lesbian women of coming out in a hospital setting; the third reviews the alienation of the self as experienced by lesbian women; and finally, the fourth section explores the feelings of lesbian women as being different in a health care setting.

6.2 Being lesbian in society

It is in the reality of everyday life that the Other appears to us, and his probability refers to everyday reality (Sartre, 1969:253).

Lesbian women confront the reality of being lesbian every day in Irish society. They exist within a predominately heterosexual society whereby the institutions reflect the heterosexual norms. This has been clearly illustrated in chapter two: institutions such as family (Hug, 1999; Byrne, 1997), education (Laytte, 2006; Norman, Galvin and McNamara, 2006; Lodge and Lynch, 2003) and religion (Kenny, 1997; Nic Ghiolla Phádraig, 1995), all of which reinforce heterosexual society, placing lesbian women on the margins of that society. In addition, as we have discussed in chapter two (section 2.6.2), there is no legal recognition of their relationships (Mee and Ronayne, 2000; Moane, 1995; Irish Council for Civil Liberties, 1990).

In their day-to-day living, lesbian women in Ireland know how to act, react and behave to exist within society (discussed in chapter two), having developed what Draucker (1999:361) calls "*everyday skilful coping*". These well-tested understandings and ways of being for lesbian women (Claassen, 2005), are normal ways of being, that enable them to negotiate the culture they exist in. However, these normative ways of being for lesbian women, maybe disrupted when they are admitted into hospital, attend a G.P.'s surgery or health care clinics for treatment. Lesbian women's coping strategies in everyday life, therefore, maybe challenged when they seek health care.

6.2.1 Coming out to family

The progression in acknowledging who you are is called coming out, in particular coming out to the self, which is the initial aspect of the process. Coming out is a precarious affair whereby lesbian women choose when, where and to whom they

relate their sexuality. It involves making decisions on whether to disclose or not to disclose, based upon whether it is safe to do so or not, resulting in the process being fraught with the unexpected, from social acceptability to rejection. In some instances lesbian family members have been unwelcomed by family and friendship groups. However for lesbian women:

Coming out can be ecstatic release, joyful abandonment, passionate embracing, sexual surging, a plunging into new consciousness, a journey of discovery (Moane, 1995:86).

Coming out is not a singular activity, but requires indicating one's sexuality time and again (McDonald, 2006; Markowe, 1996) (see chapter two, section 2.6.1 for a discussion on coming out).

Lesbian women experience coming out on numerous occasions with family, friends and co-workers. This enables lesbian women to know who they are, and by informing Others it reinforces the self:

To tell you the truth I'm very confident, very outward, couldn't give a flying you know what, who knows whether I'm gay or not. I've been out at work for many, many years, out to my family for many, many years and then I ended up in X [names hospital], and you would think people would be a little more progressive (*Aibheann*).

Another participant, *Ríoghnach*, indicated that not all women have the support of their families.

But Laoise wouldn't have her own family backup there, she'd have my family backup. Laoise has been integrated into my family, all my nieces and nephews call her auntie Laoise (*Ríoghnach*).

Aibheann's experience of being a lesbian woman is one of living her life openly about her sexuality. While *Ríoghnach* is open with her family, of which her partner Laoise is considered a member, Laoise on the other hand is not accepted by her own family.

Laoise's experience of not being accepted by her family, emanates from an experience she had with a G.P., who outed her to her parents:

I had a bad experience years ago with my own GP, donkeys years ago, family GP, outed me to my parents. ... I was cut out of the will and ostracised, sent to a psychiatrist to straighten me out and all this crap (*Laoise*).

This quote illustrates the consequences for some lesbian women of being outed. Laoise as a young woman discovering herself, did not have a choice in how she informed her family about her sexuality (see chapter three on the medicalisation of homosexuality). Makowe (1996) suggests that coming out is not a straightforward process, but rather it requires negotiating complex issues (as discussed in chapter two, section 2.3.4). Laoise received the care of a psychiatrist who declared her 'normal', which did not have the desired consequences for her. She was excluded from her family, and this took years to resolve. This illustrates the consequences a health care encounter can have for some lesbian women through lack of confidentiality.

While Laoise did not have an opportunity to tell her family in the way she may have wished, Barrfind accidentally, rather than by choice, informed her family but equally suffered negative reactions:

I remember when I came out to my family, I didn't really come out, it was by accident, but anyway, when my mother found out she went absolutely ballistic and my sister said to me, what do you do in bed? I didn't even answer her but I thought, my god, if she just had a little bit more, if she just said well I'm happy for you or upset for you or it'll take me a bit of time to get around it, but that was the question, what do you do in bed? ... It's the lack of thinking that there could be any other way (*Barrfind*).

Living in a heterosexual society with the expectations for women to be heterosexual was reinforced for Barrfind. Not only is the reality that there 'could

be another way' of being, but there is also the simultaneous questioning of the nature of a lesbian relationship, with the focus being on sexual activities. It silences women's sexual needs, whether they be lesbian or heterosexual, and reduces them to the single status of being sexual objects, rather than individuals.

Barrfind further indicates that, while she accidentally came out to her mother and sister, it is a process that never ends:

Every time you encounter somebody you have to come out all over again, and it's hard enough with family and stuff (*Barrfind*).

While Moane (1995) views coming out as a possible positive affair, an ecstatic release, leading to a path of discovery culminating in a joyful experience, this was not the reality, for both Laoise and Barrfind. It led instead to negativity and a questioning of how they could be different, as the reality of lesbianism was not in the realm of their families' consciousness. This reflects the all-invasive existence of heterosexuality rather than diversity (Kavanagh, 2006), resulting in the silence and invisibility that surrounds lesbianism in society (see chapter two).

6.2.2 The truth of the situation

Ríoghnach and Aibheann know who they are, and acknowledge the truth of their situation through disclosing their sexuality to all the significant people in their lives, such as family. Laoise was not afforded the opportunity to acknowledge the truth of her situation to her family in her own terms, while Béibinn came out by accident rather than design. Aibheann acknowledges the truth of her situation to friends and is confident enough to be open with her work colleagues. Through this, her sense of self is revealed both to herself and to others. All of the women in their own way, become through the mediation of others (Earle, 1969; Sartre,

1969). Giddens (1991:54) suggests that an individual will have a stable sense of self-identity if there is:

a feeling of biographical continuity which she is able to grasp reflexively and, to a greater or lesser degree, communicate to others. That person also, through early trust relations, has established a protective cocoon which 'filters out', in the practical conduct of day-to-day life, many of the dangers which in principle threaten the integrity of the self. Finally, the individual is able to accept that integrity as worthwhile.

Aibheann and Ríognach had already established their feelings of biographical continuity, that is, when they look back on their own life story they recognise the self.

They achieve this by communicating who they are to themselves and then to others, particularly their families. This enables them to develop trust relationships, whereby they can be themselves with themselves and others, thus establishing a comfort in their life. Through this Ríognach and Aibheann have created their own integrity, by coming out to themselves, their families, friends and co-workers. While Laoise and Bébinn did not choose the way they became to their families, they equally acknowledged the truth of their situation to themselves and Others, even though it resulted in pain. They effectively reverse the necessity that some lesbian women find themselves in, that is, of living a dual life (Clunis et al, 2005). This can necessitate passing as a heterosexual while knowing the truth of the situation.

Ríognach illustrates what it is like living her life with Laoise and their experience of heterosexual community:

The neighbours all know about us. We're not an in your face couple. I think we're just being treated like an ordinary, average, everyday

couple, nothing different, straight down the middle. It's not great, you can't say it's great, just normal. The young people around here know about us. The old people around here know about us. We've never been harassed (*Ríognach*).

Ríognach points out that to live one's life with the truth of the situation is, for her, to live a 'normal' life interacting with her neighbours young or old and building up interconnectedness. Ríognach and Laoise belong, they are part of the community in which they live. However, they are not "obviously" lesbian: 'we're not an in your face couple' which enables them to co-reside with Others and be an 'everyday couple'. Through this she expresses the normality, as she experiences it, of being part of a couple. Ríognach and her partner Laoise can be themselves in the face of Others. However, by stating that they 'have never been harassed', they indicate that their life may not be the reality of all lesbian couples, suggesting that lesbian women are always aware of the possibility of harassment.

6.3 Coming out in a hospital setting

It is this sense of self that Aibheann brings with her when she is admitted to hospital. She has a history of admissions for procedures emanating from gynaecological issues, which she indicates are part of her medical history, and the history of both her mother's and father's family. She continues the story of her wish that the health care profession would be aware of lesbianism. This expectation is the result of her own lived experience of being a lesbian woman in society:

One of the registrars, when I was there, was talking to me and whatever and she was saying, when was the last time you had sex, and when was the last time you had intercourse, and when was the last time, and I'm not one to get embarrassed or anything like that, but then she started getting down to the nitty gritty, and I was just thinking this woman does

not have a clue what it's like to be gay in this country, and have someone asking you questions like this. Then it came down to something very personal, and she said, and I was kind of out of it at this time probably as well, ... I don't know what they gave me, but I think I was starting to float away and she said well have you ever had sex with a man and I went why is it relevant, and she went oh well I need to know. I went, well no, and she said oh well technically you're still a virgin and I went I'm sorry I'm what? Excuse me, can you just repeat what you just said and she did. I was kind of there, whatever your perception of, I can't even remember what I said to her right now, but it wasn't very flattering, even though I kept my composure and didn't use any bad language, but I was not impressed. Not only did she bring this up on the first morning I was admitted, but everyday I was there she made reference to that, everyday I was there and this was last November [2005] and I couldn't believe it. I was there, who does this person think she is (*Aibheann*).

Like other people, lesbian women are vulnerable when they are in hospital, and they expect that health care professionals have an understanding of their situation. However, what Aibheann's story indicates is that some health care professionals are not only not aware of lesbianism, but are also openly prejudiced towards lesbian women. Aibheann's feelings of comfort, 'starting to float away' resulting from medication as she described it, was disrupted as she was brought back to the reality of the difference in her situation. This was illustrated by reinforcing the heterosexual norm at every opportunity by Aibheann's doctor from the initial consultation, to every day of her hospital stay. Her health care provider pronounced with authority that lesbian sex is not real sex, which is between a woman and a man. Aibheann's worth and value as a sexual human being is measured against the heterosexual norm. She is devalued as a sexual human being. Her worth, value, and understandings of who she is in the world were undermined:

It is only through being object that we can be given a value, assigned a worth, some "thing" that can be assessed (Howard, 2002:59).

Aibheann is not measured in accordance to her own community but to the general heterosexual community, the community of the assessor, that is the health care provider. Within this measurement she becomes a virgin. Her sexual activities are relegated to non-existence:

By far the most, you see that was the thing, what made me feel terrible was that morning in X [names hospital], it was almost like I felt ashamed to be gay, because this woman felt she could say that your sex life is completely irrelevant, because your partners have been female. I just thought what the hell is this woman on (*Aibheann*).

Sartre (1969:261) suggests that “*shame of self, it is the recognition of the fact that I am indeed that object which the Other is looking at and judging*”. It disrupts the sense of self, the taken-for-granted knowledge of knowing who I am. Aibheann did not allow herself to become the object of this judgment, rather she ‘almost felt’ but did not quite get there, as she questioned the ability of her health care provider to render her ‘ashamed’ of who she was. Equally, Aibheann did not play out the stigmatised role (Goffman, 1963).

Sartre (1969) suggests shame occurs once there is no freedom to be. Through questioning the validity of her health care provider to judge her, Aibheann reasserts her freedom to be. She is this being that the Other judges, a lesbian woman, she has embraced herself:

I am this self which another knows And this self which I am – this I am in a world which the Other has made alien to me, for the Other’s look embraces my being (Sartre, 1969:261).

The world as Aibheann understands it has disappeared from her and becomes a world that she does not recognise. Not only has the world become alien to her, she is simultaneously alienated from the world. However, she successfully prevents the alienation of the self.

6.4 Alienation of the self

While Aibheann manages to prevent the alienation of the self, Bébinn, on the other hand, found herself completely alienated when she came out to her provider.

Bébinn was admitted with suspected meningitis:

In a particular incident I was out in the hospital and I didn't have any relatives here or any that could come over and I was on my own, I was absolutely terrified and very, very ill and I had possibly, stupidly...ye know but I didn't really give a shite, told them that Finnsech was my partner and put her on my form as next of kin. I was told that she couldn't come in with me, she couldn't come either while I was being examined or while the doctor was speaking to me. She was sent out of rooms, and when I asked for her to be brought back in they wouldn't allow her. So it was a very frightening experience to be stuck on my own, not really knowing what was going on, I was seriously ill... and that and ye know, just having nurses not really wanting to touch me or to treat me. One incident, I went without, the sort I had, I had bacterial meningitis and I would have needed antibiotics at regular intervals and I went without them for a full day, because the particular nurses who were on refused to even look at me, let alone touch me or treat me (*Bébinn*).

Bébinn being European¹⁸ did not have members of her family in Ireland; she was frightened as she did not understand what was happening to her. Bébinn recognised that she needed support in dealing with the crises she found herself in, as she felt that she was 'stuck on [her] own' even though her partner Finnsech was with her. To be ill for her was a worrisome experience (Williams, 2001) and she was afforded no opportunity to share this with her nursing care team.

Research has shown (Williams, 2001; Fredriksson, 1999) that sharing one's concerns with a nurse is specifically part of the nurse-patient relationship. Bébinn did not choose to come out, rather she saw her needs but felt that she did it 'stupidly', experiencing all the consequences that followed. However she was not allowed to have her partner Finnsech with her, but the reality of having come out

¹⁸ Bébinn migrated to Ireland from another European country and found that her hospitalisation required a next of kin. Since none of her family resided in Ireland she chose her partner to be her next of kin

led her to being *not cared for by the nursing staff*. She went without medication, and equally she was avoided by not being looked at or touched. Sartre (1969) speaks of the look to be avoided; for Bébinn the nurses avoided her look and avoided looking at her. It is through this that Bébinn is objectified by the absent look of the Other:

He is the subject who is revealed to me in that flight of myself towards objectivation. But the original relation of myself to the Other is not only an absent truth aimed at across the concrete presence of an object in my universe, it is also concrete, daily relation which at each instant I experience. If the Other is on principle the one who looks at me, then we must be able to explain the meaning of the Other's look (Sartre, 1969:257).

Bébinn, in her attempt to find meaning in the avoidance of the look of the nurses, states she 'stupidly' announced her sexuality. She finds meaning in the absence of the look as centring on her lesbianism. She has become the kind of person to be avoided through not being looked at, thus becoming stigmatised (Goffman, 1963).

In this instance it is more than avoidance, it is extreme prejudice in action whereby nurses withdraw their care from Bébinn. MacGréil (1996:51) suggests that avoidance:

is a common minority response to dominant postures not perceived to be friendly or desirable by the members of the society. Sometimes it may be the only option open to a relatively weak minority in the face of dominant group hostility.

While MacGréil views avoidance from the perspective of minority groups or individual members' action(s), in Bébinn's situation it was the action of the dominant group, that is, heterosexual nurses, in relation to her care which led to avoidance. The gaze is that of the professional nurse rather than the look of a friend or stranger. The nurse looks at a patient to assess and guide her in her

clinical practice. Equally, she utilises the look to reassure and comfort the patient through being there (Fredriksson, 1999). Within this situation Bébinn becomes the Other, her similarities to the nurses, that is, as a woman, are negated and her difference is exposed through isolation. She becomes the difference in womanhood and exposes the fact that not all women are the same; that diversity exists. Bébinn was to be avoided and she experienced the hostility of the dominant group.

Lesbianism is something the nursing team could not cope with; they also lacked empathy with their patient. Empathy is considered “*essential for unimpaired moral judgements and behaviour*” (Myhrvold, 2003:35), and is deemed an important element of caring. However, the actions of nurses, or rather lack of them, removed the integrity of Bébinn’s being. Naef (2006:147) utilises the term “*bearing witness*”, indicating that this broadens the nurse-patient relationship as it is:

a special way of being with persons because it involves being attentive to persons’ lived experiences and truth, honouring uniqueness in respecting different ways of living a situation, supporting persons’ choices, espousing the belief that persons know themselves best, and recognizing human interconnectedness.

For the nursing staff caring for Bébinn, there was no special way of caring, of being with her. Her interconnectedness with humanity was severed by the lack of bearing witness

Consequently, the truth of her everyday life was not explored or recognised. The truth of the dominant group was reinforced by exclusion. The underlying message is that nurses only care for those like them, that is, heterosexual women.

Naef (2006) broadens the notion of empathy to facilitate difference to exist even if we do not understand the difference. Therefore, I know I am lesbian and by extension different; however, this does not deny me my connection to humanity. In other words nurses do not need to understand me to treat me and difference exists in being human; therefore we are not all the same (see chapter two and three).

6.4.1 Touching the Other

Within nursing literature there is a distinction made between physical touch and therapeutic touch (Gleeson and Timmins, 2005; Chang, 2001; Shakespeare, 2003; van Dongen and Elema, 2001; Routasalo, 1999). The latter is considered part of the healing process. However, Gleeson and Timmins (2005) and Chang (2001) suggest that little consideration is given to physical touch in nursing research. It is the elements of physical touch that concern us here. Routasalo (1999:843) states that physical touch:

is an integral part of nurse-patient interaction in virtually all nursing situations. The more the patient needs help in daily activities, the more the nurse will try to help by means of touching. Touch also plays an important part in complementing verbal communication, in turning a patient's attention to verbal communication, in calming a patient and in showing caring to a patient.

Touch then is considered an integral part of the nurse-patient relationship leading to communication (Shakespeare, 2003; Chang, 2001), giving comfort to patients (Gleeson and Timmins, 2005) and portraying acceptance of the patient (Fredriksson, 1999). Through touch the nurse makes contact with the patient, reassures them and gives them a sense of being cared for (Gleeson and Timmins, 2005; Chang, 2001):

Touching is about cleaning, washing, medical actions or taking someone's temperature; and touching is also about emotions, care, relationships, gender, intimacy, age and well-being. (van Dongen and Elēma, 2001:150).

However Bēbinn was denied this by the actions of the nurses who "cared" for her, as she was denied both touch and verbal communication. By not touching her, nursing staff suggested to Bēbinn that she was somehow infectious or rather, that nursing staff could catch what she had: her lesbianism. While Routasalo (1999) perceives touch as an enabler in turning the patient towards communication, for Bēbinn the lack of communication was a turning towards her difference. She understands this and knows that she was denied full care because of her sexuality.

Routasalo (1999:846) points out that not "*all nurses touch patients more than is necessary to perform a task*". This indicates that to carry out certain tasks nurses need to or have to touch patients; it is not something they can avoid. Fredriksson (1999) on the other hand suggests that non-touch is utilised by the nurse, to protect her/himself from the suffering of her/his patient(s); however in this instance non-touch was utilised to protect the nurse from the negativity she felt around lesbianism. Even if we take touch in nursing as task-orientated or part of professional care (van Dongen and Elēma, 2001), Bēbinn's experience was that the basic tasks of her care were not executed and more importantly, the nurses had abandoned their professionalism. Her body became the untouchable object. Nevertheless, it is the taken-for-granted aspects of nursing care that are denied here. Bulfin (2005:314) makes a pertinent point in relation to this: "*caring between the nurse and one nursed enhances personhood*". She indicates that the nurse through her/his caring practice enhances the individual being nursed and

allows them to grow as a person. In this case Bébinn's personhood and growth were stunted.

Bébinn indicated that she did not need nurses for the physical aspects of her care as her partner provided it:

Oh! I didn't need any of that, I was ok. Finnsech really looked after me. I didn't need any nursing care for that (*Bébinn*).

However, she is aware that if Finnsech was not a nurse then as she said; 'I would have been fucked!' but she equally states that if Finnsech was not in her life things may have been different:

Yeah! But then if I hadn't have had Finnsech, they wouldn't have known I was lesbian and I would have got tip-top care I'm sure! (laugh) (*Bébinn*).

Bébinn gives meaning to the care or lack of care she experienced emanating from her sexuality. If she had not stated she was a lesbian then nobody would have known and she would have received the appropriate care. Her difference would not have been exposed. She finds meaning in the conundrum of her difference, if she had passed as straight she assumes sarcastically she would have received 'tip-top care I'm sure!' Consequently, Bébinn became one of the categories of patients that are untouchable, a situation which is not new to the lesbian and gay community.

During the early years of the HIV/AIDS pandemic gay men were the untouchables. This emanated from the lack of knowledge and prejudice that existed around HIV/AIDS and gay men (Albarran and Salmon, 2000). While much has been done to alleviate this situation for gay men, this has not filtered down to lesbian women:

Context of discourse and interaction position persons in systems of evaluation and expectations which often implicate their embodied being, the person experiences herself as looked at in certain ways, described in her physical being in certain ways, she experiences the bodily reactions of others to her, and she reacts to them (Young, 2005:17)

Bébinn was placed into systems of evaluation and interaction through her illness, by being admitted to hospital. On entering hospital, a patient expects to be evaluated, assessed and cared for; they expect that their illness will be reviewed and considered, and that the person embodying this illness will be cared for. However Bébinn also experienced the kind of being she was, that is a lesbian woman, being evaluated and assessed and rendering her without care. Lesbian women like other patients expect to be treated, made well and returned home. What they do not expect, is the examination of the totality of the self exposed for Others to see and evaluate, in accordance to the values and belief systems of those caring for them from heterosexual norms. The nurses Bébinn encountered in hospital, evaluated her as a person they did not want to care for, as she was different: her difference did not warrant their time or care. She was made aware of this by the Other, nurses not wanting to care for her, or reluctantly doing so.

Van Donegen and Elema (2001:154) suggest that if nurses do not have an outlet for their feelings towards certain patients, they build up beliefs of distrust, disgust or in extreme cases contempt:

Feelings of disgust, shame, guilt, etc are hidden feelings and causes of much emotional trouble for nurses. They serve to reduce the intimacy between patient and nurse. The patient is felt as a threat.

This, to some extent, may explain Bébinn's experience, although, as the nature of professionalism in nursing is to care for the patient regardless of who they are. It

would appear from van Donegen and Elema (2001), that the actions of the nursing staff can be viewed from the threat perspective:

Perceptions of threat may be considered to reflect reaction to something that departs from 'normality' (Markowe, 1996:48).

'Normality' can be considered a cultural phenomenon, as what is 'normal' in one culture may be 'abnormal' in another culture. In this way an individual may feel threatened by what goes against her/his cultural norm, in this case the 'norm' of heterosexuality rather than diversity in Irish society.

The social anthropologist Douglas, was concerned with how people see themselves and Others, and how this effected their social interactions (Taylor-Gooby and Zinn, 2006). Douglas suggests that if an individual viewed the Other as a threat to the integrity of the self, then the interaction was limited:

the use of risk as a concept for blaming and marginalizing an Other who is positioned as posing a threat (and thus a risk) to the integrity of the self (Lupton, 1999:39-40).

The nurses can be viewed as seeing Béibinn as being different, and this results in a lack of interaction between them. While van Donegen and Elema (2001) view negative feelings as reducing intimacy between nurse and patient, Markowe's (1996) point is pertinent, as it is the mere perception of threat that leads to lack of communication. Béibinn was different, she did not represent the cultural norm of woman as heterosexual.

Van Donegen and Elema (2001) appear to suggest that nurses need emotional education/training on their hidden feelings; and how to deal with their negative portrayals of these feelings (see chapter three). Within the current curricula for Irish nursing students, communication skills, and by extension the nature of touch

are central aspects of their education programme¹⁹ (Gleeson and Timmins, 2005). Through their literature review Gleeson and Timmins (2005) state that the factors influencing nurses in relation to touch are environment and gender. Albarran and Salmon (2000:453) suggest the critical care of lesbian, gay and bisexual patients:

How they are accepted, treated and nursed will largely be determined by how informed and educated practitioners are about these patient groups and their physical, social and emotional health needs.

It would appear that in Bébinn's case, the nursing team lacked information and education on the care of lesbian patients, which resulted in Bébinn being viewed as a threat, resulting in no nursing care intervention.

6.5 Being different

While Aibheann was questioned about her sexual practices, which were related to the reason for her admittance to hospital, Bébinn's questioning appeared to be inappropriate to her condition. Here her difference was examined and probed, it would seem, for the benefit of her health care provider:

During that period, I had a few doctors who were equally as difficult, one in particular, I'd been seeing this consultant and he'd been to see me every few days, and he was asking me various questions ... I can't remember now how he got into it, but he started asking me questions about, I think he asked me whether I was sexually active and I told him that I was, but that you know...it wasn't penetrative sex that you know and he was very, very puzzled, he was, he was, what was he? He was non-European (names country) or something, he was a different, he was a different race like and he you know, maybe he had different...but he obviously had never come across a lesbian before in his life and he didn't, he couldn't get his head around it at all. And he just proceeded to ask me very, very personal questions about my sex life, and about what we did when we made love. And I'm sitting there assuming that these questions have got some sort of medical bearing because you know, I

¹⁹ Up to 2004 all nurse training in Ireland was through the apprenticeship model. The recruitment of potential candidates for nursing, was made to the hospital one wished to train in, and people were selected through an interview process (Fealy, 2006) This gave training hospitals power in relation to the type of individual they wanted as a nurse 2004 saw the development of diploma educated nurses, whereby links were made between hospitals based schools of nursing and 3rd level institutions In 2002 nursing education became a four year degree programme

didn't know any better, and I was out of my tree being ill, and on various drugs and stuff. And it wasn't til afterwards, until Finnsech was allowed back in; I asked her what the relevance of these questions were and she said no relevance whatsoever, you know, he had no right to be asking you those. And under no stretch of the imagination, was that you know relevant to any kind of, ye know diagnosis at all. I was absolutely furious because I mean you do trust, people like myself who don't have any medical knowledge whatsoever. Now I know a lot better, back two years ago [2004], I trusted the medical profession completely and thought they could do no wrong, and like it's not until now that I've learnt to question (*Bébinn*).

Bébinn had found her nursing care team difficult to deal with; she also found some doctors demanding.

The doctor-patient relationship has shifted throughout history, from a paternalistic approach to a patient-centred one, which is described in the following manner: *“the physician tries to enter the patient's world, to see the illness through the patient's eyes”* (McWhinney quoted in Kaba and Sooriakumaran, 2007:57).

Therefore, a patient-centred health care requires the health care provider, to have the ability to empathise with her/his patients, and use their patients' view of the situation to guide them in making a diagnosis. A patient-centred approach ultimately views the patient-as-person and the doctor-as-person, thus recognising the humanity of both participants in the relationship (Mead and Bower, 2000:1090).

Once passive recipients of medical care, patients are increasingly regarded as active 'consumers' (and potential critics) with the right to certain standards of service, including the right to full information, to be treated with respect and to be actively involved in decision-making about treatment.

However, Bébinn's experience is that she did not receive respect. She expected the standard of care and questioning to be relevant to her condition; however this was not the case. She was not treated from the perspective of the patient-as-

person, rather it was patient-as-that-person, bringing her lived experiences into the doctor-patient encounter.

While communication is considered the cornerstone of the doctor-patient relationship (Schouten and Meeuwesen, 2006; Ramirez, 2003) it is also suggested that:

clinicians who care for women need to be able to provide comprehensive and continuous care, including an ability to deal with psychosocial and life-style aspects (Cockburn and Walter, 1999:34).

It would appear that life-style is an all-inclusive term that includes lesbian women; but equally it is recognition that not all women are the same and that diversity exists (see chapter two and three). Bébin is the outsider, dependant on the professional to assist with her care. She initially tried to find meaning through recognising that her provider was non-European, and had never met a lesbian before. Bébin finds meaning in the reaction of her health care provider in the same manner as Aibheann does, that is, if the health care provider had never met a lesbian before, one could find some understanding in their attitude. Bébin also recognises the health care provider's difference, and presumes that his cultural experiences did not include lesbianism.

Rich (1999:202) observed that historically all cultures have had women who lived their lives with other women. This was either acknowledged or not

The fact is that women in every culture and throughout history have undertaken the task of independent, non-heterosexual, woman-connected existence, to the extent made possible by their context, often in the belief that they were the 'only ones' ever to have done so.

Bébin assumes that her health care provider has never met a lesbian before, presuming his culture does not allow it Ramirez (2003:51) suggests that cultural

competence is essential for treating diverse groups of patients, indicating that “*cultural competence can improve communication between consumers and providers*”. While Ramirez (2003) equates cultural competence with ethnicity, I argue that it also applies, amongst others, to lesbian women who are culturally diverse to heterosexual women. Cultural competence would lead doctors to an awareness of the values and practices of patients, regardless of their own set of cultural experiences. Schouten and Meeuwesen (2006) suggest that culture and ethnicity should not be equated, as within ethnic groups various cultures may exist. Equally, it can be stated that within a dominant culture of society various subcultures exist (Becker, 1963), and this diversity needs to be recognised (see chapter two and three), in the interest of proper health care for all.

6.5.1 Multiculturalism

Another participant, Barrfind, suggests that multiculturalism is an issue that is being recognised in Irish health care, leading to better services for those who came from a non-Irish origin:

There are different cultures, and it seems to be that there’s a lot happening in terms of those other things, but that being gay or lesbian is still very much hidden ... because we look like everybody else, and we’re living our lives, and we’re not going around with signs on our faces to say that this is who we are, so that adds to the whole invisibility (*Barrfind*).

For Barrfind it is the lack of recognisable features that leads to the invisibility of lesbian women in society, and by extension in health care. If we look the same, then we must be the same (Bonvicini and Perlin, 2003; Fields and Scout, 2001).

As her partner Folda succinctly puts it:

Yeah! It’s the unspokenness, I mean if you’re black you’re black, you’re obviously black, you know what I mean. If you’re a non-national you’re

a non-national, but because we don't have any kind of obvious trait (Folda).

Both Barrfind and Folda equate discrimination in health care, as the lack of obvious distinguishing markers that can set them apart, and alert health care providers that they are in the presence of a lesbian. However, there is the underlining assumption that all 'non-nationals' have distinguishable features, that readily mark them apart as different. There is also the supposition that if an individual is recognisable as different, they will be immune to discrimination.

Through his research Becker (1963:35) examined the position of those who participated in subcultures in society, indicating that:

Homosexuals have difficulty in any area of social activity in which assumption of normal sexual interests and propensities for marriage is made without question.

This could be is the kernel of the problem for lesbian women in health care; the all pervasive presumption of heterosexuality. Whether it is through experience, or the expectation of discrimination in health care or not, there is the underlying fear that it could happen:

And I think as well, the kind of fear that, because say, I wanted to get a particular service from a hospital or from a health provider, you don't want to be kind of ruining your chances. You don't want to tell them if it's not necessary to tell them, if you can get away with not telling them and then there is that kind of fear about how they're going to react, and whether that's going to prejudice the service that you're going to get. You can't compare that, you get the service then that you get, but you can't compare whether you would have been better or worse, if you had been heterosexual (Barrfind).

The fear of the consequences, of the kind of service that one can expect if one's sexuality is known, leads Barrfind to have a well-worked out strategy in place, should she need it. Namely, she will remain hidden, keeping the reality of her sexual orientation a secret:

Failure to meet the expectations of others may force the individual to attempt deviant ways of achieving results automatic for the normal person (Becker, 1963:36).

Barrfind knows that the expectations of health care providers, are that all women are heterosexual: therefore, to be normal is to be heterosexual. Her strategy then, is to act and behave normally, to ensure adequate health care. After all, she has no barometer to enable her to measure the health care she receives, with that of a heterosexual woman.

Bébinn only realised that the line of questioning bore no relevance to her medical condition, when her partner re-entered her room. This led to feelings of anger and mistrust. She had placed trust in her provider, and had to acknowledge that her medical knowledge was limited, and therefore in need of expert help. The trust she had placed in her health care provider was eroded, when she realised that the line of questioning was irrelevant to her condition. Bébinn understands that people place trust into the hands of the knowledgeable professional, because she does not have the knowledge; 'I mean you do trust, people like myself who don't have any medical knowledge whatsoever'. Equally, by not having the knowledge of appropriate questioning, her vulnerability was exposed and led to discrimination (see section, 6.4). Her freedom to be has escaped her and she is alienated from the self, from her world and the world of health care. Lachowsky's (1999:83) reflections on the duties of a doctor is worth quoting in this context:

The primary duty of the doctor, the very first one, is to do all that is possible to allow and enable his patient to live according [his] her own convictions, [his] her own scale of values, [his] her most personal choice.

When doctors recognise that all patients are not the same, that they hold values, make choices that are not similar to the health care provider's, a relationship of trust can develop based upon mutual respect (Ward and Savulescu, 2006). This would lead to a situation where invasive questioning would only be related to the condition as presented, and would not focus on inappropriate questioning of sexuality and active sexual practices.

6.5.2 Bad faith

Both Bébinn and Aibheann found meaning in the reactions of their respective health care providers, based on their health care providers' lack of knowledge or experience of lesbianism. Both women were relegated to the margins of society by the attitude and actions of their health care providers. However, Aibheann's sense of marginalisation is further compounded, when she discovers her health care provider was aware of lesbian existence within society:

What made me more surprised, was the next day then, she was filling me in that her best friend and one of her colleagues in the hospital, is in a female, same sex relationship and that one of them is pregnant by a donor that they know I was thinking, ok! In her private life she seems to be somewhat progressive, and then at work she seems to be an absolute cow towards her patients, so I think that actually made me feel worse. I remember saying it to her the next day, I just said: well I was a bit taken aback by what you mentioned yesterday; and then for her to bring it up again and give her view again, and then the next day to give her view, not only again to me, but to the doctor beside her, and it was almost like the cringe embarrassment factor with me there in the room again. I'm kind of going, it's almost like you're irrelevant, you are irrelevant if you're gay in this country and you go into a maternity hospital. She made me feel like Dr. X, you're a waste of space, let me treat the heterosexual couple behind you (*Aibheann*).

Aibheann attempts to understand and give meaning to her experience, by questioning her health care provider's attitude towards lesbian women, despite her health care provider's friendship with another lesbian woman who is also a

colleague. She is surprised, as she had attributed meaning to her health care provider's reactions, as emanating through a lack of knowledge about lesbian life, never having encountered another lesbian woman. She had said, that at the time she 'was just thinking this woman does not have a clue what it's like to be gay in this country, and have someone asking you questions like this'.

Aibheann had decided that her health care provider had no knowledge of lesbian life. This was not the case, leading Aibheann to realise that there is a strict line between one's private life and one's professional life. Privately, some health care professionals may have friendships that include diversity in sexual orientation, but publicly they reinforce the heterosexual norms of society. This could also be viewed as the recognition by the health care provider of the heteronormativity of the hospital setting (McDonald, 2006; Bonvicini and Perlin, 2003; McDonald, McIntyre and Anderson, 2003). It is also the health care provider's ability to show that she fits into this setting. Equally, it represents the success of her medical training, illustrates the effectiveness of socialising, and the ability of the health care provider in reinforcing the norms, values and belief systems of her profession (Beagan, 2000).

However, from a Sartrean point of view, the health care provider could be perceived as being in "*bad faith*" (see chapter four for a discussion on "*bad faith*"). Sartre suggests that through lying to both the self and Others, the individual is avoiding the truth of the situation. The health care provider illustrates this, by initially indicating to Aibheann that lesbian life was non-normative. She expresses the untruth of the situation, leading Aibheann to find

some meaning for her provider's initial pronouncement. On the other hand the health care provider could be said to be in 'bad faith' with her friend: the truth of the situation is that she does not view lesbian women's relationships as being equal to heterosexual relationships. When the health care provider reinforces her attitude towards lesbianism in front of another health care provider, she is the "one who practices bad faith, is hiding a displeasing truth or presenting as truth a pleasing untruth" (Sartre, 1969:49).

One aim of medical training is to produce neutral individuals who can care for their patients, regardless of their attributes: age, gender, sexuality or ethnicity (Beagan, 2000; Lachowsky, 1999). However it is also suggested that:

It is not sufficient to be responsive to the sociocultural biases of your patients; it is also essential to be aware of and reflexive about your biases in order to achieve genuine connections. If a physician acts out of his or her unexamined assumptions during an encounter with a patient, that will have an impact on the interaction, whether or not the impact is recognized (Beagan, 2000:1263).

Aibheann's health care provider is either hiding a pleasing untruth from a Sartrean sense, or her encounter with Aibheann forced unexamined attitudes to the forefront, resulting in her pronouncements. The neutral doctor from Beagan's (2000) perspective, is a myth; she argues that medical schools should examine and deconstruct the social location of their students, thus enabling the next generation of medical practitioners to relate to patients as they present themselves, not as one would like them to be. In recent years, a multicultural reality has been developing in Ireland (Fahey, 2007; Loyal, 2007), in contrast to the normative views explored in chapter two and three.

6.5.3 Finding the self

Aibheann reasserts her sense of self, by questioning her provider about her friendship with a lesbian colleague. She struggles with the ability of the Other to objectify her, musing over the effect of the private sphere overlapping the public space that her provider inhabits. After all, Aibheann did not discover the duality of her provider's attitude from another, rather from the provider who volunteered this information. In challenging this duality, Aibheann finds herself being further marginalised by her provider. This is achieved through reinforcing the heterosexual norm, by repeating her original diagnoses of virginity publicly to another colleague. This can also be viewed as the ability of her health care provider to punish Aibheann for having the audacity to challenge her pronouncements, and in point of fact, silencing her. This led to Aibheann experiencing 'cringe embarrassment factor', thus leading her to experience an "*alienation of [my] her own possibilities*" (Sartre, 1969:263).

Aibheann has become in effect what the Other judges her to be, thus disregarding her as a lesbian woman. She is effectively alienated from her own self, the possibility of being a lesbian woman. While she had successfully retained her freedom in the eye of the Other when she had a one-to-one consultation, in the face of two health care providers, her freedom escapes her. While her freedom escapes her, she takes onto the self the judgment of the Other, labelling herself a 'waste of space' who needs to clear a path for the worthy 'heterosexual couple behind' her. Equally, this tract illustrates how heterosexual women can easily establish the credibility of inhabiting the norm in the face of the Other. For the

health care provider, Aibheann has become the Other, the object by which she herself can be judged as belonging to mainstream society which denies diversity.

Aibheann recovers the sense of self when she meets another health care provider who she recognises as being lesbian, through the use of her 'gaydar'. This is the ability of lesbian women to recognise other lesbian women, before the truth of the situation is uncovered. This enabled Aibheann to regain the sense of self, not only to herself, but also in the eyes of the Other. It not only enabled her to recover, but also to acknowledge both her existence within society and her worth as a human being. Ramirez (2003) suggests that minority patients seldom meet a health care professional from their own cultural background, which he states is called "*racial concordance*" leading to patient satisfaction. Meeting someone from her own sexual minority enabled Aibheann to develop a relationship based on trust, whereby she could openly communicate. In this way we could draw parallels the notion of racial concordance to also mean sexual concordance.

Equally, who she is as a person could be explored through 'a great oul' chat', as the way a person thinks, feels and lives their lives (Ward and Savulescu, 2006) is equally important as their "*body temperature or blood-pressure*" (Lachowsky, 1999:82):

Then there was another gynae, [names her], sure my gaydar was going, and I was thinking, sure I'm in grand company here, and I obviously was and we had a great oul' chat, and she was absolutely fantastic and made me feel like a human being again, being treated in a hospital, and didn't give a crap what my sexual orientation was, I'm a woman and that's it! You're in a gynae hospital; you're here for a reason; you're not wasting anyone's time; you're sick; and we're here to make you better (Aibheann).

Through meeting a new health care provider Aibheann was able to communicate the self and is elated, as she can pronounce 'I'm a woman and that's it'. Unlike Bébinn, Aibheann finds an opportunity in the hospital setting to recover herself as a lesbian woman. There is the possibility for diversity to exist (see chapter three). She also discovers that she has a reason to be in hospital, and importantly is not 'wasting anyone's time'. Through this, she asserts her rights to health care as after all she is 'sick'.

6.6 Concluding remarks

Through their lived experience we see that lesbian women come across various attitudes towards their lesbianism, ranging from negativity to positivity. Within the Irish health care system, the majority of women experience a service that is not based upon sexual diversity. Lesbian women were Othered, having their sense of self alienated from the health care setting. Their differences were exposed Others to see, resulting in extreme prejudice in some cases.

Sexual diversity was not in the realm of experience of either doctors or nurses, resulting in an inability to care for lesbian patients. Doctors displayed the power of the medical profession, to access and pronounce judgments on lesbian women based upon the heterosexual norm. This ranged from declaring that lesbian sex was not real sex, therefore the lesbian woman was a virgin; to invasive questioning on sexual practices that bore no relevance to the illness presented. Nurses, on the other hand exhibited extreme prejudice in action by not caring for lesbian women.

The next chapter develops the theme of 'being different' that further emerged from interviews with lesbian women as service users.

Chapter 7: *A Woman-Friendly Health Care*

7.1 Introduction

This chapter will further analyse the themes that have emerged from the interviews with lesbian women as health care service users. The dominant theme is 'being different' in health care, whether that is being made to feel different or knowing one's difference, regardless of interaction with others. Heidegger (1969:63) suggests, "*this thing that is called difference, we encounter it everywhere*". As we have seen in chapter three, lesbian women experience their difference in health care through: societal views of what is 'normal' and 'natural' sexuality that are reflected in health care (Taylor, 1999); assumptions of heterosexuality (Lehmann, Lehmann and Kelly, 1998); as well as the health care needs of lesbian women (Marrazzo, Coffey and Bingham, 2005; Spinks, Andrews and Boyle, 2000). The women's health care strategy (Government of Ireland, 1997:54) advocated woman-friendly health care, creating a service that "*should not further marginalise women who are already marginalised*". Included in the strategy is an action plan which states:

Health boards will be asked to ensure that health professionals are informed about lesbian health issues and that staff respect the sexual orientation of lesbian women (Government of Ireland, 1997:64).

This chapter will explore whether this is being implemented, and is divided into five sections: the first deals with a health service based upon diversity; the second reviews the issues faced when accessing cervical screening service; the third reviews the power of the medical profession; the fourth explores the feelings of lesbian women as patients in a hospital setting; and finally, the fifth explores being a partner of a lesbian woman in health care.

7.2 Diversity in health care

In reviewing the European Charter of Patient's Rights and its application to Ireland, O'Mathúna et al (2005:133) recommends that:

Steps must be taken to ensure that access to health care services is available without discrimination and on the basis of people's health care needs.

In 2005, it was stated that health services should be provided in a non-discriminatory manner as well as taking into consideration the needs of the patients, which was already one of the aspirations of the women's health care policy in 1997. It is clear that these principles have not been achieved for lesbian women. During the consultation process that preceded the development of a women's health care policy, women had identified:

Major deficits . . . [which] . . . were the difficulty women experienced in accessing information on health and health services, . . . , and the fact that the health services are not woman-friendly (Government of Ireland, 1997:5).

Indeed, Aibheann's and Bébinn's experiences (see chapter six), suggest that a woman-friendly health service was not available to them, in spite of this being one of the goals of the women's health policy. More importantly though as Zack (2005:2) states, "[T]here is no question that women are different" this point seems to have escaped medical providers and resulted in uneven provision of health care. For instance, Aibheann's obtained her right to receive competent health care, while Bébinn was ignored and her existence negated.

The care which both women received revealed discriminatory actions on the part of their providers. Aibheann's story reveals that while some lesbian women live their lives openly and securely in the knowledge of who they are, they cannot expect their taken-for-granted understandings of their life in new situations.

While Aibheann had an underlining expectation that health care professionals appreciate the reality of diversity within sexual orientation, she discovered the fallacy of this. The only acknowledgement of the legitimacy of her existence was through another health care professional who was also a lesbian woman. Bébinn, on the other hand, trusted that her health care providers would treat her competently as she was the uninformed recipient of care. However, she learnt that this trust was misguided and vowed never to trust again, but rather, to question (see chapter six).

Aibheann's expectation was that the health care sector would be a 'bit more progressive', recognising the diversity amongst women. Bébinn on the other hand had no expectations but came out as a way to assert her needs, that is, the requirement of an advocate by her side who could either speak on her behalf or facilitate questions. While both women experienced both covert and overt prejudice during their hospital stays, Gormlaith on the other hand experienced a completely different health service.

Gormlaith was admitted to hospital for breast cancer treatment:

Cellach and I sat in the waiting area, and didn't know what was what. Then on Monday we went to see X (names consultant), and Cellach sat there with me, and you know those private places they're all posh, not that its not the public sector, he said you know. Gormlaith, I'm X, pleased to meet you, he said: would you like to come in and would you like to bring anybody with you. I said I'd like to bring Cellach my partner with me. We went in and not even a blink, and right from that moment Mel, and right through a series of events in between it, we have seen because it's our cancer or was our cancer, but right from then till the 26th March, it's been our cancer, and its been our consultant, right down to decision-making, what do you want to do? I looked at Cellach and said: what shall we do? and she said it's up to you, and right from that first day Mel, his engagement and all of his team's engagement now we met, as you know, you get medics changed every 6 months, and for

every appointment, Cellach was there right by my side, in every sense of the word, there was never a blink of an eye, there was never nothing. From day one we had a private room, all the nurses were most respectful, very would you like be on your own? No I want Cellach to stay with me, even right up till 11 o'clock (*Gormlaith*).

From Gormlaith's story, we see how her sexual orientation was not an issue; she was able to be herself and have her partner Cellach with her during her first consultation, and throughout her treatment. She was afforded the opportunity to be, experiencing 'not even a blink' from the beginning of her treatment. She speaks of her experience of breast cancer as affecting both Cellach and herself: it was 'our cancer', not Gormlaith's, but Cellach's as well. It was something both of them had to learn to live with and to be worked through together. The decision-making was a joint project to be worked through where both women could live with the outcome.

Neither Gormlaith nor Cellach became the Other in the eyes of their health care team. Unlike Bébinn, who had her partner Finnsech outside the room during consultations with her medical provider (see chapter six, section 6.4), Gormlaith and Cellach were seen together and, consequently, the reality of the truth of their situation was acknowledged. Their need to be and care for each other was never questioned, but acknowledged and facilitated by the care team. This reflects a health care service based on trust and mutual respect (Ward and Savulescu, 2006), in which the patient-as-person and the doctor-as-person (Mead and Bower, 2000) were encapsulated. Ultimately, what Gormlaith and Cellach experienced, was a patient-centred health service whereby both the medical staff and nursing staff were either educated practitioners (Albarran and Salmon, 2000), or health care professionals, who could provide care regardless of their understanding of

different modes of living (Naef, 2006) (see chapter three). As Gormlaith describes:

They were absolutely fabulous you know they would say, Cellach would you like a cup of tea? it was like as if we were joined at the hip. Right through Mel, from the first surgery, and then unfortunately, they didn't get rid of all the cancer the first time round, and they also discovered it in the lymph nodes, which that meant chemo every two weeks up in Y, so then there was the second surgery in April, same thing in there, herself, curtains around, sitting on my bed, the whole shebang, not even the blink of an eyelid, X (names consultant) his whole team, the breast care staff (*Gormlaith*).

No member of her care team had any problem with her relationship, even to the point that she reflects that they thought they were 'joined at the hip'.

From a Heideggerian (1962) perspective, Gormlaith and Cellach experienced the authenticity of the self. Through this, Gormlaith's illness opened to them the possibility to become authentic (Heidegger, 1962). When Heidegger (1962) speaks of being authentic he suggests that it is a choice. Gormlaith chose her authenticity by seeing herself as, a lesbian woman with breast cancer; it was hers and it belonged to her. As a couple, both Gormlaith and Cellach also declared their authenticity by viewing Gormlaith's illness not only as belonging to her, but as theirs. In this way they chose their possibility of becoming in whatever way the illness took them. It became a part of who they were as a couple. Equally, this points to a health care service that is based upon the provision of care centred on the illness, rather than on the type of person who presents themselves.

7.3 Cervical screening

While Aibheann was not initially overtly concerned whether her health care professional knew about her sexual orientation, Bébinn had no choice as she had

no family members available for her to call upon. Barrfind, on the other hand, feared adverse reactions to the extent that she was prepared to lie to her health care professionals, keeping her sexuality secret; she had no barometer to measure whether she received the same quality of health care as a heterosexual woman (see chapter six, section 6.5.1 for a discussion of this). Gormlaith and Cellach experienced no adverse reactions to the truth of their situation. Other lesbian women may not be as comfortable in health care encounters when it comes to coming out. One such encounter is when lesbian women seek cervical smear tests. As sexually active women, lesbian women, similar to heterosexual women, are attentive to their need for cervical smear tests, and the role they play in identifying cancer cells.

The Irish Cervical Screening Programme (ICSP) states that it:

offers free cervical screening to women aged 25-60 years in the Mid West area Cervical Screening is a worthwhile preventative health measure Smear tests can detect early changes in the neck of the womb, the earlier a change is found the easier it is to treat Results of screening smear tests reflect a reduction in risk in a woman developing cervical cancer Smear tests are not diagnostic. This reflects the limitations of the test (<http://www.icsp.ie/>).

The Health Service Executive will roll out this service to all women throughout the country in the near future. In 2007, the HSE were going through the process of advertising positions, to enable a country wide service to be available to all women. While the ICSP does not indicate who should undertake cervical screening, the New Zealand screening service does indicate which women should consider a test:

All women who have ever been sexually active are advised to have smear tests from the time they turn 20 until they turn 70 This includes single women, lesbians, disabled women, women who have been through

menopause (change of life) and women who are no longer having sex. Women who have had a hysterectomy (removal of the uterus) need to check with their doctor or smear taker if they still need to have cervical smear tests. Women who have never had sex do not need to have cervical smear test. (<http://www.healthywomen.org.nz/>).

New Zealand constructs a clear picture of who should consider a smear test, with no margin for ambiguity. It is inclusive of all women who are sexually active or have been sexually active in the past, regardless of their ability, dis-ability or sexual orientation.

While the ICSP does not achieve this, they do, however, provide an age range for women as to the relevance of cervical screening. From an Irish perspective, women from the age of 25 to 60 need to undertake screening, while the age bracket in New Zealand ranges from 20 up to 70. This begs the following question: do the Irish medical profession believe that screening is irrelevant to under 25 year olds and over 60 year old women? The most pertinent point, however, is whether the Irish medical profession or health policy makers, believe that women under 25 and those over 60 are not sexually active. This calls into question, knowledge based on women's sexual health and sexual practices by those who make decisions on women's health care, and sociocultural context of their training (see chapters two and three) which perhaps did not recognise either diversity or the lifespan of a sexually active woman.

7.3.1 Heteronormativity

However, when lesbian women initiated these steps to obtain health care, some were informed that they did not need smear tests as they were in same sex relationships. This calls into question not only the validity of lesbian

relationships, but also the nature of lesbian sexual practices. It equally indicates that certain medical procedures such as cervical smears are considered to be relevant only for sexually active heterosexual women:

I went to get a smear test in the X Centre in town, and when I explained, or when the female doctor asked me, if my partner had also been testing or if there's any kind of mention of a partner, and I said that I was gay, she then oh! Well, then it's ok, you don't need a smear test. I asked again, because being (names European country of origin) you get smear tests every year or every 2 years, and here it's actually not like that, so I was a bit surprised and shocked, and I said I still wanted to get the smear test done, even if I was gay. Sorry she didn't ask me anything about the partner, I'll take that back, she asked me about being sexually active and I said yes I am sexually active, and I'm in a gay relationship, and then she said, that's the response that I got, not needing the smear test, which I thought was a little bit stupid and unprofessional, but I did get the smear test done and that was it (*Caireann*).

Caireann's previous experience of cervical smear tests as being relevant to all women informs her knowledge.

Caireann's knowledge emanates from her cultural experience (European country of origin), which informed her when she sought health care in Ireland. She viewed the response of the health care provider, as being both 'stupid' and 'unprofessional', pointing to the fact that lesbian women expect both knowledgeable and professional health care. *Caireann* had to persuade her health care provider that, regardless of her sexual orientation, she wanted the medical procedure, despite the fact that the provider did not see it as being relevant for her health care. Heteronormativity is at play whereby the health care provider perceives procedures in relation to the types of sexual activity that are taking place, namely heterosexual sex or lesbian sex. However, the underlying attitude is that lesbian sex is not real sex. This is reflected in *Aibheann's* experience (see chapter six, section 6.3). Equally, there is a subtle interpretation that only the

penis can activate cancer cells. This could also be understood as the penis being the site of disease/infection. It suggests that only women engaged in penetrative sex, that is penis/vagina sex are susceptible to cancer, or need to take a smear test. Therefore, it could be stated that the clear message being given is that the penis causes cancer. Similarly, it would sets aside the Freudian notion of 'penis envy': why would any woman be envious of an organ that could possibly cause death and destruction of the female body? Extraordinarily, it would appear that the unintended consequence of this discourse, is that the male sexual organ is the site of infection for heterosexual women, and by extension lesbian women are safe.

Afric's experience of seeking a smear test is similar to Caireann's. These two women initiated the visit to a health care professional for different reasons; Caireann from her experience of health care in another European country and Afric's from her family's experience, namely the death of her aunt from cervical cancer:

Years previous, I had gone to have a smear test and when I went to have the smear test, I had to see 2 or 3 different nurses, and when I spoke to the first one, she said to me, that you need to see the doctors, and when I went to the doctor I said to the doctor yes, I was there for a smear test, and she was asking me about being sexually active, and I said I was and she said well, when was the last time you had sexual intercourse, and I said well I haven't had sexual intercourse with a guy, but I'm sexually active with a woman and her response to me, which was extremely negative and made me feel like I was 2 foot tall, she said well! I don't know why the hell you're here, because it's not necessary for you to have a smear test, and why in god's name would you come for one. My response being, well my aunt had died of cervical cancer, and that I obviously was worried and concerned about that. They didn't want to give me a smear test, so I insisted that I wanted one done, and to say that it was fairly horrific was an understatement, because they weren't very nice from the minute I'd been and I'd never had one, so I didn't know what to expect or anything like that. I just thought that I would never return to that clinic anyway, for starters, and I certainly wouldn't be ringing them for advice, and they were one of the clinics in X that's supposed to be a women's kind of clinic (*Afric*).

While Caireann was advised that she did not need a smear test, Afric's experience was that of wasting health care professional's time. Aibheann and Afric experience the extreme negativity of their respective health care provider's attitudes towards lesbianism.

Aibheann was declared a 'virgin', her sexual practices rendered non-existent and irrelevant (see chapter six). Afric was met with equal dismissal. This rendered Afric as feeling inferior; the image of being '2 foot tall' came to mind, which indicated she was not all there, as if a part of her was missing. This image of being smaller than herself effectively reduces Afric from the status of adulthood to one of childhood. This leads her to view herself as being insignificant and invisible. Her vulnerabilities are set out for the health care provider to look at, but equally for Afric to see. The health care professional never asked why Afric had concerns, or what brought her to seek medical care. However, Afric's experience can also be understood from de Beauvoir's (1976:141) perspective on childhood:

Childhood is a particular sort of situation: it is a natural situation whose limits are not created by other men and which is thereby not comparable to a situation of oppression; it is a situation which is common to all men and which is temporary for all; therefore, it does not represent a limit which cuts off the individual from his possibilities, but, on the contrary, the moment of a development in which new possibilities are won.

Afric is not a child, rather an adult, and her possibilities of becoming are denied to her by her health care provider. The feelings that Afric experienced were unnatural, in that she had moved out of the temporary childhood situation to adulthood, but was denied her freedom to be a thinking, rational human being. As de Beauvoir (1976:141) further states "*even in this situation the child has a right to his freedom and must be respected as a human person*". In Afric's case,

she was not treated as a human being. While de Beauvoir (1976) views the situation of childhood as being non-oppressive, Afric's health care provider oppressed her, by rendering her with feelings of not having entered full adulthood, that is, to be a full adult is to be heterosexual.

While Afric did volunteer the reason why she was seeking a smear test, this information did not result in a positive experience for her. This led Afric to conclude that, she 'would never return to that clinic anyway for starters, and ... certainly wouldn't be ringing them for advice, and they were one of the clinics in X that's supposed to be a women's kind of clinic'. Afric experienced disappointment in the quality of the care she received, but equally, she expected that a women's health clinic would have been more appropriate to her needs. She was left feeling distressed. The expectations are that a women's health clinic would understand the diversity of sexual orientation. Within them, the health needs of all women would operate in a context of diversity, rather than in a heteronormative one (see chapters two and three).

7.3.2 Being set apart

Another participant, Folda, recounts her experience of obtaining a smear test:

Again just the usual thing about, I remember going to the hospital about 10 years ago, and somebody asked me when was the last time I had sex, and I said I hadn't, or intercourse with a man, and I said I hadn't, and I was just looked on with dismay kind of thing. To me it was just an odd reaction and then I just felt upset, because I felt my god, it's like if you're not having a relationship with a man, you're a nobody really, you're a kind of a non entity, so yeah! I found that upsetting, or the usual, it really gets to me going for a smear test, and if it's a doctor filling in or whatever, are you uncomfortable having intercourse, and this kind of thing. That gets to me, I just say I'm not heterosexual. The presumption, that gets to me, and yet we all are coming and going, doing our jobs, and our shopping, paying our bills and all the rest of it, we

don't have gay written across our heads. We're not out there waving banners and sticks (Folda).

To be looked on with 'dismay' was for Folda an 'odd reaction'. Later she felt 'upset' by the reaction of her health care provider, leading to the realisation that 'if you're not having a relationship with a man, you're a nobody, really you're a kind of non-entity'. Through the look, Folda was set apart, her difference was exposed for her to see by her health care provider. Folda felt the look was not a friendly one, rather a negative look. The look did not protect her, rather it set her apart, putting distance between her and the medical provider. It rendered Folda with feelings of inadequacy, whereby she had become an object in the eyes of the Other.

Sartre (1969:260) states: "*I see myself because somebody sees me*". It is through her health care provider that Folda sees herself. She has not only become the object of the Other, she is now open to their judgements and sees herself as the Other sees her, namely, 'dismay', thus judging herself as the Other judges her:

By the mere appearance of the Other, I am put in a position of passing judgment on myself as on an object, for it is as an object that I appear to the Other (Sartre, 1969:222)

Folda stands outside of herself to take measure of the self. It is as if she looks around to find herself and how she fits into the society that she lives in. Folda achieves this by indicating the ordinariness of lesbian life through work and paying of taxes, shopping or paying bills, all of which are the taken-for-granted activities of everyday life. Lesbian women actively participate in everyday life in similar ways to heterosexuals in society. Through this, Folda indicates that lesbian women are not unlike Others in society, through their participation in the day-to-day reality of living.

This is similar to Ríoghnach's assertions, when she states that as a couple she and Laoise are treated:

like an ordinary, average, everyday couple, nothing different, straight down the middle. It's not great you can't say it's great, just normal (*Ríoghnach*).

For Ríoghnach, there is no greatness in being ordinary: ordinary is normal. For Folda, participating in the every-day activities of living is ordinary, normal. Both women indicate that they live in a predominately heterosexual society (Markowe, 1996), and on some levels they fit into this society. For Ríoghnach this is illustrated by the ordinariness of being a couple, just like a heterosexual couple, while Folda views it as the taken-for-granted activities of every day life. But for Folda the sense of normality escapes her, in her health care encounter.

In her attempt to recover the self, Folda acknowledges that lesbian women are not readily recognisable as they do not have 'gay written across our heads', thus alerting Others that they are in the presence of someone different. There is also an underlying suggestion here that if this difference was somehow readily recognisable, things might be different. She is also aware that there is an all-embracing presumption that all women are the same, namely, heterosexual. This is reinforced by Barrfind, Folda's partner, when she says:

I think it's a lack of awareness that people reckon that everybody is heterosexual (*Barrfind*).

Barrfind experiences lesbian women's invisibility throughout society and not only in health care (see chapter two). Lesbian women have effectively been erased from societal reality through the presumption that all women are heterosexual. It is this lack of awareness that creates problems for lesbian women in health care.

Folda sees the presumption of heterosexuality not just in health care, but permeating wider society. She gives an example of her experience in relation to the expectations that Others in society have of how a woman spends her weekend:

it's when people will assume that you're either single or you've a man somewhere, where did you go with himself at the weekend, or everything is built around that. I mean, I built the house for X, did the husband get your man to do it, and I just went yeah! Yeah! I just couldn't be arsed saying - well actually, I just said yeah! It's just the presumption that you're either single, or in a heterosexual relationship (Folda).

It is this reality, that society is built around heterosexuality, that she struggles with through living her life as a lesbian woman. The social expectation is that women are either single or married. The assumption is that even if a woman is perceived to be single, she is hiding a relationship with a man, while the reality is that the relationship being hidden, is that with a woman. Folda understands that within society the expectation is that a woman is heterosexual, which negates her existence and forces her to remain hidden (see chapter two) in a society where diversity in sexual orientation, is not a societal norm.

7.4. Power of the medical profession

Caireann, Folda and Afric bring to mind their experiences that go back in time, revealing that health care encounters remain in their memory for a long time, particularly when they discredits the validity of their existence. Not only does it negate their existence but also their value and worth as sexually active women. Lesbian sex is declared worthless and lesbian relationships are measured negatively in relation to heterosexual relationships. While these lesbian women had invited the health care provider to look at them, they did not like the look as it

left them feeling uncomfortable, inadequate or insufficient, in terms of who they are as lesbian women. They felt unhappy, ill-at-ease and vulnerable.

Shildrick (2002:1) points out that:

vulnerability, [is] an existential state that may belong to any one of us, but which is characterised nonetheless as a negative attribute, a failure to self-protection, that opens the self to the potential of harm.

All of the lesbian women felt this negative attribute when their sexuality was revealed, putting them in potential harm, particularly when they were told that a smear test is irrelevant for lesbian health care. While Caireann, Folda and Afric received the procedures that they sought, they did so while experiencing the negativity of the Other as not being part of the normal idea of being a woman. By receiving the procedure they wanted, Caireann, Folda and Afric protected the self from harm. However, negative attitudes from health care professionals can have consequences for further health care (Saulnier, 2002; White and Dull, 1998). Saddul (1996) points out that when lesbian women have positive experiences of health care, this has consequences for their own health as they return for further services. Lesbian women also inform their lesbian friends who seek referrals to that particular health care provider or health care centre(s) (Stevens, 1996) (see chapter three).

All the experiences recounted, illustrate the power of the medical profession to reinforce the sexual norms of society (see chapter three and six): lesbian women with the exception of Gormlaith receive a health care service that is based on heterosexuality. The medical profession has the ability to be the power brokers, thus reinforcing the norms of society, even in the face of non-normative

behaviour, therefore relegating lesbianism to the periphery of society.

Lachowsky (1999:82) suggests that the doctor-patient relationship:

like any interhuman relation, is made of what is said, what can be said and what cannot, of words and attitudes, but also of systems offered, accepted or refused, of exchange and barter. It is anything but static and monolithic, but one thing is never modified: we and we only have the right to unveil the other's body, to invade the other's mind, in a word to have access to the other's innermost privacy.

Lachowsky (1999) illustrates the power of the medical profession: through medical procedures they are given access to patients' bodies, cares and worries. They can make diagnoses, and declare whether the person inhabiting the body is ultimately going to live or die. Folda countered the negative experience, and empowered the self, by expressing the normalcy of every-day-life.

The comfort zone of a life being lived is questioned through health care encounters. Aibheann questions the doctor's position in declaring the sexual norm by saying 'who does this person think she is' (see chapter six). Through this, she counters the alienation she feels in the world of health care. Caireann and Afric counteract by asserting their identity and obtain the procedure they require, regardless of the attitudes of their health care providers. However, Aibheann's and Bébinn's sense of self was disrupted through being alienated from the self. While Aibheann recovered the self through her encounter with a lesbian health care professional, Bébinn was afforded no opportunity to do so (see chapter six). Afric on the other hand, decided that she would never return for health care or seek advice regardless of her needs in this particular clinic, as it excluded diversity in the sexual lives lived by women.

7.5 Occupying a different space

The environment of the hospital differs to that of society, and this is where the reality of being a lesbian woman must be navigated, particularly if she wants to keep her sexual orientation hidden. Ríognach has had numerous hospital admissions; she describes her experience of being a patient:

Now, when I'm in hospital, I'm in a room for women, I am always aware that I'm gay, and I will not stare people. I get very, very shy. I get to the bathroom as soon as I can, and I sort of have tunnel vision, and I'd be afraid that somebody would complain about my behaviour or something like that, although just talking to somebody, but because your chart says your orientation or whatever, it might go against you, so I do have a problem, now and especially if there's a nice woman there, you know yourself (*Ríognach*).

Ríognach recalls she is constantly sensitive of who she is, a 'gay' woman, and how a survival strategy is put in place to avoid detection. Her tactic includes: changing who she is from outgoing to 'shy', getting early to the bathroom, and having 'tunnel vision' enabling her to prevent discovery.

Heidegger (1969:26) indicates that "*To every being as such there belongs identity, the unity of the self*". It is the unity of the self that can be called into question, if patients discover that amongst them there is a lesbian woman. In other words, the 'unity of the self' is every facet that makes up the unit. For example, I am a woman, a teacher, a lesbian and a lover; all of these and more belong to who I am. The presence of the Other forces Ríognach to curtail her behaviour, so that she does not 'stare people'. Through this she experiences the fear of the consequences of being exposed as it 'might go against you'. While Ríognach protects her identity when she is a patient, she does not indicate whether her strategies were breached. In this way she has no way of knowing how Others would react to her being a lesbian woman.

In relating her experience, Ríoghnach reveals her awareness of setting up barriers to protect the self, thus denying herself a full encounter with Other patients.

I like to be beside the window, where I have a distraction. It's not that you're sitting there ogling women all day, but like, when you have women in their night attire all the time, and conversations going on, it's funny slagging men off or whatever, whatever, and you want to enter into it, but you don't know what they're saying, it can be embarrassing and it can be very isolating (*Ríoghnach*).

The window can be seen as a mechanism of the “*look to be avoided*” (Sartre, 1969:258). The window acts as an escape route by which the Other does not enter into her realm, just as the conversations in the ward act as barriers to her participation and domain of reality.

However, Sartre (1969:257) suggests that ““*Being-seen-by-the-Other*” is the truth of “*seeing-the-Other*””. For the lesbian woman, the truth of being-seen-by-the-Other is that the Other knows who she is. Equally, to know the self is to know how the Other sees her. I no longer know the self as I see it, but rather I know it as the Other sees it, and I become the object for the Other and simultaneously become my own object. I am no longer the self as I view it and understand it, rather I have become the self as the Other sees it and understands it. Ríoghnach comprehends this; her knowledge of existing as a lesbian woman in Irish society informs her, and that is what stops her from being-seen-by-the-Other. It is through this knowing that Ríoghnach filters information about the self to Others.

7.5.1 Considering Others

Ríoghnach is always aware that other patients share the space of a ward and avoids looking at them. She cannot influence the interpretations that Others will put on the look. For example, the look of an admirer is different to the look of a

friend or stranger, and can be said to be culturally understood regardless of sexual orientation. Ríoghnach fears that 'my look' may give off a meaning that does not exist. This calls into question whether a fellow patient is a patient or something else, for example an object of desire. Ríoghnach recognises this, but is also aware that she possibly misses out on authentic conversation(s), that is, conversation(s) where she can be herself without hiding her sexual orientation.

Ríoghnach's fear is that this may not be the reality, and she does not risk it as she does 'what is right for me':

It's just like I put on the 2 cloaks wherever I go, and if I was a straight woman and there was a gay woman looking at me, how would that make me feel? It'd make me feel uncomfortable. It's like as if I was a straight woman, and a man would be ogling me, that would make me feel uncomfortable too, you see. I sort of saw both sides, and I try and do the right thing for me. That would be my only problem, and it's a problem that I create myself. It's not a problem, but it's a problem that I have actually created in isolating myself, in choosing to isolate myself as a *safeguard*, although they may just embrace me if they knew I was gay or whatever, or it might set up a whole topic of conversation, and it might be a wonderful thing you'd be encouraged to come out, or whatever, but that's not why I'm there. I'm there to get an operation and to try and get well, and get out (*Ríoghnach*).

Ríoghnach uses the metaphor of the '2 cloaks', namely, cloaks that can hide or reveal what is underneath. The cloak is in her control as she decides whether to open it and show her true self, or use it as a protective device, to pass within whatever situation she finds herself in. The use of the cloak as a patient is a well tested and trusted mechanism that she employs in society to protect her identity. She brings this into the hospital environment whereby she chooses to 'isolate her [my]self' which acts as a 'safeguard'.

While this is a problem that Ríoghnach creates for herself, it is a system she puts in place to protect the self from the Other. She justifies this, by stating that her role as a patient is 'to get an operation, and to try and get well, and get out'. Through this, she indicates that she feels under no obligation to communicate on an authentic level with Others. However, Ríoghnach is also aware that there may be positive outcomes: if the Other knew her sexual orientation, this could lead to healthy debate(s) or a coming out experience(s). Nevertheless, she is not prepared to risk, this as the fear of negativity overrides the possibility of being positively received. She will not allow anything to take her focus off her goal to improve her health. Through living her life as a lesbian woman, Ríoghnach is conscious of judgements that the Other makes about lesbianism, and she shields herself from those statements and attitudes in the hospital setting, even though recognising that this may not be the case.

Nárbflaith's experience of considering the feelings of other patients, by putting herself in their shoes is similar to that of Ríoghnach's. Nárbflaith compares her experience as a patient in a woman's ward, to that of a heterosexual woman being placed in a ward with men. Through this, she sees herself as a heterosexual woman would see herself in a ward of men. By doing so, Nárbflaith adjusts her behaviour so that the awkwardness she experiences in a women's ward does not become the reality for other women patients:

kind of in a ward full of women .. yeah! I was uncomfortable about it, but as I've said, I was only in X hospital for 3 days ... sharing a room. I suppose being in your night attire and as they call it, and all the rest (laugh). Yeah! being in your night attire around women that you don't know is uncomfortable, it'd be the same as a heterosexual woman being in a ward with men. On her own, and surrounded by men, em you know (*Nárbflaith*).

Another participant, Meadhbh, expressed her feelings of being on a ward as:

I suppose there is a sort of a em, a kind of a reverse psychology thing that I just think, there's all these women in the room right, they're all in distress cos they're sick. If they find out that I'm a lesbian, and they've shared a room with me, and seen me in state of undress, i.e. in my pyjamas, which is as far as I would go (laugh). You know would they be uncomfortable with that? So its sort of, maybe I'm projecting onto them, what I would feel in their situation, or might feel in their situation, but there is that, and I suppose I am an only girl in the family, and I never shared a room growing up and stuff. You know there's all those kind of issues as well (*Meadhbh*).

Nárbflaith, Ríognach and Meadhbh, remove their sense of self by transforming it into how the Other would feel, if they knew that there was a lesbian woman in their presence. They feel their difference, even though nobody around them may have knowledge of this.

For Meadhbh and Nárbflaith, wearing pyjamas is being in a vulnerable state. It is this sense of the self being stripped which the metaphor of clothes suggest. I can present myself as I want, through how I look and appear, and clothing is a major part of this. It sends a message of who I am, where the sense of control is removed when an individual is in bed clothing. Meadhbh reflects that this sense of unease derives out of her childhood, as she never had to share a room. As an adult lesbian woman she chooses who she shares her bedroom with, or who sees her in her night attire, while the hospital setting puts her into a situation whereby she has no choice.

7.5.2 Othering the self

Nárbflaith and Ríognach use the analogy of being placed in a male ward as a lens to understand how a heterosexual woman might feel. They become the Other of Otherness. They effectively become the Otherness of womanhood. This

illustrates how lesbian women objectify themselves, in seeking to understand their situation, by viewing their behaviour through the eyes of heterosexual women via the eyes of the male. They objectify the self through imagining the situation, rather than through knowledge or shared experience of heterosexual friends. The presumption is that their gaze is somehow similar to the male gaze. They go outside of their femaleness to imagine being the male, and how his look would be. Through this, both women curtail their behaviour when they are admitted to hospital for medical procedures. They equate the interpretation of the lesbian look with that of the male gaze. The look becomes the look of the Other, their difference is displayed for all to see.

While both women expressed how they thought a heterosexual woman would feel being on a male ward, Ríoghnach was actually placed on a male ward. She recounts her experience:

I mean, the last time I was there they hadn't got a ward, and they put me in with the men. I don't mind (*Ríoghnach*).

Ríoghnach suggests that she was more comfortable being placed in a men's ward, as she does not feel the pressure to curtail her behaviour for fear of discovery. Somehow she is the same, or rather, her difference was not exposed. She was a woman on a male ward, not a lesbian woman on a female ward, where she had to hide the self.

7.5.3 Another way of being

While Nárbflaith, Ríognach and Meadhbh express concerns about the reactions of Others in the vicinity of a ward, Gormlaith suggests there is another way of being:

I didn't discuss my sexuality with them at all - there was no need - you know, in the room the nurses knew and I was on my own the first time around, and second time around for the breast cancer, and the following year, which was last year, June [2005], I was on for a feckin month, I was there, emm there was no issue of sexuality at all. I mean Cellach would come in every day, every evening and everybody around would see (*Gormlaith*).

For Gormlaith, sexuality was not an issue. As far as she was concerned the nursing staff were aware of who she was and that was sufficient. She feels no need to hide and assumes that the Others in the ward could make their own minds up when Cellach would visit her. Gormlaith was more interested in her health and health care than the reactions of patients around her. Her partner Cellach views their comfortableness on a ward from another angle:

And in fairness, and I think it does make a difference, you got a lot of bunches of flowers sent to you, a couple of surprises, different people calling, you know it says a lot about the status of the person, and I think people were able to tap into that (*Cellach*).

Here she illustrates, that the perception that Others have about an individual can dictate how that individual is treated.

Cellach views this from the perspective of status. If you are perceived as a person with status, then Others will not question who you are:

But in answer to your question, the first time around in the room, I mean Cellach was there till 11 o'clock at night you know, so there was no issue around that at all, and the second surgery, no issue, the only difference being in the open in the public ward, and this might sound very big headed, and I don't mean it, but as Cellach rightly said, that I was only seeing it as a patient, I was no different as a patient, as I was anywhere else in terms of treatment, in terms of being me and what I

needed. Cellach would come to see me everyday, I was there from Sunday night to Friday (*Gormlaith*).

Gormlaith reinforces Cellach's point suggesting that she was no different: she was like every other patient who had cancer. Gormlaith never felt the negation of the self. While Ríoghnach found participation in conversations on the ward alienating, and outside her realm of understanding, Gormlaith participated fully in the activities of the ward.

It could be said, that cancer patients find meaning of their illness, through sharing their experiences of the cares and worries of living with breast cancer:

Anne also had breast cancer, but that's another story. . . she came to see me and said, just in case I brought another glass so she brought me in two bottles of red wine you know and I think I was due to go out the day after the Friday, before the June Bank holiday, and I thought Fuck it, I'm going to have a glass of wine, had a glass of red wine and knew there was another one in there, and one women had left and we said Jesus we'll keep in touch, and she said I can't wait to go home and see the football and go for a pint in Z, so she went off anyway and there was some blood results that they weren't happy with, so it meant she had to stay - she said oh Jesus! Said, now she was very upset, what the fuck am I going to do all weekend, what can I do till fuckin Monday - I mean what could they do till Monday except monitor her, so I said come here, I said what are you dying for she says I'd love a glass of wine, so I said right I'm going, so I opened the bottle and we had a half a glass of wine each, one of the nurses came in, and she said what's that (*Gormlaith*).

What Gormlaith's story illustrates, is that when it comes to serious illness, other patients do not distinguish between difference; they are all in the one boat seeking a survival strategy, and an element of camaraderie builds up. The sharing of the glass of wine demonstrates this. Cellach captures this when she says:

I came in to pick her up, and the fuckin three of them sitting around this glass like witches around a cauldron, a fuckin glass of wine, it's your turn, it's my turn (*Cellach*).

In children's stories, the use of the imagery of 'witches' sitting around a 'cauldron' have been portrayed negatively, while in this episode it is the positive actions of three women trying to comfort another. The cauldron is the 'glass of wine' through which the symbol of friendship is portrayed.

There is an unspoken understanding of the meaning of not being able to go home for the weekend. It could have been any three of them who could have found themselves in that situation:

But again, it was just we all jelled together, and they offered me dvd's, now look it are you looking for a telly, look that's our telly, if you want to keep it you know it's all right, I said no its all right. You know, we all looked after each other, but what I think, the issue in hospital is not about who you are or what you are it's just how you are, cause you're in hospital, because you're unwell, and that's your topic, that's your agenda (*Gormlaith*).

Looking out for each other and being there for each other is what being a cancer patient brought to Gormlaith's life. She not only experienced this from Cellach, but also from other patients. She was not rendered the Other: she was part of the experience that Others had to offer and that she had to offer them as well. Through her illness, the extent of her possibilities to become was open to Gormlaith, whether that was through her health care team or patients. By embracing the personhood of Others, Gormlaith's personhood was equally incorporated.

7.6 Shadow in the background

While Cellach had no problem in caring for her partner Gormlaith in the hospital setting, other partners of lesbian patients experience being regulated to the outsider status by various techniques, such as the next of kin rule, or viewing the

presence of a woman with a female patient as a friend in hospital. These perspectives act as barriers for lesbian women to participate in the care of their partners. Meadhbh brought Nárbflaith, her partner, to the hospital and reflects on what it was like to be the partner of a patient:

I felt like I was basically the chauffeur. They insisted that she have somebody to drive her home, and I was that person, so I was the person that was driving the car, and that's all I was ... Disenfranchised. I wasn't recognised, I was just a person who was appointed to drive this person home. Drive the patient home ... I hated it. I wasn't in control of the situation which I should have been, because you were coming out of an anaesthetic and clearly not in control (laugh) (*Meadhbh*).

Meadhbh recalls she was the 'person who was driving the car', more a taxi service rather than the partner of a patient. Her role in Nárbflaith's life was negated, and the reality of their relationship was non-existent. Meadhbh recognises her need to assist Nárbflaith. She feels she should take 'control' for her, as Nárbflaith was not in a position to do so for herself. Facilitating the needs of a partner, or just being there, are the taken-for-granted dimensions of a relationship, regardless of sexual orientation. Meadhbh's inability to meet the needs of Nárbflaith rendered her feeling the most negative of emotions: 'hate'. The non-recognition of her status led to feelings of being 'disenfranchised', which in turn renders her experiencing being frustrated; not being in a position to do what she considers she should be able to do:

I am no longer master of the situation Or more exactly, I remain master of it, but it has one real dimension by which it escapes me, by which unforeseen reversals cause it to be otherwise than it appears for me (Sartre, 1969:265).

For Meadhbh, the unforeseen reversal is the reactions of the health care professionals. The ability to care for her partner is removed from her: in every other situation in her life she can care and be for her partner, but in a hospital

setting this is negated. She did not foresee this and is filled with feelings of inadequacy.

Nárbflaith views the situation from her perspective of being the patient but also reflects on Meadhbh's situation. She is constantly aware of Meadhbh's presence and how she might be feeling:

Meadhbh had to go through my sister, they put my sister down as next of kin in X, she was trying to deal with mum in Y Hospital. And she kindly sent back a message saying 'For God's sake don't die, we've enough on our plate at the moment' kind of stuff, it was a really loving message, ye know! what I mean, it was really nice ... But more or less indicating to the nurses that she would prefer that you could deal with it. Not that she was deflecting me, but Meadhbh was on, but she, she did not see the sense in her being the next of kin, when Meadhbh was here and Meadhbh was my partner. We have a very good relationship with both families. Eh! but again, Meadhbh had to, at one point the consultant was talking to me, but would not talk to Meadhbh, and wanted to talk to my sister in X, and then my sister was relaying that back to Meadhbh, and she was trying to get my child out of school, trying to do all that as well, and it was dreadful. It was so, I found it so upsetting. I just found it another burden that I didn't need to deal with, cos there was nobody there; again there was no recognisable person that could be in my corner. And you just found it impossible, you were really upset by it I think (*Nárbflaith*).

Nárbflaith understands her sister's position in relation to caring for their terminally ill mother. Nárbflaith's sister presents the lesbian world to the health care profession, but they reject this bequest and insist that she act as Nárbflaith's next of kin. While the truth of the situation was laid out for the health care professionals, they ignored it, leading to a situation of the added pressure being placed on Nárbflaith's family. Meadhbh and Nárbflaith's relationship, while recognised by her family, was negated by the nursing staff. This denied their validity as a couple. This reinforces Moane's (1995:88) assertions:

Lesbian partners have no rights of access or decision-making in the case of illness .. and have been prevented from visiting their long-term

partner in hospital. They do not have any say in the medical treatment their partner may be receiving.

Health care professionals removed Meadhbh's sense of presence towards Nárbflaith.

Not only did Nárbflaith experience the situation as a burden, but the sense of isolation of having nobody to speak on her behalf:

But on the day that actually happened, when you were on the A&E ward, I was sort of in the way ... the other thing about it was, that it was extremely difficult for me to again be the non-person ... Just the sort of shadow, the shadow in the background ... I had no right of audience really ... And I hated that. Again I was disenfranchised, I wasn't in control. I had no, I had no place there. I simply had no place, you know (Meadhbh).

Meadhbh becomes a shadow. She is not casting a shadow as we all do in twilight which gives a sense of self. I can see myself through my shadow and I know that I exist. Casting a shadow is something my body does, but to be cast into a shadow is to have something thrust upon you by the Other. Meadhbh's image of the shadow does not denote positivity; rather, it casts her into darkness, a shadow in the corner whereby the Other does not acknowledge her existence, as she does not exist within their realm. Meadhbh cannot be seen or is not seen, which she recognises. This is very different from Sartre's (1969:264) suggestion of:

My possibility of hiding in the corner becomes the fact that the Other can surpass it towards the possibility of pulling me out of concealment, of identifying me, of arresting me.

From a Sartrean perspective, the possibility of hiding in the corner is my choosing of concealing myself. However, Meadhbh was placed in the corner by the Other through non-recognition. She has no possibility of being discovered as the Other does not recognise her existence. She has become the outsider (Becker, 1963) looking in but with no say in what is happening. Meadhbh is alienated from the

world as she knows it and from herself through the actions of the Other, but, more importantly, she is alienated from her partner, Nárbflaith. Her own possibility becomes the possibility of the Other to declare who she is: a non-entity.

Both Meadhbh and Nárbflaith recount that their experience of being in hospital was a situation that “*threatens the integrity of the self*” (Giddens, 1991:54). All the mechanisms that built over time to protect the self were dismantled, and the validity of their relationship was not only questioned but cast aside. They went from a couple sharing their cares and worries to that of complete strangers. This experience informed Meadhbh and Nárbflaith the next time Nárbflaith needed health care intervention. Meadhbh used her connections in the HSE (Health Service Executive) to facilitate better health care treatment. They continue their story:

Eh! the Communications Director I think. The Communications Director, and she rang and said look, my partner’s going in, she’s having this surgery done, I’m her next of kin and I don’t want any messin. Do you know what I mean? And actually they were wonderful (*Meadhbh*).

They were wonderful. But we made that phone call beforehand, and I have to say it made a huge difference to me going in. The respect I got, it really was no bother. Now from, right from filling in the admissions form, I filled in the admissions form with a woman that knows us anyway, but I filled it in with her and she, she actually said to me, she said Nárbflaith she said, we actually in admissions, if you the take the administration of it, the administrative end of it she said, we don’t care who your next of kin is in a sense of, we actually don’t care. Its just we need a next of kin to contact if something happens you, but she said sometimes people think we do care in a sense of they’re going to judge me but she said we don’t, its just an administration thing, it makes no difference to us (*Nárbflaith*)

From my point of view, it was a totally different experience, but one of the things that annoys me about living in Ireland, is that you have to try and pull a stroke ... To get what you’re actually entitled to, and I hated doing it, and I don’t normally do it (*Meadhbh*).

Not everybody would be in a position to make direct contact with the HSE and use their influence to secure the kind of care they wish for. However, Meadhbh did so not only for herself but for her partner, thus securing a totally different experience than the last one. Meadhbh is uncomfortable about having to do so, but she feels she is put in a position where to care for her partner necessitates 'pulling a stroke'. This was an experience where both women did not lose their sense of self, rather they could be. An interesting aspect of this was the initial administration phase of entering the hospital setting, where they were told who was next of kin was not a priority, rather it was an administrative procedure. Had this information been passed on at the original admission, then Meadhbh and Nárbflaith would not have experienced what they did.

While both women were delighted about the outcome, they have reservations about how it was achieved.

Because not everyone gets that kind of treatment. That being said though, it was a very positive experience .. And I was very grateful, but should I be grateful? ... Should you be grateful for being treated the way you would expect to be treated if everything was normal, in inverted commas (*Nárbflaith*).

Nárbflaith questions whether she should be grateful for a service that should be available to all regardless of their situation. She is aware that not everyone gets the health care service she had experienced. While this was a positive experience, it still rendered her with feelings of non-normalcy. They experienced their difference in a different way; they had contacts but their contact was used to make them, as a lesbian couple, feel safe and comfortable in the hospital setting. Once again they were the Other.

7.7 Concluding remarks

A woman-friendly health service was promised in the women's health strategy document (Government of Ireland, 1997). It would appear that breast cancer services have achieved a woman-friendly health care by recognising diversity amongst women. However, cervical screening services do not recognise diversity amongst women, but more importantly have clear demarcation lines in operation, regarding the necessity of their service for all women. This led to some lesbian women experiencing both prejudice and discrimination in these services.

Partners of lesbian patients experience the spectrum of care from being openly accepted, consulted and respected in the care of their partner, to being alienated and cast aside. The next chapter develops the themes that emerged from interviews with lesbian nurses, of the understanding and meaning they give to being lesbian in the nursing environment.

Chapter 8: *Never the Twain Shall Meet: Private Lives, Public Silences of Lesbian Nurses*

8.1 Introduction

This chapter will analyse the themes that emerge from the interviews with lesbian women as professional nurses in health care:

In order to get any truth about myself, I must have contact with another person. The other is indispensable to my own existence, as well as to my knowledge about myself (Sartre, 1985:37-38).

Sartre (1985) suggests that to know oneself or to know the truth of oneself is to know oneself through the eye of the Other. I cannot become on my own, in isolation; I can only become when I interact with Others and understand their reactions towards me. I give meaning to these interactions based upon my knowledge of who I am or rather who I think I am and what Others think I am. Through this I get a sense of self. As Sartre (1969) indicates, an individual can only know her/himself through the intervention of the Other. Work is an area which represents an important part of people's lives where they encounter the Other. It provides an individual with a sense of who they are in society, through their membership of communities (Morgan, 1999). Through work, a lesbian woman's identity has to be negotiated (Markowe, 1996) as private lives and public lives can overlap. Clunis et al (2005) suggest that for lesbian women, work and identity overlap, so providing a coherent sense of accomplishment. However, for lesbian nurses, work is fraught with the unknown as to whether to hide one's sexuality, or reveal it for Others to see.

This chapter is divided into six sections: the first deals with lesbian nurses who are out and open about their sexuality in their workplace; the second reviews the experiences of lesbian nurses who feel different in their working environment; the

third analyses the negotiating practices of lesbian women when encountering the heterosexual dialogue; the fourth analyses the choices lesbian nurses make between coming out and not coming out; the fifth examines an ethical issue; and finally, the sixth explores how lesbian nurses experience their difference in the health care environment.

8.2 Being oneself in the workplace

Our occupations and the fields in which we work can mean much to the other facets of our lives because they are often linked to our identities and sense of accomplishment (Clunis et al, 2005:81).

Identities are likened to work, as they enable individuals to interact within society as workers, consumers and citizens (Morgan, 1999). Work plays a major part in the experiences of people, giving them a sense of self, value and achievement. It is also through work that we meet the Other and obtain a sense of who we are through the eye of the Other. By way of work the possibility of my becoming is open to me, through both my occupation and interactions with Others. As Markowe (1996:7) suggests, in relation to lesbian women “*coming out at work, type of job and work environment are pertinent*”. When a lesbian woman comes out at work, she needs to consider the environmental and social context in which this takes place, as they do not all value diversity (see chapter two and three).

8.2.1 A safe haven

Some lesbian nurse participants, such as Grian, who practiced in other European countries, indicated that they were out in their workplace in Europe while in Ireland; they are hidden or returned into the closet:

I suppose there were other gay people there. There was a very flamboyant European man and we were great friends, we are great

friends, so he was you know, we would have been out together, I suppose it was easier, a bigger staff complement, it was more anonymous, if you like, as well living in Europe (names city) than living in X (*Grian*).

Being employed in another Europe country enabled Grian to be out in her workplace. She suggests that the European city where she worked allowed this to happen as it was bigger, more anonymous and there was also a higher number of staff in her workplace. She accounts for this by inferring that it was easier for her to discover herself in an open environment presented by the European city in which she was employed. Grian's friendship with a 'flamboyant' gay man gifted her the ability to come out. It would appear that his ways-of-Being was infectious and spilled over on Grian, empowering her to be truthful about her situation. She was able to say to the self 'I am a lesbian woman' and a lesbian nurse in her professional life:

Everyday Being-with-one-another maintains itself between the two extremes of positive solicitude-that which leaps in and dominates, and that which leaps forth and liberates (Heidegger, 1962:159).

In Grian's case, the positive solicitude that leaps forth was liberating, her Being-with-another that is the 'flamboyant' gay man, made it possible for her to be authentic with the self and Others. Here we can see how the private and public life of a lesbian woman can be integrated with no hiding of the self.

While Grian's experience of being out was positive, Gormlaith on the other hand experienced homophobia in her private life but not in her public life as a nurse. Gormlaith and Cellach met each other in the European city where they practiced, and began a relationship soon after:

Well I suppose we had very different experiences in Europe. I mean, I came up against a lot of homophobia in Europe, not in my first job, when I came out (*Gormlaith*).

Gormlaith experienced the European country she was living in, to be homophobic. However, she found that working as a nurse and being open about who she was, did not affect her nursing friendship group or her nursing practice. This points to the fact that once a safe place is found where a lesbian woman can be, she is able to deal with issues outside of that realm. For Gormlaith the nursing environment was her safe haven.

However Cellach tells a different story:

In work, other people told the story, I didn't tell the story, I don't ever remember telling people in work, because I actually probably wasn't that well able to tell anyone in work (*Cellach*).

Cellach had an inability to voice and articulate who she was. She did not have the necessary dialogical tools to communicate the self to Others. She has no recollection of coming out to any of her colleagues. This in effect is the silencing of Cellach, whereby she is in a "position of 'not knowing'" (Goldberger, 1996:343). Cellach did not know how to come out and tell her story. She had no knowledge of how or what approach(s) to take in revealing her sexuality and who she is to Others. It can also be seen "*as a way women protect themselves and hide from dangerous authority*" (Goldberger, 1996:343). In other words, by remaining silent about who she is, Cellach protected herself from the Other.

8.2.2 Information management

While Cellach had an inability to voice who she was, Gormlaith suggests that revealing one's story involves a path of discovery:

we learnt how to again tell our story, and that's how it was for me, you know, been there, done that, got the t-shirt, this is how I tell my story, you see me, then can get to know me, it doesn't matter a pin if I sleep with men, women whatever, doesn't matter a pin, what I do with my life

if I take drugs, doesn't matter, you see me the person, then don't make the judgement first, because you only make the judgement on the information I give you or what you see (*Gormlaith*).

As a partner in a couple, Gormlaith indicates that the telling of one's story is a learning experience: it does not come naturally, there is no blueprint or reference point to begin from. This would suggest that lesbian women go through a path of discovery, when 'coming out' is fraught with ups and downs; they learn how to tell their stories in ways that are socially acceptable, resulting in positive outcomes. This is a rather different path of discovery than what Moane (1995:86) suggests could lead to "*ecstatic, joyful abandonment, passionate embracing*". Gormlaith gives meaning to her experience by using the metaphors of a concert goer 'been there, done that, got the t-shirt', almost like a badge of honour; she has gone through the required hoops, with the 't-shirt' as proof she was in a position to authentically state 'I am a lesbian'.

Gormlaith controlled the information that she revealed about the self. As she states: 'I tell my story, you see me, then can get to know me', in other words nobody can know Gormlaith, without her telling her story. Through this, she controls what the Other both sees and knows about her and it is in this way, through the knowledge she gives, that the Other can come to know her. She gives meaning to controlling information by stating that Others cannot know her, unless Gormlaith permits them into her life. From Heidegger's (1969) perspective, Gormlaith experienced the authenticity of the self and all the possibilities of becoming that were open to her, by making the choice to inform the Other that she is a lesbian woman and a nurse. However, an important element in Gormlaith's story, is her understanding that the Other can only come to know her,

if she sanctions their entry into her life and who she is. Gormlaith is aware that Others judge, but she is adamant they can only do so based on the knowledge she gives them, rather than on the impressions that they may already have formed. From Gormlaith's point of view, knowledge-based judgments are the most appropriate, as Others have information on which to base their judgment(s). By managing information about the self, Gormlaith reinforces Goffman's theory of impression management: in other words, she manages the impressions she gives off, and the impressions Others form of her. She reverses Sartre's (1969:260) suggestion: "*I see myself because somebody sees me*". Gormlaith would say in Sartrean terms that somebody sees me because I allow them to see me.

Gormlaith controlled what information she gave to people, suggesting it is through managing information about herself that someone can get to know her.

In contrast, Cellach is aware that she did things differently to Gormlaith:

You were much, much better at that, in giving all the information you gave to people, and I took a different attitude, I didn't give people any information, so other people were giving it to me, in relation to me as a person, whatever that would be, particularly my sexuality (*Cellach*).

Cellach suggests that Gormlaith was better at giving information than she was. She took a different attitude by not divulging anything about the self. Cellach encountered the Other through their definitions of who she was both as a person and regarding her sexuality. From a Heideggerian viewpoint, the Other has effectively leapt in on Cellach, dominating the definition of the self including her sexuality. The Other dominated the story rather than Cellach taking control and revealing her own story. Her story became the story as Others saw it and therefore the story that was portrayed to her colleagues. In this way Cellach's story becomes what Thomas (1931) describes as the definition of the situation.

However, Cellach's silence can be viewed from a different perspective as being "*a powerful weapon when it can be controlled*" (Hurtado, 1996:382). Cellach recognises she remains silent; the Other does not truly know Cellach and this in itself can be what Hurtado (1996:382) calls "*powerful*" viewing, as "*akin to camouflaging*" the self. By allowing the Other to define who she is, Cellach neither denies nor supports their explanations. From Hurtado's (1996) perspective, this could be seen as an empowering act: Cellach knows who she is and is happy to allow Others speculate, thus camouflaging herself in the coat of the Others' explanations of her situation.

While Grian, Gormlaith and Cellach were out when they worked in another Europe country, Gormlaith was the only one who made a conscious decision to relate her story to Others in her own way. Gormlaith considers that only those who have information about her had the right to judge her. The information she gave was on her own terms. The judgments were based upon the information that Gormlaith had given the Other. Alternatively Grian, came out by chance: as the presence of a colourful gay man acted as a catalyst for her. Cellach allowed Gormlaith to tell their story as a couple, or Others to invent her story for her. Either way, she did not participate in discussions about who she was, rather she allowed the story to unfold as Others saw fit. In this way she had no control over who Others thought she was, but, equally, she appeared to be content in the process of becoming visible on her own terms (see chapter two).

8.3 Being different

As providers of health care, it is through the eye of the Other that lesbian women, in their capacity as professional nurses, obtain a sense of self in Irish health care. They obtain a sense of not only who they are, that is, lesbian women, but also of what Others, in this case nurses, perceive lesbian women to be:

I suppose everybody, no matter how tough you are, or no matter how self-assured you are, people's perceptions, especially when you are working with people, matters you know, and how much you let them matter then, is up to you. But working in the medical profession and certainly working within a very female-dominated profession leads to a wide variety of perceptions thrown in your direction (*Finnsech*).

Finnsech is aware that how people see her matters; she is not an island but interacts with Others. She suggests that individuals take onto themselves the perceptions of Others to varying degrees, implying it is up to the individual to decide on what extent the opinions of Others replicates the self and their actions. This mirrors Goffman's (1963:28) assertions according to which Finnsech must "*face unwilling acceptance*" of herself "*by individuals who are prejudiced against persons*" who are like her, that is, lesbian women.

Working in a predominantly female profession, such as nursing, brings Finnsech's awareness of her lesbianism to the fore. She indicates that there is a 'wide variety of perceptions' about lesbian women amongst the nursing profession:

What does not vary is the necessity for her (him) to exist in the world, to be at work there, to be there in the midst of other people, and to be mortal there (Sartre, 1985:38).

Finnsech exists in the world that is populated by Others. She cannot exist on her own, as she needs the Other for her existence to be apparent. Through her existence Finnsech is aware of her lesbian identity in everyday situations; however, through her work as a nurse, her identity can come to the forefront.

Through this, she is aware of the perceptions of her colleagues towards lesbian women (see chapter three for a discussion of such perceptions).

8.3.1 Break-time chatter

Finnsech's coming out at work was not intentional or planned, rather she found herself in a place where she did not want to be other than herself:

A specific incidence I remember, was we had been on a set of nights with a group that I, with about 4 of us, that I had worked with for about 6 months so, I wasn't out at this point to these particular colleagues and we had done a weeks nights and everything is very laid back and personal when you're working nights over Christmas, people talk about their families, where they'd rather be you know and you spend, your longer breaks, you spend a lot more time sort of discussing your personal lives (*Finnsech*).

Finnsech reveals that Christmas time at work leads to different conversations and more sharing of personal lives amongst nursing colleagues. Although predominantly a Christian religious ritual, Christmas in Irish culture through the dominant position of the Catholic Church (see chapter 2 for a discussion on this) epitomises the family. Christmas reinforces the norms and values of the heterosexual family by recognising no other family structures. It underpins what Tovey and Share (2000:306) indicate as the importance of "*religion in the shaping of our contemporary society, its continuing relevance in terms of everyday social life*". The relevance of Christmas for Irish society, is that it is one of many rituals that is seen as traditionally focusing on the heterosexual family as the primary unit of society. Nussbaum (1997:229) succinctly states: "*society shapes not only tradition, but also the experience of people who grow up in it*". Whether an individual participates in the religious ritual or not, the Christmas period in Ireland is traditionally a time for families. Finnsech experienced more

exchanges being initiated around family and so found herself having to answer questions she was not prepared for.

8.4 Heterosexual dialogue

Finnsech experienced Christmas, as the time when private and public lives collided through talk between colleagues. Other lesbian nurses such as Saoirse, perceive this as being part and parcel of normal every day talk amongst nurses:

I find it very hard at break-times, all we seem to talk about are weddings and engagements, babies and what schools to send your children to and I just find its very draining, listening to it all the time (*Saoirse*).

Another participant, Grian, put this in an alternative way:

I was kind of looking at how, you know, social aspect in work, and I suppose you have to sit down, you have to listen to, I mean the young ones are all getting married, and all about their dresses, and all about for half the night, and photographs, and then, the women and men my age then would be with their children, and their photographs, and then the older ones would be about their extensions as well, but it does get a bit boring, I mean, some people who ask me, oh! are you going out with anybody (*Grian*).

While Finnsech experiences her difference at a particular period in her work environment, Grian and Saoirse come into contact with this on an ongoing basis through day-to-day conversations. Saoirse describes social conversations in her workplace, as being 'very hard' and 'draining', as she is listening to discussions she cannot participate in. She is socially isolated from her peers, as she does not fit into the rituals of the heterosexual norm that is engagements, weddings, babies, children and schools. These are the tools, as Saoirse experiences it, of the heterosexual dialogue.

Her lived reality does not include these rituals on a personal level. She expresses this in the following manner:

I feel very different to the other nurses ... don't have a lot in common with the other nurses (*Saoirse*).

Heidegger (1969:63) suggests "*this thing that is called difference, we encounter it everywhere*". Saoirse experiences her differences on a daily basis in the workplace. Her present situation does not include the reality of family life that is portrayed to her from her colleagues as the heterosexual norm. As we have seen in chapter two, there is no recognition of same-sex relationships or their family structures in Irish society. Since lesbian women are having children, and some have children from being previously married, they are creating their own family structures (Chrisp, 2001; Pharr, 2007; Markowe, 1996); but this is not part of Saoirse's reality. She feels different to her colleagues, encapsulating this by stating that she does not 'have a lot in common with the other nurses'. She views her colleagues as being Others through which she can judge herself but more importantly, be judged (Sartre, 1969). She cannot participate fully in the day-to-day exchanges that happen between colleagues at break-time. However, her difference is exposed for her to see and while her colleagues may not know this, Saoirse does. In Sartrean terms it is through the Other that she knows herself.

Grian on the other hand, views talk amongst nurses at break-time as a chore in that she states: 'you have to' both 'sit down' and 'listen' to the stories that are shared at break-times. It is almost like a weight on her shoulders or a burden whereby the 'you have to' indicates that there is no escaping, and it is a duty to be performed.

As Skidmore (2004:236) succinctly states:

For many workers a distinguishing feature of the workplace is the regular, if not daily, contact with a group of co-workers with whom one is obligated to interact.

As Grian cannot participate in these exchanges she finds them ‘a bit boring’; in other words, for Grian these conversations are tiresome and tedious. They are also repetitive whereby she can almost predict what the topic at break-times will be, and she will remain invisible in these conversations (see chapter three).

8.4.1 Negotiating the heterosexual dialogue

Grian finds ways around questions about her personal life, particularly in relation to marriage and children. She finds her route by not participating in the conversation on the self and turning it back on the questioner:

By not talking about yourself and asking, I suppose asking them questions, and they are talking about themselves then (Grian).

She removes the focus from herself and orientates the Other towards themselves through asking them questions about the self. In this way she negotiates the presentation of the self in front of the heterosexual norm. Grian puts distance between herself and Others by placing the spotlight on the Other, and removing it from herself. She not only successfully distances herself from the Other but also from the assigned categories that make up heterosexuality. In this way she successfully keeps her lesbianism hidden. Grian reflects:

I’m a listener more than a talker (Grian).

She positions herself favourably for the Other as being a listener. In this way she does not have to interact on a personal level with her colleagues. She successfully deflects any queries about herself and becomes the ear for Others to

talk about themselves. By being a listener Grian regulates information about the self (Saulnier, 2002; Scherzer, 2000).

Grian's actions could be interpreted from a Sartrean point of view as the hiding of the self:

My possibility of hiding in the corner becomes the fact that the Other can surpass it toward his possibility of pulling me out of concealment, of identifying me, of arresting me (Sartre, 1969:264)

Grian's hiding in the corner, is the act of turning the conversation away from herself to the Other. The act of listening prevents her discovery and the ability of the Other to see her as a lesbian woman. Equally she does not become "*this self that the other knows*" (Sartre, 1969:261).

As she does not disclose herself there is no opportunity for the Other to know her. Grian's concealment remains. This illustrates Draucker's (1999:361) point, when he states that individuals participate in acts of "*everyday skilful coping*". Those are the skills for everyday living which enable an individual to participate in the situations in which they find themselves. One of the skills that Grian has developed for everyday living in her capacity as a nurse is that of listener which enables her to exist within the nursing community. By becoming a listener she does not have to participate by divulging the self; she can remain "*hidden from the Other*" (Sartre, 1969:49) but is perceived as participating in the conversation. Grian, however, participates in the conversation through asking questions of the Other and listening. This is different for Saoirse, as she indicates that she does not take part because she lacks commonality with her colleagues. For her, there is nothing to discuss, and the possibility of her becoming through interaction with

Others is limited. Similarly Grian's possibility of becoming is equally limited through her interactions or lack of interaction with the Other

8.5 A chink in the closet

Finnsech found her own life being questioned and brought to the fore, and therefore had to make a decision on whether she would come out or not. She had to make a choice of whether to tell her colleagues or not:

And as a result of that, it got to the point where I was either going to have to lie or come out, and that's the simple truth of it. You know like you can no longer be gender non-specific and sort of politely decline to sort of, get involved in certain, you know, questions that were being directed at me, and I either was going to answer them, or I was going to lie, and that for me was just never an option. (Finnsech).

Lying for Finnsech was 'never an option', she wanted to be truthful about her situation. The truth of her situation is that she is a lesbian woman who does not fit into the life realities that surround her. Finnsech could have chosen to lie and fit in with her colleagues but she made a choice not to. Sartre (1985:44) indicates "*Choice always remains a choice in a situation*". She made the choice in the situation she was confronted with, either she came out or remained in the closet.

Sartre (1985:44) further indicates that "*one makes a choice in relationship to others*". Finnsech made a choice in relation to Others but also in relation to herself. Equally, if she remained in the closet, she could continue to play the 'gender non-specific' game, unless or until she reveals the truth of the situation. She decided not to be gender non-specific but rather to come out. Through this, Finnsech "*chose her (it)self*" (Heidegger, 1962:68), thus embracing and acknowledging her lesbianism. In this way she attributes meaning to her situation through her essence. Finnsech chose her authenticity and affirmed her essence

(Heidegger, 1962). Through coming out, she has accepted what Heidegger (1962:68) calls "mineness", that is, she has stated 'I am lesbian'; it is mine, it belongs to me, it cannot be given to me rather it is part of who I am and my possibilities. She has given herself her authentic self. From a Heideggerian point of view, nobody can do this for an individual, it is up to the individual to do so. Nobody can give 'mineness' and equally nobody can take it away.

8.5.1 The perception of lesbian women by Others

In choosing to come out, Finnsech had to contend with the reactions of the Other:

And so I got, I got a mixed response, I suppose the only coherent one really initially was surprise, they were you know singularly surprised that I was gay, which I always then find surprising and always query why is that so surprising? And I met with all the usual stereotypical kind of, it just doesn't seem like you know, you just don't seem like you're gay, and I was like, well, what should somebody who's gay seem like, to which I get d'you know, and I can't help but laugh when I get into this kind of conversations, like just, you know (Finnsech).

What this segment reveals is that Finnsech's colleagues hold stereotypical views of lesbian women, who they are, as well as of their ability to know when they were in the presence of one. However, Finnsech did not fit these notions. Finnsech's behaviour falsely suggested to the Other that they were in the presence of what "they demand but may discover they haven't obtained" (Goffman, 1963:58) namely, women like themselves, that is, heterosexual women. This is why the initial reaction was that of 'surprise' that she did not fit the concept of heterosexual women, that is, the Others' point of view of being 'like us'. However, this is reflective of normative heterosexuality whereby talk and actions, in conjunction with institutional structures, reveal the privileging of heterosexual coupling (Young, 2005).

Equally, Finnsech did not fit the perception that the Other had of lesbian women. Key to this is the opinion that lesbian women are readily identifiable to Others. The idea that lesbian women look, act and behave in similar ways to heterosexual women and are unidentifiable (Nussbaum, 1997) is not in the realm of the Other's consciousness:

She may be married or divorced, have children, dress in the most feminine manner, have sex with men, be celibate - but there are lesbians who do all these things. Lesbians look like all women and all women look like lesbians. There is no guaranteed method of identification (Pharr, 2007:89).

From Pharr's (2007) perspective lesbian women look, act and behave like all other women, with some participating in heterosexual rituals. It is the sameness of women that erases the ability of the Other to identify them. Through this sameness, there is an inability to acknowledge that difference may exist between women who appear, act and behave like other women. In other words, if I am different then I must somehow show my difference. I must have an outward sign, whereby Others can recognise that they are in the presence of a woman who is different to them. The problem is then that not all lesbian women are readily identifiable, thereby leading to confusion with the deeply-held assumptions of who a lesbian woman is.

Within Finnsech's story there is an implicit notion that she identifies with the Other's understanding of who a lesbian woman is. This is suggested in the indirect answering of Finnsech's query: 'what should somebody who's gay seem like'? While stereotypes were suggested, they could be classed as imagined stereotypes of lesbian women by her heterosexual nursing colleagues. However, Finnsech did not fit these stereotypes. Her nursing colleagues portrayed a

vocabulary deficit, whereby they lacked the ability to discuss Finnsech's sexuality or perhaps they did not want to. This reinforces Lodge and Lynch's (2003) study on the second-level educational system in Ireland, where students have an inability to speak about diverse sexuality and responded in a negative or aggressive way when confronted with same-sex reality (see chapter two). Finnsech experiences negative reactions of the Other as she does not fit the stereotypical view of lesbianism.

The audience(s) lesbian women come out to, can be fraught with perceptions of what or who lesbian women are, and are embedded in social context (Markowe, 1996):

She is acting within a context that is likely to include some awareness of a lesbian stereotype, notions of normality/abnormality, perceptions of generally negative attitudes towards homosexuality; and possibly some ideas relating to explanations of homosexuality as innate or environmental (Markowe, 1996:133).

Coming out is not only a personal action on the part of the lesbian woman, it is related to societal views and perceptions. In choosing to come out, a lesbian woman needs to take into account the social context in which her coming out takes place (see chapter two). The social context of Finnsech's coming out story is embedded in the traditions, beliefs, norms and values of both the nursing profession (see chapter three, section 3.7), and cultural ideas concerning the Christmas period which reflects heteronormativity. Finnsech's recollection of coming out to her colleagues, leads her to view the funny side of what the Other considers a lesbian woman to be. She has the ability 'to laugh' at the stereotypes used by her colleagues, which of course do not fit with Finnsech or her reality of living her life as a lesbian woman.

8.5.2 Making a choice to come out or not

However, if Finnsech did not come out but rather 'lied', would she still be making a choice? Sartre (1985:39) provides us with a way out of this conundrum of whether we are making a choice when we come out or not:

Choice is possible, but what is not possible is not to choose. I can always choose, but I ought to know that if I do not choose, I am still choosing.

Therefore, when a lesbian nurse does not come out in the workplace, she still makes a choice: in Sartrean terms I can choose one way or another. In other words, a lesbian nurse chooses to either come out or remain in the closet. It is a conscious decision made by her. Other lesbian nurses who participated in this study, were not able to look back at coming out stories in the workplace with a smile. From a Sartrean perspective, they made choices in the social settings they found themselves in:

I'm not out in work here, but I would think that some people would know me from outside work, so I'm sure it's about you know, which really doesn't bother me either. I'm not in, but I'm not out either. That's if you can be (Grian).

Grian's implicit assumption is that her colleagues know.

She has not confirmed her sexuality oneway or the other to her colleagues. She views herself as neither being in the closet nor out of it and wonders whether it is possible to be both. In other words, Grian suggests she did not make a conscious decision to remain in the closet. De Beauvoir (1976:9) indicates that human existence is always ambiguous, and it always has more than one meaning:

Let us try to assume our fundamental ambiguity. It is the knowledge of the genuine conditions of our life that we must draw our strength to live and our reason for living.

Grian is aware of the ambiguity of her situation, but she knows the truth of her situation and has the ability to live with it. She understands the “*genuine conditions*” (de Beauvoir, 1976:9) of her life: she is a lesbian woman, and a nurse in her professional life.

Grian mainly works nights, does not work on a particular ward and does not go out socially with her colleagues:

I choose not to, so I stay below the radar (*Grian*).

Grian states she is not ‘bothered’ whether her colleagues know her sexuality or not. However, she takes steps to shield her identity by staying ‘below the radar’, thereby protecting both herself and her identity. Equally, by choosing to stay ‘below the radar’ Grian is hiding who she is. Discovery for Grian is to “*grasp simply the death of my possibilities*” (Sartre, 1969:264). Sartre (1969:264) further states it is a “*subtle death: for my possibility of hiding still remains my possibility; inasmuch as I am it, it still lives*”. The “*subtle death*” of Grian’s possibilities is the perceptions that Others have of her as a nurse:

I think my reputation is, as a nurse, is pretty built up now (*Grian*).

By protecting her identity Grian perceives her reputation as a nurse being intact.

It would appear that it is the possibility of losing her status, which she has spent time building, that keeps Grian in the closet. This is the “*subtle death*” that Grian is avoiding, as she considers that all the work to build her reputation would be tarnished, if the Other knew. Sartre deems the possibility of hiding as something that remains for the individual’s. It is the possibility of losing her status as a nurse that lives for Grian, thus keeping her in the closet and staying below the

'radar', and preventing discovery. This also reflects Goffman's (1963:69) concept of "stigma management" which he suggests "pertains mainly to public life". If the Other notices Grian, then other things about her maybe exposed.

8.5.3 Professional reputation

Grian perceives that hiding her identity does not affect her nursing practice, but what is of paramount importance is the protection of her reputation:

I mean, it wouldn't really affect my practice, as a nurse, and it's for me, it's how when I started off nursing, but now it's you know, it's work. I choose my own hours, I work night duty, it's easier, it's more money so I mean yeah, staying below the radar. I choose to, I mean it's easier to not from being a lesbian, from a lesbian point of view (*Grian*).

From a Sartrean point of view, Grian has made the choice to hide the self from the Other thus remaining in the closet at work. She achieves this through the type of duty she does; namely night duty. She justifies this by stating that she makes 'more money'; more importantly it is 'easier' if her work colleagues do not know she is a lesbian. Being 'easier' from a 'lesbian point of view' to stay below the radar, can be interpreted from Pharr's (2007:88) position "*the word lesbian is still fully charged*", carrying with it the "*threat of loss of power and privilege*". The subtext of Grian's story can be read as her wish to maintain her position within the nursing profession.

By staying "below the radar" Grian has generated a way of "*self-surveillance*" (Humphrey, 1999:137). By being a listener she can check what she reveals to the Other. Grian is aware that this was the case for her when she was younger: she perceived "knowledge of her sexuality would have led to difficulties in her practice. She is aware of her choice. Sartre (1985:39) indicates, "*I build the*

universal in choosing myself. I build it in understanding the configuration of every other man". Grian builds her universe by choosing herself; she understands her choice to remain in the closet at work giving meaning to this in economic terms. Grian's perception of being a nurse has shifted from what Others might have thought, to economic stability. She also understands that Others may be aware of her sexuality, but they have no confirmation of their knowing. Her difference is not exposed for Others to see, rather she lives with the reality of her difference in the choices she makes in the workplace.

8.5.4 Seesaw

Whereas Grian chooses to remain in the closet at work, Muirgel has experienced both coming out to her colleagues and remaining closeted:

I think it's quite, it's quite difficult in some senses, I think generally people have reacted fairly well when I've told them that I am, but whether it's my own paranoia or not, I still feel uncomfortable in many situations in work, and I feel that it may negatively affect my chances for promotion, even though I have been promoted, I still do think that. That worries me from time to time (*Muirgel*).

Muirgel finds it difficult to make the choice to come out or not, with her overriding concern being her nursing career. While she states that she has not experienced discrimination in her career path to date, she remains fearful that her sexual orientation will be a block to promotion in the future. Heidegger (1962:176) suggests, "*Only something which is in the state-of-mind of fearing can discover what is environmentally ready-to-hand is threatening*". Muirgel's fearfulness could be read as her perception of the nursing environment, as threatening to her nursing career and to some extent to the self if she came out. The integrity of the self would be exposed if her colleagues knew she was a

lesbian woman. Equally, if her sexual orientation were discovered there could be a block to her progression.

However, she considers this as possible paranoia, although it is fear, which Nussbaum (2004:13) defines as a “*response to imagined bad possibilities*” that inhibits her. Her experience is that being open does not act as a barrier to promotion but she constantly worries that it will in the future. In other words, she believes that she will be allowed to climb the career ladder to a point, and then her sexual orientation will negate her ability to go further. While she acknowledges the irrationality of these feelings, they still dominate her thoughts. In de Beauvoir’s (1976:37) terms, Muirgel imagines there is a “*ceiling, which is stretched over*” her head. This is reminiscent of the ‘glass ceiling’ that feminists fight against in relation to women in the workplace. Muirgel imagines that a ‘glass ceiling’ may exist for lesbian women in the nursing profession, leading her to view her sexuality negatively. If Muirgel was not lesbian, she might not have to worry about her promotional prospects in the same way:

Like the child, they can exercise their freedom, but only within this universe which has been set up for them, without them (de Beauvoir, 1976:37)

De Beauvoir articulates the lack of freedom of a child in a universe constructed by adults; Muirgel’s position can be read in a similar manner, as her freedom to be a lesbian nurse, is constrained by a profession constructed on heterosexuality rather than diversity (see chapter three).

8.6 An ethical dilemma

An ethical dilemma is reflected in Muirgel's current situation, as he is going for an interview for a higher grade in nursing. The environment in which she works has a policy, that a female should accompany a male regardless of whether they are a doctor or nurse when interacting with a female patient. Muirgel has concerns that in her particular situation she should be forthcoming about her sexuality. Muirgel argues it is the only logical conclusion she can come to:

I have good reason for feeling the same way, it's possible I'll go on shortly to get a job as a clinical nurse specialist in X clinic and, I don't know whether or not to raise this subject, I don't know whether I just, I feel a bit lost about this one actually, and there's no-one I can ask for advice about this in nursing that I know of anyway, that I can say look, you know, should I declare my sexuality, and have a male nurse with me all the time, because that would be the equivalent, that would seem the reasonable thing to do you know, to protect myself, but you just don't know (*Muirgel*).

Not being able to talk with someone in her profession about her concerns puts Muirgel at a loss, in particular who she could turn to, when she thinks of the desire to be truthful about her situation.

This awareness of being lost reinforces her difference in her career, as a heterosexual nurse does not have to consider if s/he needs to come out when weighing up career options. However, it does point to the fact that the working policy in Muirgel's health care facility is based upon heterosexuality, denying the possibility that any other sexuality could exist amongst health care providers. Equally, it reinforces research (Kavanagh, 2006, Tiemann, Kennedy and Haga, 1998), which established that health care services were based upon the assumption, that all of their female clients were heterosexual. With this assumption that all female clients are heterosexual, rather than having a diverse

range of sexualities, then it is a small step to conclude that this supposition also holds for female health care providers, and the rules and regulations for practice are based upon heterosexuality (see chapter three for a discussion of this).

While Grian remains in the closet to protect herself and her reputation as a nurse, Muirgel views the possibility of coming out on two levels: self-protection and professional status as a nurse. She understands that working with particular clients may lead to misunderstandings that could have consequences for her career:

I work with Y [names person], who are prone to making kind of grand comments or statements about people, and not thinking about the consequences as well, so I'd be a bit worried about that (*Muirgel*).

She has witnessed 'comments' or 'statements' taken out of context by patients and having consequences for practitioners regardless of sexuality. Muirgel worries that, should someone in her client group discover her sexuality, it could result in her ultimately risking her career. In this case, not coming out is not a choice but an action designed to protect the self from false allegations. Equally, it would mean that she would not have to worry about it in the future. Can it be said from a Sartrean point of view, that Muirgel is still making a choice? After all he suggests that whether we make a choice to do something or not, we are still making a choice.

In Sartre's (1985) work, making a choice can be viewed as emanating from within the self. I choose to do something or not, as the case may be. However, I argue that for Muirgel the choice is taken away from her as Others (her patients) have the potential to direct the decision she makes. Therefore, it is outside of her

control. Muirgel is not making a choice to come out to her superiors because she feels it is the right thing to do; rather she fears the consequences of being discovered by a client, which could filter up through the echelons of her work environment. Muirgel is not making a choice as her decision results from fear of perceived or imagined consequences, if she remains closeted. Her freedom to choose has been taken away from her. However, her immediate conundrum is that if she comes out, this could affect her potential to obtain a position at a higher level.

8.7 Knowing one's difference

While Muirgel weighs up the pros and cons of her present predicament, she reflects on her career as a nurse and the effect that being lesbian has had on that:

I suppose when I was a younger, when I was a younger nurse I, was very concerned with hiding my sexual identity, and that took up an awful lot of time and energy, and I think it made me come across as a lot shyer than I actually am, because I felt uncomfortable, and I seemed very awkward in situations where I shouldn't have really. But as I got older then I kind of accepted myself more, I became more confident and I told a few people in work, and I have to be honest they've, closer people in work reacted fairly well (*Muirgel*).

Muirgel recognises that she invested both emotional energy and time into concealing her sexuality when she was younger. This resulted in her feeling and behaving 'awkward in situations', that she should have been comfortable in and appearing 'shy' to Others. These could be considered "*unmeant gestures*", (Goffman, 1959) thus discrediting her performance. However, Fletcher (2007:210) suggests that for nurses "[s]elf-image influences our behaviour and performance in the workplace and affects how we think and act". For Muirgel, her self-image as a nurse was distorted by the reality of being lesbian in a

heteronormative environment. Being comfortable with the self is something she has developed with age, enabling her to come out to some of her colleagues.

Muirgel was always conscious of her difference in nursing; however she reached a level of comfortableness with the self that enabled her to come out to her colleagues. Saoirse, on the other hand, is immobilised by her difference:

I've always felt very isolated and lonely, I feel very different to the other nurses, I'm in my current job 6 years and I'm not out to any of my colleagues (Saoirse).

Saoirse experiences isolation and loneliness in her professional life as being a direct result of her sexuality, and she is not out to her colleagues. She feels different to them. Heidegger (1962:157) suggests that even if there are Others around us present-to-hand, "*Dasein can still be alone*". Dasein refers to the human being in the world who is "*always involved in the practical world of experience*" (Johnson, 2000:136). Heidegger (1962:157) indicates that even if we are "*among them*" we encounter them "*in a mode in which they are indifferent and alien*".

Indifference for Heidegger is where we pass one another by. While Saoirse's colleagues may be indifferent to her, it could be argued that she too is indifferent to them by not coming out, she is passing them by. Saoirse experiences alienation from colleagues. While Saoirse is a Being-in-the-world, so too are her colleagues. However, Heidegger (1962) suggests that Being-alone is still Being-with in the world. We cannot feel Being-alone outside the Being-with-Others. In other words, Saoirse experiences her aloneness as Being-with-Others; she does not live through aloneness when she is on her own because she has the support of

those who know her completely. Equally, from a Heideggerian point of view Saoirse's aloneness is a closing off of her self to Others. She denies herself the possibility of being open to the Other and the relationship of Being-with-Being.

Saoirse expands on why she does not come out to her colleagues:

I'm in an all female environment, mostly, they're a pleasant group to work with, but I've heard both positive and negative comments about gay people, so I really haven't felt comfortable to come out to any of them yet. They may have guessed, I'm not really sure, one of my colleagues is a lesbian nurse, and that makes a big difference, because at last I have somebody that I can talk to at coffee breaks, and just, even to say what I did at the weekend (*Saoirse*).

She works in a mainly female environment. While her colleagues are pleasant, she has heard both positive and negative comments about 'gay people'. It is these negative comments which have led her to feel uncomfortable, causing her to be unable to come out. How her colleagues view people like her dictates to Saoirse her course of action, namely, to remain in the closet. However, finding a colleague who is also a lesbian nurse has enabled Saoirse to be herself at least with one person. She can be. She asserts 'I have somebody' to whom she can be both a lesbian woman and a nurse. She can open herself up and "*is grounded in one's having Being-with-one-another as one's kind of Being at the time*" (Heidegger, 1962:161). By Being-with her lesbian nurse colleague, she is Being herself at each coffee break and no longer has to hide herself, with Others she remain hidden.

8.8 Concluding remarks

Heidegger (1962:161) suggests:

[W]hen, one's knowing-oneself gets lost in such ways as aloofness, hiding oneself away, or putting on a disguise, Being-with-one-another must follow special routes of its own in order to come close to Others.

As we have seen, the majority of the participants in this study hide their sexuality to varying degrees from their work colleagues. Finnsech decided that she did not want to lie as she was not going to play the gender non-specific game, and therefore came out to her colleagues. Grian has not come out, becoming a listener acts as a mechanism, to keep her sexual orientation hidden. Muirgel originally invested a lot of time and emotional energy into disguising herself from her colleagues when she was younger, but has come out to some of her colleagues. However, she is worried that she may have to come out to her employers in order to move up a grade, which to her may lead to a glass ceiling in her career path. Saoirse remains hidden to her colleagues because of the attitudes they hold towards people like her, only finding a voice with another lesbian colleague. Each of these lesbian nurses followed what Heidegger (1962, 161) called "*special routes*", which enabled them to work closely with the Other.

The next chapter develops the theme of "performance", that is, how lesbian nurses perform as nurses, whether closeted or out in the workplace.

Chapter 9: Diversity in the Workplace

9.1 Introduction

This chapter will further analyse the themes that emerged from the interviews with lesbian nurses of their experiences of working in the health care environment. The dominant theme is 'performance' in health care, that is, how lesbian women undertake their performance as nurses in health care:

When an individual plays a part s/[he] implicitly requests her[his] observers to take seriously the impression that is fostered before them. They are asked to believe that the character they see actually possesses the attributes s/[he] appears to possess, that the task s/[he] performs will have the consequences that are implicitly claimed for it, and that, in general, matters are what they appear to be. In line with this, there is a popular view that the individual offers her[his] performance and puts on her[his] show 'for the benefit of other people' (Goffman,1959:28)

Research has found that lesbian nurses work in environments that are homophobic (Giddings and Smith, 2001), lack social support and understanding (Beals and Peplau, 2005), and in some cases lesbian nurses negotiate their self image (Fletcher, 2007). The performance of the lesbian woman, when she plays the part of a nurse, reinforces the culture of nursing, thus presenting the impression she is part of the nursing community. From Goffman's (1959:28) point of view, she puts on a show "for the benefit of others". In this case the Others are a lesbian nurse's nursing colleagues, seemingly indicating that she belongs and is a member of that community.

Heidegger (1962:161) states that individuals take "special routes" when the "knowing-oneself gets lost in such ways as ... hiding oneself". Chapter eight has illustrated some of the ways lesbian nurses utilise "special routes" in concealing the self from their colleagues. This will be further developed through analysing

the performances that lesbian nurses undertake, to fit into the nursing community while at the same time hiding the self.

This chapter is divided into three sections: the first deals with the presentation of the self in the workplace; the second examines the consequences of coming out for lesbian nurses; and finally, the third analyses the vulnerability of lesbian nurses.

9.2 Presentation of the self

Gormlaith and Cellach who are in a relationship with each other, found ways around the hiding of the self in front of Others by introducing or presenting themselves as friends to their work colleagues, thus hiding the true nature of their relationship to the Other:

Well I suppose I can speak first, because when I came back from Europe, Cellach and I worked together. We came back together, Cellach was given an X post, and I was given a Y post, and that's what attracted us back home. We went in there as friends, and we worked very well together as friends, and staff respected us in every way. We went out as friends with the staff, and as far as they were concerned, as we thought, we were friends, nothing else (*Gormlaith*).

Both Gormlaith and Cellach previously worked in Europe and made the decision to come back to Ireland together. They were attracted home by employment opportunities that were offered to them. They worked for the same organisation, disguising their relationship as friendship. This enabled them to work and socialise with their colleagues and to gain their respect.

They were also under the misguided impression that their colleagues considered them as friends, and that their disguise worked:

When we left the job, and then eventually they realised, and we said you do know we were a couple, “we’ve known for years, for God’s sake what’s wrong with you - it was no bother - we knew as soon as we met ye that ye were a couple” (*Gormlaith*).

Gormlaith and Cellach made the decision to come out to their colleagues when they were leaving that particular employment. However, they discovered that their disguise, or in Heidegger’s (1962:161) term “*special routes*”, did not work and the image they had worked hard to provide was seen through. Their performance (Goffman, 1959) as friends and the presentation of the self was being read in a different light:

And it was almost like a surprise for them that we were surprised and didn’t know - “what, what, you didn’t know” “No, what”. You know this type of thing (*Gormlaith*).

Gormlaith recalls her colleagues’ surprise that she and Cellach did not realise that their relationship was common knowledge. The assumption by both parties was that the Other knew. Cellach expresses it in another way:

We were just such a couple we don’t realise that it’s very visible – it’s everything you do, the way you talk to each other, you know (*Cellach*).

They perceived their relationship as being ordinary, however, every action that was visible for the Other to see which was false. It was this that the Other saw; while Cellach and Gormlaith viewed their behaviour towards each other as an outward sign of friendship, the Other was reading it as more than friendship. Their special route had been detected from the beginning but it had no effect on Others’ perception of their nursing practice.

While Gormlaith and Cellach were happy with the event, they suggest that it was the manner in which they presented themselves that led to such a reaction:

it was a very positive experience for us, but again it was how we presented ourselves (*Gormlaith*)

According to Gormlaith's and Cellach's opinion, it is how lesbian women present themselves in public that leads to positive experiences, and somehow, if lesbian women do not present themselves in a socially acceptable way, then negativity accrues. This is reflective of Tong's (1989) assertion that lesbian women should show discretion in public life as discussed in chapter two. The presentation of the self then becomes an important element in how lesbian nurses are perceived in the profession:

Thus, when the individual presents her/[him]self before others, her/[his] performance will tend to incorporate and exemplify the officially accredited values of society, more so, in fact, than does her/[his] behaviour as a whole (Goffman, 1959:45).

Gormlaith suggests that presenting herself as a mature, professional woman, with a number of years of experience led to positive experiences.

We were two mature, two experienced nurse managers who had been in the nursing practice, I have now been in it well for 30 years, I haven't practiced for the last 2 years, Cellach has been in it for, well it was then 14 years its 22 years now (*Gormlaith*)

Gormlaith and Cellach's performance was reflective of the expected performance of an experienced professional nurse.

It can also be read that by working together Gormlaith and Cellach gave each other confidence to be. Unlike Saoirse's and Muirgel's experience (see chapter eight) they had each other to talk to, and work out situations that may have disrupted the self. However, the presentation of the self, as they articulate it, can be problematic, as not all lesbian women have a professional background and maturity could be considered something that comes with age. It could be deduced from Gormlaith's and Cellach's perspective, that the manner in which the self is presented dictates lesbian nurses position within the profession. In other words

their professional life is first, and their personal life as lesbian women comes second. This of course is problematic as it suggests that lesbian nurses must live a dual existence, performing one way in public and privately in another, suggesting these two aspects of their lives never meet. This is constraining as it requires lesbian nurses to remain hidden within the workplace (see chapter three).

9.3 Consequences of coming out

The majority of participants went to great lengths to find special routes to hide their lesbian identity or present themselves as other than who they are. Some lesbian nurses did come out to their colleagues. Grian, who was out in another European country, went into the closet upon returning to Ireland; while Gormlaith and Cellach presented themselves as friends. We have seen that Finnsech made a choice to come out. She did it in the context she found herself in; being on duty during the Christmas period. Finnsech made a choice of not wanting to lie and decided to be truthful about her situation, choosing to be gender-specific about her partner. In voicing her difference, Finnsech experienced stereotyping from her colleagues of their perceptions about lesbianism (see chapter eight, section 8.5).

Finnsech later encountered further consequences of coming out in her nursing practice:

And so, that was one of my sort of more unique coming out stories, but as a result of that, the following week, one of the girls, we were very, very busy and she had 14 patients, and I think I had 11 or something like that, and we were quite busy, and I found that she had come into my section to sort of you know help, with my workload, and I was just like, oh right, cheers, thanks a million (*Finnsech*).

Finnsech initially viewed her colleague's assistance as one of 'giving a hand', as something nursing colleagues participate in. As Heidegger (1962:163) suggests,

“the Others are encountered as what they are; they are what they do”. Finnsech encounters Others as nurses in her work environment. She perceived her self as being ‘very, very busy’ and accepted the help from her colleague; in the Heideggerian sense, this is what nurses do. However, we should bear in mind Goffman’s (1959:72) insight that *“impressions fostered in every-day performances are subject to disruption”*.

9.3.1 Disrupted performance

Finnsech continues her story:

A particular woman was back and from a surgical procedure, and was quite unstable, and quite ill, and needed a couple of interventions, and so I got her reviewed, and you know done the necessary things, and one of the interventions that she needed was urinary catheter. And at this point this other nurse thought it appropriate to, you know give me a hand so I didn’t say anything, I thought, ah! I’m just being paranoid, and I said I’m busy and you know she’s giving me a hand, ah! until I kind of was up and I was busy doing something else, and the nurse who was in charge at the time turned around and said to me, Finnsech why is you know this particular person in your section doing your work when she has x,y and z to do in her own? And I said, oh! I thought she was all organised and she was giving me a hand, and she said no, she’s not, she’s down there putting a catheter into one of your patients, she goes: sort it. And I said ok (*Finnsech*).

In this segment Finnsech gives us a glimpse of her nursing care, revealing her intervention for her patient and doing, as she puts it, ‘the necessary things’ by getting the patient reviewed. One of the outcomes of Finnsech’s intervention was the necessity for her patient to have a catheter. It was when she was due to carry out this procedure that her colleague offered assistance. When Finnsech states she felt paranoid, she shows awareness that revealing her sexuality to Others could have possible consequences for her as a nurse. Through this, she begins to question the true nature of the Other’s ‘helping hand’. However, she accepted the ‘help’ and pushed her concerns aside.

Finnsech only became aware that her 'paranoia' had sufficient basis, when the nurse in charge questioned the presence of the Other. After all, she too was busy and had numerous tasks to carry out. This brought forth the realisation that the Other had lied to her. Sartre (1969:49) indicates that those who lie must '*possess a complete comprehension of the lie and of the truth which s/[he] is altering*'. However Finnsech took the Other's offer of help as the truth of the situation. In other words her colleague had time to help as her work was under control, a situation where "[i]t is sufficient that the Other can take the lie for truth" (Sartre, 1969:40). By questioning the existence of the Other on the ward, the nurse in charge pointed out to Finnsech the truth of the situation. The Other was busy also and had procedures to carry out.

Equally, the subtext of the intervention of the nurse in charge could be read as probing Finnsech's ability to carry out her nursing duties. Finnsech's response to the Other was to view her as being well organised and having time to assist her. However, this reflects the Others perception of Finnsech's organisational skills and ability to carry out her duties. Finnsech's ability to carry out her nursing duties was being judged by the nurse in charge; thus Finnsech became aware of the falsehood of her reasoning in relation to the Other's 'helping hand'. From Goffman's (1959) perspective, Finnsech's impressions of the performance of her colleague was disrupted.

Finnsech continues her story by illustrating how she sorted out the problem she was confronted with:

I, you know, went down, and I kind of stepped behind the curtain, and I said to her, you know, it's no problem, I can do that now, I'm free, I

didn't realise you had things to be doing and she was like no, no, no, no that's fine I'm in the middle of it now, I'm just gonna start it, its grand Finnsech, don't worry. And I said, so, at that point, you know, there was nothing much I could do. I kind of stepped back and said, ok, thanks a million, fine, and to which point I heard her kind of say to this woman don't worry now I'll sort it for you, that's grand and I kind of said, ok, I haven't heard any of the other conversation so I'll just leave it and when she came out then, I just kind of dealt with it there on the spot. I said look you know, I said, I've been doing that procedure and plenty of others I said last week, the week before, the last 6 months, I said the only thing that has changed I said is the knowledge that you now have about me. I said, I said do you get your kicks giving old men washes, and she kind of looked at me and I said, cos it's not how I get mine, I said so don't do it again. And she was like you know very stunned and kinda quiet and kind of said Finnsech that's not what I...and I said just don't, and she you know apologised and to her credit then in the subsequent weeks made huge efforts to kind of, you know, cop herself on I suppose but it was, you know, I don't think it was meant maliciously, but it was, you know, I suppose, not one of the more pleasant aspects (*Finnsech*).

Finnsech informed the Other that she was free and was available to carry out the procedure. She also enlightened the Other of her awareness of their workload, which was met with 'I'm in the middle of it now'. Finnsech decided that she would step back and allowed the Other to continue. She made a choice to deal with the situation when the Other had completed the procedure. The Other had the ability to judge Finnsech's practice, but, more importantly, what she thought was Finnsech's reason for being a nurse.

This story illustrates a particular stereotype that exists of lesbian women, whether they are nurses or not, namely that lesbianism is centred on erotica (Stevens, 1996.1998). It could be pushed further by saying that this particular colleague viewed lesbian women who become nurses, as fulfilling their erotic fantasies. Of course the underlining message here is that female patients are not safe from lesbian nurses. Through the actions of the Other Finnsech has been constituted as the Other. Finnsech became the Other of Otherness. On another level, Finnsech's

colleague has the power to reinforce the norms, values and belief systems of the nursing profession based on heterosexuality. For her nursing colleague Finnsech has become the Other, the object through which she herself can be judged as belonging to mainstream society.

When she became aware that the Other was not acting out of collegiality, Finnsech challenged her by turning the stereotype back on her. In so doing, Finnsech recovers her freedom to be. She poses the possibility, that as a heterosexual woman the Other gets her 'kicks' from 'washing old men'. In other words Finnsech has turned the day-to-day practice of washing male patients, into a sexual act for her heterosexual colleague, thus pointing out that, for her as a lesbian nurse, the task of inserting a catheter for a female patient, is not sexual but rather one of carrying out her practice. Finnsech caught the Other in the lie, thus rendering her ashamed of her actions. She did not allow the Other to give meaning to her actions but instead Finnsech imputed her own meaning, making her view of the situation clear to the Other.

Rendering the Other ashamed, can be interpreted from her reaction of being 'very stunned and kinda quiet'. From a Sartrean perspective shame is "*shame of the self, it is the recognition of the fact that I am indeed that object which the Other is looking at and judging*" (Sartre, 1969:261), (see chapter three for a discussion of this). In this sense, Finnsech judges the Other through her actions, which were not, as they were initially interpreted, helpful but derived out from prejudice towards lesbianism. Through her judging, Finnsech successfully transformed her colleague to the status of Other.

Shame can also be viewed as a “*productive and potentially creative emotion*” (Nussbaum, 2004:206). However, Nussbaum (2004) suggests that shame can force us to undertake goals resulting in valuable outcomes. “*It often tells us the truth. certain goals are valuable and we have failed to live up to them*” (Nussbaum, 2004:207). The goal of nursing is the care of the patient. Through Finnsech’s shaming of her colleague, the Other discovered the truth of the situation, that is, Finnsech carried out the goal of nursing through her practice on a day-to-day basis. The Other also discovered the truth of the situation through Finnsech’s intervention. The Other had negated her own nursing goal as the care of the patient, and allowed her own attitudes towards lesbianism to overpower her by interfering. In addition, she discovered Finnsech had been carrying out catheter procedures as part of her nursing practice, prior to the pronouncement of being lesbian. Finnsech’s practice was only questioned upon this information. After all, the only thing that had changed was the information that Finnsech revealed about herself. Though it was this that led to the Other’s actions.

Up to that point, Finnsech belonged to the community of nurses she worked with. From Mead’s (1934) point of view Finnsech had integrated the values, beliefs and norms of the nursing community. Finnsech was like them; her nursing practice was never questioned, but the revelation about the self brought her belonging, her being the same, into question for one of her colleagues. Finnsech’s difference was exposed for the Other to see and judge. However from Nussbaum’s (2004) point of view Finnsech’s colleague had faced the truth of the situation; she had lied and failed to live up to the values of being a nurse. Upon realising, the Other both apologised, and made ‘huge efforts’ in relation to Finnsech. This could be

read as the truth unearthing goals that are held by every nurse irrespective of sexuality, namely, the care of the patient. Equally, it can be read as shame unearthing “*an aspect of my being*” (Sartre, 1969:221). An aspect of her being discovered by Finnsech’s colleague is that she does not understand lesbianism, and has judged Finnsech on the basis of deeply-held attitudes towards lesbianism. By her actions Finnsech’s colleague placed her as Other and herself as the judge of the Other.

9.4 Being vulnerable in nursing

While coming out for Finnsech led to being told she did not ‘fit’ with the stereotypes of lesbian women, equally her nursing practice was also judged. Muirgel, on the other hand did not have to contend with negativity towards her nursing practice; she was confronted with the reactions of Others:

I still felt a general sort of I suppose, discomfort, that people had. I wouldn’t say that they were bullying me or anything like that, but I did feel uncomfortable, and I kind of would have had to work then to make them feel at ease. On some occasions I felt the disapproval from my colleagues, particularly colleagues from overseas. I think whether it’s the culture or not I don’t know, but whereas they would be very accepting of male homosexuality, female homosexuality is a big no, no (Muirgel)

Muirgel’s initial feelings were of being uncomfortable, ill-at-ease and vulnerable, resulting from the judgments of Others. This can be interpreted as Muirgel’s failure to protect the self (Shildrick, 2002) from the look and reactions of Others towards her. Muirgel became aware of her difference through the disapproval from the Other, whether they were Irish or non-Irish. Sartre (1969:260) suggests “*I see myself because somebody sees me*”. Through the disapproval of her colleagues Muirgel sees herself. Muirgel has not only become the object of the

Other, she is now open to their judgements; and sees herself as Others see her, an object of 'disapproval', thus seeing herself as Others judge her.

Being the recipient of the Others' disapproval led Muirgel to experience an "alienation of [my] her own possibilities" (Sartre, 1969). She had become, in effect, what the Other judges her to be; she has objectified the self, thus disregarding herself as a lesbian woman. Muirgel is in effect alienated from the self, the possibility of being a lesbian woman, as "*Being-seen-by-the-Other*" is the truth of "*seeing-the-Other*" (Sartre, 1969:257). When she came out Muirgel was able to see the truth of the Other, and their attitudes and perceptions towards lesbian women. Feeling uncomfortable was the truth of the Other's look. She has now become the self, which the Other knows (Sartre, 1969). Through this the Other had the ability to objectify her, thus alienating her from herself and the world as she knew it, as "*the alienation of myself, which is the act of being-looked-at, involves the alienation of the world which I organize*" (Sartre, 1969:263). The world of nursing as Muirgel knew it and understood it, had disappeared from her and became one that she did not recognise.

Her participation in the day-to-day reality of nursing suggests that a lesbian nurse is perceived as no different from her heterosexual nursing colleagues, until she comes out. Muirgel's taken-for-granted activities of everyday life in the world of nursing crumbled. Not only has the world become alien to her, she is simultaneously alienated from the world. She was different and in her difference did not belong in a profession that is based upon the assumption of

heterosexuality (see chapter three for a discussion of this). Therefore, Muirgel can claim she is what she is not, and not what she is (Sartre, 1969).

Through their uncomfortableness the Other is effectively judging her. Muirgel is denied her possibility of being-in-the-world with Others as an opportunity for the coexistence of difference. She also is aware of the discomfort of the Other. She had to work to make the Other feel comfortable around the fact that she was lesbian. The responsibility was put on her to ease the situation for the Other. Through taking on the discomfort of the Other, and working on easing it, she prevents the alienation of the self. More importantly, she works on the preventing her freedom, that is, the possibility of being different escaping her.

Muirgel gives meaning to the non-Irish Other's disapproval as cultural difference, by assuming male homosexuality was more acceptable and female homosexuality less so. However, in viewing non-Irish colleagues as problematic in relation to homosexuality, there is the underlining expectation that her Irish colleagues would have an awareness, knowledge and understanding that lesbianism exists in society. As we have seen from her experience this is not the case. Cultural difference in and of itself, does not lead to the understanding of the existence of lesbian culture. The cultural encounter explored in chapter six, unravelled inappropriate questioning of a lesbian woman of her sexual practices by a doctor which had no relevance to her medical condition. Equally, there is an expectation of a non-diverse, homogeneous society (chapter two), and heterosexual health care (chapter three).

9.4.1 Discrimination in nursing

Coming out led Muirgel to experience the disapproving gaze of her colleagues, while Finnsech found that her nursing practice was called into question by one of her colleagues (see section, 8.3.1). When Cellach initially came back to Ireland, she did not experience problems in relation to her sexuality in nursing. Both she and Gormlaith presented themselves as friends in the nursing profession, thus hiding the true nature of their relationship. However, in a different employment, she came across difficulties in her nursing practice, and was denied a promotion that she felt she was well qualified for:

When you take everything away from somebody, and at that time it felt like as if everything was being taken away, because I had come back very ambitious - we wanted to get on, and it was important for me to get on, and I wanted to get out to the national scene, and you know, I wanted to be a part of all that. There was no secret about that ambition, I mean other people had that ambition. So that was really no secret, and they were letting me know they were not going to let that happen, and when I challenged it and went back I was told that, look, if you want to take it further, look at what we've done to you so far, and that wasn't the real issue, that was the personal issues (*Cellach*).

Cellach is aware that she is ambitious in her career. It is important for her to succeed at what she does, which she does not hide. She found meaning in not obtaining the position as 'everything being taken away' from her. Clunis et al (2005:81) observe that, for lesbian women, "*identities and sense of accomplishment*" are often linked. Her ambitions were thwarted and she felt her professional life had overlapped the personal.

Cellach's sense of self and her possibilities of becoming through her nursing practice were disrupted. Equally, she gives meaning to the situation through reflecting on the power structures of the organisation she worked in. The Other judged her, and Cellach became the object of their judgment. The world of

nursing, as Cellach understood it, became alien to her, a world she did not recognise. Sartre (1969:261) suggests:

I am this self which another knows. And this self which I am – this I am in a world which the Other has made alien to me, for the Other's look embraces my being

Cellach's alienation from the world of nursing, was a result of her questioning the system and asking for changes to be made. Cellach had trained in Europe, where asking questions and pushing boundaries were part of her nursing practice. Her sense of self as a nurse and her ambitions within the profession are disrupted. Sartre (1969:263) points out that "*the alienation of myself, which is the act of being-looked-at, involves the alienation of the world which I organize*". Cellach is alienated from the world as she organises it, and thus her ambitions are questioned. She experiences an "*alienation of [my] her own possibilities*" (Sartre, 1969:263). Cellach is alienated from the self, the possibility of being a lesbian woman and a nurse.

Cellach continues her story.

I soon learnt that there wasn't, people were not tolerant of that at all, they were clocking up and saying this one is getting too feckin big for her boots, and the interview was a symbol of their way of letting me know we can do what we want - you will not change this organisation, you will not interfere with this organisation, you are nothing in this organisation (Cellach).

Through her training and practice in Europe, Cellach believed that her actions in the organisation were acceptable, that she could question practices. This after all had been her experience in nursing, and she brought this back with her when she decided to practice in Ireland. However, she 'soon learnt' that this was not the case and for her, the interview symbolised that her actions were unacceptable.

The interview also symbolised the power within the Irish nursing organisation she worked for. The organisation had the power to dictate to employees that change was not permissible, and that either an individual fits with the structures in place, or that individual leaves. What she learnt was that the culture of nursing in Ireland was not open to change. While coming out had been a learning experience, working in an Irish health care setting equally requires a learning curve to be negotiated. Cellach's situation could be interpreted as:

[I]ndividuals are made accountable to different expectations and behaviours because they belong to certain significant social groups that have been socially categorized in our society into a specific, well-defined set of expectations (Hurtado, 1996:374).

Cellach belonged to a community of nurses with social expectations of the behaviour of their members. To be a true member, Cellach had to integrate their norms, values and belief systems. However, through her questioning she contravened these. Cellach recognised the ability of the organisation to dictate her value and her worth as a nurse, but she successfully prevents herself from becoming the object of the Other's judgment.

Cellach reads her situation as being directly related to her sexuality. She continues her story:

But I think not only that, I do believe there was a certain amount of Jesus, this one was getting far too big for her boots, and she's a fucking lesbian, and she has to be easy to destroy you know, it can't take an awful lot - she's a feckin lesbian, it won't take a lot to destroy her. All we need to do is that when she goes for a job, that we know because she has made it very clear she's interested, if we can knock her down there what can she do about it, where is she going to go, sure she's a lesbian - is she going to tell everyone that she didn't get the job because she's a lesbian - is she going to out herself like that to expose herself, no but coo-wee you put a man in the place and there was another way of doing it. So you know, that's what we did, and it was very easy - it was fantastically easy, because I did possess the qualifications. I did possess

the experience, and I could articulate it, and I could describe where we were at (*Cellach*).

Cellach uses the metaphor of 'too big for my boots' to describe the position she found herself in. This metaphor, can be read as Cellach being over-confident, viewing herself as being better than anyone else, and that she had moved beyond her nursing grade. This is how Cellach gives meaning to the actions of the Other. In other words, the metaphor is a device through which Others know their place within society or, in this case, within the nursing environment. It can also be read as Cellach wearing a boot size which symbolises the nursing grade she does not occupy, thus suggesting that there is a size she adequately fits. In this way she should choose her behaviour, or rather behave in a way that adequately represents her position in the organisation. Cellach understands that Others wear the 'big boots' that are suitable for the position they hold in the organisation. Cellach did not hold a position that enabled her to try the boots on for size.

Cellach imputes meaning on the actions of the Other, suggesting a lesbian woman would not contest a decision as it would force her to come out, to go public. She perceives that Others thought they had the power to 'destroy', rendering her with an inability to act upon the situation. The use of the word 'destroy' by Cellach calls up images of violence in a way that Others can knock down, pull down, tear down, wreck or smash those in their path, challenging authority and norms. Chapter two discusses societal reactions to those who lived outside the norms of society, and chapter three discusses health care particularly the medicalisation of homosexuality, which would lead to Cellach not being left standing, but rather obliterated as she would be silenced. Cellach perceives the actions of the Other as resulting in violence to the self. Through this, she had no mechanisms to

defend the self. She gives meaning to the situation as acting would mean exposure for her: her sexuality would be on display for Others to see. Cellach would be vulnerable to the Other's look and open to judgments. Cellach's sexuality, would be exposed because of her career, her professional life. In this way, the image conjured up by the use of the word 'destroy' acts as an effective mechanism to silence Cellach, rendering her voiceless. Would a lesbian nurse expose herself to the judgments of the Other?

Moreover, would a lesbian nurse have the capacity to cite their lesbianism as a reason for not getting a job? Cellach perceives that the Other thought they had the authority to silence her. The images that Cellach portrays of those with power and authority are violent. Heidegger (1962) suggests that being authentic is a choice; however, in Cellach's experience the Other can remove that choice and by extension her authenticity. They could put her in a place where being authentic was dangerous to the self. This could equally be read as Cellach experiencing "*the threat of being cut asunder, abandoned, and left outside society's protection*" (Pharr, 2007:88). In other words, Cellach concluded that if she had exposed her sexuality in an effort to obtain her right, the implicit threat is that she would be abandoned by the nursing profession, and left without their protection if things went wrong.

However, Cellach discovered she did not have to come out or go public, as she excitedly exclaimed: 'coo-wee you put a man in the place and there was another way of doing it'. Instead of her sexuality becoming the issue, gender became the issue. When Cellach considered pursuing the situation in relation to her sexuality

she did not have an avenue opened up to her. Although Cellach had the qualifications and the ability to say what she wanted to say, a man was offered the position. In this way Cellach recovers the self. Through the actions of the Other, Cellach was able to assert her freedom. De Beauvoir (1976:98) reminds us:

[E]very individual may practise her [his] freedom inside her [his] world, but not everyone has the means of rejecting, even by doubt, values, taboos, and prescriptions by which s/[he] is surrounded

From de Beauvoir's point of view Cellach shows the strength to reject the values and ideals of the organisation she works in, which are not open to diversity, to change, to the acceptance of difference (see chapter two for how this is embedded in Irish society, and chapter three within the institution of health care).

9.5 Concluding remarks

Being oneself for lesbian nurses is a troublesome affair. The participants in this study who had worked in another European country were either out in their place of work, or had an inability to articulate who they were (see chapter eight, section, 8.2). Gormlaith suggested that Others could only judge her based upon the information she provided. Neither Grian nor Cellach articulated who they were to the Other, with Cellach acknowledging that the Other provided the definition of who she was, regardless of its validity (see chapter eight, section 8.2.2). However, upon returning to Ireland, they made a decision to go back into the closet, and employed mechanisms to hide their sexuality, such as being a listener, or presenting their relationship as friendship.

In conversation with lesbian nurses, the majority revealed they remained in the closet, with some fearing the consequences for their professional status, if their

sexuality was revealed in an Irish health care setting. The experience of being different for some lesbian nurses was heightened through the heteronormativity of conversations amongst nurses (see chapter eight, section, 8.4). Those who did reveal their sexuality to the Other suffered the consequences of their judgments, with the most extreme result being the questioning of the reason lesbian women would consider nursing as a career, or being denied a promotion that they were adequately qualified for.

Through their lived experience, lesbian nurses negotiate their sexuality in the workplace. Being members of the nursing profession, the majority of the participants face their difference on a day-to-day basis, revealing a profession that does not acknowledge diversity amongst its members. However, it is pertinent to keep in mind Skidmore's (2004:233) observation that, when we review the experiences of lesbian women of the workplace the "*contours of the heteronormative workplace are thrown into somewhat sharper relief than would otherwise be the case*". Therefore, lesbian women as nurses practice in a cultural environment whereby the norms, values and belief systems of nursing are based upon heterosexuality rather than diversity.

Chapter 10: *Conclusions and Recommendations*

*Stories hold a saving power of their own;
the power to invite us to listen to voices
that might otherwise have been unheard whispers
in the margins of modern healthcare.*
(Dinkins and Sorrell, 2006)

This research provides an analysis of the experiences of lesbian women, firstly as service users and secondly as nurses working in Irish health care, from a hermeneutical phenomenological perspective. Van Manen (1990:5) informs us that this approach to research is “*always to question the way we experience the world, to want to know the world in which we live as human beings*”. The lived experience of lesbian women as human beings in the world of health care is thus explored in this research. The study illustrates how lesbian women understand and give meaning to the situations in which they find themselves. Regardless of whether they are service users or nurses, their stories exemplify attempts to reconcile the self with a culture of health care based upon heterosexuality. This reflects initial studies (Regan, 1981; Cochran and Mays, 1980) and later studies (Gibbons et al, 2007; Hinchliff, Gott and Galena, 2005; Saulnier, 2002; Stevens, 1995) which report that diversity in women’s sexuality, is not recognised in health care settings.

Lesbian service users report experiences of ‘being different’ in health care encounters, and lesbian nurses encounter their difference from their colleagues. However, they experience their difference both as patients from other patients, and from those who are providers of health care, whether they are doctors or nurses in a health care setting. While their differences are exposed for both themselves as lesbian women and Others to see, Heidegger (1962) suggests there

is always a possibility to become, that is, I am not finite, I am constantly becoming through a reflective process of my situation. Therefore, lesbian women find meaning and understanding in both their situation as well as in who they are in their day-to-day interactions within society, which they bring into health care. Dasein, that is, the human being in the world, exists within society (Heidegger, 1962) and through interconnectedness, the lesbian woman becomes whoever she is by making a choice (Sartre, 1985) whether to come out or not. While a lesbian woman knows her difference, she decides whether to expose it to Others. However, there are times where she does not have a choice. This concluding chapter presents the key findings and outcomes of this study by uncovering the meanings and understandings that lesbian women give to their experiences of health care.

This chapter is divided into seven sections where the first deals with the similarities of experiences between lesbian service users and providers of health care. The second section reviews the key findings for lesbian women service users with the third revealing the key findings for lesbian nurses. The fourth section explores best practice provision for lesbian service users while the fifth analyses best practice for a diverse workplace. The sixth makes recommendations for the implementation of best practice in health care in Ireland and the seventh offers recommendations for future research.

10.1 Similarities of experience

This study reveals, that both lesbian service users and nurses' experience being lesbian in the health care environment, as a troublesome affair. A key theme for

both sets of respondents is 'coming out'. Lesbian nurses develop what Heidegger (1962:161) calls "*special routes*" in concealing the self from their colleagues. They also encounter stereotypes and prejudice when their sexuality is revealed. Lesbian service users, also experience overt and covert prejudice when their sexuality is known. These findings point to a health care profession based upon heterosexuality with of diversity not recognised. If lesbian nurses do not feel safe to disclose who they are, then it is understandable why lesbian service users would be reticent in revealing the self.

10.2 Key themes for lesbian women service users: coming out, being different and friendly health care

Three key themes emerged during the interviews with lesbian service users: 'coming out', 'being different' and 'friendly care' in health care encounters. The following three sections will provide a summary of these findings:

1. Coming out: Lesbian women experienced 'coming out' in health care encounters through discrimination and prejudice. These were manifested in both overt and covert ways (see chapter six). Howard (2002) suggests that it is through objectification that we get a sense of worth and value of ourselves as human beings. For some lesbian women, the sense of value and worth they experienced in health care encounters was through being objectively measured against the heterosexual norm, rendering lesbian sexual practices non-entities as they were, for instance, pronounced as virgins. Equally, inappropriate questioning by the health care provider can lead to discrimination. An example of this is in chapter six (section 6.5) where Béibinn was questioned about her sexual practices which bore no relation to her condition: suspected meningitis. However, health care

providers can reinforce the heterosexual norm in the face of diversity, which leads to some lesbian women being confronted by their difference when they come out. A goal of medical training is the production of neutral individuals who can care for patients, regardless of their attributes (Beagan, 2000; Lachowsky, 1999); however, it would also appear to be effective in reinforcing the norms and values of heterosexuality, which does not address difference properly.

Sartre (1969) indicates that through the look, an individual obtains a sense of self during the presence of the look of the Other. Some lesbian women reported that there was an absence of the look from their nursing care team when their sexuality was known, resulting in extreme prejudice and discrimination in action (see section, 6.4). Nurses withdrew care, resulting in the lesbian woman knowing that the kind of person she is, that is, a lesbian woman, is not accepted in health care. This also threatens the manner in which nurses' care for her. This illustrates the lack of respect afforded by some nurses to lesbian patients, which directly contravenes the women's health care policy quoted in chapter 1. It also demonstrates that some nurses do not know how to accommodate a lesbian patient.

2. Being different: The care of the self is paramount for all women, no more so than when it comes to cervical cancer. Some lesbian women found that when they sought smear tests, they were treated from a heteronormative stance; their concerns were dismissed or they were set apart from heterosexual women. Thus, their difference was exposed for both the lesbian woman but also her health care provider to see. Heteronormativity was experienced through service users being

informed that lesbian women did not need a smear test, as the sexual activities that they practiced were not considered to be a risk for cancer cell activation. In one case a lesbian woman was asked why she had to attend a clinic for a cervical smear. Her concerns were dismissed, reducing her to a childlike status. Another lesbian woman experienced the look that set her apart, whereby she was judged by the Other (Sartre, 1969). All the lesbian women experienced the negation of their existence as sexually active women, but more importantly their worth and value as human beings. Only by asserting themselves did the lesbian women obtain a smear test.

While lesbian women faced their difference during their encounter with health care providers, partners of patients were either recognised or cast aside, and their concerns for their loved one were negated. Some lesbian women found that they were unable to be present for their partners during their hospital stay. They were not afforded the same consultation rights with the medical care team as a family member would. One of the problems in this area is the lack of legal recognition of lesbian couples; with its resulting effect in situations such as those of a hospital stay (see section, 7.6).

3. Friendly health care: While the majority of participants in this study revealed experiencing a *non-friendly* women's health care service, there is an area according to the experience of Gormlaith and Cellach that seems to have achieved a woman-friendly health care: breast cancer care. Within the breast cancer care service, the truth of the lived experience can come to the fore. It points to a service that is based on trust and mutual respect (Ward and Savulescu, 2006),

leading to the incorporation of the patient-as-person (Mead and Bower, 2000). Within this service it was the illness that was focused upon rather than the person presenting with the illness. This led to lesbian women experiencing the authenticity of the self with all the possibilities of becoming wherever the illness led them (Heidegger, 1962).

Within this study, breast cancer health care also exhibited an ability to recognise lesbian relationships. This would suggest that other health care services can be created that incorporate the patient-as-person, thus recognising the patient as being-in-the-world, bringing with her all facets that make up personhood into health care. However, it must be noted that the breast cancer service that was utilised was in the private sector, which may explain why a more woman-friendly health care service was experienced by one example in this study.

In this context, the 1997 women's health policy document recognised that a woman-friendly health service did not exist for women (Government of Ireland, 1997). One of the aspirations of *A Plan for Women's Health. 1997-1999* (Government of Ireland, 1997), was the creation of a health care service whereby women who are marginalised within society, would not be further marginalised in health care. From the findings of this study, the creation of a woman-friendly health service has not yet materialised for most lesbian women, as they still experience marginalisation in health care. A further recommendation within the *Plan for Women's Health. 1997-1999* (Government of Ireland, 1997), was an action plan to be implemented for lesbian health care:

Health boards will be asked to ensure that health professionals are informed about lesbian health issues and that staff respect the sexual orientation of lesbian women (Government of Ireland, 1997:64).

The findings of this study illustrate, that most lesbian women were not respected when they received health care.

10.3 Key themes for lesbian nurses: coming out and performance

The key themes that emerged from interviews with lesbian nurses were ‘coming out’ which is also a theme shared with service users, and ‘performance’ in their work environment.

1. Coming out: Lesbian women who worked as nurses in another European country were ‘out’ in their place of work, but reverted to the closet when they came back to Ireland. The heterosexual dialogue amongst nurses in general leads some lesbian nurses to experience social isolation by becoming acutely aware of their difference. However, lesbian nurses are also conscious that coming out may possibly cast doubts on their professional reputation (see chapter eight).

While the majority of participants in this study remained in the closet, some decided to come out and reveal the truth of their situation. However, the reaction of colleagues uncovered deeply-held stereotypes of what lesbian women look like, suggesting that if a lesbian woman did not ‘look like’ a lesbian then she could not possibly be a lesbian. This reinforces Pharr’s (2007) and Nussbaum’s (1997) insight that lesbian women look, act, and behave like all other women and they are not readily recognisable. Therefore, it is the sameness of women that erases the ability of the other to identify lesbian women. This is similar for lesbian

service users, who reported that health care providers did not recognise sexual diversity amongst women. Through this, there is an inability to acknowledge that difference may exist amongst women who appear, act and behave like other women, and that this difference is socially accepted in a society that recognises diversity.

2. Performance: This study reveals that stereotypes exist within the nursing profession, focusing mainly on a possible explanation of why a lesbian woman would want to become a nurse: namely, fulfilling erotic fantasies. In this way the lesbian nurse becomes the Other of Otherness. A participant found her position in the nursing organisation in which she was employed challenged (see chapter nine). She discovered that her particular workplace did not foster a questioning environment, whereby boundaries could be challenged and pushed forward. The process of an interview resulted in her not obtaining a position for which she felt she had the qualification, and consequently her reflecting on her situation. She concluded that her sexuality was the underlying problem. While she challenged the decision, she did so based upon gender rather than sexuality.

One lesbian nursing couple presented themselves as friends to their work colleagues under the false impression that their presentation of the self was accepted. They discovered upon resigning from their posts, that the impressions fostered were outwardly accepted, while the truth of their situation was known. Their performance of their friendship did not coincide with the cultural norms of friendship, thus revealing the true nature of their relationship. In addition, this

couple did not experience negative consequences in relation to their personhood or sexuality.

10.4 Best practice for the provision of health care for lesbian women

Best practice for lesbian health care will be explored with examples from Ireland, the United Kingdom, Canada and the United States of America²⁰. This will be investigated in relation to a) nurses and b) doctors.

a) Nurses: The Health Service Executive (HSE), replaced all regional health boards in Ireland in 2004, with the responsibility “*to improve, promote and protect the health and welfare of the public*” (www.hse.ie). It is therefore the responsibility of the HSE to promote and provide adequate health care provision for lesbian women. Health boards were directed to create an action plan to “*ensure that health professionals are informed about lesbian health issues*”, and that all health care staff were to “*respect the sexual orientation of lesbian women*” (Government of Ireland, 1997:64). A further action strategy was laid out for the development of a woman-friendly health care:

Each health board will prepare a regional plan for women's health to implement the commitments for the national Plan and the issues identified during the consultative process over the period 1997-1999. Health boards will review their staff development and training programmes to include sensitivity training in relation to attitudes to women clients and patients (Government of Ireland, 1997:83).

This plan lays down the type of action that needs to be undertaken to create a woman-friendly health care; reviewing staff attitudes, and developing training programmes for sensitivity. This would suggest that information, per se, will not

²⁰ This is a result of internet search for the provision of health care for lesbian women

enable health care professionals to change attitudes, training programmes also need to be implemented.

In the United Kingdom the Royal College of Nursing (RCN)²¹ acknowledged the importance of the development of best nursing practice in relation to lesbian and gay health care. They issued guidelines for nursing staff in 2003 which state:

Nurses in clinical practice need to ensure that they never intentionally behave in a way which marginalises clients or patients. They must examine their behaviour towards clients to ensure that it cannot be considered as prejudicial, actively seek to raise awareness of the problem amongst colleagues and discourage unhelpful responses, and explore all possible ways of supporting and assisting lesbians and gay males using their service (Royal College of Nursing, 2003:3).

While the RCN offers support to nurses in their clinical practice to lesbian and gay patients, they also clearly state that it is the nurse's responsibility to examine and review their own attitudes towards this patients group. Equally, the RCN recommends that educational courses designed for both pre- and post-registration should have a strategy dealing with lesbian health care.

East Lancashire Hospitals NHS Trust in the United Kingdom *Being with Patients* programme (www.beingwithpatients.nhs.uk), which was set up in 2004, offers an example of best practice in sensitivity training. This programme was designed for nurses with the following aims:

1. *To raise awareness amongst staff of what it really means to be a patient;*
2. *To understand the implications of behaviour and attitudes in clinical situations,*

²¹ The RCN was set up in 1928 by Royal charter. It is a major voice for nursing in the United Kingdom. They develop guidelines for best nursing practice and shaping health policy. Upon completion of training a nurse registers with the National Nursing and Midwifery Council of the United Kingdom. In Ireland a nurse registers with An Board Altranais (Nursing Board).

3. *To experience and test new behaviour in a safe, confidence-building environment;*
- 4 *For all participants to actively develop an open, intuitive culture of patient centred care* (www.beingwithpatients.nhs.uk, emphasis in the original).

A multi-method approach was used in this training programme: first “*the experience of patients*”; secondly, using a “*hearts and minds approach*” whereby they reviewed the culture of nursing, and the need for change; and thirdly, the learning experience whereby a whole range of techniques, “*including dramatised case studies, simulated patients, new video technology, and experiential exercises*” were used (www.beingwithpatients.nhs.uk). The evaluation of the programme, which ran for two years, revealed:

that enabling an entire ward team to undertake relevant elements of the ‘Being with Patients’ programme is feasible and does positively shift the caring attitudes and behaviours of nursing staff (Reid, 2006:1).

The success of this programme points to the ability of nurses to *revise attitudes* towards patients, when they are trained in a safe environment. Whilst this programme is not specifically designed for the care of lesbian patients, it can be utilised to develop a programme that is inclusive of lesbian health care.

Another example of the development of best practice is the Gay, Lesbian, Bisexual and Transgender (GLBT) Health Access Project (www.glbthealth.org) funded by the Massachusetts Department of Public Health in the United States of America. This project was set up in 1997, to provide training and assistance to all health service providers on the health care needs of GLBT people. Their mission is:

To foster the development and implementation of comprehensive, culturally appropriate, quality health promotion policies and health care

services for gay, lesbian, bisexual and transgendered (GLBT) people and their families (www.glbthealth.org).

A community standard of practice document was developed to enable health care providers to provide health care for GLBT people, and their families. They have generated standards and indicators in six areas, which they state are a “*benchmark for both providers and consumers*”:

1. *Personnel*
2. *Client's rights*
3. *Intake and assessment*
4. *Service planning and delivery*
5. *Confidentiality*
6. *Community outreach and health promotion* (www.glbbyhealth.org)

These are comprehensive standards with indicators that can be utilised to track the implementation of a GLBT-friendly health care. The issue of ‘personnel’ will be explored in section 10.5 on lesbian nurses. As an example, in relation to the provision of GLBT-friendly health care, the standard on ‘client’s rights’ states that “*comprehensive policies are implemented to prohibit discrimination in the delivery of services*” (GLBT Health Access Project, 1997:3). Four indicators were developed ranging from written policies to the signing-off by all staff of such policies. By so doing all health care providers, whether they are in institutions such as hospitals, clinics or primary health care practices provide health care based upon equality of access and provision of care.

b) Doctors: The Irish Medical Organisation recommends that all its members sign up to the Dignity and Respect in the Workplace Charter.

Health Canada produced a booklet and tip sheet²² on the *Caring for Lesbian Health* (http://www.hc-sc.gc.ca/hl-vs/pubs/women-femmes/lesbi_e.html) to promote best practice amongst doctors. The tip sheet recommends that all health care providers read the booklet on lesbian health care, and keep in mind eleven points: these range from the use of heterosexual language in questioning a lesbian service user to seeking out workshops to enable the provider to provide the best possible health care.

Finally, in the United Kingdom the British Medical Association indicates: “Doctors should respect patients ‘regardless of their lifestyle, culture, beliefs, race, colour, gender, sexuality, disability, age, or social or economic status’ (<http://www.bma.org.uk/ap.nsf/Content/Sexualorientation~patients>). Doctors in Ireland should also treat all patients on the basis of respect, regardless of their attributes such as sexual orientation.

10.5 Best practice for an integrated work environment in health care

Under the heading of diversity, the HSE handbook for all employees clearly states that:

People are not alike. Everyone is different. Diversity, therefore, consists of visible and non-visible factors which include personal characteristics such as gender, race, age, background, culture, disability, personality and work-style. Harnessing these differences will create a productive environment in which everybody feels valued, their talents are fully utilised and organisational goals are met. Diversity is about recognising and valuing difference in its broadest sense (www.hse.ie)²³

Most importantly, the HSE does recognise that diversity exists in society, and will be represented in their employees. They further state:

²² Health Canada uses the term ‘tip sheet’ which is an information sheet for health care providers

²³ There is no date of publication on the website

The HSE recognises and values the diversity of all Employees and is committed to developing working practices which will allow every Employee to contribute his or her best, regardless of race, gender, family status, membership of travellers' community, marital status, religion or belief, age, disability or sexual orientation (www.hse.ie).

The HSE recognises through its *Employee Handbook* diversity in sexual orientation. However, the findings of this study would suggest that they need to develop and implement *training for all health care professionals to create a working policy.*

One of the standards developed by the GLBT Health Access Project in Massachusetts, United States of America, is centred on personnel. Three standards with indicators which can track implementation of the standards themselves were developed. The first standard suggests that health care environments should “*establish, promote and effectively communicate an inclusive, non-discriminatory workplace environment*” for GLBT employees (GLBT Health Access Project, 1997:2). The second standard encourages visibility and the third standard has the same terms and conditions of employment inclusive of benefits for GLBT people. Finally, the RCN in their guidelines for best practice with lesbian and gay patients indicate that in the workplace, nurses “*need to challenge homophobia and heterosexism ... whenever they encounter it*” (Royal College of Nursing, 2003:4). Therefore, it is the responsibility of every nurse, regardless of sexual orientation, to ensure that the health care environment is one where the diversity acknowledged in the HSE Handbook can exist.

10.6 Recommendations for the implementation of best practice in health care

Lesbian health care has been acknowledged as important and guidelines for best practice developed; for example, by the RCN and the East Lancashire Hospital NHS Trust *Being with Patients* programme, in the United Kingdom; Canada has also produced a booklet *Caring for Lesbian Health*. In the United States of America, the GLBT Health Access Project was developed for health care professionals working in the health care environment. Drawing on best practice from these three specific examples, there are four main recommendations that would enable lesbian women to obtain a woman-friendly health care in Ireland:

1. The policy that already exists within the HSE needs to be developed further with training for all health care professionals.
2. The development of a programme based upon the East Lancashire Hospital NHS Trust *Being with Patients* programme adapted to the Irish context.
3. The RCN guidelines be utilised by the NCNM²⁴ as a blueprint to develop guidelines for best nursing practice in the Irish context.
4. The GLBT Health Access Project standards for practice can be utilised by the HSE in developing best practice for all health care providers in providing health care for lesbian women. They can be implemented to fit an Irish cultural context that already experiences diversity.

²⁴ In November 2007 the Government published *Heads of Proposed Nurses and Midwives Bill* for public consultation. In part seven, head 60, it is proposed to dissolve the NCNM and to divide the current responsibility that they hold, between the HSE and An Board Altranais. This removes an independent voice for nurses as the HSE is an employer and An Board Altranais is the body that registers a qualified nurse, and also is responsible for dealing with misconduct issues. Equally, both the HSE and An Board Altranais may have a conflict of interest in developing best practice for lesbian nurses in the work environment. Presently the NCNM is in an ideal position to promote diversity amongst nurses and best practice in nursing care.

While the Irish Medical Organisation and the HSE policy documents recognise the existence of diversity amongst its staff they need to make sure that the policies are implemented. In light of this it is recommended that:

1. The RCN guidelines on challenging homophobia in the workplace in a safe environment be implemented.
2. The HSE develop a programme similar to the GLBT Health Access Project with standards and indicators for sexual diversity within the workplace that is suitable in an Irish context.

Standards of best health care practice for lesbian service users and lesbian nurses working in the health care environment have not been developed in Ireland. In chapter 12 of the document entitled “Creating a woman-friendly health service” (Government of Ireland, 1997:82), it is stated that:

In many cases, women are critical of the attitude and tone with which services are delivered, rather than the technical quality of the service itself, suggesting a need for sensitivity training for staff on this issue

The findings of this study would suggest that “*sensitivity training for staff*” has not yet been implemented in relation to lesbian health care. However, there were also examples when “*the technical quality of the service*” was limited, suggesting that there is a link between sensitivity training and delivery of service. This may explain the experiences of the lesbian women who participated in this study.

In Ireland, the National Council for the Professional Development of Nursing and Midwifery²⁵ (NCNM) was set up in 1999, with the mission:

²⁵ “The National Council for the Professional Development of Nursing and Midwifery was created on foot of: *The National Council for the Professional Development of Nursing and Midwifery (Establishment) Order, 1999 (SI Number 36 of 1999)* from the Minister for Health and

to promote and develop the professional roles of nurses and midwives in partnership with stakeholders in order to support the delivery of quality nursing and midwifery care to patients/clients in a changing healthcare environment (www.ncnm.ie).

The NCNM are the nursing body in Ireland that can issue guidelines for best nursing practice. However, through the promotion of quality of health care, the NCNM needs to recognise and develop guidelines on lesbian health care. While this plan was developed prior to the establishment of the HSE, it is the responsibility of the HSE to ensure that both a woman-friendly health care, and sensitivity training programmes are established, for all health care professionals. In chapter two, detailed information on the educational sector points to the fact that while a Relationship and Sexuality Education programme was developed there was resistance to its implementation in 63% of second level schools (Norman, Galvin and McNamara, 2006:65). While there are factors influencing the implementation of the RSE programme in Irish schools (see chapter two, section 2.5.2), such as the role of the Catholic Church (Norman, Galvin and McNamara, 2006), these barriers may not exist in health care. To date, neither the HSE nor the NCNM have developed best practice guideline for the care of lesbian patients. While the HSE recognises the existence of sexual diversity amongst health care professionals, it needs to create a working policy.

10.7 Recommendations for future research

This thesis makes four initial recommendations for continuing research in this area and raises a number of key research considerations, arising from the findings of this study. The presentations of the self by lesbian service users or lesbian nurses in health care environments generate unique challenges. Lesbian women

Children (SI Number 376 of 1999) entitled The National Council for the Professional Development of Nursing and Midwifery (Establishment) Order, 1999” (www.ncnm.ie).

face discrimination and prejudice when they come out to service providers. The majority of lesbian nurses choose to remain in the closet, while those who come out face stereotypical judgments about what a lesbian woman looks like. A safe environment needs to be created within health care whereby lesbian nurses and service users can safely disclose their sexuality. This study thus makes four key recommendations:

1. Future studies of aspects of cancer care as experience of terminal illness

From this study one couple experienced breast cancer care as a woman-friendly health care. While they initially experienced breast care in the private sector, part of their treatment was in the public sector. Health care professionals ability to provide health care based upon diversity may be due to the nature of dealing with potentially terminal illnesses. In this way the provision of health care is based upon mutual respect and trust (Ward and Savulescu, 2006).

Additionally, a phenomenological study of lesbian women's experience of breast cancer needs to be undertaken, to elicit if the findings of this study are the reality for other lesbian women. Further research should also examine the culture that exists within breast cancer care. This work could uncover what enables those to work within this field, without prejudice or discrimination. The findings of this study may enable other health care professionals to develop a practice based upon sexual diversity.

2. Future studies of the effects of being in the closet on lesbian nurses' health

The findings from the current study reveal, that lesbian nurses are acutely aware of their difference in their profession and choose to remain in the closet. While this research shows that lesbian nurses blend into the heterosexual community of nursing (King, 2003), it points to the lack of social support and understanding of lesbianism, within the nursing profession. This may result in lesbian nurses experiencing low self-esteem and poor psychological well-being through living a dual life. Hershberger, Pilkington and D'Augelli (1996) suggest, that lesbian and gay adolescents face stressors in their life from family rejection, physical abuse or fear of the consequences of disclosure of their sexual orientation. The results from this research suggest that lesbian women in health care professions face similar stressors. Living with these stressors may have consequences for both the physical and mental health of the lesbian nurse. Future research should uncover how lesbian nurses cope with these stressors, and in particular how they affect their health status.

3. Future studies addressing the culture of the hospital

The findings of this study, illustrate the lack of understanding of the existence of sub-cultures within society. It would appear that in Irish health care, some nurses and doctors lacked what Ramirez (2003) calls cultural competence, so negating the values and practices of lesbian culture. However, the findings of this study show that other personnel, such as administrators within the hospital setting, hold judgmental attitudes towards lesbian women. Ramirez's (2003) study points to the importance of undertaking a study to explore the intercultural nature of Irish hospitals. Such a study would uncover the culture that exists within this setting.

Patients come into contact with many members of the cultural setting within a hospital from administrators, orderlies, doctors and nurses. Through this study, the culturally shared and common sense observations of everyday experience within the hospital setting, can be uncovered.

4. Future studies on the education of the health care profession

The findings of this study, suggest that the education of both doctors and nurses needs to include sexual diversity, as part of the curriculum. Both doctors and nurses need to be educated to re-engage with patients, developing a way of being with patients and build up an understanding of their own attitudes and beliefs on the health of their patients. Research needs to be carried out on how the training of doctors and nurses reflects sexual diversity between women. It also needs to examine whether a module on sexual orientation could change attitudes towards lesbian patients. It needs to answer the following questions:

- What are the modules in place that currently deal with sexuality?
- What are students' attitudes prior to undertaking a course on sexuality?
- Does undertaking a module on sexuality affect students' attitudes?

Should the study illustrate that diverse sexuality is not been taught, then a module needs to be created.

While a study on current sexuality education would elicit insights into whether students are being introduced to sexual diversity; a further study on practising health care professionals needs to be undertaken. It could include an attitudinal survey to uncover current attitudes towards lesbian patients. It would also seek to

address health care professionals' needs, in relation to providing health care for lesbian patients, the results of which could be used to develop awareness training.

10.8 Concluding remarks

This thesis, presents a unique study on the health care experiences of lesbian women of Irish health care, by focusing on 12 service users and 7 nurses. Being the first study of its kind to incorporate both service users and providers in Ireland produced limitations, namely the non-generalisability of the findings, but further research in this area will help to further support the findings generated. This is one interpretation of the findings which is open to more "*potentially richer or deeper description*" (van Manen, 1990:31). However, this study gives meaning and understanding to the experiences that lesbian women provide as either service users or nurses, within the health care environment. Equally, my own experience as a lesbian service user offers depth to this study, by providing privileged access to lesbian women's stories.

The epistemological framework used within this thesis is phenomenology. The philosophies of Heidegger (1962) and Sartre (1969) underpin the study to explore the lived experience of lesbian women in health care. The process of doing hermeneutic phenomenological research, begins with the research topic which requires the researcher to iteratively and flexibly generate meanings with the material (Ironsides, 2005). In analysing the data, I 'dwelled' in a Heideggerian sense with the data, until the interpretative themes emerged.

This thesis has focused upon lesbian women being-in-the-world of health care, both as service users and providers of health care in their capacity as nurses. Lesbian nurses know the world of health care on a professional level, as well as lesbian women. This differs for service users as their knowledge of the world of health care is that of the outsider, rendering them vulnerable to knowledgeable professionals. Lesbian women's susceptibility has been well documented: judgments about sexual orientation (Marrazzo, Coffey and Bingham, 2005; Saulnier, 2002); age-related assumptions (Hinchliff, Gott and Galena, 2005; Harrison, 2001; Scherzer, 2000) and use of heterosexual language (Gibbons et al, 2007; McDonald, McIntyre and Anderson, 2003; Stevens, 1996). Lesbian women who are nurses are aware of the attitudes that prevail about lesbian women in the health care environment, as they encounter them in their working lives through: homophobia (Giddings and Smith, 2001); lack of social support and understanding (Fingerhut, Peplau and Ghavami, 2005) leading to non-disclosure of their own sexuality (O'Hanlan et al, 2004; Shelby, 1999), due to the covert or overt discrimination in the workplace. This study reveals similar findings in an Irish context.

Heidegger (1962) and Sartre (1969) provide a theoretical framework from which the meanings and understanding of lesbian women in the world of health care can be interpreted. Findings from this analytical framework suggest, that the aspiration of creating a woman-friendly health care (Government of Ireland, 1997) for lesbian women, has not been achieved in Ireland. While both the Irish Medical Organisation and the HSE, have policies in relation to diversity in the workplace, lesbian nurses do not perceive health care environments as safe

entities in which to be. Consequently, this thesis contributes to the knowledge of lesbian women's lived experience in Irish society, from a health care perspective. It makes a unique contribution to the body of knowledge on marginalised groups in Irish society, and how they can be further marginalised within institutions that do not recognise diversity.

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Appendix A: *Informed Consent Form*

The Lived Experience of Lesbian Women of the Irish Health Care System

My name is Mel Duffy and I am a lecturer in Sociology in the School of Nursing, DCU. This research is being carried out as a Ph.D. project with the School of Applied Language and Intercultural Studies, DCU. Dr. Agnès Maillot is my supervisor and she can be contacted on 01-7005544.

There is very little written about lesbian women's experiences in Irish society whether on a day-to-day basis or their contributions to society. This is reflected in the Irish literature where little is known about lesbian women's experiences in the health services. I would hope that by contributing to this study the results would enhance our understanding of lesbian women's experiences of the health care services and enhance their experiences in the future.

In the first part of the study I want to know what it is like for you as a lesbian woman when you access health care. In the second part of the study I would like to examine the experiences of lesbian nurses working in the health care environment. The research involves detailed interviews. The interviews will be taped and will take about 45-60 minutes. All interviews will be anonymous and recordings will be destroyed immediately after they have been transferred to written format.

Electronic copies will be saved on a laptop specifically for my research and upon obtaining the degree award the laptop will be rebooted to original specs thus destroying all data saved on it. This will be undertaken with the supervision of the research supervisor.

Participant – please complete the following (Circle Yes or No for each question)

| | |
|---|---------------|
| <i>Have you read or had read to you the Plain Language Statement</i> | <i>Yes/No</i> |
| <i>Do you understand the information provided?</i> | <i>Yes/No</i> |
| <i>Have you had an opportunity to ask questions and discuss this study?</i> | <i>Yes/No</i> |
| <i>Have you received satisfactory answers to all your questions?</i> | <i>Yes/No</i> |
| <i>Are you aware that your interview will be audiotaped?</i> | <i>Yes/No</i> |

Participants may withdraw from this study at any time without any consequences. Confidentiality of the participants will be respected at all times.

Signature:

I have read and understood the information in this form. My questions and concerns have been answered by the researchers, and I have a copy of this consent form. Therefore, I consent to take part in this research project

Participant's Signature: _____

Name in Block Capitals: _____

Witness: _____

Date: _____

Appendix B: Plain Language Statement

Title of study

The lived experiences of lesbian women of the Irish healthcare system

My name is Mel Duffy and I am a lecturer in Sociology in the School of Nursing, DCU. This research is being carried out as a Ph.D. project with the School of Applied Language and Intercultural Studies, DCU. Dr. Agnès Maillot* is my supervisor and she can be contacted on 01-7005544.

As lesbian women go about their daily lives with nobody knowing that we are lesbian. People do not know much about your daily experience or what it is like to live your life as a lesbian woman. Wherever lesbian women work or live their sexuality is hidden because they look and act like other woman. This means nobody knows much about how lesbian women live their lives, for example what experiences they have of being educated, whether they join religion ceremonies, what kind of family life they have and/or lesbian women's health needs.

If we do not talk about lesbian women then we are not recognising that different types of women live in Ireland. By not talking about different kinds of women we are saying that all women are the same. Some lesbian women behave as if they were heterosexual, so that nobody can point out their difference and treat them unfairly.

In the first part of the study I want to know what it is like for you as a lesbian woman when you access health care. In the second part of the study I would like to examine the experiences of lesbian nurses working in the health care environment. The research involves detailed interviews. The interviews will be taped and will take about 45-60 minutes. All interviews will be anonymous and recordings will be destroyed immediately after they have been transferred to written format.

Participants may withdraw from this study at any time without any consequences.

If participants have concerns about this study and wish to contact an independent person, please contact:

The Secretary, Dublin City University Research Ethics Committee, c/o Office of the Vice-President for Research, Dublin City University, Dublin 9. Tel 01-7008000

*Dr. Margaret Gibbon began supervising this work in 2004 and due to retirement Dr. Agnès Maillot took over.



CALLING ALL LESBIANS

The lived experience of lesbian women of the Irish health care service

My name is Mel Duffy and I am a lecturer in Sociology in the School of Nursing, DCU. I am a lesbian researcher interested in other lesbians' experiences of health care services and encounters. This research is being carried out as a Ph.D. project with the School of Applied Languages and Intercultural Studies, DCU.

There is very little written about lesbian women's experiences in Irish society whether on a day-to-day basis or their contributions to society. This is reflected in the Irish literature where little is known about lesbian women's experiences in the health services. I would hope that by contributing to this study the results would enhance our understanding of lesbian women's experiences of the health care services and enhance their experiences in the future.

I would like to know what it is like to be a lesbian woman when you seek health care from a G.P. or as a patient in a hospital. This is a phenomenological study.

Phenomenology describes the real life experience. This study involves a confidential in-depth interview, which will take approximately 45-60 minutes. Your participation will be confidential and your anonymity will be protected at all stages of this study.

If you would like to participate in this study you can contact me on 086-8769400. This mobile number is for the sole purpose of this research and will not be used by any other individual. Please feel free to pass it on to other lesbian friends, relatives or colleagues you feel may be interested in taking part in this survey of lesbian views and experiences.

Appendix D: *National Council for the Professional Development of Nurses and Midwifery*

Lesbian Women's Experiences of the Health Service in Ireland

There is very little written about lesbian women's experiences in Irish society. This applies in all areas of life and is also reflected in the nursing literature where little is known about this subject. Research is currently being carried out as part of a Ph D project undertaken by a lecturer in sociology at the School of Nursing, Dublin City University. The overall aim of this phenomenological study is to enhance the understanding of lesbian nurses' contribution to and experiences in the nursing profession, as well as throwing light on the experiences of lesbian women availing of healthcare. The researcher would like to know what it is like to be a lesbian nurse working in the health care environment and plans to conduct confidential interviews with volunteers.

For further information on what is involved in participating in this study contact

Ms Mel Duffy
Lecturer in Sociology
School of Nursing
Dublin City University
Glasnevin
Dublin 9

T: (086) 8769400.

The researcher has advised the National Council that this mobile number is for the sole purpose of this research and will not be used by any other individual.