School of Public Health

Understanding the Higher Rates of Smoking Among Lesbian and Bisexual Women

Judith Ann Comfort

This thesis is presented for the degree of
Doctor of Philosophy
of
Curtin University

June 2012

Declaration

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgement has been made.

This thesis contains no material, which has been accepted for the award of any other degree or diploma in any university.

Candidate's name: Judith Ann Comfort

Signature:

Acknowledgements

There are many people to thank who contributed in some way to me completing this piece of work. My supervisor Jan Lewis who has been there from the start has provided timely, wise and insightful feedback and support at all stages of the research and the write up. My co supervisors Maryanne Doherty-Poirier provided valuable critique on the final thesis while Gareth Merriman provided insights into early chapters. To my reference group who were especially helpful in the early stages of the research thank you. To my work colleagues in the School of Public Health, many of whom have been through or are on their own PhD journey, who offered understanding and encouragement. To Rita Freijah for assistance in final preparation.

My many friends have been there all the way with equal amounts of distraction and encouragement. I look forward to rejoining the social world again. My family although not in Perth have been at the end of phone calls and emails along the journey.

To the participants who were willing to share their stories and speak openly about their experiences my heartfelt thanks. I hope in this work I have done justice to your words and that this research contributes just a little to improving the understanding and health of lesbian and bisexual women.

To the wonderful world that is the many facets of the lesbian community in Perth you continue to nurture me. May we look forward to a time of acceptance by all of all that is the rich diversity that makes up our society.

Abstract

Smoking control measures and the resulting falling prevalence of smoking are one of the public health success stories in Australia. However while approximately 17 percent of adults still smoke, prevalence data indicate that this is not evenly spread across the community. Smoking rates are much higher in marginalised groups such as Indigenous Australians, low socioeconomic status populations and those with mental health issues. Smoking rates are also higher in lesbian and bisexual women. This research attempts to answer the question why.

While the majority of lesbian and bisexual women lead happy lives with good healthy lifestyle choices there is overwhelming evidence that this is not the case for all of these women. Higher rates of substance use, overweight and obesity, mental health and other health issues are reported. Smoking rates are higher than the wider Australian female population and this has been found in other Western countries as well.

Using qualitative research methodology of grounded theory, in-depth interviews were undertaken with a group of women who identified as lesbian or bisexual and were either current smokers or recent ex-smokers. A comprehensive literature review was also completed and further qualitative data was obtained from one on-line lesbian social networking site. A conceptual framework of symbolic interactionism was used for the research approach, which allowed for issues of identity formation and reflection, social influence, and behaviour to be analysed.

Both smoking and minority sexual identity have undergone rapid social change with the former becoming increasingly socially undesirable and the latter slowly becoming more socially accepted. This provides a backdrop for the reporting of the results of the research. In trying to explain the higher levels of smoking in this group, three core categories of dissonance, resolution and redefinition factors emerged. Knowledge, expectations, denial, identity, stigma, loss and fitting in all contribute to reported dissonance for participants in both their smoking behaviour and their sexual orientation identity. Resolution was reached through justification, identity

declaration, minimising of social loss, reported positives of behaviour and ways of managing stigma. Redefinition factors were articulated as relating to changing social acceptability and life-course. The core categories are encapsulated in the core theme of self-concept.

In discussing the results and providing recommendations for future action it became clear that minority membership of two groups, that of smokers and of sexual minority identity, play an important part in self-concept and to understand and address higher rates of smoking prevalence required acknowledgement of this. More inclusive mainstream smoking control interventions are required that acknowledge the unique and complex interplay of factors for this group. In addition there is scope for targeted interventions at a lesbian/bisexual women or gay community level as a clear connection to some community attributes was reported.

Stigma at many levels (internalised, structural, covert and overt) and discrimination based on sexual orientation still exists in Australia and many countries. Until fundamental changes occur in the real acceptance of sexual orientation diversity at a broad community level, poor health in this minority group will result. Social change on both of these areas has been encouraging but there is still much work to be done for true equity to be reached. Smoking control has accomplished a measure of success however until low smoking prevalence is achieved in all marginalised populations there is still much to realise. Smoking is still the largest cause of preventable morbidity and mortality and therefore the public health dollar must stretch to encompass and succeed in these challenging areas before we can say that we have won the battle. This needs to be done while being cognisant of the stigma that is attached to being a smoker today.

This research project adds to the literature by exploring and understanding the complexities of smoking behaviour in lesbian and bisexual women. Recommendations are made for public health interventions to address this.

Table of Contents

Figures

Abbreviations

ABS	Australian Bureau of Statistics
ACON	AIDS Council of New South Wales
AMA	Australian Medical Association
AIHW	Australian Institute of Health and Welfare
CDC	Centers for Disease Control and Prevention (USA)
CI	Confidence interval
DSM	Diagnostic and Statistical Manual
ETS	Environmental Tobacco Smoke
GLCS	Gay and Lesbian Community Services (WA)
GLBTI	Gay Lesbian Bisexual Trans Intersex
GLHV	Gay and Lesbian Health Victoria
HREOC	(the Australian) Human Rights and Equal Opportunity Commission
HIV/AIDS	Human immunodeficiency virus/acquired immunodeficiency syndrome
LGB	Lesbian Gay Bisexual
LGBT	Lesbian Gay Bisexual Trans
NSW	New South Wales
NDSHS	National Drug Strategy Household Survey administered by the AIHW
GTM	Grounded Theory Methodology
OECD	Organisation for Economic Co-operation and Development
SMW	Sexual Minority Women
WHO	World Health Organization
WA	Western Australia
WSW	Women who have Sex with Women

Glossary of terms

Bisexual: A person who is sexually attracted to both men and women, although not necessarily to the same degree.

Closet (in the closet): Undisclosed sexual orientation or gender identity – the opposite of being 'out' (see coming out). Individuals may hide their sexual orientation from all others, or in specific situations or from specific people e.g. at work, from parents.

Coming out (being out): Voluntarily acknowledging one's own sexual orientation. An individual's own acknowledgement may be referred to as 'coming out' to yourself. This precedes any 'coming out' to others. An individual may be 'out' in some aspects of their life but not in others e.g. with close friends but not with family of origin. A person may be involuntarily 'outed' by others.

Ex-smoker: "A person who has smoked at least 100 cigarettes or equivalent tobacco in his or her lifetime, but does not smoke at all now" (Australian Institute of Health and Welfare, 2011, p. 61).

Family of choice: Opposite of family of origin where an individual sees their family as made up of close friends not related by birth or marriage.

Family of origin: People related by birth or marriage including parents, siblings, aunts, uncles, nieces, nephews etc.

Gay: General term for same sex attracted people or homosexual person of either sex. Also used to refer to just men who primarily have emotional and sexual attraction to men.

Gay community: Used to refer to a subset of society composed of people who are not heterosexual. Subset of the gay community would be the lesbian community.

Gender identity: Person's sense of self as being either male or female. Gender identity does not always match biological sex; for example, a person may be born biologically male yet have a female gender identity.

Gay scene: Generally referring to nightclubs and social events that are directly either exclusively or largely attracting gay, lesbian and bisexual participation.

GLBTTIQQ: An abbreviation of Gay, Lesbian, Bisexual, Transgender, Transsexual, Intersex, Queer, Questioning i.e. people who are not heterosexual or are gender diverse. There are variations of how this term is used and may be shortened or in a different order e.g. LBG.

Grey literature: "Information produced on all levels of government, academics, business and industry in electronic and print formats not controlled by commercial publishing i.e. where publishing is not the primary activity of the producing body." (Grey Literature Network Services, n.d.). This could include community newsletters or group correspondence.

Heteronormative: A belief whether conscious or unconscious that the social world is composed only of heterosexual people and this is reflected in both individual and institutional constructs.

Heterosexism: Belief that heterosexuality is the only 'natural' sexuality and that it is inherently healthier or superior to other types of sexuality.

Heterosexual: An individual with a primary sexual, affectional and/or emotional attraction toward persons of the opposite sex. Heterosexuals are sometimes referred to as 'straight'.

Homosexual: Same sex attracted people. An individual with a primary sexual and affectional orientation or emotional attraction toward persons of the same sex. Male homosexuals are often referred to as 'gay', whereas female homosexuals may be referred to as 'lesbians'.

Homophobia: Irrational fear or hatred of homosexuals (lesbians and gays). This manifests as discrimination and prejudice at an individual or institutional level and includes emotional and physical violence.

Internalised homophobia: Self-hatred that gays and lesbians struggle with as a result of heterosexual prejudice. They accept and believe the negative messages of the dominant group as they relate to gay men, lesbians, bisexuals.

Intersex: Born with biological attributes of both sexes.

Lesbian: Term used to describe women who experience lasting romantic and sexual attractions for other women.

LGB: Lesbian, Gay, Bisexual.

LGBT: Lesbian, Gay, Bisexual, Trans.

LGBTI: Lesbian, Gay, Bisexual, Trans, Intersex. See also *GLBTTIQQ*

Minority sexuality group/women: A term used by some to encompass all people/women who do not identify as exclusively heterosexual. 'Minority' as the majority of the wider population identify as exclusively heterosexual. Some have expanded this to 'minority sexuality and gendered groups'.

Out or out of the closet: Being open about one's minority sexual orientation or gender identity. See *Coming Out*.

Passing: The practice of a person pretending to be a sexual orientation other than their real one. Often used to describe someone being assumed to be a heterosexual rather than identified as gay or lesbian.

Pink triangle: A colloquial term describing the geographic area of inner city suburbs that are perceived to have a higher than average concentration of gay residents.

Queer: An umbrella politicised term that includes a range of non heterosexual, alternative sexuality and gender identities.

Regular smokers/users: See *'smoker'*.

Rollies: Hand rolled cigarettes using commercially available cigarette papers and tobacco. Usually with no filter however a filter can be fitted.

Same sex relationship (same sex attracted SAA): A relationship between two women or two men.

Sexual identity: What people call themselves with regard to their sexuality. Labels include 'lesbian,' 'gay,' 'bisexual,' 'bi' or 'queer'.

Sexual minority: Refers to lesbian, gay, bisexual, transgender, and questioning people as a minority in a predominantly majority heterosexual population.

Sexual minority women (SMW): Refers to women who are not exclusively heterosexual and generally includes lesbian and bisexual women.

Smoker: "A person who reported currently smoking daily, weekly or less often than weekly" (Australian Institute of Health and Welfare, 2011, p. 247).

Straight: Term used for someone who is heterosexual.

Tailor-made: Manufactured cigarettes sold commercially in packets of 20 to 50 individual cigarettes.

Trans: An umbrella term encompassing transsexual, genderqueer, sistergirl and other gender diverse identities that often do not fit neatly into the male/female dichotomy and/or intentionally reject the gender they were born into.

Women who have sex with women (WSW): Women who engage in sexual activity with other women but who do not necessarily self-identify as lesbian.

Chapter 1: Introduction

1.1. Introduction

During her school years Kay (not her real name), had an increasing feeling like she did not socially belong. She felt on the outer. In an attempt to find belonging she joined a slightly rebellious group whose behaviour included smoking. Smoking seemed like a good way to be like the others and there always seemed to be someone who had some cigarettes so she started to experiment with smoking. It was pretty awful but she persisted. Smoking was one activity that was hidden from her parents as she knew they would disapprove. Towards the end of her high school years there was a growing awareness that she could be sexually attracted to girls rather than boys. Feeling very uncertain about what to do with these feelings but intuiting this was not a positive thing, and not being sure who she could discuss this with, especially as even her loose friendship group made fun of homosexuals, she tried to deny these feelings. She continued to follow what were deeply ingrained social expectations. She had a series of short term boyfriends. This at least kept her parents off her back.

She left school and her smoking increased, and she became more open with her smoking. Increasing independence meant she was able to buy her own cigarettes. She had friends but not close friends. She fitted in as best she could.

In one of these groups she found another girl who was also struggling with emerging same sex attraction however Kay did not feel she could disclose her own confusion about this. Her mother continued to drop hints about getting married and having grand children. At a party Kay finally acted on her attraction for another woman. However there followed a painful time of trying to deny this same sex attraction knowing that to identify as a lesbian would meet with family disapproval and would mean that she belonged to a group that she had only ever heard negative things about.

Twenty years later Kay reflected on her life as a lesbian and the role smoking had played in this. She moved out of home shortly after finally admitting to herself she was a lesbian and went through a time of intense participation in the 'gay scene' which revolved around nightclubs and parties. She eventually came 'out' to her family and other important people in her life. The strain of keeping this part of her life secret was difficult. When she did eventually declare her sexuality she lost some important friends and her oldest brother. Her mother was more understanding than she anticipated although it was another two years before she told her father. She still did not smoke around her parents but all her friends saw her as a smoker.

Her life settled down to include a mostly gay group of friends, house sharing and eventually moving to her own place. She relied less on the nightclub scene for socialising, and private parties and gatherings became more common. Smoking bans were introduced to more and more social venues and eventually to pubs and nightclubs. She occasionally still visited these places and found herself part of the smokers' huddle where she felt comfortable. Other times like at work or when visiting her family she smoked in an increasingly clandestine manner. She had tried to quit quite a few times but it was always harder than she imagined. About half of her friends were smokers, which made it hard. She tried to quit when she was feeling confident to do so and had a period of two years of not smoking. However following a traumatic relationship breakup she took up smoking again as a coping strategy.

She knew it was something that was unhealthy. She felt a social pariah in many settings because of her smoking. She cut down on her smoking and ended up with a weekday pattern of smoking but her consumption often doubled on the weekend. She had many good reasons to smoke and balanced this with trying to lead a life that would minimise the impact of smoking e.g. she tried to keep fit. Over the years she became very comfortable with her sexuality, accepting that she was always going to be part of a minority and that not everyone approved of homosexuality. That was just how it was. She could not go back in the closet. She had been taunted with abuse a couple of times about being a lesbian but not for some time and it was nothing serious. Her mother seemed to finally accept that this was not a phase and that she would not marry. She sometimes still felt guilty about letting her mother down.

Kay did not think her experiences were that different to many lesbians and said that she thought lesbians probably drank more alcohol than other women, and that they did not smoke more than the broader community of women. She answered an advertisement looking for lesbians who smoked for a research project.

1.2.   Statement of Problem

Tobacco smoking has long been on the list of health behaviours requiring attention by the majority of governments and organisations seeking health improvements both globally and nationally (World Health Organization, 2003). Several countries including Australia have achieved impressive gains in tobacco control and as a public health issue smoking is often championed as a success story (Chapman, 2007). Nonetheless the issue of tobacco control will remain on the health agenda especially as it has become apparent that despite falling prevalence at a population level in Australia, some groups continue to have a high prevalence and consequent burden of disease from tobacco smoking (National Preventative Health Taskforce, 2009). As Schroeder (2008, p. 2286) stated "Despite the tremendous recent progress against tobacco use, it is premature to declare victory" as smokers are increasingly on the periphery and within networked groups of society.

A more sophisticated understanding of the minority groups where tobacco smoking remains at a greater prevalence than the wider community is required. The lesbian and bisexual women's population is one such group and this research project aimed to explore what was behind the evidence that this is a higher prevalence group (Gruskin, Greenwood, Matevia, Pollack, & Bye, 2007). Using a qualitative approach, a better understanding of the social context emerged and this may ultimately lead to a more successful and sophisticated approach to tobacco control for this group, resulting in falling prevalence in line with the wider community. Poland et al. (2006) has urged that we need to explore the social context of smoking in order to appropriately tackle the issue in the remaining smoker population (Nichter, Nichter, & Carkoglu, 2007; Poland et al., 2006).

This research was concerned solely with tobacco smoking, which is smoking of the dried and processed leaves of plants in the genus *nicotiana*. It is acknowledged that other drug substances are also smoked including marijuana (*cannabis*) and cocaine (*benzoylmethylecgonine*). Marijuana is sometimes smoked in combination with tobacco. Tobacco is a legally available substance globally, with production and marketing largely controlled by trans national tobacco corporations (Scollo & Winstanley, 2008). Over 90% of tobacco use in Australia is in the form of manufactured or tailor-made cigarettes (Scollo & Winstanley, 2008) and although tobacco can be consumed in other forms including pipe smoking, smokeless tobacco (snuff, chewing tobacco), this is a minority form. Research has concentrated on tobacco consumed as cigarettes and the current research concentrates on this cigarette use.

1.3. Research Question

Lesbians and bisexual women smoke tobacco at a higher prevalence than the broader population of women. This research sought to understand the reasons behind this.

1.4. Research Aim and Objectives

The aim of this study was to develop a theory of smoking behaviour within the lesbian/bisexual[1] women's community.

Through describing the social actions and interactions of lesbian/bisexual women who smoke, the following objectives of the study were met:
1. Synthesise a coherent description of the social activities and social interaction of smoking behaviour among lesbian/bisexual women.
2. Assess individual explanations and beliefs about smoking behaviour.

---

[1] The term lesbian/bisexual is used in this work acknowledging this does not represent a single entity or community and that in some situations this group needs to be disaggregated for clarity. There are also women who are not exclusively heterosexual who do not identify as lesbian or bisexual. They may share some of the same social impacts though of belonging to a marginalised group.

3. Analyse the impact of belonging to, and identification with a marginalised group on smoking behaviour.

4. Generate social definitions of smoking among lesbian/bisexual women.

5. Interpret the role of smoking within an individual's life-course to assess the effect of life-course on smoking behaviour of lesbian/bisexual women.

6. Develop recommendations for approaches to reduce the prevalence of smoking among lesbian/bisexual women.

1.5. Ethics Process

Prior to the commencement of the field work stage of this research, necessary ethics approval from the Curtin Human Ethics Committee had been received. Ethics approval SPH-0411-2008 was given on 16 October 2008. The research was considered to be of low risk to participants and all steps were undertaken to ensure that research methodology adhered to the stated ethical approach as outlined in the ethics application. This included confidentiality of interview material, safekeeping of all participant records, the right of participants to withdraw from the study at any time and adequate referral advice to participants.

Ethical considerations are addressed in more detail in Chapter 3. The letter advising of ethics approval is located in Appendix A.

1.6. Benefits of the Study

The National Preventative Health Taskforce 2008 report identified that for Australia to become the healthiest nation by 2020 it needed to concentrate on overweight and obesity, tobacco smoking and harmful alcohol use (National Preventative Health Taskforce, 2008a). Projections based on current smoking patterns of uptake and quitting, predict the prevalence of smoking in Australia in the year 2020 will still be 14% (National Preventative Health Taskforce, 2008b). If we can better understand lesbian smoking then there is a potential benefit in being able to assist this community group and hence decrease the overall prevalence.

The important United States of America (USA) landmark report *Lesbian Health: current assessment and directions for the future*, identified several reasons why there is a need to direct research attention to lesbians (Solarz, 1999). This included gaining knowledge to improve the health status and health care of lesbians; to confirm beliefs and counter misconceptions about the health risk of lesbians; and to identify health conditions for which lesbians are at risk or tend to be at greater risk than heterosexual women (Solarz, 1999).

While there is conclusive quantitative research on lesbian health behaviours in the area of cigarette smoking, covered in Chapter 2, there is very limited explanatory data that provides an in-depth understanding of the higher prevalence of smoking in this group and the relationship to membership of a marginalised group. Defining an explanatory theory for the role and prevalence of smoking amongst lesbians will provide much needed insight to guide smoking control measures for this group. The inadequacies of research into the health of LGBT[2] populations have been noted in several prominent books and articles (Auerbach, 2008; Baernstein et al., 2006; Meyer, 2001; Meyer & Northridge, 2007).

Several calls have been made for more research to better understand the reasons lesbian and bisexual women continue to smoke at higher rates than the general population and the barriers to quitting (Baernstein et al., 2006; Gay and Lesbian Medical Association, 2001). Some have argued "that it should be identified as a priority population for intensive, targeted tobacco control efforts" (Greenwood & Gruskin, 2007, p. 569). While some reasons have been posited to account for this higher prevalence, including stressful daily life due to homophobia and discrimination and the social role of bars in the lesbian community, the current

---

[2] The acronym LGBT refers to lesbian, gay, bisexual, transgender and transsexual individuals. There is much debate on terminology for this group and other terms are also used including gay, GLBT (gay, lesbian, bisexual, trans), sexual minority groups, and sexual and gender diverse. Some discussion on the challenges of identity and labelling issues is found in Chapter 3. In this research, LGBT will be used as a general term to include people who are not exclusively heterosexual in identity, attraction and/or behaviour both male and female.

research literature failed to fully explain this (Baernstein et al., 2006; Greenwood & Gruskin, 2007).

Understanding the social context of smoking in the lesbian community may at the same time provide general theoretical insight for other health related behaviours in this group including other licit and illicit drug use, overweight and obesity, mental health and poor uptake of health screening. All of these have been noted in the literature as being over-represented in this group indicating that lesbian/bisexual women exhibit generally poorer health (Aaron et al., 2001; AL. Diamant & Wold, 2003; Mayer et al., 2008; Pitts, Smith, Mitchell, & Patel, 2006; Sandfort, 2006; Solarz, 1999). Investigating cigarette smoking potentially has led to an understanding of a range of health compromising behaviours of this group, and an understanding of the impact of belonging to a marginalised group with consequent stigma and prejudice which impacts on health outcomes (Stuber, Meyer, & Link, 2008). Potentially there is a wider picture that can be painted linking the marginalisation of belonging to a sexual minority that is reflected in overall poorer health status of lesbian/ bisexual women (Commonwealth of Australia, 2010; IOM (Institute of Medicine), 2011).

Understanding the social context of smoking in this marginalised group may also provide insight into smoking behaviour in other marginalised groups. Increasingly in Australia smoking has ceased to be a mainstream behaviour but is now largely concentrated in marginalised groups, for example people in lower socioeconomic groups, culturally and linguistically diverse communities and the Indigenous community (Poland et al., 2006).

1.7. Limitations of the Study

While every attempt was made to ensure that this research is of a robust nature, like any research there were also limitations. This revolved especially around the issue of generalisability. Due to the non-probability sampling and the localised setting of Western Australia (WA) the findings have limited generalisability to other lesbian groups. As recruitment was likely to have only attracted those women who were

already connected to the lesbian/bisexual women's community and identified as lesbian/bisexual women, there was an under representation of lesbian/bisexual women who do not openly identify as such (Diamond, 2005). This is illustrated by the homogeneity of scores for participant level of comfort with their sexual identity. This is a common limitation in much of the research in the LBGT health area and has been extensively discussed (Binson, Blair, Huebner, & Woods, 2007; Brogan, Frank, Elon, & O'Hanlan, 2001; Malterud et al., 2009).

To be eligible to participate in the research, participants needed to be 18 years or older. It is acknowledged that women younger than 18 can and do identify as lesbian/bisexual women and may smoke (Austin et al., 2004). Younger women may also be coping with their emerging sexual identity and this can be an age when smoking initiation may take place. The majority of women interviewed for this study were very comfortable with their sexuality and had been 'out' for some considerable time. They also identified as regular smokers and were not in the initiation phase. Hence a further limitation of the research was that it did not explore the experience of women younger than 18 who identify as lesbian/bisexual women.

The majority of smokers commenced smoking during their teenage years and during this period of initiation, when environmental, sociodemographic, behavioural and personal psychosocial factors were likely to be at play (McDermott, Russell, & Dobson, 2002). Psychosocial factors could well encompass issues of emerging minority sexuality. It is interesting to note that the Freedom Centre, the major gay based youth organisation in WA was seeing an increasingly younger cohort with an average age of 16 years of age, even though people up to 24 years of age were welcome (D. Wright, personal communication, June 14, 2009).

Non-probability sampling biases were also possible if the sample was uncharacteristic of the population. Regrettably with poor general research about what constitutes the LGBT population it was difficult to ascertain how characteristic the research sample was. However looking at the demographics of the sample, see Chapter 5, it should be noted that on many indicators this was a diversity of lesbian/bisexual women who made up the sample. This strengthened the contention that the sample was in fact characteristic of the wider lesbian/bisexual women's

community. Meyer and Wilson (2009) contended that depending on the research question and the community of interest, recruiting from the LGBT community may in fact be the most appropriate approach and hence it should not always be seen as a critique or limitation.

This research was limited by the lack of representation of bisexual women. This limitation applied to much research in the area (Diamond, 2008; Heath & Mulligan, 2008).

The recruitment information used the terms 'lesbian and bisexual women' and hence may have resulted in women who do not use these identity labels but nonetheless are not heterosexual, not participating in the study. However when asked in the interview what label if any participants used, approximately one quarter of the sample used terms other than lesbian or bisexual. It was therefore difficult to clearly state the impact of this limitation.

Participant recruitment used identity as a single measure of sexual orientation. Yet as discussed in the literature, sexual orientation includes two other measures; that of sexual attraction and sexual behaviour (Laumann, Gagnon, Michael, & Michaels, 1994). Using the single measure of sexual identity is acknowledged as a limitation in this research and a limitation that is common in other research.

The sample relied on volunteer participation. This may result in a further limitation as volunteer recruitment may have attracted a particular type of participant (Meyer & Wilson, 2009). A non-probability sample was used and the limitation that volunteer bias could be present is acknowledged. It may be that only those smokers who were interested in exploring their own smoking behaviour responded to the recruitment strategies.

A further limitation was that the sample was not ethnically diverse and was almost exclusively ethnically of white Anglo European background. This may reflect barriers women of colour or minority ethnicity face in being part of the LGBT community, and additional challenges to being open around their sexual orientation identity as a lesbian/bisexual woman. It also reflects the smaller percentage of

culturally and linguistically diverse LGBT found in most research in this population. For example the Australian *Private Lives* survey of 5,476 respondents reported 77.8% of their participants to be of Anglo background (Pitts et al., 2006).

1.8.   Researcher Sensitivity and Limitations

A researcher brings their own values, life experience, knowledge and academic training to any research undertaking. When qualitative research is undertaken the influence of this is likely to be more pronounced. I therefore brought both sensitivity and limitations to the research based on my own personal qualities and background. The initial decision to investigate lesbian/bisexual women's cigarette smoking was made in part due to my professional and personal experiences.

I have undertaken previous LGBT health research and hence I am aware of the health disparities of this group. I was also drawn to this research topic by my own experiences and a desire to understand others who had shared life experiences of being a lesbian. I also draw on a long professional career in public health specifically in anti-smoking and cancer control.

I therefore feel I brought sensitivity which Corbin and Strauss (2008, p. 19) defined as the "ability to pick up on subtle nuances and cues in the data that infer or point to meaning" to the research. Sensitivity has also been discussed in terms of the concept of being an 'insider'. Oyseman and Swim (2001) have discussed this in relation to the issue of stigma, and state that it is important to look at stigma from an insider's perspective saying that often stigma is discussed from the perspective of the dominant group. An 'insider' can provide perspectives on what constitutes prejudice and ways of coping with this. As a lesbian I have had to deal with issues of stigma and stigma management, and again I feel that this provided a high level of sensitivity to the research.

While identifying as a lesbian provided an insider's perspective it has also been an advantage to have connections to some of the lesbian community, a necessary

ingredient for good research in the LGBT area as discussed by Solarz (1999) and others (Platzer & James, 1997).

There is often an assumption, as Morris and Rothblum (1999) have discussed, that those undertaking lesbian research were themselves lesbian. My experience was definitively the assumption by participants that I was lesbian. In interviews I made it clear I was a lesbian and hence I was able to conduct interviews with a sensitivity that illustrated a shared experience and meaning to identifying as a lesbian. This also contributed to an elimination of cultural mistrust, which is possible with research on any minority group when researchers come from a position of poor cultural understanding or experience of the group of interest.

As a qualitative researcher I also acknowledged as Crooks (2001, p. 24) has discussed in relation to the broader area of women's health research, "we may, knowingly or unknowingly, challenge the blind spots women cultivate to protect themselves from their feelings and losses". The subject matter of smoking in lesbian/bisexual women means that there is the potential for participants to explore issues that they may not have explored previously, potentially sensitive and emotional issues such as why do you continue to smoke when you know the evidence, what was your 'coming out' experience? To that end, my own researcher sensitivity contributed to rapport with the participants. This was verified in the feedback from the email follow-up questions reported in Appendix J.

While bringing an insider's perspective that assisted in achieving a high level of sensitivity there were also limitations from the approach. This included the need to quickly establish trust between myself and the participant early in the process as the majority of participants were only interviewed once.

The lesbian community, as discussed in Chapter 3, is not a homogeneous or always a harmonious whole. While I am part of the community, I am certainly not connected to all parts of the community, and some lesbian women may have felt that my interest in lesbian health issues had nothing to do with them. This may have been a limitation in terms of participation decisions by some women.

Corbin and Strauss (2008, p. 13), whose approach to grounded theory guided the methodology, suggested the characteristics of good qualitative researchers as being:

- A humanist bent.
- Curiosity.
- Creativity and imagination.
- A sense of logic.
- The ability to recognise diversity as well as regulatory.
- A willingness to take risks.
- The ability to live with ambiguity.
- The ability to work through problems in the field.
- An acceptance of the self as a research instrument.
- Trust in the self and ability to see value in the work that is produced.

I found this list a useful way of conceiving my own research approach to the question and affirming that I had the requisite skills to bring to the research. Chapter 4 discusses in more detail issues of reflexivity that also point to sensitivity considerations.

In order to represent my researcher sensitivity to the subject matter and in recognition that all qualitative research reflects subjective experience to some degree, much of this thesis is written in the first person voice.

1.9. Definition of Terms

Within this research there are several definitional issues that need clarification. A glossary of commonly used specific terms is provided in the preface material as well as an explanation of abbreviations found in the thesis. While this provides valuable assistance to the reader, some key definitions are discussed in more detail here. This research was about lesbian and bisexual women and smoking using a specific methodological and conceptual framework. These terms need clarification.

The term 'lesbian and bisexual women' as used in this research are defined as women whose sexual orientation is not exclusively heterosexual. They have in common that they are attracted to women either exclusively (lesbian) or attracted to both men and women (bisexual). WSW (women who have sex with women) has been used by some. However as Young and Meyer (2005) discuss, this term does not encompass the social dimensions of sexuality and hence was not used in this research. More recently the term 'mostly heterosexual' or 'mostly straight' has emerged describing women who are not exclusively heterosexual in sexual attraction and behaviour and do not identify as lesbian or bisexual (Corliss, Austin, Roberts, & Molnar, 2009; Thompson & Morgan, 2008). The area of labelling of sexual orientation is complex and while not the focus of the current research, it is further explored in Chapter 3 where it is also acknowledged that sexuality is increasingly being seen as fluid and that there are limitations with any labelling. In terms of inclusion in the research, participation was by self-identification with the term 'lesbian' or 'bisexual woman'.

Minority sexuality is sometimes used to encompass all people who do not identify exclusively as heterosexual and as a way of moving away from having to list every kind of non heterosexual identity as seen in the acronym LGBTQ. The term diverse sexuality and gendered groups has also been used but not widely.

The term 'gay community' is often used with little or no definition of what this relates to. In part, this is due to the multifaceted nature of the community such that it is difficult to define singularly. There is also little agreement within the wider sociology or psychology literature on a definition of community. There can be an underlying assumption that communities are homogenous and inclusive when the reality is often that they are composed of disparate groups and there may be competing interests (Green & Tones, 2010). However the work of McMillan and Chavis (1986, p. 9) discussed a sense of community as "a feeling that members have of belonging, a feeling that members matter to one another and to the group, and a shared faith that members' needs will be met through their commitment to be together", and is based on five dimensions (membership, influence, integration and fulfilment of needs and shared emotional connection). Lemon and Patton's (1997) work has attempted to define lesbian community using four characteristics of: 1)

social networks or social cliques of lesbians who have continued interaction on the basis of a shared sexual identification and common interests and affection; 2) a shared group identity with the broader lesbian community which is the basis for identification beyond individual social networks; 3) a sharing of values and norms that have a common theme; and 4) an institutional base made up of lesbian and gay organisations, places, groups and bookshops etc. These definitions of community when viewed together encapsulated a broad characterisation of community and the sense in which it is employed in this research.

Heath and Mulligan (2008) in their work on the positive influence of lesbian community on health, did not attempt to define community but left this as self-defined by the sample participants. In the gay health literature there has been more discussion about community connectedness rather than defining community. For example the work of Mills et al. (2001) with the gay male community in USA used several specific measures over a defined time period including involvement during the previous year in gay community groups, involvement with the non gay community and the use of gay media. They also measured community cohesion, community alienation, and 'outness' to arrive at scores of community connectedness.

In this research little attempt has been made to define community although Chapter 3 describes the rich diversity of this community. It is used loosely to mean a group of people with a shared culture or a community of identity. Again participants were free to interpret and report on the gay community as they used the term.

Smoking in this research paper referred to cigarette smoking which is likely to be manufactured cigarettes (tailor-made) and to a lesser extent roll your own (rollies). As has been detailed in section 1.2 above, this is the primary mode of tobacco consumption in Australia. The term smoker and ex-smoker follow definitions used by the Australian Institute of Health and Welfare where an ex-smoker refers to a person who has smoked at least 100 cigarettes or equivalent tobacco in their lifetime, but does not smoke at all now (Australian Institute of Health and Welfare, 2011). A smoker was a person who reported currently smoking daily, weekly or less often than weekly (Australian Institute of Health and Welfare, 2008a, 2011).

Grounded theory was used as the methodological approach and is further explained in Chapter 4. In this research the grounded theory used followed the analytic approach as espoused by Corbin and Strauss (2008).

Symbolic interactionism was the conceptual framework that underpinned the research. Again there are multiple symbolic interactionism approaches which are outlined in Chapter 4. Blumer's (1969) approach to symbolic interactionism as interpreted by Charon (1998) was used to inform the research.

The above is intended to outline some of the key definitional usages in this research. Other definitional discussions will be covered in the literature review and the discussion section.

1.10. Thesis Organisation

This thesis followed a logical framework of outlining the research topic and aims before providing background to the issue by way of an extensive literature review. The methodology is presented before the results and discussion are provided. The thesis ends with a summation and some concluding comments. A set of Appendices provides additional information as referred to in the main body of the work. Each chapter is listed below with a short description of what is covered.

Chapter One: Introduction – provides a statement of the problem; aims and objectives of the study; ethics process; benefits of the study; limitations of the study; researcher sensitivity and limitations; and definition of the terms.

Chapter Two: Literature review – provides a critical discussion of literature on smoking as a health issue; the health impact of marginalisation; and lesbian smoking.

Chapter Three: Background to the gay and lesbian community – provides an introduction to the place and history of lesbians and bisexual women within Perth, the setting for this research.

Chapter Four: Methodology – explains the qualitative methodology used in this study within the conceptual framework of symbolic interactionism.

Chapter Five: Results – presents the research interview data under core categories and a core theme.

Chapter Six: Discussion – this presents an interpretation of the results in relation to other literature and in addressing the aim of the research.

Chapter Seven: Recommendations and conclusions – makes concluding comments on the research including recommendations for practice to reduce the gap between smoking rates of lesbian/bisexual women and heterosexual women.

Appendices: The Appendices include copies of the research recruitment material; qualitative interview guides; participant reflection on interviews; and a timeline on women's smoking.

1.11. Chapter Conclusion

This introductory chapter has provided an outline to the research topic, aims and objectives of the research, the research sample and approach employed. The benefits and limitations of the research were also highlighted before providing an outline of how the thesis is organised.

The following chapter introduces the literature on smoking and specifically that which relates to lesbians and smoking.

Chapter 2: Literature Review

2.1. Chapter Introduction

The review aims to assess the literature critically in two main areas. Firstly that tobacco smoking is an important public health issue and still represents the largest preventable cause of mortality and morbidity. Secondly the literature review will consider lesbian smoking in terms of both prevalence data and the social context of smoking in this group.

In order to better understand the social position of lesbian/bisexual women the following chapter presents a description of the gay community and issues of marginalisation for this group.

Databases including Proquest, Web of Knowledge, Medline, ScienceDirect and PsychInfo were used to create an extensive Endnote library of over 700 entries to support the research project. This covers lesbian/gay health literature, substance use literature and research methodology. The majority of literature used was sourced from peer reviewed journal articles. Several key books and edited collections were also invaluable. Some 'grey' literature was consulted, especially that generated from gay community groups, for example for descriptions and history of the gay community and sourcing community resources on smoking.

2.2. Smoking: a Health Issue

2.2.1. The health burden and consequences of smoking

Smoking is a high priority public health issue. "Tobacco smoking is the single most preventable cause of ill health and death in Australia, contributing to more drug-related hospitalisations and deaths than alcohol and illicit drug use combined. It is a major risk factor for coronary heart disease, stroke, peripheral vascular disease, cancer and a variety of other diseases and conditions" (Australian Institute of Health and Welfare, 2008b, p. 132). It accounts for 7.8% of the total burden of disease in

Australia with tangible costs estimated to be AUD$10.8 billion, or about 1.3%, of the gross domestic product in 2004-05 (Australian Institute of Health and Welfare, 2008b). Knowledge of the negative health consequences of smoking date back to 1950 when the link between smoking and lung cancer was first reported (Doll, Peto, Wheatley, Gray, & Sutherland, 1994). Since that time many governments have put in place a range of tobacco control measures (Chapman, Byrne, & Carter, 2003).

Tobacco smoking imposes a large health burden globally with an estimated 4.9 million deaths annually (Jha, Chaloupka, Corrao, & Jacob, 2006). Tobacco is the single most preventable cause of death in the world today and exceeds deaths caused by tuberculosis, HIV/AIDS and malaria combined (World Health Organization, 2008). This is predicted to increase to 8 million deaths worldwide by 2030. It is estimated that 80% of the world's tobacco-related deaths will be in low and middle income countries by 2030 (World Health Organization, 2008).

Smoking tobacco has been linked to a range of adverse health effects and this list of conditions continues to increase (US Department of Health and Human Services, 2004). Active smoking is particularly linked to a wide range of cancers, especially lung cancer being responsible for around 80% of all lung cancer deaths and 20% of all cancer deaths (Australian Bureau of Statistics, 2006). Other cancers that are caused by smoking include cancer of the bladder, cervix, kidney; and oesophageal, oral and pancreatic cancers. Some cardiovascular diseases and respiratory diseases are also caused by smoking (US Department of Health and Human Services, 2004). One of the major conclusions made by the US Surgeon General in 2006 was that "smoking harms nearly every organ of the body, causing many diseases and reducing the health of smokers in general" (US Department of Health and Human Services, 2004, p. 8). Conservative estimates suggest that smoking kills about one half of all regular users (Doll, Peto, Boreham, & Sutherland, 2004).

For women smoking results in some specific health consequences including reproductive effects such as difficulties in becoming pregnant, risk of miscarriage, menstrual symptoms and early menopause. Higher rates of foetal death and stillbirths, low birth weight and pregnancy complications are also related to smoking (McDermott et al., 2002; US Department of Health and Human Services, 2004).

Lung cancer continues to account for the largest cancer mortality in Australia with 7,427 deaths recorded nationally in 2005 or 19% of total cancer deaths. For the first time lung cancer deaths (2,716) overtook breast cancer deaths (2,707) in Australian women in this year. It is projected that lung cancer deaths in women will increase as a result of increased smoking in Australian women in the 1970s and 1980s (Australian Institute of Health and Welfare, 2008b; Australian Institute of Health and Welfare & Australasian Association of Cancer Registries, 2008).

Cancers attributed to smoking in Australia in 2005 have been put at an estimated 11,308 new cases and 8,155 deaths or over 11% of all cancer cases and 21% of cancer deaths. Smoking was the greatest contributor to the burden of cancer accounting for one fifth of attributable cancer burden in Australia in 2003 (Australian Institute of Health and Welfare & Australasian Association of Cancer Registries, 2008).

While there is often an emphasis on the health effects of heavy smoking, several large studies have confirmed that even 'light smokers', usually defined as smoking 1 to 4 cigarettes daily, have an increased relative risk of smoking-related mortality (Bjartveit & Tverdal, 2009). Bjartveit and Tverdal's (2009) own study found a 1.5 increase in relative risk of dying from any cause and a threefold increase in relative risk of dying from ischemic heart disease in 'light smokers' (1 to 4 cigarettes a day).

Passive smoking (also known as second-hand smoke and environmental tobacco smoke), the breathing in of tobacco smoke by non-smokers, can also lead to harmful health effects for both children and adults (Scollo & Winstanley, 2008). The Surgeon General's report of 2006 concluded that second-hand smoke causes premature death and disease in children and in adults who do not smoke and that there is no risk-free level of exposure to second-hand smoke (US Department of Health and Human Services, 2006). Scollo (2008) referring to unpublished calculations from the Department of Health and Ageing, based on the work of Collins and Lapsley (2008), report that an estimated 113 Australians died from passive smoking in 2004-05 primarily from ischemic heart disease. Government controls in Australia and some other countries have sought to limit exposure to passive smoking. The Government of Western Australia's recent legislative amendments seek to protect children and

adults from the harmful consequences of passive smoking through restrictions on smoking at beaches, in motor vehicles, playgrounds and outdoor dining areas (Government of Western Australia, 2009).

Of the total gross Australian health care costs resulting from all forms of drug abuse in 2004-05 approximately 44.4% were attributable to tobacco (Collins & Lapsley, 2008). This amounted to AUD$669.6 million in that year of which 5% were related to passive smoking health expenditure (Collins & Lapsley, 2008). The social cost of smoking in Australia for the financial year 2004-05 were estimated to be AUD$31,485.9 million made up of AUD$12,026.2 million tangible costs (lost production, health care, fires, resources used in cigarette production) and AUD$19,459.7 million intangible costs (value of loss of life) (Collins & Lapsley, 2008). This represents 56.2% of the total cost of drug use in Australia in 2004/05 (Collins & Lapsley, 2008).

2.2.2. Smoking control and resulting falling prevalence of smoking

Tobacco control measures have been adopted differentially across the world since the negative health effects of smoking were first reported in the 1950s (Hall & Gartner, 2009). From the late 1960s Australia has had a long and world leading history of tobacco control. Action has included extensive advertising bans, taxation leading to increases in the price of cigarettes, legislation to support increasing numbers of smoke-free public places, an end to tobacco industry sponsorship of public events, strict limits on availability, national Quit campaigns and other strategies (Chapman et al., 2003; The Cancer Council Western Australia, 2008; White, Hill, Siahpush, & Bobevski, 2003; Woodward & Kawachi, 2003). The National Tobacco Strategy 2004-2009 provides the policy framework for comprehensive tobacco control in Australia (Ministerial Council on Drug Strategy, 2005a).

Australia has a strong legislative framework that provides the foundation for tobacco control. For example health warnings on cigarette packs and advertisements were enacted in 1972 (White et al., 2003). The legislation on health warnings on cigarette packs has been progressively strengthened with a new system of graphic health warnings taking effect from 1 March 2006 (Department of Health and Ageing,

2008). Advertising restrictions have applied to tobacco products in Australia since 1973. By 1995 the only form of advertising allowed in Australia was point of sale advertising (Department of Health and Ageing, 2007; White et al., 2003). In WA under the recently passed Tobacco Products Control Amendment Bill 2008, all tobacco products must now be out of sight at point-of-sale (Australian Council on Smoking and Health, 2009). Other legislation relates to minimum pack size, smoke-free public areas, minimum legal age for purchasing tobacco, product content disclosure and taxation levels (White et al., 2003). In a world first legislation has been passed that will see plain packaging for cigarettes in Australia from December 2012 (Parliament of Australia, 2011). This has resulted in Australia having some of the strongest legislative controls on tobacco in the world (Chapman et al., 2003). The success in tobacco control in Australia can be seen in the declining prevalence of smoking and also in the denormalisation of smoking at a societal level (Chapman & Freeman, 2008).

Globally the WHO Framework Convention on Tobacco Control provides the first multilateral treaty with over 150 countries committed to reducing the impact of tobacco in their country (World Health Organization, 2003). It is based on the global adoption of six effective tobacco control strategies: raising taxes and prices; banning advertising, promotion and sponsorship; protecting people from second-hand smoke; warning of the dangers of tobacco; offering assistance to those who want to quit and carefully monitoring the epidemic and prevention policies. Australia was an early signatory to this Convention and has already adopted at varying levels the six control strategies (World Health Organization, 2003, 2008).

Such comprehensive publicly funded tobacco control initiatives have had a positive influence on reducing smoking prevalence and the denormalisation of smoking in many communities (Chapman, 2007). The tobacco industry continues to counter efforts of the public health movement in promoting smoking, particularly in developing countries (Chapman & Freeman, 2008; Pierce, 2007).

Smoking prevalence in Australia has fallen from a peak prevalence for men in 1945 when 72% of men smoked and in 1976 when 33% of women smoked (Scollo & Winstanley, 2008). Since then general prevalence has decreased from 35% in the

1980s to approximately 26% in the early 1990s (White et al., 2003; Woodward & Kawachi, 2003). The National Drug Strategy Household Survey reports daily prevalence at 15.1 in 2010 (females 13.9%, males 16.4%) with ex-smokers at 24.1% and never smoked at 57.8% (Australian Institute of Health and Welfare, 2011). This same survey reported that the highest prevalence of daily smokers was in the age group 40 – 49 years (19.5%) closely followed by 30 – 39 years (18.5%) and 20 – 29 years (18.0%) (Australian Institute of Health and Welfare, 2011)[3]. Figure 1 below shows the decline in smoking prevalence in Australia since 1985 and a gradual convergence of smoking rates for men and women.
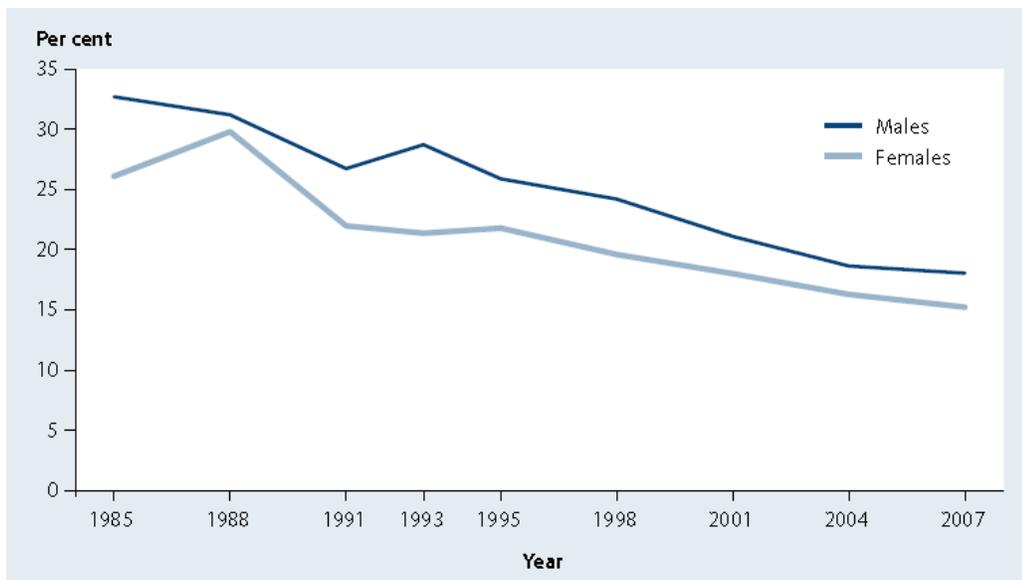
Figure 1. Daily smokers: population aged 14 years and over, 1985 to 2007, Australia. (Australian Institute of Health and Welfare, 2010, p. 85)

International smoking prevalence comparisons with other Organisation for Economic Co-operation and Development (OECD) countries for 2005 show that Australia has one of the lowest prevalence rates along with the United States (17.0%), Sweden (16.2%) and Canada (15%) (Australian Institute of Health and Welfare, 2007). Many developing countries have large gender disparities in smoking prevalence rates and

---

[3] There are several data sources in Australia that provide smoking prevalence data. Although there may be minor inconsistencies in the reported figures they all definitively show the steady decline of smoking in Australia since the 1980s.

high overall prevalence. For example Indonesia where 58% of males smoke and 3% of females smoke gives an overall prevalence of 29% (Scollo & Winstanley, 2008).

Declining smoking prevalence has seen a denormalisation of tobacco, a result of anti-smoking campaigns (Chapman & Freeman, 2008). Hammond et al. (2006) reported that smokers in Canada, United States, United Kingdom and Australia perceived little approval for their smoking behaviour and held poor opinions of the tobacco industry (Hammond et al., 2006). Eighty per cent of smokers in this study agreed that society disapproves of smoking. Additionally higher socioeconomic status (SES) groups in this study reported stronger social and industry denormalisation (Hammond et al., 2006). This has led to smoking being experienced as a stigmatised behaviour (Bayer & Stuber, 2006). Phelan et al. (2008) conclude that stigma and prejudice operate together as a single entity, function in several ways notably as a domination to keep people down, as norm enforcement and as disease avoidance. Stigma and prejudice promote smoking as a deviant behaviour and reinforce its denormalised status.

Declines in smoking prevalence in Australia however has not been uniform (Chapman, 2007). Higher prevalence is found in high-risk groups including Indigenous Australians, socioeconomic disadvantaged groups (National Preventative Health Taskforce, 2008a) and lesbian and bisexual women (Z. Hyde, Comfort, McManus, Brown, & Howat, 2009; Pitts et al., 2006).

2.3.   Lesbian Smoking

2.3.1. Prevalence of smoking in lesbian and bisexual women

Until the early 20th century Australian women generally were not cigarette smokers (Scollo & Winstanley, 2008). As in other Western countries women in Australia began smoking more widely from the 1920s and 1930s (Scollo & Winstanley, 2008). By 1945 approximately a quarter of women smoked (McDermott et al., 2002). Smoking prevalence for Australian women peaked at 33% in 1976 (Scollo & Winstanley, 2008). Since then there has been a steady decline in smoking rates to the

current level of smoking which has approximately 15% prevalence (Australian Institute of Health and Welfare, 2011). Figure 1, charts the decline over the last 20 years. There has been a corresponding increase in the number of women who report as ex-smokers or never smokers (McDermott et al., 2002).

Current prevalence and consumption patterns for Australian women from the 2010 National Drug Strategy Household Survey reported a smoking prevalence for women of 13.9% compared to 16.4% for men (Australian Institute of Health and Welfare, 2011) and provides a general picture of smoking among women. This sample of Australians 12 years and older also demonstrates the continuing trend of a converging of rates for women and men (Australian Institute of Health and Welfare, 2011). Daily smoking prevalence for women peaks in the age group 40 to 49 years however from 20 to 49 years there is little difference with almost one fifth of women smoking (see Table 1) (Australian Institute of Health and Welfare, 2008a, 2011). When daily and weekly smokers are aggregated, peak smoking for women occurs in the 40 to 49 age group (20.0%) followed by the 20 to 29 age group (19.0%) and 30 – 39 age group (18.2%) (Australian Institute of Health and Welfare, 2011).

Table 1

Tobacco Smoking Status, Women Aged 12 Years and Older, By Age, 2010 (Percent)

Smoking status	Age group (years)								
	12–17	18–19	20–29	30–39	40–49	50–59	60–69	70+	Total (12+)
	Females								
Daily	3.2	12.8	16.3	16.8	18.8	16.0	11.6	4.5	**13.5**
Weekly	*0.6	**1.1	2.7	1.4	1.2	0.9	0.6	*0.2	**1.2**
Less than weekly	*0.8	*1.5	2.5	1.8	1.1	*0.7	*0.4	**0.3	**1.2**
Ex-smokers[a]	*1.7	*2.8	12.0	25.6	28.4	28.3	29.2	21.5	**21.2**
Never smoked[b]	93.8	81.8	66.5	54.5	50.5	54.1	58.2	73.6	**62.9**

(a)   Smoked at least 100 cigarettes (manufactured and/or roll-your-own) or the equivalent amount of tobacco in their life, and reports no longer smoking.
(b)   Never smoked more than 100 cigarettes (manufactured and/or roll-your-own) or the equivalent amount of tobacco.
*   Estimate has a relative standard error of 25% to 50% and should be used with caution.
**   Estimate has a relative standard error greater than 50% and is considered too unreliable for general use.

Note. Adapted from "2010 National Drug Strategy Household Survey" by Australian Institute of Health and Welfare, 2011, p. 25

The lowest prevalence at 4.5% is found in the age group 70+ years. In all age groups Australian men have a higher daily prevalence than women except in the age group

12 to 17 years. The mean number of cigarettes smoked per week was lower for women who smoked 96.9 cigarettes and men who smoked 108.6 cigarettes (Australian Institute of Health and Welfare, 2008a, 2011). Almost universally women smoke factory-made (tailor-made) cigarettes with an estimated 1% or less who smoke tobacco in other forms such as pipes, cigars or loose roll your own cigarettes (McDermott et al., 2002). Tobacco is also smoked by some when mixed with marijuana (Scollo & Winstanley, 2008). The average age of initiation, defined as smoking a first full cigarette was 16 years (Australian Institute of Health and Welfare, 2011).

The above data relate to Australian average figures. As discussed earlier, membership to a vulnerable group as defined through social or economic indicators or through membership of a minority group, is likely to result in higher smoking prevalence. Smoking rates in women tend to decline with increasing socioeconomic and educational status (Australian Institute of Health and Welfare, 2008b, 2011; McDermott et al., 2002). The 2010 National Drug Strategy Household survey reports on socioeconomic status and smoking, illustrating that in the lowest quintile 24.6% of respondents smoked compared to 12.5% in the highest quintile (no gender analysis given) (Australian Institute of Health and Welfare, 2011). This report includes sexual orientation and smoking however with no gender specificity and with homosexual and bisexual identity grouped together. Smoking prevalence for heterosexuals was approximately half that of homosexual/bisexual respondents (17.5% compared to 34.2% respectively) with 16.6% being not sure/undecided about their sexual orientation (Australian Institute of Health and Welfare, 2011). Although this is a crude measure it provides one of the first Australian population based drug use surveys where sexual orientation information has been requested and supports the premise that drug use both licit and illicit including tobacco is higher in people who identify with a sexual minority (Australian Institute of Health and Welfare, 2011).

Smoking prevalence among women in Australia (17% in 2007, 13.9% in 2010) compares favourably with other developed countries such as Canada (16% in 2006), USA (15% in 2003) and the UK (23% in 2005) (Australian Institute of Health and Welfare, 2011; Scollo & Winstanley, 2008). In many developing countries smoking has traditionally been a male behaviour and women have had low rates of smoking;

for example China (women 2%, men 67%) and Vietnam (women 2%, men 35%) (Scollo & Winstanley, 2008). With aggressive marketing and increasing Westernisation these traditionally low rates are threatened (World Health Organization, 2008).

In seeking to present prevalence data on smoking for lesbian and bisexual women[4] several hurdles are faced. Firstly there is limited research in the area (H. Ryan, Wortley, Easton, Pederson, & Greenwood, 2001) and secondly there are validity challenges (Malterud et al., 2009; H. Ryan et al., 2001). In addition few studies have sufficient numbers of bisexual women to allow for a separate analysis and so they are often combined with lesbian women (Beatty, Madl-Young, & Bostwick, 2006). Those that have been able to separate out bisexual women usually results in a very small cohort of bisexual women; however it appears that bisexual women have higher prevalence than lesbians on a range of drug use (McCabe, Hughes, & Boyd, 2004). Before presenting prevalence data it is important to understand the limitations this places on any discussion.

Malterud et al. (2009) have specified in detail the validity challenges in undertaking epidemiological research in marginalised groups specifically amongst lesbians. They conclude that researchers need to reveal all relevant methodological details when discussing findings on lesbian health to allow a more open interpretation of results. Methodological challenges identified by Malterud et al. (2009) and others (Binson et al., 2007; Greenwood & Gruskin, 2007; Hughes & Eliason, 2002; Meyer & Wilson, 2009; H. Ryan et al., 2001) are discussed below.

There is conceptual indistinctness of the term and membership of the group 'lesbians' the prevalence of which is put between 2% and 10% (Solarz, 1999). There

---

[4] As discussed in both the introduction and in Chapter 3 while there are limitations to sexuality labelling this research is using the terms lesbian and bisexual women to encompass those women who are not exclusively heterosexual and identify as such. More recent research has sought to disaggregate these two groups as there may be some different social drivers at play. The category 'mostly heterosexual women' has also emerged as another identifiable group of higher smoking prevalence. This research does use lesbian and bisexual women acknowledging there are limitations however it is a contended area.

is indistinctness around whether the term is based on attraction, behaviour or identity or some combination. For many women sexual identity is fluid and is not a fixed entity and therefore it can be difficult to distinguish a sampling pool and the generalisability of results (Malterud et al., 2009).

Because lesbian identity relies on disclosure there are a range of issues that impact on whether a lesbian seeks to disclose, such as stigma, which results in both selection bias and information bias which affect internal validity. Hence recruitment is likely to comprise some level of convenience sampling, which could be seen as 'marginalisation bias' (Malterud et al., 2009).

External validity issues also exist in terms of generalisability of findings from one group of lesbian/bisexual women to another, and to the wider population of women in general. Those who respond to surveys and disclose sexual identity do not necessarily represent the health of non participant lesbian/bisexual women, making comparison between groups of lesbians and the population of women problematic (Malterud et al., 2009). As Malterud et al (2009) state there is a challenge to be clear about what a study seeks to explain and whether belonging to the marginalised group is the risk factor itself, or whether this is potentially a confounder.

Cultural dimensions impact on how sexuality is conceptualised and emerges within a society. Hence the situation in North America, where the majority of lesbian health research has been undertaken, may not be comparable to other countries e.g. small Nordic countries with differences in lifestyle, the role of gay community groups, and the operation of the health system; potentially all impacting on health outcomes (Malterud et al., 2009).

Studies of small marginalised groups are at risk of type II error as the number of participants required to determine risk is often far higher than the recruited population, and the problematic defining of the study population may lead to further error (Malterud et al., 2009).

Ryan et al. (2001, p.148) acknowledging many of the above limitations, reviewed 12 studies from 1987 to 2000 that reported on gay, lesbian and bisexual (GLB) smoking,

concluding that despite the methodological limitations, when the 12 studies were considered together they "strongly suggest that the prevalence of smoking may be higher among adolescent and adult lesbians and gay males than in the general population. Prevalence was consistently higher than in the general population comparison data, even though samples surveyed tended to have a higher educational attainment, a strong predictor of low smoking rates in the general population". Estimated smoking rates for LGB ranged from 11% (respondents from a lesbian health conference), 38% to 59% among youth (28% to 35% comparative national figures) and 50% among LGB adults (28% comparative national figures) (H. Ryan et al., 2001). Caution in interpreting these results is required as many of the studies relied on convenience sampling and sexual minority groups were not disaggregated.

A later review of the literature published in 2009 considered 42 studies over the period 1987 to 2007 which measured smoking prevalence in gay, lesbian and bisexual populations (Lee, Griffin, & Melvin, 2009). This review confirmed that smoking rates in LGBT populations was higher than the broader community, reporting that lesbians had between 1.2 and 2.0 the odds of smoking compared to heterosexual women. People who identify as bisexual had the highest rate of smoking; for example a Washington study of bisexual women found they were 1.2 times more likely to smoke than lesbians (Lee et al., 2009). Age data found that older lesbians were less likely to smoke than younger lesbians (Lee et al., 2009). Despite noting the methodological limitations and inconsistencies such as a lack of consistency in definitions of both smoking behaviour and sexual orientation/identity measures in the studies included, the authors concluded that smoking rates were higher in sexual minority women and men (Lee et al., 2009).

The last decade has seen an increase in the number of published works reporting on smoking prevalence in lesbian/bisexual women some of which have attempted to addresses previous methodological limitations. Lesbian health research may lack robust epidemiology and generalisability and hence comparing studies can be difficult. Table 2 below is indicative of research since 2000 that reports prevalence rates for smoking by lesbian and or bisexual women and where reported comparative data on heterosexual women. It is not intended to be a systematic review but is illustrative of research findings in the area.

Table 2

Studies Reporting on Lesbian and Bisexual Women's Smoking Prevalence

Year/country of data collection; author/publication year	Study population	Survey tool/recruitment	Lesbian/bisexual women smoking prevalence %	Heterosexual women comparative smoking prevalence %	Questions asked	Limitations/strengths
Data collected 1998, Australia (Murnane, Smith, Crompton, Snow, & Munro, 2000)	LGB survey in Victoria, of 518, 222 who were lesbian or bisexual women	Postal survey on alcohol and other drug use sent through 4 LGB community organisations	Tobacco use by age group 20-29 years: 40.0% 30-39 years: 44.9% 40-49 years: 24.4% 50-59 years: 21.4%	NDSHS 20-29 years: 29.0% 30-39 years: 24.2% 40-49 years: 24.6% 50-59 years: 9.7%	Substance use questions including ever smoked and current smoker	Limitations: non probability community sample recruitment. Lesbian/bisexual women combined group. Strengths: same questions as used in AIHW NDSHS for comparison. 37.6% return rate. Quantitative and qualitative data collected.
Data collected 1997, USA (A. Diamant, Wortley, Spritzer, & Gelberg, 2000)	4,697 women from Los Angeles County Health Survey of whom 51 self identified lesbians, 36 as bisexual women	Random digit dialling telephone interview looking at several health measures and access and use of health care.	Current smokers lesbians 37%; bisexual women 50%	14% women Los Angeles Country Health Survey	Los Angeles County Health Survey including tobacco use past and current cigarette smoking	Limitations: small number of self identified lesbian/bisexual women. Strengths: population based study that measured lesbians and bisexual women's health behaviour and use of services.
Data collected 1996, USA Gruskin, Hart et al. 2001	Health Maintenance Organisation, 8,113 women 20 years and older, 120 (1.5%) identified as lesbian/ bisexual	Health Maintenance Organization (HMO) mailed member survey	25.4% overall, 20-34 age group 33.3%; 35-49 age group 29.1%; 50+ age group 12.1%	12.6% overall. 20-34 age group 13.2%; 35-49 age group 14.4%; 50+ age group 11.3%	What is your sexual orientation? Straight, gay, bi Do you smoke now? (used as current smoker), plus alcohol questions	Strengths: population based stratified by age with control for some variables. Limitations: 48% return rate maybe because asked questions of sexual orientation. Only asked about sexual orientation not behaviour. Small number of LB respondents, limited analysis of this group may be hard to generalise to all LB population.

Year/country of data collection; author/publication year	Study population	Survey tool/recruitment	Lesbian/bisexual women smoking prevalence %	Heterosexual women comparative smoking prevalence %	Questions asked	Limitations/strengths
						Unsure how representative membership of a HMO is.
Data collected 1998, USA (Aaron et al., 2001)	3,960 surveys distributed to LGB in Pittsburg response from 1,010 self identified lesbians 18 years or older	Surveys distributed over 8 months through mailing lists to LGB organisations, directly to social groups, at large LGB events and snowball. Self-reported questionnaire.	Lesbians 18 years and older 35.5%	20.5% of women 18 years and older in CDC Behavioural Risk Factor Surveillance System from total of 88,181 women.	Range of health issues and whether currently smoked cigarettes	Limitations: different recruitment approaches of study population and comparative population. Study results not generalisable to those lesbian who are 'not out'. Community identified sample. Strengths: large cross-sectional lesbian community sample from defined geographic area. Did not combine lesbian/ bisexual women. Weighted comparative group to reflect age and education.
Data collected 2000, Australia (Hillier, DeVisser, Kavanagh, & McNair, 2003)	Part of the Australian Longitudinal Study of Women's Health 9,260 women aged 22-27 years old in 2000. 755 self identified non hetero women.	Prospective longitudinal postal survey with age cohort	Non heterosexual women current smoker 45.6%	Exclusively heterosexual current smoker 25.0%	Range of health and behaviour questions. Smoking status and cigarette consumption of current smokers.	Limitations: not stated Strengths: probability sample
Data collected 1999, USA (Eisenberg & Wechsler, 2003)	National random sample of 10,301 college students on 119 campuses. 61% women, 5% opposite and same sex attracted, 2% same sex only	Self-administered 20-page questionnaires mailed to sample.	33% exclusively same sex attracted 51% bisexual women	34% heterosexually attracted	Substance use questions. Smoking status, figures for used in last 30 days	Limitations – self reported data, use of 'sexual activity' rather than identity/attraction measures. Strengths – cross sectional, large random sample
Data collected 2001, USA. (McCabe et al.,	2,091 undergraduate	Random from larger student	47% bisexual women smoked past month	22% heterosexual respondents	Substance use and mental health	Limitations: did not include lesbians.

Year/country of data collection; author/publication year	Study population	Survey tool/recruitment	Lesbian/bisexual women smoking prevalence %	Heterosexual women comparative smoking prevalence %	Questions asked	Limitations/strengths
2004)	university female students, 49 (2.3%) bisexual women, 2,042 heterosexual. Lesbians too small to analyse (16)	population. ½ mailed survey, ½ invited to complete on-line.	10% smoked a pack or more daily	smoked past month 4% smoked a pack or more daily	questions. Smoking in past month. Smoking one pack or more of cigarettes a day	All respondents from one university potential lack of heterogeneity and generalisability. Did not ask about how 'out' respondents were Strengths: random sample and inclusion of heterosexual comparison group
Data collected 1995, USA. (Case et al., 2004)	Information from 90,823 women registered nurses, aged 32-52 in 1995 included 694 lesbians and 317 bisexual women from Nurses' Health Study II – general health survey	Prospective cohort mailed questionnaire.	Current smoking lesbians 18.9%, bisexual women 20.6%. Any past smoking 33.5% lesbians 31.5% bisexual. Smoking 15 or more cigarettes a day 58.6% lesbian women 59.1% bisexual women.	Current smoking heterosexual women 10.6%. Any past smoking 23.9% Smoking 15 or more cigarettes a day 51.4%.	Range of health behaviours and risk factors surveyed. Current cigarette smoking, if non-smokers history of past smoking	Limitations: occupational homogenous sample (nurses). Reliance on self reporting. Adjusted for age, ancestry and region of residence. Strengths size of sample. Heterosexual comparison.
Data collected 2001, USA (Tang et al., 2004)	California Health Interview Survey 44,606 respondents, 343 self-identified lesbian, 511 bisexual women	Population based telephone survey , random digit dial telephone sampling, 18 years to 65	Current smoking lesbians 25.3%; bisexual women 27.8%	Current smoking heterosexual women (data from same survey) 14.9%	Have you smoked at least 100 cigarettes in your entire life? Do you now smoke cigarettes every day, some days, not at all?	Limitations: only used sexual identity for sexual orientation measure Smoking one of range of questions Strength: used population-based sample allowing for comparison group Controlled for demographic variables Large sample Use of standard comparable smoking measures

Year/country of data collection; author/publication year	Study population	Survey tool/recruitment	Lesbian/bisexual women smoking prevalence %	Heterosexual women comparative smoking prevalence %	Questions asked	Limitations/strengths
Year of data collection not stated, USA (Bowen et al., 2004)	Targeted Boston neighbourhood survey. Total of 205 completed surveys, 35 sexual minority women (SMW).	Either interview of self completed mailed survey asking range of health behaviour questions.	SMW ever smoked 46%, SMW current smokers 20%	Heterosexual women ever smoked 46%, heterosexual women current smokers 18%	Ever smoked 100 cigarettes in lifetime, current smoker.	Limitations: Small size of sample Limited generalisability due to neighbourhood effect Strengths: comparable demographics Asked multiple sexual orientation questions but reported on identity Household probability sampling
Data collected 2003, USA (McCabe, Hughes, Bostwick, & Boyd, 2005)	A random sample of 19,378 full-time undergraduate students at Midwestern research university, final sample 9,161 (56% female). Collected information on sexual identity, attraction and behaviour – different participant numbers for each.	Email to random sample of university students invited to complete a web-based student life survey	Sexual identity: Only homo/lesbian 50.0% Mostly homo/lesbian 36.4% Bisexual 45.1% Mostly hetero 33.8% Sexual attraction: Only women 28.6% Mostly women 33.3% Equally men and women 29.5% Mostly men 33.6% Sexual behaviour: Same gender 18.4% Both genders 47.8% Not sexually active 8.0%	From same survey Sexual identity; only heterosexual 17.6% Sexual attraction; only men 16.6% Sexual behaviour; other gender 25.9%	Substance use including past month cigarette smoking, sexual identity, attraction and behaviour	Limitations: self reported sexuality measures. Not capture fluidity of sexuality Strengths: use of multiple measures to assess sexual orientation Probability based sample which was large enough to permit stratification by gender and comparisons across sexual orientation subgroups.
Data collected 2004, Australia (Richters, Song, Prestage, Clayton, & Turner, 2005)	440 women who identified as lesbian, bisexual, queer or 'other' aged 17 to 64	Self completed survey at large Sydney LGB event.	Current smoker 34.3%, ex-smoker 30.2%, never smoked 31.6%. Of current smokers, the majority	Australian Study of Health and Relationships, current smoker 25.9%, ex-smoker	Range of health and behaviour questions. Whether current, ex, never smoked	Limitations: convenience sample which reflects features of a community-attached group. Strengths: smoking one question out of wide range of

Year/country of data collection; author/publication year	Study population	Survey tool/recruitment	Lesbian/bisexual women smoking prevalence %	Heterosexual women comparative smoking prevalence %	Questions asked	Limitations/strengths
	attending LGBT event.		(84%) smoked fewer than 20 cigarettes a day, 15% smoked more than 20 a day and only two women smoked more than 40 cigarettes a day.	24.8%, never smoked 49.2%.		health behaviour questions.
Data collected 2003/2004, USA (Bye, Gruskin, Greenwood, Albright, & Krotki, 2005)	2,287 + Californian LGBT people of which 1,192 LGBT women (29.7% lesbian/bisexual women; 28.8% other LGBT women)	Disproportionate, stratified random digit dial telephone survey	Current smoker all LGBT women 32.5% Daily smoker all LGBT women 23.7%. (lesbian/bisexual women current smokers 28.4%, other LGBT women 38.8%; lesbian/bisexual women daily smokers 22.8%, other LGBT women 26.3%)	From comparable 2002 California Tobacco Survey Current smoker heterosexual women 11.9%, daily smoker 8.9%	Standard WHO current have smoked at least 100 cigs in life and report currently smoking Included sexual identity and sexual behaviour	Limitations: non stated Strengths: relatively large sample Good comparative data Disproportionate, stratified random sample (over-sampled lesbian/gay enclaves and under-sampled other parts of the state Tobacco specific survey
Data collected 1998 - 2000, USA (Burgard, Cochran, & Mays, 2005)	California Women's Health Survey, large annual health survey approx 4,000 women each survey, total of 350 women who had any sexual behaviour with a female and 10,854 with male only.	Random digit dial telephone survey on range of health issues	Current smokers, any female sexual partners 29.8%	Current smokers only male sexual partners 17%	How frequently they currently smoked cigarettes not at all, some of the time, every day	Limitations: used sexual behaviour as proxy for sexual orientation; did not ask sexual identity Despite size statistical power still limited when interrogating LB data Strengths: probability sample Analysed both alcohol and tobacco use based on sexual behaviour and age groups Good comparative data
Data collected 2003, USA (Dilley et al., 2005)	Behavioural Risk Factor Surveillance System results from	Random digit dial phone interview on range of health	Current smoking lesbian/bisexual women 31.4%	Current smoking heterosexual women 18.3%	Self identity for sexual orientation Have you smoked	Limitations: used only sexual identity measure Combined lesbian and bisexual

Year/country of data collection; author/publication year	Study population	Survey tool/recruitment	Lesbian/bisexual women smoking prevalence %	Heterosexual women comparative smoking prevalence %	Questions asked	Limitations/strengths
	Washington and Oregon; 14,362 heterosexual women, 350 lesbian/bisexual	issues			at least 100 cigarettes in your entire life? Do you now smoke cigarettes every day, some days, not at all?	women Strengths: population based survey Comparative data Adjusted for age and education
Data collected 2005, Australia (Pitts et al., 2006)	5,476 LGBTI Australia-wide respondents to Private Lives study, 1,929 women	On-line survey on social and health indicators. Targeted advertising of survey through LGBTI community	LGBTI women recent regular use of tobacco 35.6%	24% tobacco prevalence National Health Survey (ABS)	Use of drugs on more than five occasions in the previous month	Limitations: poor comparative statistics – no gender breakdown Recruitment restricted to those with Internet access and probably community connection Part of wider health and well being study hence limited questions on smoking Strengths: large LGBTI sample
Data collected in 1999 and 2002 (Gruskin & Gordon, 2006)	Random sample of 40,000 female and male Kaiser Permanente Medical Care Program in Northern California, 20 – 65 years old. Included 210 lesbians and 12,188 heterosexual women. General health surveys	Mailed general health surveys in 1999 and 2002	Before adjusting for sociodemographic differences, current lesbian smokers 14.5%. After adjusting for age, race/ethnicity, and education lesbians significantly more likely to be smokers (OR: 1.60, CI: 1.02–2.51).	Before adjusting for sociodemographic differences, current heterosexual women smokers 12.4%	Have you ever regularly smoked cigarettes? Do you smoke cigarettes now?	Limitations: despite large sample still small number gay/lesbian and skewed to higher socioeconomic spectrum. Smoking questions part of larger health survey Only one question regarding sexual identity Strengths: independent stratified random sample Large sample size Good comparative data – drawn from the same large probability sample of health plan members Controlled for sociodemographic and negative affect differences between the lesbians/gays and

Year/country of data collection; author/publication year	Study population	Survey tool/recruitment	Lesbian/bisexual women smoking prevalence %	Heterosexual women comparative smoking prevalence %	Questions asked	Limitations/strengths
						heterosexual segments of the population.
Data collected 4 separate surveys 1996 – 2005, UK (Meads, Buckley, & Sanderson, 2007)	4 surveys of lesbian and bisexual women in Midwest: 1. Lesbewell 1 (1996) 69 respondents 2. Lesbewell 2 (1996/7) 354 respondents 3. Measure for Measure Survey 1 (2002) 449 respondents 4. Measure for Measure Survey 2 (2005) 166 respondents	Paper questionnaires through variety of convenience samples in gay community. Measure for Measure 2 included an on-line version. Range of health issues covered.	4 survey results for current smoking 42% to 55%: 1. 42% 2. NA 3. 54.8% 4. 48%	2004 household surveys - routinely collected data: 21% West Midlands women aged 16+, 28% UK single women aged 16+.	Range of questions each survey: 1. I smoke 2. Smoking not recorded 3. Do you smoke? How many per day? Age started smoking? 4. Do you smoke? How many per day? Ever tried to quit?	Limitations: could be confounding factors e.g. social environment Results may not be strictly comparable between studies because different methodologies Used self identity for orientation Combined lesbian and bisexual group Different definitions used across surveys and different to national data set questions Limited comparative statistics Use of convenience samples Strengths: despite different size of study population in each survey and different questions, many results similar
Data collected 2002 – 2004, USA (Gruskin et al., 2007)	Data were derived from a 2003–2004 survey of LGB individuals living in California as well the general population 2002 California Tobacco Survey. Total LGBT respondents 1,950 including 898 women.	Population based disproportionate stratified sample. Random digit-dialling survey instrument.	Current smoking combined daily and non daily smoking 28.8% lesbians, 26.9% bisexual women, 43.6% women who have sex with women (WSW)	Daily and non daily smoking total 12% women in 2002 California Tobacco Survey	Self identify as lesbian, bisexual or have had sex with a woman even if don't identify as LB. Smoking questions similar to California Tobacco Survey, (100 cigarettes in life and current smoking every day or some	Limitations: some sub segments of the LGB population were under sampled, which could have affected reported smoking prevalence Broad smoking cessation trends may make it difficult to compare data with earlier cross-sectional studies. Strengths: population based disproportionate stratified sample Standard measures of tobacco use allowing for comparative

35

Year/country of data collection; author/publication year	Study population	Survey tool/recruitment	Lesbian/bisexual women smoking prevalence %	Heterosexual women comparative smoking prevalence %	Questions asked	Limitations/strengths
					days).	data Use of both identity and behaviour measures for LGB allowed some segmentation of results
Data collected 1999 - 2001, UK (Mercer et al., 2007)	General population 16 to 44 total of 11,161 people; 6,399 women included 118 women who had sex with women and men, 21 women who have sex with women exclusively	British Natsal probability survey. Face to face interview range of health issues especially sexual health and behaviour followed by computer assisted self-interview.	Women who have sex with women light smokers 24.7% heavy smoker 16.1%. Women who have sex with women and men light smokers 40.2% heavy smokers 23.7%	Women who have sex with men 21.4% light smokers, 16.6% heavy smokers	Smoking status and consumption level data	Limitations: findings are not generalisable to other age groups Small absolute numbers reporting sex with women. Based on sexual behaviour not on sexual identity Strengths: probability sample
Data collected 1994 and 1996, USA (Hughes, Johnson, & Matthews, 2008)	550 lesbians and 279 matched heterosexual women part of the Multisite Women's Health Study.	Paper based self completed survey on general health status and risks. Non probability targeted recruitment including snowballing.	Lesbian current smoking 19%. Lifetime smoking 61%. Lesbians of colour more likely to smoke than white counterparts.	Heterosexual women current smoking 19%. Lifetime smoking 54%	Current smoking including consumption level and lifetime smoking.	Limitations: bisexual women excluded Small number of questions related to smoking Recruitment limitations Strengths: multiple minority status analysed Lesbian sample large and from several urban locations
Data collected 2006 - 2007, Australia (Z. Hyde et al., 2009)	917 Western Australian lesbian/bisexual women convenience sample	Principally through large gay community event also gay organisations, other events. Self completed paper questionnaire, minority on-line.	Lesbian/bisexual women who reported they smoked 28.1%	14.8% Western Australian Health and Wellbeing Surveillance Survey, 2007.	Smoking current, post, never and frequency and consumption	Limitations: convenience sample Large range of health and wellbeing questions asked Strengths: large cohort

Year/country of data collection; author/publication year	Study population	Survey tool/recruitment	Lesbian/bisexual women smoking prevalence %	Heterosexual women comparative smoking prevalence %	Questions asked	Limitations/strengths
Data collected 1999 – 2001, USA (Trocki, Drabble, & Midanik, 2009)	2000 National Alcohol Survey N= 7612 (3,896 women included in analysis), exclusively heterosexual women 3,723, heterosexual with some same sex behaviour 87, bisexual 50, lesbian 36	Random digit dialling computer assisted telephone survey – smoking including marijuana use	Heterosexual but with same sex behaviour smokers 34.1% adjusted odds ratio (AOR 95%CI) 2.23; bisexual women 44.4.% AOR 2.4; lesbian 23.1% AOR 0.9	Exclusively heterosexual women smokers (n= 3,723) smoking prevalence 19.1%	Tobacco smoked in cigarettes in last year used in analysis although range of smoking questions asked	Limitations: that not all may have disclosed sexual orientation Numbers of minority sexuality respondents small Strengths: national representativeness of probability sample Considered group who identify as heterosexual but have same sex behaviour
Data collection 2003 to 2005, USA (Pizacani et al., 2009)	Combined data for Oregon (n = 30,394) and Washington (n = 59,550).1.4% (n = 647) identified as lesbian and 1.6% (n = 639) bisexual women	Random digit dialled annual cross-sectional survey, behavioural risk indicators and demographic data from Behavioural Risk Factor Surveillance System (BRFSS).	Current smokers lesbian 29.5%, bisexual women 35.9%	Heterosexual women17.3%	Current, ever, former, quit attempts, quite intention, knowledge of harms.	Limitations: BRFSS excludes those without telephone, institutionally housed. LGB status by self report of sexual orientation Strengths: state-wide population based survey range of smoking –related indicators Heterosexual comparative group
Data collected 2001-2008, USA (Conron, Mimiaga, & Landers, 2010)	Aggregated over years 2001 - -2008 Massachusetts Behavioral Risk Factor Surveillance Survey, total of 67,359 respondents 719 of whom identified as lesbian 432 identified as bisexual women.	Random-digit-dialling, 1 adult (18 years and older) per household answering phone survey. Survey covered range of health issues.	Current lesbian smokers 26.3%; current bisexual women smokers 36.9%. Adjusted odds ratio compared to heterosexual respondents lesbian women 2.20, bisexual women 3.0 (95%CI).	Heterosexual women current smokers 19.4%	Self reported as current, former or non smoker	Limitations: cross section design Single item, self reported items Strengths: large population based sample stratified by sexual orientation identity and gender

Year/country of data collection; author/publication year	Study population	Survey tool/recruitment	Lesbian/bisexual women smoking prevalence %	Heterosexual women comparative smoking prevalence %	Questions asked	Limitations/strengths
Data collected 2003-2007 USA (Fredriksen-Goldsen, Hyun-Jun, Barkan, Baisam, & Mincer, 2010)	Washington State Behavioural Risk Factor Surveillance System (BRFSS) data; 1,496 women who identified as minority sexual identity 1.4% lesbian (n=779) 1.6% bisexual women (n=717)	Random digit dialling 18+ survey looking at quality of life measures including some health risk behaviours	Lesbian smokers 29.34% Bisexual women smokers 38.74%	No comparative data	Self reported sexual orientation. Current smokers defined as having smoked 100 cigarettes in lifetime and smoking every day or some days	Limitations: only captures those who self identify as sexual minority women Strengths: disaggregated lesbian and bisexual women. Based on large probability population sample.

38

A wide variation smoking rates for lesbian/bisexual women is reported in the above table reflecting differing methodologies, differing definitional measures (sexual orientation and smoking) and population subgroup variation. For example Gruskin (2006) discusses that this study based in the San Francisco Bay area is an area with lower overall prevalence with highly effective tobacco control measures. Despite the range of reported prevalence the majority of studies report higher prevalence of smoking in lesbian/bisexual women. Where these groups have been disaggregated bisexual women were found to smoke at a higher rate than exclusively homosexually oriented women (Conron et al., 2010; Fredriksen-Goldsen et al., 2010; Pizacani et al., 2009; Trocki et al., 2009). Several explanations have been put forward for this including that bisexual women may show a tendency towards new or risky behaviour including sexual behaviour and substance use and that they may be marginalised or lack social legitimacy from both straight and lesbian peers and substance use may be in response to this stress (Eisenberg & Wechsler, 2003; Ross, Dobinson, & Eady, 2010).

In general later studies employed more robust methodology including an increasing number of population probability studies. Some studies have found little or no differences between lesbian and heterosexual women's smoking prompting discussion about whether the differential has been overemphasised in the past. Both Bowen (2004) and Gruskin (2006) comment that the similarity of prevalence may reflect a homogeneity of small geographic area. Hughes (2008) also discusses homogeneity of sampling as potentially accounting for similarity of prevalence in addition the influence of a volunteer sample that may have included healthier and more educated participants. This study also supports that education level is an important predictor of smoking regardless of sexual orientation and she calls for increased research to better understand influences on lesbian smoking (Hughes et al., 2008). Probability studies however can suffer from small number of sexual minority women within the sample, making interpretation of results difficult (Sandfort, 2006).

One of the most comprehensive works done in the area of gay smoking is that completed by the California Department of Health Services (Bye et al., 2005). This research looked at a range of smoking issues from consumption, quit attempts, exposure to environmental tobacco smoke (ETS), tobacco advertising and anti-

smoking messages. The California study has demonstrated an age influence on smoking where increasing age is associated with lower prevalence, as is found in most tobacco prevalence studies (Bye et al., 2005). Smoking rates tend to be highest for young people but declines with age and some of the prevalence gap between the LGBT population and the wider community closes as age increases. However the California study still reported higher rates for those aged 65 years and over in the LGBT population (Bye et al., 2005). This has also been observed in several other studies and a summary of these is contained in Table 3.

Table 3

LGBT Women's Smoking Prevalence by Age Groups

Skinner, (1994)[5]	Gruskin et al., (2001)	Gruskin et al., (2007) Lesbians	Gruskin et al., (2007) Bisexual women	Gruskin et al., (2007) WSW	Tang el al., (2004)	Bye et al., (2005) Californian LGBT Tobacco survey 2003-04	Hyde et al. (2009) WA study	Murnane & Smith, (2000)
18-25 years 52.9%	20-34 years 33.3%	18-24 years 73.5%	18-24 years 29.3%	18-24 years 52.9%	19-34 years 20.9%	19-24 years 47.0%	15-24 years 43.2	20-29 years 40.0%
26-34 years 43.8%	35-49 years 29.1%	25-44 years 28.9%	25-44 years 32.2%	25-44 years 42.8%	35-44 years 35.3%	25-44 years 35.3%	25-34 years 24.1%	30-39 years 44.9%
35+ years 38.1%	50+ years 12.1%	45-64 years 19.7%	45-64 years 11.5%	45-64 years 41.5%	45-66 years 25.6%	45-64 years 25.6%	45-54 years 18.3%	40-49 years 24.4%
		65+ years 0.9%	65+ years 0.0%	65+ years 51.3%[6]		65+ years 19.0%	55+ years 7.3%	50-59 years 21.4%
Total 41.4%	Total 25.4%	Total 28.8%	Total 26.9%	Total 43.6%	Total 25.3%	Total 32.5%	Total 28.1%	Total 32.7%

Age impacts on differences in women's smoking prevalences (see Table 3). Gruskin et al. (2001) for example reported higher rates of smoking for lesbians and bisexual women overall, however for the age group 50 years and older the difference in

---

[5] Skinner's sample of homosexual women asked smoking behaviour in last month

[6] Not statistically significant – small numbers in this oldest age group

prevalence was minimal (12.1% for lesbian and bisexual women compared with 11.3% of heterosexual women).

Valanis et al. (2000) in their US Women's Health Initiative (WHI) survey looked at post menopausal women 50-79 years old (a sample of 93,311 from a total WHI survey of 161,859; 1,313 identified as lesbian or bisexual) and found that smoking prevalence amongst older LGB women was still higher than non LGB women (see Table 4). Smoking status was based on participants having ever smoked at least 100 cigarettes and whether they currently smoked cigarettes. This work showed adult lesbians as having the highest level of current smoking and that they were also less likely to have never smoked.

Table 4

Smoking Status by Sexual Orientation Group (Percentage)

	No adult sex n = 1,420	Heterosexual n = 90,578	Bisexual n = 740	Lifetime lesbian[#] n = 264	Adult lesbian* n = 309
Never smoked	68.2	50.0	32.0	36.5	30.0
Past smoker	26.9	42.8	56.1	53.5	55.7
Current smoker	5.0	7.2	12.0	10.0	14.4

[#] sex only with women ever
* sex only with women after 45 years old

Note. Adapted from "Sexual orientation and health: Comparisons in the Women's Health Initiative sample." by B. Valanis, D. Bowen, T. Bassford, E. Whitlock, P. Charney, and R. Carter, (2000), *Archives of Family Medicine*, *9* (9). pp. 843-853.

The California study also showed that smoking was highest in those with the least education (less than 12 years education 54.6% of LGBT women smoked) while college graduate or higher was the lowest prevalence (18.8%) (Gruskin et al., 2007). This mimics similar trends in broader prevalence studies where education is often a predictor of smoking levels (Australian Institute of Health and Welfare, 2011). However other research looking at LGB smoking, found higher education has not been a protective factor (Z. Hyde, Comfort, McManus, & Howat, 2007).

The literature on smoking draws particular attention to the time of adolescence as a time of important transitions and influences that can include the commencement of

smoking. This is an important public health issue as adolescents who smoke are more likely to become adult smokers and to develop smoking-related health problems later on in their lives (Hublet et al., 2006; Scollo & Winstanley, 2008). For youth who are exploring minority sexual identity again there is often reported higher smoking prevalence. Easton et al. (2008) in their large study examined smoking and romantic attractions/relationships of young people aged 12 to 19 years. They concluded that adolescent boys and girls with both-sex attractions or relationships, were more likely to have commenced smoking rather than remaining non-smokers compared to their peers who had opposite sex attractions or relationships. Despite the limitation on the lack of a standard measure of sexual orientation, Easton et al. (2008) surmise that these higher rates are likely to result from the difficulties these youth face in terms of daily stress related to homophobia, discrimination and feelings of not belonging. Remafedi and Carol (2005) support this contention also illustrating that LGB youth were significantly more likely than their non LGB peers to smoke at school, initiate cigarette use before 13 years and smoke in the past month.

This section has highlighted a number of studies that demonstrate higher smoking prevalence in non heterosexual women. The prevalence data presented though shows variability in methodology, sampling, comparative data and prevalence figures.

2.3.2. The social setting of lesbian and bisexual women's smoking

Poland et al. (2006) have called attention to the importance of looking at the social context of smoking in order to understand: 1) the growing concentration of smoking among socially and economically marginalised groups and 2) looking at diverse sources of resistance to tobacco control. This inevitably involves looking at the determinants of health and also requires examining community levels of smoking rather than just individual behaviour (Poland et al., 2006).

It is also necessary to understand that there is a broader historical and social context of women's smoking which also influences the setting of lesbian/bisexual women's smoking. This history of women's use of cigarettes in the Western world reflects a changing social approval or disapproval and desirability or undesirability of smoking, and women's changing place in society (Elkind, 1985). The tobacco

industry responded to this with targeted advertising to women starting in the 1920s. Themes such as slimness, women's equality, freedom of choice, independence, glamour and romance have all featured in tobacco advertising and also the portrayal of women who smoke in movies (McDermott et al., 2002). Appendix B contains a more detailed social and political timeline of women's smoking.

As suggested by Poland et al. (2006), the current research therefore needs to examine such things as contemporary collective patterns of consumption, construction and maintenance of social identity and the role of smoking in this. Poland et al. (2006) identifies six dimensions of the social context of smoking which to date have largely been missing from the tobacco literature. This includes considering power relations, collective patterns of consumption; the role of industry marketing; and smoking as a social activity rooted in place (Poland et al., 2006).

Understanding the social context of groups who smoke in order to better target interventions is important. For example the work of Hsia et al. (2007) examined the acculturation and meanings of smoking among Asian and American college students, and reported that there are a range of meanings given to smoking, some of which are about belonging to a group and being socially accepted. Social acceptability is often an important step towards regular smoking (Hammond et al., 2006). "Tobacco use, as with many health behaviours, is strongly influenced by social norms and one's perception of acceptable behaviour" (Hammond et al., 2006, p. 225). The collective dynamic of smoking behaviour within a large social network has been researched illustrating the influence on both smoking maintenance and smoking cessation behaviour (Christakis & Fowler, 2008).

While there has been an attempt to describe and understand the social context of women's smoking there is a paucity of research in understanding the social context of lesbian and bisexual women's smoking (Elkind, 1985). Any research has tended to concentrate on the role of the so called bar and club scene in relation to drug taking more generally. Greenwood and Gruskin (2007) proposed a model to illustrate the complex combination of factors at play at the individual, peer/family, social and environmental level that explains the higher use of illicit drugs in the LGBT community. The research of McKrinan and Peterson (1989) discussed the cultural

history of homosexual communities which produced a high proportion of social settings that involved alcohol or other drugs and where stress-related substance use may be prevalent among a stigmatised minority and bars have a significant social focus. While this provides a starting framework, Greenwood and Gruskin (2007) urge more research at both a quantitative and qualitative level to fully explain the link between belonging to a sexual minority and higher drug prevalence.

Since the 1920s, bars have been an important part of Western lesbian culture and continue to be so. While there has been research on the role of nightclubs and illicit drugs (Parsons, Kelly, & Wells, 2006) there has been less work done around licit drugs. Harland (2002) discussed that within the commercial club and pub scene drug use including tobacco use may be part of what it means to be LGB. She also noted the serious lack of alcohol and drug free gay events, which means that smoking is embedded in these environments, and suggested that smoking is possibly a shared cultural practice.

One of the most comprehensive studies examining the social setting of the lesbian bar has been a qualitative study by Gruskin et al. (2006) illustrating the important role of the bar culture to lesbians. Bars were seen to play a positive role by providing a place that participants said they felt safe, provided support over their life-course and helped build a sense of community and family away from the stress experienced in other communities and relationships (Gruskin et al., 2006). Alcohol consumption often occurred in tandem with increased tobacco and illicit drug use within this environment (Gruskin et al., 2006).

This position is supported by the Gay and Lesbian Medical Association 2001 document which suggested that that higher rates of smoking in lesbians may in part result from being a shared cultural practice linked to a sense of personal and collective identity (Gay and Lesbian Medical Association, 2001). In their research with community leaders, Offen et al. (2008) reported that some respondents also viewed tobacco and alcohol as part of the identity forming process and it was seen almost as a normalisation of part of the 'coming out' process. The work of Trocki et al. (2009) also confirmed that bar patronage is higher among non heterosexual women in a population based sample looking at cigarette and marijuana use.

Heffernan's (1998) research, which did not include tobacco, examined the nature and predictors of substance use among lesbians and concluded that the most significant predictor of alcohol use was a reliance on bars as a primary social setting. These results were echoed in the research of Aaron et al. (2001) on potential social factors that contribute to different health risk behaviour of lesbians, includes a reliance on bars as a place for social gathering as one factor. Kerby, Wilson, Nicholson and White's (2005) study found that high substance use among the lesbian community appeared to be related to the social connection this provided and was not associated with low self-esteem as predicted.

While bars have undoubtedly played an important social role for many lesbians/bisexual women, for many of them this may be a transitory phase or may not feature strongly as part of their social network, where heterosexual friends and networks are equally important (Dane, Masser, MacDonald, & Duck, 2010; Z. Hyde et al., 2007; Pitts et al., 2006).

Poland (2006) called for consideration of tobacco industry action in relation to minority groups. There is evidence, restricted at this stage to research from the USA, that tobacco companies target LGBT communities and have done so for several decades (National Cancer Institute, 2008; E. Smith & Malone, 2003; Washington, 2002). For many years Brown and Williamson (a major trans national tobacco corporation) sponsored smoking lounges at large fundraising banquets of a prominent US gay organisation (Offen, Smith, & Malone, 2005). Philip Morris, another trans national tobacco corporation, committed funds to AIDS work however in so doing they also commenced advertising and marketing to the gay community (Offen et al., 2005). While it has been hard to substantiate such activity in Australia (R. Borland, personal communication, March 14, 2009), it is interesting to note that while the tobacco industry has seen the LGBT community as a worthwhile target group, public health has in the main neglected this approach.

2.4.   Chapter Conclusion

This literature review has covered the issue of smoking both providing information on health consequences of smoking and the burden of disease from smoking and the generally declining prevalence. Finally smoking among women, particularly lesbian/bisexual women was discussed along with the epidemiological challenges inherent in this research. Every endeavour has been made to ensure the inclusion of the latest research however as this is an emerging field this presented a challenge.

The literature review helped to set the stage for interpreting the data collected from interviews presented in Chapter 5. The next chapter presents issues related to social marginalisation by including a brief overview of gay social history and a description of the community under consideration in this research.

Chapter 3: The Lesbian Experience

3.1. Chapter Introduction

Chapter 3 presents an overview of the recent history of homosexuality at an international, national and state level. This provides a background to understanding the historical and social context of being a lesbian or bisexual woman in Australia today. It also briefly redresses the balance by suggesting there are positive aspects of being a lesbian or bisexual woman.

There are specific works that give a comprehensive coverage of gay social history (Flood & Hamilton, 2008 295; Murphy, 2008; Ottosson, 2009; Pride History Group Sydney, 2009; Rimmerman, 2008; Robinson, 2008; Willett, 2000). This chapter therefore is not an exhaustive review of the literature of gay history but rather provides the background to the rapid social change that has seen increasing social acceptability of homosexuality within many Western countries over the last 100 years. Care should be taken that this greater social acceptability does not mask the very real impact of belonging to a minority sexual identity group within a dominant heteronormative social setting. It also indicates that advocacy leading to greater acceptability and inclusion at all levels: social, legal, fiscal and health status is still required.

There are less works that address specifically lesbian history or bisexual women's history so much of this chapter discusses broader LGBT history, which tends to incorporate lesbian history.

3.2. Broad Historical Setting Internationally

Attitudes to homosexuality vary across different cultures, religious views and historical periods however LGBT people have persistently occupied a place at the margins of society (R. Crooks & Baur, 2010). A recent report documents over 80 countries around the world where homosexuality is illegal; five of which (Iran, Mauritania, Saudi Arabia, Sudan and Yemen, and in parts of Nigeria and Somalia)

where homosexual acts are punishable with death (Ottosson, 2009). This presents one extremity of the social response to homosexuality. For many countries particularly Western countries, the last century has seen social change towards increasing acceptance and inclusion of LGBT people. This has been a long slow process marked along the way by significant turning point events (IOM (Institute of Medicine), 2011).

In modern Western history, homosexuality has been viewed very much as a sin within the Judeo-Christian tradition (R. Crooks & Baur, 2010). Today Christian theology has a more varied response however there are still many sectors that hold to a fundamentalist position where homosexuality is viewed as against the 'natural order' (R. Crooks & Baur, 2010). The other end of the spectrum has churches with 'out' gay clergy (Rodriguez & Ouellette, 2000).

There is also a long history of medical responses to homosexuality from the 1800s involving active 'treatment' of this behaviour as a disease requiring radical intervention such as castration (1800s), electric shock treatment and/or lobotomy (1950s) (Murphy, 2008). A shift in attitude from the early to mid 1900s meant homosexuality moved from a sin to homosexuality as a mental illness, and hence requiring treatment (R. Crooks & Baur, 2010).

At the same time the medical profession was actively 'treating' homosexuality, in 1864 the German Karl Ulrichs began to write and publish about his own homosexuality (Ridinger, 1996). This influenced the formation in the early 1900s of perhaps the first gay group in Germany run by and for gay people who were concerned to both educate themselves and seek civil rights (Ridinger, 1996). However during the rise of the Nazis following World War I there followed what Ridinger (1996) has called 'legalized terror' from the Third Reich. It is estimated that between 5,000 and 15,000 homosexual men were sent to concentration camps (Ridinger, 1996). In Germany homosexual groups were declared illegal and homosexuals (particularly men) were targeted as opposition activists and considered 'un-German' (Ridinger, 1996).

World War II facilitated large single sex groups of people getting together and saw a relaxation of some gender roles that enabled gay men and women to perhaps find each other. However by the late 1940s under the more conservative McCarthy era there was a return to gender stereotypes, labelling of gays as perverted and deviant and greater difficulty in gay people celebrating their lifestyle (Ridinger, 1996). It was in this period (1950 to 1969) that the early homophile movement in America arose and early gay groups such as the Mattachine Society and the Daughters of Bilitis, a lesbian group, were formed (Ridinger, 1996). These groups aimed to educate America to understand and accept homosexuality and to entrench this through legislative change. A gay press began publishing gay newsletters and magazines, and although small, chapters of the Daughters of Bilitis started in several key American cities and a chapter also started in Melbourne (Ridinger, 1996).

In 1969 what was to become known as the Stonewall Riots occurred in New York and radical action that would become gay liberation started seeking gay rights. This was also the time of a growing counter culture and an anti Vietnam sentiment in America (Rimmerman, 2008). For the gay movement it signalled that gay people would no longer be treated as second class citizens including having their clubs routinely raided by police (which happened at the Stonewall Bar in June 1969 and resulted in rioting) (Ridinger, 1996). Along with women's liberation, lesbian feminism also emerged challenging not just the sexism of the wider community, but also that of gay males. It was an era concerned to show gay people the oppression they lived under and the need for radical social change (Rimmerman, 2008). This included targeting the American Psychiatric Association annual conference in 1971 and challenging the then current consideration of homosexuality as a mental disorder (Rimmerman, 2008). By 1974, both the American Psychiatric Association and the American Psychological Association had removed homosexuality from the Diagnostic and Statistical Manual (DSM) of Mental Disorders (Kirby, 2003). This did not go unchallenged and groups such as the Christian Right continued to see homosexuality as evidence of moral degeneracy (Rimmerman, 2008). The removal of homosexuality from the DSM was a hard fought concerted political action from homosexual organisations, some sectors of the wider human rights movement, with supporting epidemiological data that questioned the 'scientific' basis for considering "homosexuality *simpliciter* a mental disorder" (Mendelson, 2003 p. 683).

HIV/AIDS first emerged in 1981 and it appeared to be concentrated in the gay male community in the USA and was soon labelled a "gay disease" (Rimmerman, 2008). There quickly followed a large mobilisation of gay activists demanding increased research on HIV, greater support for those living with AIDS and acceptance of HIV positive people (Ridinger, 1996; Rimmerman, 2008). This contributed to a greater LGBT cultural visibility and slow social change and acceptance and also a galvanising of HIV/AIDS international action and partnerships (Rimmerman, 2008).

HIV mobilised gay people to fight for legal recognition of partnerships, anti discrimination laws and the repeal of other legislation that disadvantaged gay people, activism that has continued globally since this time (Rimmerman, 2008). However the tragic 1998 case of Matthew Shepard, a young gay man who was killed in Wyoming in a violent anti gay hate crime, illustrated that despite increasing visibility gay people were not universally accepted (R. Crooks & Baur, 2010).

Male homosexuality was removed from the International Classification of Diseases register in 1999, however transexualism and gender identify disorders still remain (Ministerial Advisory Committee on Gay and Lesbian Health, 2003; World Health Organization, 2010).

Increasingly discrimination based on sexual orientation is seen as a human rights issue and at the UN General Assembly in December 2008, just over a third of member states or 66 nations, including Australia, supported the groundbreaking statement confirming the inclusion of sexual orientation and gender identity as part of international human rights protections (International Gay and Lesbian Human Rights Commission, 2008). However this has not meant universal positive social change towards greater protection and inclusion of LGBT people globally as only one third of the UN membership supported this statement (International Gay and Lesbian Human Rights Commission, 2008).

3.3.   Gay History in Australia

Several good texts outline the history of homosexuality in Australia (Robinson, 2008; Sydney's Pride History Group, 2009; Willett, 2000) and there are active gay history and archive groups who aim to record the social history of this group (Australian Gay and Lesbian Archives, 2010; Sydney's Pride History Group, 2009). This section therefore provides a brief outline of some of the important milestones in gay history in Australia. There are very few specific historical texts that relate solely to lesbians or bisexual women however women have been active in both advocacy and community building in Australia for many decades and are included in general gay histories (Willett, 2000). The lack of lesbian only history may also reflect that men who have sex with men was a specific illegal activity in Australia up until the 1960s (Robinson, 2008). Lesbian and bisexual women were less affected by legal sanctions however were just as impacted on through social disapproval for most of Australia's post colonial history.

In Australia in the 1950s, as in America, homosexuality was illegal and subject to prosecution although prosecution was restricted to homosexually identified men not women (Kimmel, Rose, & David, 2006). Although female homosexuality was not formally recognised or outlawed, lesbians have experienced homophobic abuse and discrimination (Ministerial Advisory Committee on Gay and Lesbian Health, 2003). The attitudes of society in general, towards homosexuality were ones of persecution, condemnation, hatred and discrimination, with homosexuality commonly viewed as a 'sickness, sin and disgrace' (Kimmel et al., 2006, p. 1). Consequently although there was an active 'gay scene', in many capital cities in Australia this was until recently, generally concealed from the wider population with few people disclosing their sexual orientation for fear of reprisal (Willett, 2000).

As a result of fear and invisibility, there was little motivation from the homosexual subculture for political activism or public debates until the late 1960s (Willett, 2000). In the early 1970s the first openly and politically active group, Campaign Against Moral Persecution (CAMP) was formed and was a significant player in advocating for gay law reform and rewriting gay history in Australia (Willett, 2000). For

lesbians as late as the 1960s Sydney's lesbian social life mainly took place in a closed and secretive community with house parties, social clubs and a few discrete bars (Pride History Group Sydney, 2009). Gradually over the next two decades, commercial venues for gatherings became more public. There was also a more visible lesbian feminist presence with political activists during the women's liberation days (Pride History Group Sydney, 2009).

In 1972 South Australia was the first Australian state to decriminalise male homosexual acts (Bull, Pinto, & Wilson, 1991). Other states followed over the next two decades, and finally in 1997 Tasmania became the last Australian state to decriminalise sex between consenting adult men in private (Kirby, 2003). In 1984, a decade after the American Psychiatric Association removed homosexuality from the DSM, the Australian Medical Association removed homosexuality from its list of illnesses and disorders (Australian Medical Association, 2002; Kirby, 2003).

The first *Gay Mardi Gras* held in Sydney in 1978 was a commemorative event to mark nine years on from the Stonewall riots (see page 50). Sydney Gay Mardi Gras evolved into a celebration of sexual diversity, which encouraged visibility and community participation. Other cities developed their own similar events which are now firmly embedded in gay communities in most Australian capital cities attracting both LGBT and straight participants. In Perth this manifests in *Pride*, a month long celebration of cultural events each October (Pride WA Inc, n.d.). In Melbourne it is the *Midsumma Festival* which has a tradition of over 20 years (Midsumma, n.d.).

In 2007 the Australian Human Rights and Equal Opportunity Commission (HEROC) identified 58 areas of discrimination between same sex and opposite sex de-facto couples covering a wide range of laws (Berman, 2008). This led the Federal Government in 2009 to introduce the Same-sex Relationships Act, which removed discrimination against same sex couples, ensuring entitlement to the same rights as opposite sex couples (Department of Health and Ageing, 2009). This resulted in changes to 85 pieces of legislation or acts of Parliament including the Aged Care Act 1997, Health Insurance Act 1973 and National Health Act 1953 (Department of Health and Ageing, 2009). In 2010 a public education campaign was conducted

specifically aimed at gay and lesbian people to advise of the implications of these changes (LGBT Health Alliance, 2010).

Despite the introduction of the Same-sex Relationships Act, it is still not possible for same sex couples to legally marry under Australian law. A number of states however have made legislative changes to allow commitment ceremonies and the listing of same sex relationships on the state's relationship register (Department of Health and Ageing, 2009).

Table 5 provides a timeline of some of the historical milestones in Australia's gay community. It relies heavily on information from eastern Australia, which reflects the larger size of the communities there compared to Western Australia and that more comprehensive historical records are available there. This does however provide a good indication of gay social history of Australia including Western Australia as change in one domain is often reflected across Australia.

Table 5

Time Line: Gay Social History in Australia

Decade	Significant event
1950s	• Homosexuality was illegal for males and those engaging in homosexual acts were prosecuted • Homosexuality still listed as a mental illness under the International Classification of Diseases • Discrimination was systemic in Government institutions • Openly homosexual men were banned from employment in Federal Government jobs with highly classified information (they were thought to be prone to pressure from foreign intelligence services making them a national security risk) • Societal attitudes towards homosexuality were of persecution, condemnation, hatred and discrimination • Little motivation from the homosexual subculture for political activism or public debates as the 'gay scene' was concealed from the general population for fear of reprisal - 'gay scene' remains invisible • The first attempt (unsuccessful) was made at homosexual law reform
1960s	• 1969 Stonewall Bar riots in New York – start of visible LGBT activism in the USA - which motivated the formation of similar gay activist groups around the world including Australia • Engaging in homosexual acts in all States in Australia is still a criminal act

Decade	Significant event
	• The first gay rights organisations in Australia established (ACT Homosexual Law Reform Society - Canberra and Daughters of Bilitis – Melbourne) • Support for homosexual law reform by the Humanist Society NSW • Calls for decriminalisation of male homosexual acts made by the NSW General Assembly of the Presbyterian Church • NSW Council for Civil Liberties homosexual subcommittee agrees to support law reform similar to that of the UK
1970s	• The first branch of CAMP (Campaign Against Moral Persecution) formed in Sydney, Australia's first openly gay activist group and other branches soon followed • CAMP Inc. - Australia's first homosexual magazine, published and distributed • Australia's first gay and lesbian demonstration occurs • The group Gay Liberation formed in Sydney • First National Homosexual Conference is held in Melbourne • NSW General Assembly of the Presbyterian Church votes for homosexual law reform • Homosexual Counselling and Information Service of WA is established and later becoming the Gay and Lesbian Community Services • Australia's first commercial gay magazine William and John is published • Canberra and Goulburn Anglican Synod votes for homosexual law reform • Gay Teachers Group formed • South Australia became the first state or territory to legalise sexual conduct between males • First Sydney rally held which would become the annual Mardi Gras
1980s	• The Australian Medical Association removed homosexuality from its list of illnesses and disorders • The Migration Act 1958 changed to allow Australian citizens and permanent residents to sponsor their same sex partners • ALSO Foundation formed in Victoria • The Gay Rights Lobby launched in Sydney • First reports of AIDS cases from the USA and in Australia • First National AIDS Conference held • Australian Federation of AIDS Organisations is formed • World AIDS Day first celebrated • NSW is the first state to prohibit discrimination against homosexuality
1990s	• Tasmania decriminalises homosexual acts, the last state to do so • Commonwealth passes the Human Rights (Sexual Conduct) Act 1994 - Section 4 legalising sexual activity between consenting adults in private) throughout Australia • The Rainbow Flag is adopted as a gay symbol

Decade	Significant event
	• Federal cabinet lifts the ban on gay men and lesbians in the defence forces
	• First Australian lesbian couple adopt a child (Adelaide)
	• The Australian Centre for Gay and Lesbian Research at University of Sydney is launched
	• First International Lesbian Day is declared
	• First gay and lesbian exhibition, *Pride and Prejudice*, is held at the Australian Museum
	• Federal Industrial Relations Commission extends family leave to same sex couples under Federal Awards
	• Queer Youth Cultural Coalition is formed
	• First sexual health booklet for lesbians is produced in Australia
	• WA Equal Opportunity Commissioner releases a report recommending the inclusion of sexuality in the Equal Opportunity Act 1984
	• PRIDE WA collective is formed (1990) and Northbridge becomes home to the annual gay Pride celebrations (1991)
	• Brian Grieg and John Hyde first openly gay men in WA to be elected to public office in local government and in 1996 Giz Watson first openly gay female elected to the Australian parliament
	• Many police jurisdictions appointed gay community liaison committees or officers
2000s	• Victorian Parliament passes statutory amendments providing same sex couples the same legal rights as heterosexual couples regarding inheritance, stamp duty exemption, property division, workers compensation, State superannuation, recognition as a parent of non biological child, recognition as 'next of kin'
	• 2003 Tasmania became the first state to create a relationship registry for same sex couples with nearly equal rights to married couples excluding adoption
	• All states, except South Australia and Northern Territory, allow adoption by LGBT people
	• 2003 the Uniting Church allows sexually active gay men to be ordained as ministers
	• 2004 Marriage Act 1961 changed to prohibit same sex marriage
	• Most states allow assisted reproduction technology and invitro fertilisation for same sex couples
	• Amendment of the ACT Government's Parental Leave Legislation, allowing same sex parents the same access to parental leave as heterosexual parents
	• The Victorian Relationship Register commences
	• Victorian Government establishes a Ministerial Advisory Committee on Gay and Lesbian Health
	• 2004, Northern Territory enacted the Law Reform (Gender, Sexuality and De-Facto Relationships) Act 2003 to remove legislative discrimination against same sex couples in most areas of Territory law
	• 2007, the Human Rights and Equal Opportunity Commission (HREOC) released its Same-Sex: Same Entitlements report
	• The WA Acts Amendment (Lesbian and Gay Law Reform) Act 2002 removed all remaining legislative discrimination toward sexual orientation by adding the new

Decade	Significant event
	definition of "de facto partner" into 62 Acts, provisions and statutes
	• 2009, a same sex marriage bill was introduced unsuccessfully by the Australian Greens (the majority of Australians support same sex marriage)
	• Federal Government introduces Same-Sex Relationships (Equal Treatment in Commonwealth Laws—General Law Reform) Act 2008 which recognises de-facto and registered same sex relationships, ensuring same sex couples and their dependent children receive the same entitlements as married and heterosexual couples and their dependent children.

Adapted from "The development of homosexuality" by Australian Studies Centre On-line (n.d.); "A chronology of lesbian and gay communities and movements in Sydney" by Pride History Group, (2009); "Living Out Loud a history of gay and lesbian activism in Australia" by G. Willett (2000).

3.4. The Gay Community in WA

The previous section has mapped some key historical events that have led to changes in social attitudes towards LGB people both globally and in Australia. These events also impacted on WA and the evolution of a gay community in WA which is described in this section. Although the term 'gay community' is well used, as discussed in the introduction there is a lack of clarity and definition of what this is. Gordon (2006, p. 174) in her study of lesbian community reported her participants as indicating "this community both exists and doesn't – it is palpable, but intangible". Using characteristics from the works of both McMillan and Chavis (1986) and Lemon and Patton (1997) community is about having a sense of belonging and connectedness, of shared norms values and identity, supported through networks and institutions. As Willett (Willett, 2003, p. 413) states "There is now, undeniably, a gay and lesbian community in Australia. Its existence is attested by the usual criteria for such things – social venues, a variety of media… lobby groups, spokespeople, interest groups, welfare organisations and so on".

This section describes the gay community and specifically the lesbian community in Western Australia, the setting for this research. The work of Lemon and Patton (1997) provides some concrete indicators of factors that can be considered to define lesbian community. Despite media portrayals and terminology there is not one lesbian or gay community as noted by respondents in the Victorian survey conducted

by Murnane (2000) and the research of Heath and Mulligan (2008). Research has discussed the place of bisexual women within the lesbian/gay community which is often one of marginalisation from this and the broader community (Rothblum, 2010) and caution in interpreting bisexual women's experience of the lesbian community is needed. What follows results from my own observations as an active member of parts of this community, from informal discussion with several key members of the community and reflections made by some participants on what has been referred to by Wykes (1999) as this "mythical lesbian community". The community although small has many subgroups within it, which illustrate the diversity of the lesbian community and the difficulty in making generalisations and arriving at one definition of 'community'.

Western Australia has a population of 2,059,400, (50.2% or 982,966 of whom are female), 64% reside in the capital city of Perth (Australian Bureau of Statistics, 2009). Census data does not collect information on sexual identity and hence no accurate population figures exist on the number of LGB people within the State. However a recent Australian study looking at sexual identity, sexual attraction and sexual experience among a representative sample of adults (A. Smith, Rissel, Richters, Grulich, & DeVisser, 2003) indicated that 97.7% of females identified as heterosexual. Using this figure, it could then be estimated that 2.3% of the WA female population may identify as non heterosexual, giving an approximation of 22,608 women of diverse sexuality in WA. This is likely to be an under count due to reasons previously given about the reluctance of some lesbian and bisexual women to identify as such in surveys and also because other surveys put the likely percentage of lesbians in a population higher than 2.3% (Bye et al., 2005).

As in many Western countries, LGB people are often attracted to live in cities in part as this is where gay facilities are more likely to be located, it is easier to participate in a more visible community, there is a history of 'safe' venues and there may be a perception that there is a greater acceptance of a gay lifestyle (Browne & Bakshib, 2011). Perth has the largest, although small on a world scale, gay community within WA (Willett, 2000). There are limited gay-only entertainment or public spaces currently restricted to two licensed premises in the central entertainment area. This

also reflects an increase in the number of venues that are known as 'gay friendly' serving both straight and openly gay customers.

Not all LGB people seek out, participate or identify with the more visible gay community or gay events. There is a diversity of communities within the broader WA gay community, some of which are not Perth based. This has also been reported in a Victorian study (Murnane et al., 2000) and also by Heath and Mulligan (2008). In the current sample, many women said they did not feel connected to or part of this city based community and rarely participated in community based events. However many of these women who may not identify with an inner city 'gay scene' did talk about their own lesbian social networks or social cliques fulfilling one of the community criteria identified by Lemon and Patton (1997). Similar connections have been noted by others (Rothblum, 2010). Bisexual women may have different community attachment and may be less connected to the gay community and resources as reported by Heath and Mulligan (2008) in their South Australian sample.

Heath and Mulligan (2008) reported on different experiences of finding, accessing, and belonging to the lesbian or gay community. This ranged from those who found this easy to those who found it difficult to locate a community, unwelcome or felt they did not fit in (Heath & Mulligan, 2008). For some the need to find and identify with community was especially important in counteracting social marginalisation at the time of acknowledging newly realised sexual orientation (Heath & Mulligan, 2008; Rothblum, 2010).

With a complete lack of well referenced works in this area the description of the lesbian community in WA that follows relies on personal communication (Z. Carter, personal communication, September 14, 2009; V. Cass, personal communication September 22, 2009; J. Darbyshire, personal communication, May 18, 2009) and 'grey' literature. There are greater sources of factual information on the gay community from the two largest Australian communities in Sydney and Melbourne. Although some parallels can be drawn, WA has its own history and subgroups. Descriptive categories illustrating the diversity of lesbian lifestyles that loosely could be seen as making up a lesbian community are listed in Table 6, which provides an

illustrative rather than an exhaustive list of identities or groups. Many lesbians/bisexuals would not identify with any of these groupings yet consider themselves part of the community. Community membership is likely to represent taking part in local activities with a particular group of mainly lesbian/bisexual women and incorporates many smaller overlapping communities (Gordon, 2006). Women may or may not identify with these groups and many would identify with multiple groups. Membership is likely to be fluid and members may belong to multiple groups in the course of their life or no group at all. As lesbian and bisexual women also indicate good connection to the non gay community, their communities also incorporate other communities of interest, occupation and geography that in some cases may be stronger than their association to the gay community. This recognises multiple community membership and the variety of functions served by these communities (Lehavot, Balsam, & Ibrahim-Wells, 2009).

Table 6

Lesbian Subgroups

Subgroup	Description
ATSI	Aboriginal and Torres Straight Islanders.
Baby dykes	Young women newly 'out' or still questioning often up to age of late twenties.
Bisexual women	Attracted to both males and females.
Came 'out' later in life lesbians	Declared sexuality later in life often after 40 i.e. often following a long heterosexual relationship with or without children from that union.
BDSM	Bondage, discipline, dominance/submission, sadism and masochism community who practice these consensual sexual practices.
Career lesbians	Well educated, successful or aspiring professional careers, financially secure.
Country lesbians	Lesbians who live in a non metropolitan area.
Diesel dykes	Masculine looking often seen as tough by others and are visible at particular licensed venues e.g. the Court Hotel.
Dyke	General term used within the community by some particularly older lesbians especially politically aware lesbians. If used by outside the community often used as a term of offence. Often implies some feminist position.
Gay	Although used in a general sense to refer to all homosexually oriented people including women, it is also used by some lesbians to refer to lesbians who are less politically active or politically interested in particularly gay politics but have a homosexual lifestyle.
Gender queer and pansexual	Identification that sees sexuality as fluid and not based on a fixed binary.
In the closet	Have not openly disclosed their sexuality. May refer to

Subgroup	Description
	one part of their life e.g. in the closet at work. Generally not well connected to the gay or lesbian 'scene'. Can be any age group may include older women who grew up in a time when there was less visibility and acceptance around homosexuality. May still be in a heterosexual relationship.
In the suburbs	Living outside of the inner city gay friendly suburbs. Often living a usual suburban life. May not be well connected with the community.
Lesbian mums	Usually with younger children either through previous heterosexual partnership or increasingly through assisted reproductive technology with same sex partner. Family arrangements vary as to involvement of partners, sperm donors etc.
Lifetime lesbians	Have never had a significant heterosexual relationships and often came 'out' earlier in life e.g. as teenagers or in their twenties.
Lipstick lesbians	Straight-looking women, often considered more 'femme', or feminine looking.
Not on the scene	Lesbians/bisexuals who do not participate in the gay night club/pub scene.
Older lesbians	Older women some of whom have identified as lesbian for the majority of their life. Often seemingly invisible in the gay community.
Party lesbians	'Out' on the gay night club and pub scene. May involve drug taking.
Politically active lesbians	Involved in social, political, environmental change usually for social justice often more broadly based than just gay issues although often at the forefront of these as well.
Polyamorous	Practice of having more than one intimate relationship at a time within a consensual and open framework of all players. Not restricted to minority sexuality individuals.
Queer	Term used more often by younger women who may not use the label lesbian and may want to be identified with a more fluid kind of sexual identity. There are 'queer collectives' on most university campuses. Queer theory critical thinking approach emerged in 1990s.
Questioning	Young people who are unsure of their sexuality and are questioning issues of identity and community. This can commence in early high school. Some special support facilities for this group.
Sporty dykes	Lesbians involved team sports often with other lesbians especially women's football, softball, basketball.
Straight acting	Lesbians/gays/homosexuals deliberately acting and dressing so as to be identified as heterosexual.
Women of colour	Lesbians who identify with non Anglo white background.

The inner city suburb Northbridge has long been the location for many of the historical beginnings of the WA gay community through social clubs, private entertainment venues and gay activist activities (Gay and Lesbian Equality, nd). As Darbyshire (2009, p. 2) says, "although invisibility has always been both a protection

and a curse for the gay and lesbian community there is no doubt that same sex attraction and activity has contributed to the colour and flavour of the area known as Northbridge over the last century. One can say that this area has always been the place for gay people to meet, to party in, to live and work in - but it has not always been a safe home". This tradition of Northbridge and the inner city still plays an important part in community identity for many gay people and many private establishments over the years have gained a gay and lesbian following in Northbridge (Darbyshire, 2009).

The term 'gay scene' is often used to describe the nightclubs that are exclusively gay or gay friendly and which tend to be located within the Northbridge area of central Perth. This tends to attract a younger group of people and is often associated with levels of licit and illicit drug taking and music (Z. Hyde et al., 2007). Several studies report higher use of so called 'party drugs' by lesbian and bisexual women particularly younger women and this indicates perhaps the attraction and use of the inner city night club 'gay scene' (Z. Hyde et al., 2007; Parsons et al., 2006). Northbridge and the central city has also traditionally been the location of several gay community groups' offices and the site for other community events. This includes WA Pride (Pride WA Inc, n.d.), Gay and Lesbian Community Services (GLCS, 2009a), PFLAG (Parents and Friends of Lesbian and Gays) (PFLAG, n.d.), the Western Australian Aids Council (WAAC, n.d.) and the Freedom Centre (The Freedom Centre, 2009). The Northbridge History Project has documented many of the sites that have had a gay connection in the inner city area (Darbyshire, 2008).

On a community level there are many groups that women may belong to which are not related to the 'gay scene' but attract predominantly gays . This includes such things as sport (football, badminton, tennis, etc.) cultural (choir, dancing), social groups (outdoor, church, gay families with children) and political activist groups (gay rights, older gay advocacy) (GLCS, 2009a). There are also groups within mainstream organisations, for example within the State School Teacher's Union B-Legits is a group for LGBT teachers (State School Teacher's Union WA, 2011).

There is also a strong youth oriented program within WA that seeks to provide support and social outlets including queer collectives that are found on most

university campuses (Cross Campus Queer Network - WA Branch, n.d.) and the Freedom Centre run by WA AIDS Council (WAAC) (Freedom Centre, n.d.).

While many gay and lesbian people live in the inner city or in close proximity suburbs, often termed colloquially the 'pink triangle', many more live in outer suburban areas. Many lesbians in these suburban areas are very involved in the broader suburban community which may include raising children. Their association with the gay community may be non-existent or restricted to participating in several events during Gay Pride month, which occurs annually in October predominantly in central Perth. The two events which attract the widest participation, Pride Fair Day (large outdoor community picnic and fair event) and the Pride Parade (a night time street parade of floats through the Northbridge area) both occur during this month (Pride WA Inc, n.d.). These events also attract large numbers of non gay people. There are also lesbians who have no connection with these events or did so at an earlier stage in their life but no longer do. Anecdotally these women are aware of community events but choose community connections outside the gay community.

The geographic spread of the gay community from the traditional inner city locations has resulted in what Greig (2010, p. 35) has termed "community deconstruction". Contributing factors include younger gay people who do not feel the need to only socialise in gay venues and are happy to live in the suburban areas, and the increased use of the Internet and social networking to connect to others, community groups and relevant community agencies. Greig (2010) also states that ever increasing house prices in the inner city areas has made many of these traditional gay hubs unaffordable. Many gay people are also more connected to a suburban community of residence especially if they have children, rather than to an exclusive gay/lesbian community (Morris, Balsam, & Rothblum, 2002). Socialising along a gay/straight divide that resulted in the formation of 'gay ghettos' in past times has in many cities in Australia and other countries gradually diminished in response to greater acceptance of LGBT people changing geographically what is considered the 'gay community' (Browne & Bakshib, 2011).

With a third of the State's population living outside the Perth metropolitan area, lesbians also reside in many regional and remote areas. Several of the regional

centres, notably Geraldton, Busselton and Denmark/Albany, have an identified lesbian community based on geographic proximity. These communities have their own formal and informal community events and social networks of lesbians (GLCS, 2009a). Lesbians also reside in more remote areas, and with the phenomenon of the mining industry in the more isolated Pilbara area, some lesbians are part of this work force and live either in these small communities or as part of the fly in fly out workforce. In this instance while they work in these remote areas they usually return to Perth for a week or more each month (The Pink Sofa, n.d.). An identified lesbian community is less likely in remote areas although lesbians often know of or socialise with other lesbians especially through social media (The Pink Sofa, n.d.). Lesbian/bisexual women who have established themselves in non metropolitan areas are likely to have strong reasons for this geographical choice and community connection with other LGBs may or may not exist (Oswald & Lazarevic, 2011).

There are many ways that lesbian women connect with each other using electronic or social media defined as "a group of Internet-based applications that . . . allow the creation and exchange of User Generated Content" (Kaplan & Haenlein, 2010, p. 61) such as chat rooms, lesbian dating services and on-line forums. Both GLCS (2009b) and the Freedom Centre (2009b; The Freedom Centre, 2009) host on-line forums. Other social networking tools such as Facebook, MySpace, BeBo, Yammer and Twitter are also used to facilitate community connection (Z. Carter, 2009). Networking through such social media provides important avenues for women to remain connected to other lesbians without necessarily being part of the 'gay scene' of the inner city, not available a decade ago.

There is a rich tradition of gay print media which has been important in helping to define community with several past specific gay publications including Women Out West, Grapevine, Lesbian Connection, Hot Gos and West Side Observer (Z. Carter, 2009; Darbyshire, 2009). Currently Out in Perth is the only regular WA gay print publication however; some national gay publications including Lesbians on the Loose and DIVA are also available in WA. Web based news such as Gay in WA, Out in Perth, Pink Sofa, Pink News, 365gay.com are also an important part of gay community (Z. Carter, 2009).

Age and 'coming out' status may impact on community participation and identity (Beals & Peplau, 2005). Women who are exploring sexuality and claiming minority sexuality younger in life are likely to participate in gay community nightclub activities as reported by others (Gruskin et al., 2006). Some women discover their lesbian identity later in life and may leave a long-term heterosexual life with or without children (IOM (Institute of Medicine), 2011; Morris et al., 2002) and may or may not participate in the 'gay scene'. They may find other community groups to belong to. Not everyone is attracted to or wants to participate in the 'gay scene'. There are however a number of women who come to a lesbian identity later in life and may like younger people, go through a time of being heavily involved in the gay community including the 'gay scene' perhaps as part of identity formation (Gruskin et al., 2006).

There is often a perception held by the non gay community and media that the gay community in Perth is a harmonious small community where everyone knows each other and lives what has been portrayed in the popular media as a 'gay lifestyle' (Walsh, 2008). The American, MGM Worldwide Television distributed 'L Word' which ran from 2004 to 2009 is one such portrayal of a Vancouver based group of lesbians who live glamorous lives with relationship issues being the prime concern (Anon, 2009). This like many portrayals of lesbians on television is a stereotype of lesbian community (Netzley, 2010). An article that appeared in the Perth lifestyle magazine *Scoop* titled 'Happy Days' describes the gay lifestyle in WA and also some of the difficulties of being part of this minority (Walsh, 2008). The reporter who undertook this article had originally expected to write a more upbeat article and was clearly unprepared for some of the diversity and community difficulties that were discussed by informants (Z. Carter, personal communication, September 14, 2009).

A large scale study of the health and wellbeing of lesbians and bisexual women in WA, included questions on community connectedness and the results hint at the diversity of experience and importance of community (Z. Hyde et al., 2007). Only one third of participants (31.8%) felt either very or mostly connected to the gay and lesbian community, whilst over half (52.9%) felt very or mostly connected to the broader community (Z. Hyde et al., 2007). Connectedness to the gay and lesbian community decreased with age, yet over 40% of respondents said that most or all of

their female friends were either lesbian or bisexual. Older women were slightly more likely to have a greater number of lesbian or bisexual women friends. Over half (58.3%) had either none or a few male friends who were gay. Over a third of respondents visited gay bars (35.4%) and dance parties (9.1%) monthly or more often, while 16.1% rarely or never visited a gay bar (Z. Hyde et al., 2007). This indicates, as reported by others, that for the majority of lesbian and bisexual women connection to other same sex women is important although not an exclusive social network (Pitts et al., 2006; Rickards & Wuest, 2006).

This diverse and geographically dispersed population of lesbian and bisexual women formed the setting for this research and the recruitment sample.

3.5. Issues of Identity, Prevalence and Stigma

The history and community description above provides the social background to understanding the study population. Three other issues, identity formation, prevalence of a lesbian/bisexual population and stigma and discrimination also have an important impact on the lesbian experience. These are introduced below.

3.5.1. Identity

It is acknowledged that the use of identifiers such as lesbian, bisexual, queer, or LGBT is problematic when there is such diversity at an individual and community level and it can be easy to end up working with stereotypes of these terms (Ferris, 2006; Geiger, Harwood, & Hummert, 2006). In the research literature there is no agreed definition for minority sexualities and it is usually left up to individual researchers as to how they define these terms (Beatty et al., 2006). However it is generally accepted that there are three dimensions of sexual orientation: 1) sexual orientation identity, 2) sexual behaviour, and 3) sexual attraction, although there is little consistency about how these terms are used (Sell & Silenzio, 2006; Solarz, 1999).

Historically sexual identity formation has been conceived primarily as a linear event (Cass, 1979; Coleman, 1982; Troiden, 1979). Early staged models looked at both personal acceptance and social or group identity development (Swann & Anastas, 2003). For example, stage 1 initial vague awareness of difference; stage 2 the process that leads to understanding oneself as lesbian; stage 3 disclosure of one's new identity to non heterosexuals; stage 4 disclosure of one's identity to heterosexuals; and stage 5 identification with lesbians as a group or community (Swann & Anastas, 2003).

Such linear models have been criticised by some who propose that sexual identity development is a flexible process involving both progression and regression (Sophie, 1986), or that identity is fluid (Diamond, 2005; Mayer et al., 2008). McCarn and Fassinger (1996) propose a model that looks at both individual sexual identity and group membership identity. Floyd and Stein (2002) in their work consider defining milestone experiences. Diamond (2005) argues that traditional models of minority sexual identity of lesbian and bisexual do not capture the fluidity that may exist in self-identity over time. Some women maintain a stable lesbian identity once they 'come out', some maintain a stable bisexual identity, some alternate between lesbian and non lesbian label and some don't adopt any label; recognition that variability of sexual attraction may occur over a lifetime and that sexual identity may also change (Diamond, 2005). Thompson and Morgan discuss an identity they term 'mostly straight' as a further refinement of notions of fluidity, transitions and developmental stages (Thompson & Morgan, 2008). Tabatabai (2010) demonstrates the complexity of labelling for women who have moved from an exclusively lesbian sexual orientation and identity to later having long-term relationships with men. Equally women may arrive at a lesbian identity later in life following a period of heterosexual identity (Kitzinger & Wilkinson, 1995; Rickards & Wuest, 2006). Queer theory is likely to say that lesbians are one variety of a larger category called 'queer' and that lesbians define their identities in a variety of ways (Swann & Anastas, 2003). "There are multiple pathways that lead to a sexual-minority status" (Morgan & Thompson, 2011, p. 17).

The use of traditional categories to describe minority sexuality identity especially in young people who are establishing an identity has been discussed by several authors

who also acknowledge that the issues surrounding sexual identity are influenced by wider social changes and attitudes to same sex attraction (Cohler & Hammack, 2007; Glover, Galliher, & Lamere, 2009). Glover et al. (2009) propose the use of a multidimensional model that captures identity development and identity exploration through examining a range of continuums rather than compartmentalising within predefined labelled categories, assists in understanding adolescent sexual minority status as a process that is not uniform among groups or individuals. Cohler and Hammack (2007) discuss the rapid social change which has seen some adolescents being less concerned with gay labels or a need to seek out exclusively gay social outlets. There may not be an identifiable sexual identity crisis for all adolescents claiming minority sexuality which may encompass such terms as pansexual, queer and polyamorous (Cohler & Hammack, 2007; Thompson & Morgan, 2008).

Laumann et al. (1994) show the difficulty of enumerating same sex sexual orientation. In their survey of 1,749 women, 150 women of whom reported same sex sexuality and of this sample, there was a small proportion (15.3%) of consistency between the categories desire, identity and behaviour, while desire was the most reported single category at almost 60% (Laumann et al., 1994). Questions on behaviour were in relation to partners or practices while desire and identity questions were about current state of mind for example "Do you think of yourself as heterosexual, homosexual . . ." (Laumann et al., 1994, p. 293). An Australian survey of 9,134 women aged 16 to 59 years reported similar findings with 14.9% reporting congruence between experience, attraction and identity. This surveyed women who reported any same sex attraction or experience or non heterosexual identity and is illustrated in Figure 2 (A. Smith et al., 2003).
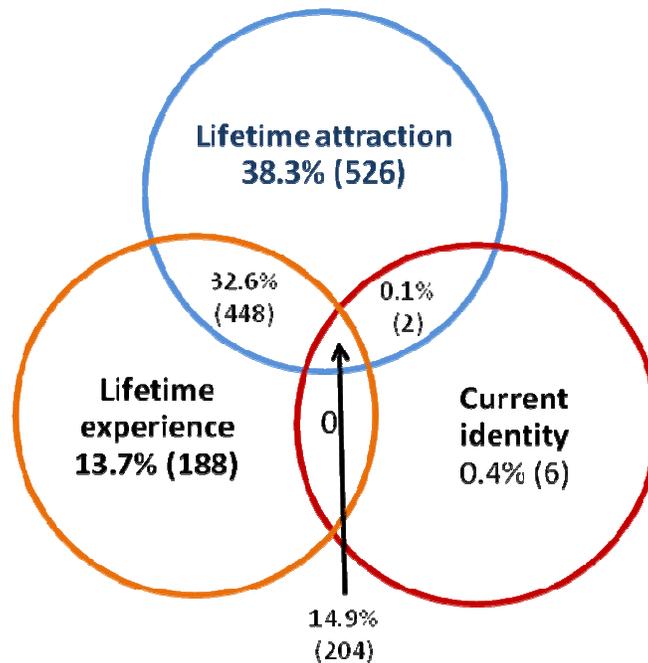
Figure 2. Relationship between current sexual identity, lifetime sexual experience & lifetime sexual attraction among Australian women.
Adapted from Smith, A., Rissel, C., Richters, J., Grulich, A., & DeVisser, R. (2003). Sex in Australia: sexual identity, sexual attraction and sexual experience among a representative sample of adults. *Australian and New Zealand Journal of Public Health, 27*(2), p. 141.

Young people may lack clarity about identity and labelling. Many young people do not use such identifiers as lesbian or gay but may describe their same sex attraction as 'unlabeled' or 'questioning' at this early stage as they come to terms with issues of sexuality while being very aware of the social ramifications of identifying as gay (Savin-Williams, 2001).

The identity label 'bisexual' may also be non fixed or fluid depending on the individual's experience, their community identity and who they may be in a primary relationship with (Diamond, 2008). There is more acceptance that identity is not fixed, may not be captured in a single category and that a number of sexual minority people when asked would categorise themselves as not using a label at all (Diamond, 2008; Tabatabai, 2010). New categories and labels also emerge over time, for example 'mostly heterosexual' and 'pansexual'.

To understand the lesbian or bisexual experience requires an understanding of the concept of 'coming out'. This is when a person acknowledges that they are not exclusively heterosexual. At its simplest there is a 'coming out' to oneself which is necessary before 'coming out' to others. Because of the heteronormative nature of society where the general assumption is that all people are heterosexual, 'coming out' can be a difficult although potentially empowering process (Ferris, 2006; Kitzinger & Wilkinson, 1995). 'Coming out' is a constant process throughout the life-course as new situations arise and decisions are made as to how 'out' to be (Ferris, 2006; J. Kaufman & Johnson, 2004). Johnson has called this a 'revolving closet door' (Johnson, 2008). This can occur perhaps on a daily basis (Pitts et al., 2006). Van Dam (2008) has discussed this as lesbians undertaking a cost benefit analysis of when to disclose and this constant decision results in some level of chronic stress for lesbians. There is often a constant self monitoring about how 'out' to be resulting for some in a "constant and ongoing struggle" for identity maintenance (Hequembourg & Brallier, 2009, p.282). Research has confirmed the potentially negative effects of not being 'out' to oneself or to friends and family (Beals & Peplau, 2001; Morris, Waldo, & Rothblum, 2001). There is also the potential of being 'outed' by someone without permission, which can result in compromising or stressful situations. A New Zealand study found that 58.7% of LGB respondents in this large study said they had been 'outed' without permission (Henrickson, 2007).

A HREOC report submission documenting experiences of marginalisation and discrimination of people in same sex relationships illustrates the constant decisions about 'coming out':

> *As 'out' as I may believe myself to be, the truth is we all have to make decisions every day about coming out in different circumstances. In the community the default assumption is heterosexual, and we are always having to make decisions about whether to correct that assumption and make ourselves more visible and expose ourselves to discrimination ….* (Human Rights and Equal Opportunity Commission, 2007, p. 411).

Pitts et al. (2006) reporting on a large Australian study found that while 98.2% of females were 'out' to at least one person (94.3% for men) this is not consistent across all groups of friends and family and hence demonstrates the complexity of defining a level of openness about minority sexual identity. For example only 76.5% were 'out' to their parents, 52.8% were 'out' to work or study supervisors, 43.7% were 'out' to neighbours, 23.7% were 'out' to sporting club associates and only 17.2% were 'out' to their children (Pitts et al., 2006).

The lesbian experience then is usually associated with the need to define one's own identity and determine to what extent to share this knowledge. Even though for some women they may feel connected to and part of this community, they do not use a label to indicate their sexual orientation, further complicating the identity issue. In the Private Lives survey 4.8% of respondents, both male and female, stated they did not use a label (Pitts et al., 2006). In a 2007 Western Australian lesbian survey 8.5% of respondents stated they did not use a label (Z. Hyde et al., 2007). The lesbian experience is also closely related to being a minority group numerically.

Despite an indication that there is not one single lesbian or bisexual identity or community, at the same time some women are likely to confront issues of conformity. Heath and Mulligan (2008) found that women who did not match the community norms or expectations were at the margins of the lesbian community and that community experience was not always positive. They also found that bisexual women were often found in the margins of the broader gay or lesbian community and did not always find community acceptance a finding also reported by others (Rothblum, 2010).

3.5.2. Prevalence

Difficulties exist in defining the size of the LGB population and the female component of this due to both the complexity of defining LGB status and a lack of accurate statistics. The Australian Study of Health and Relationships used computer-assisted telephone interviews with a sample of 9,134 women and 10,173 men and included questions about sexual orientation. When questioned on identity 97.7% women identified as heterosexual (97.4% for men), 0.8% as lesbian or homosexual

(1.6% for men) and 1.4% as bisexual (0.9% for men) (A. Smith et al., 2003). On attraction 84.9% of women reported only opposite sex attraction and experiences. Some same sex attraction or experience was reported by 15.1% of women. Almost 10% of women reported sexual attraction and sexual experience that was inconsistent (A. Smith et al., 2003). An Australian Medical Association (AMA) position paper quoting Hillier puts the proportion of the population that is not exclusively heterosexual between 8-11% (Australian Medical Association, 2002).

Prevalence data from other countries is similarly inconsistent. The UK government estimates that 5-7% of the population is homosexual (men and women) based on a review of eleven population surveys conducted in the USA, UK and the Netherlands. (Meads et al., 2007). The Californian LGBT Tobacco Study suggests that prevalence of LGBT people make up 1-8% of the population depending on what criteria is used (Bye et al., 2005). Self identification yields 1-3% in most household studies while a definition based on sexual behaviour in the last year is slightly higher; a definition based on sexual behaviour since adulthood yields 4-5%; one based on sexual behaviour in one's lifetime yields 4-7% ; and those based on desire or attraction yields the largest estimates of 8% (Bye et al., 2005). In the 2002 USA National Survey of Family Growth, Mayer (2008) reported that 4.1% of the US population aged 18 to 44 identified as homosexual or bisexual. For women in this age group 1.3% identified as homosexual and 2.8% as bisexual (Mayer et al., 2008). In the study by Sell et al. (Sell, Wells, & Wypij, 1995) comparing the prevalence of homosexual behaviour with the prevalence of homosexual attraction, again illustrates the complexity at arriving at a definitive prevalence. They found that prevalence of homosexual behaviour over the previous 5 years varied between 2.1% to 10.7% across the countries of United States, United Kingdom and France dependent on the research methodology. When attraction only is considered the figures ranged from 16.3 – 20.8% and this is considered a conservative estimate (Sell et al., 1995).

Information from a US Women's Health Initiative Survey of a sample of 93, 311 post menopausal women aged 50 to 69 found 97.1% were heterosexuals (based on sexual activity) (Valanis et al., 2000). Self identified lesbians represented only 0.6% of the sample almost equally divided between lifetime lesbians and those who

identified themselves as lesbians only after age 45 and 0.8% identified as bisexuals (Valanis et al., 2000). Although this represents the lower end of prevalence of same sex orientation this could be the result of recruitment strategies and the older age group (Valanis et al., 2000).

This illustrates that in Western countries heterosexuality is the overwhelmingly identified sexual orientation while non heterosexual orientation based on one of the three key dimensions makes up a minority of a maximum up to 15% of the female population.

3.5.3. Issues of LGB stigma, discrimination

Despite advances in the general acceptability of homosexuality in many developed countries, and the rapid social change as documented earlier in the chapter, this remains a marginalised group (Flood & Hamilton, 2008; Gay and Lesbian Medical Association, 2001; Mayer et al., 2008). The social dimension of identification with a minority diverse sexuality group means LGBT communities remain outside the mainstream of heteronormativity which can lead to discrimination (Klugman, 2007). Herek (2007, p. 172) and others have described 'sexual stigma' as stigma based on sexual orientation and is manifest in "society's negative regard for any non heterosexual behaviour, identity, relationship or community". There is evidence of the marginalisation, stigma and discrimination of lesbians and gay men through both legal and social constructs (Human Rights and Equal Opportunity Commission, 2007; Kertzner, 2007; Pitts et al., 2006). Concrete examples of marginalisation of gay people include:
- 58 federal laws in Australia were identified which breach the rights of same sex couples and sometimes their children in a range of areas including employment, health care costs, superannuation and aged care (Human Rights and Equal Opportunity Commission, 2007).
- The Equal Opportunity Act (WA) specifically lists sexual orientation as a basis of unlawful discrimination in certain areas of public life (GALE & GLCS (WA) Inc, 2003).
- Hate crimes against LGBT are well documented (GALE & GLCS (WA) Inc, 2003; Herek et al., 2007). Herek reports that 20% of LGBT people reported

personal or property crime, and nearly 50% verbal abuse related to sexual minority status (Herek, 2009). In a large Australian study 56.4% of LGBTI female respondents reported personal insults or verbal abuse, 15.2% experienced threats of violence and intimidation and 7.2% physical violence due to minority sexual orientation (Pitts et al., 2006).

- A number of LGBT people are not connected to the community or try to 'pass' as straight and may be considered 'in the closet' (Rimmerman, 2008);

- Many LGBT people modify their daily activities in particular environments due to fear of prejudice and discrimination. In an Australian research report 67% of respondents indicated they did this (Pitts et al., 2006);

- High profile people e.g. sports people may experience difficulty in 'coming out'; which may result in negative consequences (Sartore & Cunningham, 2009);

- Poorer health outcomes on a range of indicators (Meyer & Northridge, 2007);

- The Universal Periodic Review of July 2010, by the Australian Human Rights Commission specifically mentions that people who are lesbian, gay or bisexual are not covered by any federal law prohibiting discrimination on the grounds of sexuality. They go on to recommend that sexuality be included as grounds of discrimination federally and that the Government take steps to enable equal recognition of same sex marriage (Australian Human Rights Commission, 2010).

- An Australian Human Rights Commission reported the high levels of discrimination, violence, harassment and bullying presented by LGBTI people with inadequate protection under current laws (Australian Human Rights Commission, 2011).

Discrimination and stigma is not restricted to overt acts but also includes more subtle forms such as social exclusion due to minority sexuality which was reported by 34.3% of LGBTI females in a large Australian sample (Pitts et al., 2006). Social exclusion can manifest as a lack of connection to the broader community as reported by Hyde et al and others (Z. Hyde et al., 2007; Pitts et al., 2006). Social exclusion is a named social determinant of health (Marmot, 2005).

Homophobia is a term often used to describe the manifestation of such discrimination (Robinson, 2008). Herek (2000) and others (Amadio, 2006) propose that sexual prejudice is a preferable term as it does not make assumptions about motivations of such discrimination and places it as a broader concept. Herek (2000) uses this to encompass negative attitudes towards homosexual behaviour, people with homosexual or bisexual orientation and communities of gay, lesbian and bisexual people. Three principal features of prejudice (it is an attitude /judgement; it is directed at a social group and its members; and it is negative) are observed in sexual prejudice (Herek, 2000). Levels of sexual prejudice are not uniform and can be affected by such things as religious affiliation, education level and personal knowledge of LGB people (Herek, 2000).

Herek (2000) summarises some of the underlying motivations for sexual prejudice as: an unpleasant interaction with a gay person which is then generalised to the whole community; fears around homosexuality which may reflect a person's own discomfort with their own sexuality; and that the gay community is seen as representing values that are directly in conflict with one's personal value system.

Herek (2007, p. 906) provides a comprehensive discussion on sexual stigma which he defines as "the negative regard, inferior status, and relative powerlessness that society collectively accords to any non heterosexual behaviour, identity, relationship, or community". This differs from other stigmas e.g. race, because generally an individual's sexual orientation is not readily apparent to casual observers (Herek, 2007). Sexual prejudice tends not to be regarded as undesirable or inappropriate and it may attract strong disapproval (Herek, 2007). Sexual stigma manifests at both an institutional and an individual level. At an institutional level this is manifested through the historically legitimised inferior status e.g. in the law through 1) promotion of heterosexual assumption, and 2) heterosexism which problematises homosexuality (Herek, 2007). At an individual level sexual stigma can result in acts of violence; felt stigma through an individual's expectations that they will be subject to sexual stigma and/or internalised stigma, where an individual accepts sexual stigma as a part of her own value system; and self-concept (Herek, 2007; Wright & Perry, 2006). Internalised sexual stigma has also been labelled internalised homophobia (Robinson, 2008). The legitimacy of sexual stigma is increasingly being

challenged (Flood & Hamilton, 2008; Herek, 2007; Meyer & Northridge, 2007; Robinson, 2008).

Internalised homophobia is multidimensional manifesting in such circumstances as isolation, deception, fear of discovery, self-hatred, religious condemnation and may result in psychosocial difficulties (Szymanski & Chung, 2001, 2003). Connection to a supportive lesbian/gay community has been reported to be an important mediator for internalised homophobia contributing to a greater sense of self-esteem and identity as a lesbian (Beals & Peplau, 2001; Szymanski & Chung, 2003).

Swim et al. (2007) using a daily diary approach looked at daily encounters with heterosexism of a sample of students over a one week period. They report an average of 2.00 heterosexist hassles (range 0 – 8 per day); 0.78 hassles about which uncertain if heterosexist and 8.38 hassles not perceived as heterosexist. The majority of heterosexism encounters were verbal e.g. comments that dealt with gay stereotypes and general denigration of LGB individuals, while behavioural hassles included exclusion because of known or perceived sexuality or receiving poor service (Swim et al., 2007). Although this was a small sample, it shows that sexual prejudice is an ongoing experience.

It should also be acknowledged that marginalisation may happen within the gay community itself; that is, a shared sexual orientation does not make for acceptance of all (Browne & Bakshib, 2011). Heath and Mulligan (2008, p. 295) reported on respondents who felt very disconnected from the lesbian community and found that community was "sometimes exclusionary, censorious or difficult to negotiate". Bisexual women especially may feel disconnected to community (Rothblum, 2010).

Meyer (2003, 2007) has proposed a theoretical framework, the minority stress model, to explain the adverse mental health outcomes of stigma and prejudice experienced by LGB people. For LGB people mental health problems can result from four major minority stress processes: 1) experiences of prejudice events; 2) expectations of rejection or discrimination, 3) hiding and concealing of one's sexual orientation and 4) internalised homophobia when negative social attitudes of sexual stigma are turned inward (Meyer, 2007).

3.6. Positives of the Lesbian Experience

While the majority of the gay health literature concentrates on documenting health deficits in LGBT people, there is a recent acknowledgement that many people experience positives from a LGBT identity. Riggle et al. (2008) identified three domains with 11 themes that self identified lesbians (n=350) and gay men (n=203) reported on an on-line survey seeking information on the positives of their sexual orientation. These domains were disclosure and social support; insight into and empathy for self and others; and freedom from societal definitions and roles. Together they encompass such positives as belonging to a community, creating families of choice, strong connections to others, serving as positive role models, authentic self and honesty, personal insight into sense of self, increased empathy and compassion for others, involvement in social justice and activism, and freedom from gender-specific roles (Riggle et al., 2008). The authors acknowledge that although there were limitations with this research it does illustrate a number of interrelated positive aspects of being a lesbian or gay man. Further research is required to examine how these manifest in psychological wellbeing (Riggle et al., 2008).

The work of Heath and Mulligan (2008) illustrates the diversity of lesbian and bisexual community experience and that women can negotiate their place within this with positive outcomes. They do however acknowledge that the gay or lesbian community can also be problematic in terms of the norms and expectations of this community and difficulties are experienced by some in establishing community belonging (Heath & Mulligan, 2008).

Cohler and Hammack (2007) discuss a new generation of non heterosexual youth who in challenging a traditional dialogue about the difficulties of being gay have found empowerment, resilience and building of positive minority communities through their own personal narratives of identity. This has similarities with developmental process of adolescence regardless of sexual orientation and also reflect social change which has made it easier for youth today to identify as non heterosexual (Cohler & Hammack, 2007).

These studies present aspects that may contribute to resilience, good health and wellbeing of LGBT community members. This literature acknowledges that many LGBT people navigate community connectedness and identity issues with affirming and positive outcomes while also accepting that for other members belonging to a sexual minority group has resulted in challenging and negative outcomes.

Older women who adopt a lesbian identity later in life, although acknowledging the challenges of leaving heterosexuality, invariably report being more content with their life choice on becoming a lesbian (Jones & Nystrom, 2002; Rickards & Wuest, 2006).

Under Meyer's (2007) minority stress model LGB community involvement, support and networks operate positively as a protective factor. This conclusion is supported by the work of Health and Milligan (2008) and Riggle (2008).

3.7.   Chapter Conclusion

Chapter 3 has presented information on the lesbian experience as a backdrop to understanding the social setting of the study population. While the historical snapshot provided evidence of an increasing acceptance of people of minority sexualities, it also provided information on attitudes that portrayed gay people as deviant with all the associated stigma and prejudice. Stigma is still experienced by most gay people today.

Issues of identity illustrated that this minority sexuality is not clear cut, fixed or easily enumerated. The notion that a single lesbian or gay community exists was also deconstructed and the complexity of community identity and experience was illustrated. The chapter concluded with examples of recent research that have examined positive aspects of a gay or lesbian identity.

Chapter 4: Methodology

4.1. Introduction

This chapter provides a discussion of the methodology employed for this research. The chapter commences with an evaluation of grounded theory, the chosen research approach. Symbolic interactionism is then presented as the conceptual framework for the project. Reflexivity, an important component of any qualitative research, is discussed before presenting details on the sources of data, data collection methods and data analysis employed. The chapter concludes with a discussion on quality criteria for the research.

4.2. Grounded Theory – A Methodological Approach

A clear methodological approach is required for any research project. Qualitative methodology has been employed in order to explore more than prevalence data on smoking and try to understand the reasons for smoking behaviour of the study group. Such insights could not be gained from a laboratory based project and hence naturalistic methods, a cornerstone of qualitative methodology were employed (Avis, 2005). It was also clear that active participant involvement in data gathering to arrive at an insider's view and an insight into participants' accounts of their lives would be necessary to answer the research question.

Holloway and Todres (2005) suggest that qualitative researchers need to clarify the following to help in the determination of the methodological approach:
- The particular status of the chosen research and methodological decision.
- Whether any other procedures have been included.
- Reflexive account of the intended audiences.
- The kind of knowledge production that was intended.
- Some of the historical and cultural contexts within which the research is positioned.

Grounded theory has been used in several previous research projects examining smoking particularly in seeking to understand the meaning and function of smoking. This includes the study by Laurier et al. (2000)(2000; Nichter et al., 2007) on daily and life-course of smoking and the study by Nichter et al. (2007) examining stress and smoking among young people. Smoking campaign evaluation studies have also used qualitative methodology to capture smoker beliefs and attitudes (R. Ryan, Hill, Rubenstein, & Ross, 2010). Grounded theory was selected as the most appropriate methodological approach for the research question in this current study.

4.2.1 Grounded theory approaches

Grounded theory was first formalised by Glaser and Strauss in 1967 while undertaking a study investigating the experience of chronically ill and dying patients in hospital (Glaser & Strauss, 1967). This demonstrated its worth as a social research approach that allowed for the investigation of social phenomena, which was able to capture personal experiences and basic social processes.

Their structured approach to grounded theory aimed to bring the strengths of quantitative research rigor to a qualitative methodology using an inductive approach to build theory (Walker & Myrick, 2006). As expressed by Charmaz (2003, p. 251) "The rigor of grounded theory approaches offers qualitative researchers a set of clear guidelines from which to build explanatory frameworks that specify relationships among concepts".

Following from Glaser and Strauss's early work there was increasing interest in an interpretative approach to research which valued participants' own stories and experiences (Benoliel, 1996). This included a consideration of the social and interpersonal context; emphasis on intention and conscious construction of meaning; emphasis on experience and basic social processes and the role of reflective intelligence as a conscious choice (Wilson & Hutchinson, 1991). Grounded theory was also clearly directed to the discovery and the generation of theory, while acknowledging that knowledge is never static (Bryant & Charmaz, 2007a). Accepting that people are constantly negotiating their world means that there will be constant change in social theories of explanation (Charmaz, 2006). This negotiation

with the world is also one of the underlying premises that symbolic interactionism seeks to explain (Charon, 1998).

As grounded theory gained a greater following there also emerged a more robust critique of the methodology and a differentiation in approach of the original authors, (Bryant & Charmaz, 2007b). Essentially Glaser took a position which held to a more flexible, less proscriptive and less structured research methodology relying on an inductive approach (Bryant & Charmaz, 2007b). The Strauss approach, later to become the work of Corbin and Strauss (2008) developed a more structured and systematic methodology using both inductive and deductive approaches to data analysis. This was in part a response to the increasingly widespread use of grounded theory without attention to the process and a rise in descriptive studies which lacked the outcome of theory development (Corbin & Strauss, 2008). Walker and Myrick (2006) in discussing this difference in approach clearly see that it is a difference of process and procedure, most obviously seen in their approach to coding, rather than radically different perspectives (Corbin & Strauss, 2008; Walker & Myrick, 2006).

Differences in approach to grounded theory methodology (GTM) emerged and continue to emerge into what Bryant (2007b, p. 11) has called a 'family of methods claiming the GTM mantle'. While there has been much discussion around differences of approach, several authors have drawn attention to the importance of noting the common features that underlie any grounded theory methodology (Bryant & Charmaz, 2007b; McCann & Clark, 2003b). McCann and Clark (2003b) list seven points of commonality that identify and define a grounded theory approach:

1. Theoretical sensitivity: this involves being able as the researcher to pick up on subtleties and cues from the data. The researcher needs to approach the research with a certain amount of insight into the subject and the participants (Corbin & Strauss, 2008).

2. Theoretical sampling: this involves the second stage of sampling when the existing data begins to point to emerging ideas that require further investigation. It results in a return to the field for data collection with an emphasis on exploring these new concepts (McCann & Clark, 2003a).

3. Constant comparative analysis: this involves the simultaneous act of data collection and analysis throughout the research. This underlies the analysis

process and leads firstly to categorisation and then to theory development. It enables similarities and differences from the data and emerging concepts to be considered (Corbin & Strauss, 2008; McCann & Clark, 2003a).

4. Coding and categorising the data: this involves the exploration of the data by looking for similarities and differences within the data and assigning categorisations or coding to these. Coding moves from basic descriptions through to conceptual ordering to the theory building (Patton, 2002).

5. Literature as a source of data: existing literature on the subject of concern has much to add as a data source in directing questions of the data, in providing direction to theoretical sampling, contributing to and checking of theory development and in sensitising the researcher to the subject (McCann & Clark, 2003a).

6. Integration of theory: theory generation is an important outcome of grounded theory however it is not the final step; rather it is integrated to the various stages throughout the analysis; for example, in directing reading of the literature and in theoretical sampling. The theory then emerges from the data (McCann & Clark, 2003a).

7. Theoretical memos and diagrams: this allows another avenue for the researcher to analyse and clarify concepts and their relationships as they emerge from the data. They can be either their own written notes (theoretical memos) or visual (diagrams) (McCann & Clark, 2003b).

These seven points can be seen as the fundamentals of grounded theory. Or as Charmaz (2003, p. 250) states, "essentially, grounded theory methods consist of systematic inductive guidelines for collecting and analysing data to build middle-range theoretical frameworks that explain the collected data".

These fundamentals are illustrated in the approach taken in the current research, which is aligned to the more structured approach of Corbin and Strauss (2008). This provides direction on the use of analytic procedures and techniques to guide the researcher. Their approach still allows for flexibility and intuition of the researcher through the qualitative data analysis process (Corbin & Strauss, 2008). The approach taken also incorporates the work of Charmaz (2003) which has been labelled the constructivist approach, and incorporates an emphasis on the methodological

strategies and the role and context of both the researcher and the research setting. Constructivist grounded theory places primacy on the firsthand knowledge of the empirical world and assumes the relativism of multiple social realities (Charmaz, 2006). Knowledge is created by both the viewer and the viewed and aims towards an interpretative understanding of subjects' meaning from studying people in natural settings (Charmaz, 2003).

Charmaz's (2003) constructivist approach to grounded theory results in a pragmatic research perspective responding to the individual research situation. She advocates the need to gather rich data by using a variety of sources, remembering that interviews, because they rely on recall of our interviewees, provide reconstructed material. Coding begins early to define and categorise data. This early coding is the commencement of theory generation through the building of ideas inductively. Using the constant comparative method means comparisons are occurring at many levels, for example comparing different people, data from the same individual at different points in time, comparing incident with incident, comparing data with category and categories with categories (Corbin & Strauss, 2008). The importance of memo writing is that it helps in theory development providing the chance for the researcher to explore any unstated assumptions from subjects and implicit meanings (Charmaz, 2003). Any gaps in the data are used to direct returns to the field to collect more data; the theoretical sampling stage (Charmaz, 2003).

Theoretical sampling provides the opportunity to explore specific issues that have arisen from previous data collection and to refine ideas (Charmaz, 2006; Corbin & Strauss, 2008). It is not designed to increase the size of the original sample but to assist in the identification of conceptual boundaries and pinpoint the fit and relevance of our categories (Corbin & Strauss, 2008). Theoretical sampling is fundamental to the development of formal theory (Charmaz, 2003). Data collection including theoretical sampling continues until saturation is reached (Corbin & Strauss, 2008). In its broadest sense saturation means when no new concepts or codes are emerging from the data (Charmaz, 2003; Corbin & Strauss, 2008).

Constructivist grounded theory recognises the interactive nature of both data collection and analysis, resolves recent criticisms of the method and reconciles

positivist assumptions and post modernist critiques (Patton, 2002). Charmaz (2003) suggests that there are several strengths of this grounded theory. Firstly, the methodology provides strategies that guide the researcher step by step through an analytic process. Secondly, there is a self-correcting nature of the data collection process. Grounded theory also implicitly provides a foundation to generate theory rather than providing a purely contextual description. Finally grounded theory relies on the use of comparative methods (Charmaz, 2003; Corbin & Strauss, 2008).

The constructivist approach also recognises the interaction inherent within the research process of the data collection and categorisation, with what the researcher brings to the process (Patton, 2002). The research is not an exercise in objectivity which aims to arrive at meaning not at truth (Patton, 2002). This allows for a more intuitive, impressionistic level than an objective approach with the data available for repeated viewing and the posing of new questions (Charmaz, 2003).

4.2.2.   Grounded theory: the appropriate methodological approach

With consideration of the research question and the decision that a qualitative approach was required, grounded theory was chosen as the appropriate methodological approach. Grounded theory as espoused by Strauss and Corbin (1998), incorporating the constructivist approaches of Charmaz (2003), provided the methodological approach for the research. This allowed for the recognition that the researcher plays a dialectic and active role; an integral part of the research process. The researcher comes to the project with existing knowledge and perhaps experience in the area under investigation (Corbin & Strauss, 2008). The use of existing literature is also important to both the early sensitisation to the research question and to the ongoing research as it assists with theoretical sensitivity and then supports emerging theory (Corbin & Strauss, 2008).

Other strengths of this approach include that it allowed for the development of theory of individual or group behaviour across particular behaviour, in this case women who identity as gay/lesbian or same sex attracted and who are current or recently quit smokers (Corbin & Strauss, 2008). It allowed the research question to be framed in terms of seeking to arrive at a theory, in this case 'why do more lesbian/bisexual

women smoke?' An explanatory theory emerged based on both perspectives of respondents through the telling of their personal stories with personal reflection and with reference to the existing literature (Holloway, 2005).

Grounded theory also allows for a range of methods of data collection and especially allows for data investigation to take direction from an ongoing consideration of the data collected (Patton, 2002). In this case semi-structured interviews which allow for the investigation of new concepts as they emerged through previous interviews were the prime data source (Holloway & Todres, 2005).

The data analysis process of grounded theory relies on a constant comparative method to accommodate rich text data into coherent groupings and hierarchies leading to creative theory and model development (Holloway & Todres, 2005). Data collection within grounded theory analysis follows a structured procedural approach and makes use of axial coding to allow the identification of links and relationships between different coded phenomena (Corbin & Strauss, 2008; McCann & Clark, 2003b). Interviewing and coding continued until saturation of data was achieved (Corbin & Strauss, 2008). This means that no new codes emerged.

It also enabled the inclusion of the wider social cultural scene which impacts on the individually socially constructed world of participants (Corbin & Strauss, 2008). The research sought to understand both the macro and the micro world, which manifested in minority sexuality and with smoker status.

An additional strength of this approach is that it facilitated the voices of the participants, lesbian/bisexual women smokers and ex-smokers, to be heard (Bluff, 2005). As the research project was concerned with an area where there has been little qualitative research undertaken, this was an important contribution that grounded theory was able to make.

Grounded theory is also able to accommodate change during the research process in response to the evolving data collection and analysis (Corbin & Strauss, 2008). With a paucity of good descriptive literature in the area under research, flexibility was required to allow for further exploration of emerging themes and to ensure that the

voice of the study participants was both captured and used to tell their story (Patton, 2002). Grounded theory has also been demonstrated to be especially appropriate where there is minimal knowledge of a social phenomenon, as in the case of the question under review in this research (Maijala, Paavilaimen, & Astedt-Kurki, 2003).

Morse (2001) has commented that grounded theory relies on the researcher to be able to approach their area of study with sensitivity and also ensure the inclusion of comment and information on the cultural context under research. Without inclusion of the cultural context, research findings will lack a vital component and one that grounded theory can accommodate but many research projects do not include (Corbin & Strauss, 2008). In view of the changing social acceptability of homosexuality (increasing acceptance) and smoking (decreasing acceptability), grounded theory allowed for the changing cultural context to be captured.

Grounded theory is also able to capture changes that occur over time in terms of the impact of a series of events (Bluff, 2005). Again, this was appropriate to the subject under study as both smoking behaviour and sexuality evolve during a person's life and each usually involves some significant milestones (IOM (Institute of Medicine), 2011; Laurier et al., 2000).

Hence grounded theory, following the approach of Corbin and Strauss (2008) and Charmaz's (2003) interpretation that incorporates the role and context of both the researcher and the research setting, were used in the research.

4.3.   Symbolic Interactionism – A Conceptual Framework

4.3.1   The need for a conceptual framework

The research process according to Crotty (1998), starts with the research question; which for this research was, why do lesbians smoke at higher rates than other women? From my existing knowledge and perceptions of drug use, both the social setting and individual factors need examination to arrive at any explanatory framework. I also believe that the meaning of our social experience and social world

are constructed and hence a constructivist approach and theory that accommodates this point of view was inevitable. I wanted to find a conceptual framework that would assist in maintaining this world view, assist with the organising of large amounts of data and would progress the research to arrive at explanations and theory and not merely description.

While not all grounded theory approaches make use of a conceptual framework, there is support for having a conceptual framework to inform qualitative research (Anfara & Mertz, 2006; Corbin & Strauss, 2008). If a conceptual framework is seen as a foundation that guides the whole research process as presented by such authors as Anfara and Mertz (2006), and Miles and Huberman (1994), it will influence and guide how the researcher approaches their study at all stages. It provides a way of focusing the study and providing a 'lens' for the researcher to assist in refining the research question, the research methodology and the analysis (Anfara & Mertz, 2006). A well chosen conceptual approach also "allows us to see in new and different ways what seems to be ordinary and familiar" (Anfara & Mertz, 2006, p. xxvii). I wanted to go beyond the prevalence data on smoking in lesbians and bisexual women, and hence adopting a conceptual framework that provided new insights was important.

Numerous conceptual perspectives and methodologies exist for a qualitative research project. The current research investigating the use of a legal drug (tobacco), and the role this plays for a particular social group (sexual minority women), with reference to any shared meanings and responses to living in a heterosexist society, led to an exploration of symbolic interactionism as a conceptual framework.

Symbolic interactionism put simply explores the shared meanings that an individual brings to social situations and how these meanings in turn create their reality (Charon, 1998). It aims to understand how people perceive, understand and interpret the world (Reynolds & Herman-Kinney, 2003). Believing that both individual and societal responses and interactions to tobacco smoking and homosexuality are likely to be influencing the use of tobacco amongst lesbian and bisexual women, symbolic interactionism was deemed the appropriate research conceptual framework.

4.3.2. Conceptual basis of symbolic interactionism

The historical antecedents of the theoretical movement that became known as symbolic interactionism, have been linked with various scholars and movements. Charon (1998) puts the work of psychologist and sociologist George Herbert Mead (1863-1931) as the founder. Although the work of John Dewey, Charles Cooley, William James, Charles Peirce, and William Thomas are also listed as contributing to the development of Mead's work (Charon, 1998). Goulding (2002) names Charles Cooley along with Mead as the founding influence. Loconto and Jones-Pruett (2006) document the contribution of Charles Ellwood to early symbolic interactionism.

Mead and his student Hubert Blumer (1900-1987) are most often, if simplistically cited as the founders of symbolic interactionism (Loconto & Jones-Pruett, 2006). Mead's ideas on society, self and mind provide three of the foundations of the theory which eventually developed to became known as the Chicago School and challenged traditional approaches to sociology which had emphasised a quantitative and comparative approach when looking at social facts (Reynolds, 2003).

The Chicago School proposed that it was necessary to understand social life through naturalistic enquiry that saw people as social actors in their environment at a particular time; the philosophy of pragmatism (Dennis & Martin, 2007). Symbolic interactionism provided one perspective within sociology, one way of understanding reality (Charon, 1998). Its basic tenet was that the actor's view of actions, objects and society had to be studied seriously with an emphasis on the origin and development of meaning (Crotty, 1998).

In seeking to understand why lesbians smoke it is essential to see this behaviour as relating to the interaction of this participant group with the wider society and the meanings that both participants and society put on this sexual identity and the behaviour of smoking.

It was Blumer who formalised Mead's theoretical approaches and concepts and coined the term 'symbolic interactionism' in a 1937 publication (Loconto & Jones-Pruett, 2006). Blumer (1969, p. 2) delineated the three premises upon which

symbolic interactionism is based: "The first premise is that human beings act towards things on the basis of the meanings that the things have for them… The second premise is that the meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows. The third premise is that these meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he encounters".

Symbolic interactionism is concerned with explaining social actions in terms of the meanings that individuals give to them (van Krieken et al., 2000). Symbolic interactionism sees human behaviour as largely governed by the internal processes by which people interpret the world around them and give meaning to their own lives (Charon, 1998). There is a belief that individuals possess a self-concept or image of themselves which is reinforced or modified in the process of interaction with other members of society (Charon, 1998). How they are seen by others is also important, for example the labelling of deviancy (van Krieken et al., 2000).

Meaning is established as people interact, and inevitably guides human behaviour (Charon, 1998). As a result, human beings are said to be in a continual state of emergence in which they both influence, and are themselves influenced by the people with whom they interact, and the situation in which they find themselves (Chenitz & Swanson, 1986). Exploring interactional processes gives an opportunity to explore research topics flexibly, offering insight into meanings attached to the everyday world and the circumstances in which people find themselves, as these meanings are formulated (Chenitz & Swanson, 1986).

Building on Blumer's (1969) three early premises Charon (1998) defined five core ideas of symbolic interactionism. The first, symbolic interactionism focuses on the nature of social interaction that is the dynamic social activities taking place among persons. The individual is not a passive player in this process. The second that human action is caused not only by social interaction but also results from interaction within the individual. Importance is given to the role of thinking. Thirdly, that humans do not sense their environment directly but instead define their situation as they go along in their action. Individuals react to a reality that they have defined. Fourthly, that individuals respond to the present situation as defined in the present.

While the past may influence this definition, it does not determine current actions. And finally humans take an active part in the cause of their own actions (Charon, 1998).

While undoubtedly society shapes humans; for example, it gives us our social roles and symbolic objects, a two way process is at play. Society members, through the possessing of mind and self, also shape society with their ideas and actions that in turn influence direction and interaction of others to arrive at cooperative action (Charon, 1998).

In seeking to understand the health compromising behaviour of cigarette smoking, which is undertaken by a minority of Australians, (approximately 20% of the total population) but is undertaken in larger numbers by a minority group (lesbians and bisexual women) within the broader society, there is likely to be an interplay of societal factors that may help explain this. Lesbians belong at different levels of involvement to a range of simultaneous societies, whose influences again may help in unravelling the smoking story. For example, some lesbians are very identified with the gay community that has its own symbols, objects and meanings. Simultaneously lesbians are part of the wider community and participate in its workforce, and as consumers etc. This wider community may have different symbols and meanings. They also have other community membership/s. They also belong to a group known as 'smokers' or 'ex-smokers'.

Identity is another core concept that is explored within this research examining lesbian smoking behaviour. It is also a core concept to understanding symbolic interactionism. Identity is how we call ourselves and present to others in social situations (Charon, 1998). Within symbolic interactionism the social self emerges, resulting in self-identity through testing of our own interpersonal environment in addition to the evaluations reflected from others (Charon, 1998). Identity provides a perceived social location, and forms part of the concept of self (Charon, 1998; Holstein & Gubrium, 2003). With self awareness and development of the 'I' and 'me', further key concepts in symbolic interactionism, comes the basis for being able to operate cooperatively in society. Social expectations and community attitudes are shared and result in working towards cooperative action (Charon, 1998; van Krieken

et al., 2000). Conversely where meaning is not shared, as may be the case around minority sexuality, then symbolic interactionism can help explain societal and individual processing of this (Charon, 1998).

For LGBT individuals, self and group identity formation is important, possibly fluid and may change over a lifetime (Sophie, 1986). Symbolic interactionism can provide a framework to ask questions regarding what realities are like for individuals, what they are composed from and what social factors condition their production (Eliason & Schope, 2007; Holstein & Gubrium, 2003). Seeking to understand identity issues for minority sexuality women potentially provides some explanation around smoking behaviour including why not all lesbians smoke.

4.3.3. Symbolic interactionism: the appropriate conceptual perspective

There are many reasons why symbolic interactionism provided the appropriate conceptual framework for this research. As Crooks (2001) has stated, when discussing the need for qualitative research approaches to women's health, we need to understand women's experiences, their own understanding of health related issues and the social interactions that inform their own meaning. The conceptual framework of symbolic interactionism allows for a research approach that examines how women construct meaning, use symbols and determine their course of action (D. Crooks, 2001). This goes to the core of this research project.

Since Irving Goffman's (1963) work, which applied symbolic interactionism to the analysis of stigma, this topic has remained a special interest to health researchers. According to Goffman (1963), people who do not fit into society at some level may be made to feel ashamed, and experience a disrupted or spoiled social identity. They often adapt to this to 'pass' within society (Goffman, 1963). They may also join a social group of similarly stigmatised individuals and assert their difference as an identified group (Willis et al., 2007). Sexual minority women interact in social environments of varying levels of heteronormativity at both a societal level and at the level of self acceptance (Balsam, 2003). Some lesbian women have had very negative social and personal experiences due to their identified sexuality.

Symbolic interactionism can be used to better understand this situation and has had a history of being used to understand the social experience of minority groups (Hylton, 2006). Smoking has increasingly become a stigmatised social activity. It has moved from a behaviour that was considered acceptable, indeed providing positive social rewards and identity, to a situation in Australia where 50 years later it is generally seen as a marginalised and stigmatised activity (Bayer & Stuber, 2006).

Adopting a symbolic interactionism conceptual framework allows for an explanation of the complexities of human behaviour including that of multiple perspectives. It acknowledges that social meaning is not fixed for the individual in defining self but is subject to development and change (Holstein & Gubrium, 2003). Smoking can be considered from a range of perspectives, for example an understanding of the reasons women start smoking and continue to smoke, often for decades, provide two different perspectives of the smoking experience (Scollo & Winstanley, 2008). Participants presented a range of personal experiences, influenced by changes within themselves and changes at the wider social level in response to both smoking behaviour and to belonging to a minority sexuality group.

Several previous works looking at aspects of minority sexuality have successfully used symbolic interactionism. This includes Suter (2008) whose work on lesbian family roles used Perinbanayagam's (2003) interpretation of symbolic interaction to delineate that communication is viewed as the key means by which identity is negotiated; that identity is a social process where interactions with others shape identity and that simultaneous analysis of both structure and process were critical. The concept of Goffman's (1963) 'role' and stigma is an important consideration (Suter et al., 2008).

The work of Hylton (2006) which looked at stigma management of lesbian and bisexual social work students, also used a symbolic interactionism framework. Hylton (2006) accepts Blumer's view that individuals bring to each social encounter a multitude of meanings that they derived from their histories of interaction within society. She recognised that the process of defining social situations can be highly complex for lesbian and bisexual women because they are constantly interacting in new and changing social settings. Decisions are required and enacted repeatedly in

managing stigma (Hylton, 2006). Stigma is an important dimension in this research on both the level of sexuality and of being a smoker.

The symbolic interactionism of the Chicago School provides the appropriate conceptual framework for this research, which informs the methodology. It also sensitises the researcher to explore material from new perspectives that contributes to uncovering new relationship, explanations and theory. The use of symbolic interactionism as the appropriate conceptual framework was verified through both the literature and discussion with academic supervisors.

4.4.   Reflexivity

As with all qualitative research approaches the researcher needs to acknowledge their personal input and impact on the research process (Patton, 2002). Corbin and Strauss (2008) discusses the importance of this within grounded theory as the concept of reflexivity, although there is little direction on how to achieve this. Reflexivity, as defined by Hall and Callery (2001, p. 258) is the "influence of the investigator-participant interactions on the research process, and relationality, which addresses power and trust relationships between participants and researchers". They urge researchers to address the issue of researcher subjectivity through reflexivity and relationality to increase the rigor of their project. Inclusion and discussion of good reflexive practice also allows others to judge the quality of the data (Hall & Callery, 2001).

Mruck and Mey (2007, p. 521) eloquently discuss that the interaction of the researcher in the research process occurs at all stages of the grounded theory methodology, starting with the decision on the research topic and parameters, to sampling, data collection, coding and presentation of findings. All steps are subject to "complex and unavoidable interactions" (Mruck & Mey, 2007, p. 521).

Similarly documenting relationality between the researcher and participants elucidates the way the relationship operated at a practical level and how this may have worked towards creating common ground with the participants (Hall & Callery,

2001). How I responded to requests for advice on quitting cigarettes, what level of empathy I demonstrated and how the issue of my own self disclosure were managed are all areas in this research project where I bought my own subjectivity to the material and interaction with participants.

Within the research, both reflexivity and relationality were undertaken. An ongoing reflective journal maintained throughout the life of the project, provided a means of capturing my beliefs, attitudes and knowledge that I brought to the research and how these were impacted and changed through the research process. Prior to the data collection phase, I also undertook to write down my own assumptions around the research topic. This allowed for the opportunity to have my own assumptions challenged and to also be very open to new concepts that contributed greatly to my own self development through the research process (Corbin & Strauss, 2008). By honestly and fully documenting assumptions, also allowed for greater authenticity in the framing of the questions to ask participants.

I had previously completed research in the area of lesbian health and have strong community and social connections with the lesbian community in Perth. While I am not a smoker, I had what I would call a brief experimental phase of smoking as an undergraduate student. I see myself as a member of the lesbian community and therefore bring some 'insider' understanding of this community to the research (Platzer & James, 1997). I briefly shared this background with all participants. However I was very aware that being a member of the community does not mean similarity of experience or perspective (Pitman, 2002). It was also important that I did not make assumptions about the community under study or fall into the trap that Silverman (2007, p. 11) outlines of "studying your own society, (when) much of what you see around you seems 'obvious', existing as a mere unnoticed backdrop to your life..." I was constantly alert to having my own perceptions of the lesbian community challenged and being able to present what might be obvious to an 'insider'.

So while there was the advantage of being an 'insider', based on experience of belonging to a minority sexuality identity, there was a recognition that within the gay/lesbian community there are many sub groups, most of which I do not have

experience of or relate to. Hence my experience was also that of an 'outsider' based on smoker identity, race, class, education and sexuality identity labelling (Pitman, 2002). I am known to some members of the community and some subgroups of the community however certainly not to the majority of WA lesbians.

Similarly to Kanuha's (2000) experience of being an 'insider 'researcher, I was affected by the personal stories of many of the participants especially around the difficulties of 'coming out' and the stigma experienced as a lesbian. While this was not every woman's experience, there were some personal stories that I did find difficult to listen to and it was not unnatural for me to reflect on my own experience of being a lesbian, sexual identity issues and issues of stigma related to being a lesbian. There was therefore an impact on me as the researcher in undertaking interviews as discussed in the literature on qualitative research (Patton, 2002).

A research reference group (Appendix C) composed of invited professionals with knowledge and experience in the area of lesbian community, public health, licit and illicit drugs (specifically cigarette smoking), was formed in the early stages of the research. Two members of the lesbian community were included. This group assisted in providing a formal reflective arena during the research project, with regularly convened meetings. I was also fortunate to be able to utilise other colleagues in a debriefing sense that often resulted in further insights and self reflection. This provided a necessary and welcome 'outsider' perspective.

4.5.   Sources of Data

One strength of grounded theory is the possibility of using multiple sources of data (Corbin & Strauss, 2008). This research began by briefly examining the literature to clarify the research question. Current literature was consulted in detail to write the literature review, providing the initial source of data. Literature contributed ideas throughout the research and was a continuing data source throughout the research. Internet based information was used to both gain more understanding of the gay community and to examine responses to the issue of smoking via a lesbian social networking site. In-depth interviews provided the main data source. My own memos

and field notes taken during the interview and analysis process contributed to the data. A description of the data sources follows.

4.5.1. Literature

As suggested by Corbin and Strauss (2008) existing literature has an important part to play within a grounded theory approach. It was reviewed at different stages of the research for different reasons.

There is a growing base of literature on gay health. With the removal of homosexuality from the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders in 1973, followed by the American Psychological Association in 1974 adopting resolutions to normalise homosexuality, gay health literature has become more broad based (Shankle, 2006). The vast majority of health practitioners now see homosexuality not as an illness, but a sexual orientation (R. Crooks & Baur, 2010). With this, gay health literature started to address a wide range of health issues including substance use. While there are still gaps in the literature and limitations to the conduct of research, there has emerged a healthy discipline in the area, particularly in developed countries, notably in the USA. Many developing countries where taboos on same sex relationships exist either in criminal law or socially, there is less literature available (Meyer & Northridge, 2007).

Literature was used to direct the conceptual and methodological approaches of the research and provided an additional source of data to the major source, which was interview data. Reference to the literature occurred throughout the research process. This included particularly at the following points:

- In defining the research question and aims of the study;
- To ascertain that this was an under-researched area of gay health study;
- In the preparation of my PhD candidacy;
- In deciding on the conceptual framework and methodological approaches;
- In assisting with early analysis and coding of the data;
- In the preparation of a comprehensive literature review (see chapter 2);

- In the analysis and interpretation of the collected data; and
- In the formulation of a theory of why lesbians smoke.

Early on in the conceptualising of the research project a preliminary literature review was undertaken to assist with the defining the research area. This illustrated that a gap existed in the existing literature (Sandelowski & Barroso, 2003). The literature was consistent in demonstrating higher smoking rates in lesbians but with inadequate explanation as to why, confirming the researcher's view that this was a worthwhile research area. As the analysis of literature proceeded, a more in-depth literature review commenced. This was used to help direct the initial thoughts on appropriate question areas to include in early interviews, and assisted in early interrogation of the data. Later the literature was useful in considering the appropriateness of emerging conceptual approaches. The investigation of the literature also enhanced sensitivity of the researcher to the topic area. The inclusion of relevant literature as a valid data source follows the grounded theory approach outlined by Corbin and Strauss (2008).

The extensive literature review of both peer reviewed and 'grey' literature informed both the literature review in Chapter 2 and the discussion in Chapter 6. This was constantly being added to and updated as new literature emerged through tracking of various databases and personal attention to key publications.

4.5.2. Internet based data source

The text content of the Australian lesbian specific Internet site, the Pink Sofa was also used to provide another rich source of data (The Pink Sofa, n.d.). Contact was made with the Customer Service Director of the Pink Sofa prior to the research to advise of the study and to request that the Pink Sofa run a notice advertising the survey. Both of these requests were agreed to.

The Pink Sofa provides a forum area for members to contribute on-line to a variety of topics (The Pink Sofa, n.d.). Active forums include such areas as careers, parenting, travel, current affairs, 'coming out' and wellbeing. Under the latter are several forums where various aspects of smoking are discussed.

The use of Internet based information for qualitative research purposes and particularly ethnographic data collection is a growing area (Markham & Baym, 2009). The Internet provides various contexts for data collection including texts such as on-line posting and textual elements such as threads or links. Researchers have also examined how the Internet is used as a means of communication within social lives (Orgad, 2009).

Information on Pink Sofa forums is in the public domain and therefore I was able to read these contributions but in no way entered into correspondence with any of the authors. I searched the Pink Sofa forum areas for any entries that related to smoking.

These were located under the following two forum topics:
1. Wellbeing
    a. Sub forum - women's health; and
2. Have your say.

These were downloaded and converted to one single Word document with a notation on the date of the entry and the posting member's on-line nickname. Some entries were threads in that they were a conversation between several Pink Sofa members. Others were single entries wanting to tell a story about smoking or quitting or seeking information. All this information is freely available in the public domain. This exercise generated approximately 10,000 words of text, which was then analysed. This represents a total of 84 individual postings. The text rich data from the Pink Sofa site was de-identified and then incorporated into the data analysis and coding process using the qualitative software package NVivo.

4.5.3. Interviews

In-depth interviews with lesbians who currently lived in WA and were either smokers or ex-smokers provided the primary data source for this research. Semi-structured interviews were conducted to allow participants a clear voice in telling their stories on tobacco smoking and the lesbian experience and provided rich data (Corbin & Strauss, 2008). Further details on the recruitment process and analysis are outlined in this chapter.

4.5.4. Other sources

Corbin and Strauss (2008) state that other data collection methods can be used to ensure that the research process results in rich data and captures the researcher's own experience. Memos and field notes provided additional data collection and contributed to the final analysis (Bluff, 2005; Corbin & Strauss, 2008).

4.6. Data Collection Methods

Having provided an overview of the methodological approach, conceptual framework and sources of data the following section outlines how the practical aspects of data collection were undertaken.

4.6.1. Sampling

Sampling of LGB populations presents some unique challenges starting from imprecision about the population under investigation (IOM (Institute of Medicine), 2011). LGB research has progressed from utilising convenience samples often obtained in a purely clinical setting, to community based surveys and some probability sampling. The cost of the later in dealing with a numerically small minority population is often however prohibitively expensive (Meyer & Wilson, 2009). Meyer and Wilson (2009) go on to outline three challenges in sampling an LGB population: not all LGB people identify as such; the basis of identity (sexual identity, sexual behaviour or sexual attraction) is inconsistently used and; members belong to a highly stigmatised minority. The appropriate sampling is however ultimately dictated by the research question.

As the current research is concerned with generating theory around the topic of smoking by lesbian/bisexual women, and not to estimate the prevalence of smoking in this group, qualitative research methodology has been employed using non-probability sampling.

There are several major types of non-probability sampling. Convenience sampling refers to sampling that is undertaken at an identifiable location to achieve maximum recruitment of the study population (Liamputtong, 2010). Within LGB research, this has usually resulted in recruitment of study participants at such venues as gay bars or through community group memberships. Although this may be easier for a researcher to find participants, there is a risk of bias because of self selection within limited environments (Bowen, Bradford, & Powers, 2006).

Quota sampling uses existing knowledge about the population of interest to build some representativeness into the sample (Beanland, Schneider, LoBiondo-Wood, & Haber, 1999). For example, parameters that are likely to affect the research findings such as age and level of education, are proportionally represented within the sample. Purposive sampling on the other hand, relies on the researcher's knowledge of the population and its elements to arrive at a recruitment strategy to target participants of interest (Beanland et al., 1999; Liamputtong, 2010).

Non-probability purposive sampling was used in this qualitative study and later followed by theoretical sampling, adhering to grounded theory methodology (Beanland et al., 1999). The sample was a purposive sample as recruitment relied primarily on connections with the gay community with follow-up snowballing techniques. In order to answer the research question it was important that unlike much earlier work in LGBT health, the sampling was taken out of a clinical setting which allowed for recruitment from the general social setting of the gay community.

Any participant who came forward and met the eligibility criteria was included in the sample. Table 7outlines the parameters for eligibility and exclusion.

Table 7

Participant Eligibility and Exclusion

Eligibility criteria
• Be 18 years of age or older – this was not independently verified but was a statement contained in the signed consent form.
• Identified as lesbian, gay, queer, bisexual or same sex attracted. Such definition was by self definition and/or labelling.
• Using the AIHW (2011) definition, participants must have been a smoker or an ex-smoker. A smoker is defined as a person who reported currently smoking daily, weekly or less often than weekly. An ex-smoker is defined as a person who has smoked at least 100 cigarettes or equivalent tobacco in their lifetime, but does not smoke at all now.
• Be resident in Western Australia. This was verified through checking of residential address as supplied on the consent form. Length of residence in Western Australia was not considered.
• Be fluent English speakers. This was ascertained during the process of arranging the interview time.
• Be willing to participate in a one on one interview for approximately one and half hours.
• Be able to confirm a mutually agreed time and mode for the interview to be conducted. All interviews, with the exception of one participant who lived in a regional centre in the State and was interviewed by phone, were conducted in a face to face situation.
Exclusion criteria
• Those defined as a 'never' smoker. This is a person who does not smoke now and has smoked fewer than 100 cigarettes or the equivalent tobacco in their lifetime (Australian Institute of Health and Welfare, 2011).
• Individuals who identified as transgendered. Transgendered is used as an umbrella term relating to individuals who do not fit neatly into the male/female dichotomy and intentionally reject the gender they were born into (Shankle, 2006). It is acknowledged that as a group transgendered women face unique challenges and although it is probable that smoking rates are also higher in this group than the wider community, it was beyond the scope of this research to examine these issues (Greenwood & Gruskin, 2007; R. Kaufman, 2008).
• Those who were close friends or colleagues of mine. I felt that interviewing close friends would compromise the integrity of the data collected.

Snowball sampling as described by Patton (2002), where participants were asked at the conclusion of the interview to nominate other women who may be able to inform the research, were followed up by the researcher. Snowballing can provide a good method of recruitment especially when researching hidden groups such as lesbians. However often times samples generated through snowballing may not reflect racial or ethnic diversity (Swann & Anastas, 2003).

Snowballing was found to result in fewer contacts than anticipated. I surmised that in part this was due to the fact that smoking was seen as a stigmatised activity and perhaps participants thought that it would appear that the research was about encouraging quitting smoking rather than exploring why women smoke. Also there

was a reluctance to provide phone numbers of friends and in the end I had to rely on asking participants to pass on flyers to other potential participants. Five women were recruited through this method.

Subsequent theoretical sampling to verify data, explore directions and gaps as indicated from the concurrent data collection and analysis was used to enhance theory development (Corbin & Strauss, 2008). This involved both theoretical sampling of new women and repeat interviews with earlier participants, with a view to exploring areas that had subsequently emerged from the data.

Data collection continued until data saturation, as described by Corbin and Strauss (2008) was attained. Although the methodology precludes the predetermination of sample size, it was anticipated that the completion of 30 in-depth interviews would provide sufficient data for saturation (Strauss & Corbin, 1998). Saturation was reached with twenty seven in-depth interviews, and a total of twenty eight interviews were completed and analysed.

Although data saturation is often imprecisely defined it generally refers to the stage when no new data is emerging (Corbin & Strauss, 2008). It does not refer to any predetermined notion of the number of interviews to achieve this and Corbin and Strauss (2008) propose that theoretical sampling provides a way of achieving this through using new emerging data to guide future questioning to explore new ideas. The use of a semi-structured interviews allowed for some consistent questions to be explored while theoretical sampling was also used to assist in data exploration and saturation in the research (Corbin & Strauss, 2008).

Guest et al. (2006, p. 65) define data saturation more precisely as "the point in data collection and analysis when new information produces little or no change to the codebook". They demonstrated that data saturation may be achieved with a small number of interviews. In their case interviewing West African female sex workers saturation occurred after 12 of the 60 completed interviews (Guest et al., 2006). They emphasise that the number of interviews to achieve data saturation will be influenced by such things as cultural competence of the respondents, homogeneity, interviewer sensitivity, quality of the interview and the goal of the research (Guest et al., 2006).

In the current research, participants had a high level of cultural competency in the two areas of interest (minority sexuality and smoking), and there was a level of homogeneity amongst participants due to recruitment criteria. As outlined, I have high levels of sensitivity to the subject areas and considerable interview experience. These factors contributed to achieving data saturation after 28 in-depth interviews. As coding progressed with each new interview, fewer new categories were being generated and the last two interviews coded to existing named codes indicating saturation had been reached. The on-line data from the Pink Sofa forums that were coded after the interview process was complete also coded to existing categories.

4.6.2. Interviewee recruitment strategy

Recruitment of the purposive sample was drawn from the population of resident Western Australian women who self identified as lesbian/bisexual or same sex attracted women who were either current smokers or recent ex-smokers and who were over 18 years of age. Community recruitment was broad based to maximise the participation of women from a diversity of ages, and economic, education and employment backgrounds. The recruitment strategy as outlined in Table 8 was used to obtain the sample participants.

Table 8

Recruitment Strategy

Strategy	Description
Gay print and electronic media	Advertisements were run in the only gay monthly newspaper in WA, Out in Perth and also placed on the two main general gay websites Gay in WA and Out in Perth.
Existing lesbian social and community groups	Emails were sent to any identified gay community group in WA with a request to send to their members or place on their website. This included two regional lesbian networks.
General media	Curtin University issued a general media release which was picked up by one local radio station (6NR) and the Community group of newspapers where they ran a story.
Electronic media	Apart from websites mentioned above electronic media included being listed on the Pink Sofa website, through some social networking based listings such as Women on Women and some individual Facebook pages.
Commercial venues	On several occasions I attended the Court Hotel (the primary recognised gay hotel in Perth) to undertake direct recruiting and hand out flyers/cards and also at Grapeskin a monthly gay women's only session at a licensed venue.
Community events	Flyers/cards were made available at several community events.

All recruitment material carried a short description of the project, a mobile phone number and an email address. A sample flyer and card are found in Appendix D.

I have good connections with the community of interest and hence felt confident of being able to access this community and recruit sufficient participants for the integrity of the research in a timely manner. In the end recruitment was more difficult than initially assumed.

This required that the recruitment strategy was revisited and additional attempts were made to interest women, particularly using electronic media and using women who had already been interviewed to assist with sending out information on the research to their own networks.

It was impossible to know how many women saw the notices calling for participants to be interviewed and it was also difficult to know why some women may have ignored or actively decided against being interviewed. One evening spent talking to smokers at a women-only monthly event at a licensed venue, was instructive in understanding some of the barriers to participation. Three themes emerged from women who declined a request for an interview. These were:

1. **Smoking is not a community problem**. Some women responded that they did not see smoking in the lesbian community as being a problem and therefore not something worthy of research. Most of these women were surprised/unconvinced that lesbians as a group smoked at higher levels than the wider women's community; "Do we smoke at higher rates? I don't see that." Sometimes this was followed-up with a listing of what they thought I should be studying as being of greater importance as a lesbian/bisexual health issue. This included illicit drugs, mental health and obesity.

2. **Time constraints**. Several women said they did not have the time especially when told an interview time would be arranged for a later time and that it would involve a one on one interview of at least an hour; "What an hour? I am way too busy," was a typical response where time constraints were given as the reason for being unable to participate.

3. **Did not identify as a smoker**. Some women when approached declared they were not really a smoker despite usually having a cigarette in their hand; "I

am giving up"; "I only just started again but I am not really a smoker"; "I quit for years", "I will only have one cigarette tonight so I am not really a smoker" are some of the responses that illustrate this point.

Although these could be seen as excuses by current smokers, the net result was that they were not interested in being interviewed.

Recruitment was concentrated in the Perth area as this is where the greatest number of lesbians/bisexual women are located. I also made one interviewing trip to a regional centre to interview 4 women.

4.6.3. Interviewing

Twenty seven face to face interviews and one phone interview with a participant who resided in regional WA, were conducted. All interviews were conducted by myself, which also resulted in my complete immersion in the data (Hylton, 2006). It also meant there was a consistency of approach and as appropriate to grounded theory, a linear development of the semi-structured interview outline that went through approximately seven iterations during the course of the interviews (Patton, 2002). This also reduced interviewer bias from interviewer variability (Patton, 2002). Appendix E contains a copy of the final interview guide used. This represents the starting point for the interview as I was also led by the direction taken by participants.

The use of a semi-structured interview resulted in a systematic and comprehensive approach to data collection but still allowed for exploration and probing of topics as appropriate and as the analysis proceeded (Patton, 2002). The interview guide provided the flexibility to explore and probe and to build a conversation within the research topic. This systematic approach also ensured the best use of the interview time (Patton, 2002). To ensure responsiveness to the data being collected, as the study progressed and concepts began to emerge, modification to the interview guide was required, which allowed exploration of emerging areas (Corbin & Strauss, 2008). Every effort was made to ensure the questions were open ended to allow

participants to tell their own story in relation to their smoking beliefs and behaviours (Corbin & Strauss, 2008).

The semi-structured interview guide covered the following major areas: smoking initiation, current smoking patterns, reasons for smoking, positives and negatives of smoking, 'coming out' and identity issues, relationship of smoking to sexuality, quitting and response to anti-smoking campaigns. Taking a symbolic interactionist framework, areas of questioning sought to unpack individual understanding and self reflection on the two major areas of being a lesbian/bisexual women and being a smoker/ex-smoker within both the lesbian community and the broader community. The variety of individual stories meant that using symbolic interactionism allowed for a deep exploration of issues, self understanding and reflective process; the 'I' and 'me' within 'society' (Blumer, 1969). The interview concluded with a one page demographic survey that collected information on such things as age, smoker identity, cigarette consumption, and occupation. See Appendix F for details.

Interviews took place in a safe and mutually agreed upon private venue. Most often this was in a convenient cafe. Some interviews were also conducted in participants' homes or work places.

All participants were provided with an information sheet which provided a simple explanation of the background and aims of the research (see Appendix G). A further sheet containing information on support agencies that could be contacted if participants felt the need to discuss any issues that arose from the interview was also provided (see Appendix H).

A written consent form was obtained for all interviews prior to the conduct of the interview. This included a statement describing the participation being requested and seeking permission to digitally record the interview. This was given in all cases. Interviews were conducted during the period February 2009 to January 2010.

Two pilot interviews were conducted with two aims. One was to test the interview questions and proposed structure of the interview, which also provided an opportunity to test initial ideas in the subject area. Secondly, the pilot interviews

provided valuable feedback to me on my personal interviewing style. As I would be conducting all interviews it was imperative that my interviewing style would result in quality data generation and a comfortable interview. Two acquaintances of mine were used for these interviews; one of whom was a current smoker and one whom was an ex-smoker who quit three years ago. Each provided valuable verbal feedback to the researcher on these two areas and where appropriate, amendments were incorporated into the subsequent interview process. The use of pilot interviews is a step recommended by several authors in the field (Duffy, Ferguson, & Watson, 2004; Fassinger, 2005).

Prior to the interview taking place, there was usually a period of negotiation to arrive at the location and time of the interview. This was conducted primarily through emails and phone calls. This informal negotiation also allowed participants to ask questions about the research more generally and about my own credentials in both an academic sense and in being a member of the lesbian community. This contributed to an initial gaining of trust and establishing rapport with participants. This was further enhanced by the fact that interviews took place in an environment usually of the participant's choosing. Before an interview commenced I took the time to explain the background of the interview, why I was interested in this subject and a little about myself. This informal, unrecorded greeting phase allowed further rapport building, and demonstrated my "ability to convey empathy and understanding without judgement" with participants (Patton, 2002, p. 366). At all times I endeavoured to maintain a neutral, non judgemental stance so as to foster an environment where participants felt at ease in discussing issues raised in the interview. Several participants verbalised that they wanted to give me "what I wanted in the interview" or give the "right answer". All such comments were met with assurances that all their stories were valid and there was 'no right answer'.

At the conclusion of the interview when the recorder was turned off, there was usually a period of further casual chat where I was able to answer participant questions and to share some more of my own situation. I felt this was an important phase of the interview and allowed participants to give any concluding comments in an unhurried way.

In this informal closing section of the interview, participants sometimes did divulge important information that I considered was valuable to record. This was usually done with hand written notes taken once the participant left. This note taking also allowed me to capture initial impressions and self reflection of the interview process, and was used where appropriate, to inform subsequent interviews. Such field notes also contribute to the audit trail of the interview process (Corbin & Strauss, 2008).

Interviewees were not compensated financially or otherwise for their time or participation and this was clearly stated in the consent form. It was hoped that interviewees saw this as contributing to community, filling a research gap and an interesting topic to explore themselves.

The issue of being an 'insider' in this research project also contributed to the interview style. Being an 'insider; though does have both positive and negative aspects. 'Insider' status can assist when researching especially sensitive issues or sensitive sub populations especially in terms of increased access and rapport with participants (Patton, 2002; Pitman, 2002). However there is also the issue of researcher bias (Platzer & James, 1997). This sometimes required a balancing act during the interview process, which was captured in the reflective journal and debriefed as required. Many participants often prefaced a remark with 'you know what I mean'. I was careful to check such information in order to ensure accurate understanding of information presented and not presume an understanding.

4.6.4. Interview follow-up

Several authors have discussed the potential impact of interviews on the participants (Corbin & Strauss, 2008; Patton, 2002). As Patton states (2002, p. 405) "Interviews are interventions. They affect people. A good interview lays open thoughts, feelings, knowledge, and experience, not only to the interviewer but also to the interviewee". Acknowledging the fact that research interviews impact on those being interviewed, I undertook interview follow-ups. Approximately three weeks post interview I sent out a short email with three questions, as I was curious to understand how participants felt about the interview process and whether the reflective opportunity of the interview had affected how they felt about their own smoking. This follow-up also

provided me as the researcher with valuable feedback on my interview style and indicators as to if participants felt constrained in any way in the interview environment.

The following questions were asked:

1. Did the interview change your views or understanding of your own smoking or smoking in general? How?
2. What were the positive elements of the interview experience for you?
3. What were the negative elements of the interview?

As I did not want to appear to be pressuring participants for feedback, only one email was sent and no follow-up reminders were sent. One participant did not have email and was not contacted. Of the total of 28 interviews conducted 27 follow-up emails were sent (Appendix I). Responses were received from nine participants and are discussed in Appendix J.

4.7. Data Analysis

A brief discussion of the data analysis process undertaken to arrive at the results is presented here. More detail, especially coding steps is contained in the results chapter. The constant comparative method of grounded theory underpinned data analysis, allowing for an inductive approach to theory generation. This resulted in concurrent data collection and analysis. The analysis followed four broad phases as outlined by Miles and Huberman (1994):

- Data collection: interviews, field notes, other data sources including current relevant literature, The Pink Sofa data (The Pink Sofa, n.d.) and memos.
- Reduction: open coding.
- Data display: conditional matrixes, memos and diagrams.
- Conclusions: drawing together, verifying and theory development.

These four phases were however non-linear in that with constant comparison, interview collection and analysis took place simultaneously as interviews were completed (Corbin & Strauss, 2008). With each interview, new open codes were developed and further grouped using axial coding. Matrixes were then used to look at

relationships within the data. My own memos provided ongoing commentary on the data. Diagrammatic representation of emerging relationships was also mapped to provide early figurative ideas for theory development. At the conclusion phase theory development was further refined.

4.7.1. Interviewing

In-depth interviewing, a cornerstone of grounded theory, provided the primary data for analysis. Such an approach relies on extensive interaction with participants who are a part of the research process (Corbin & Strauss, 2008). Textual data for analysis came from these interviews, field notes and my own analytic process and reflections through the research (Corbin & Strauss, 2008).

Interviewing in general followed the interview guide (see Appendix E). However as data collection preceded I actively made decisions in the course of each individual interview to further pursue interesting leads as they presented themselves. These leads resulted from my own understanding of the area and intuition that certain areas of further investigation could lead to new or richer data direction. The interview guide was also amended approximately seven times during the course of conducting the interviews as new indicative areas presented themselves.

4.7.2. Transcriptions

All interviews, following consent being obtained, were digitally recorded and then transcribed either by a professional transcriber who was employed for this purpose or by myself. In the end 25% were transcribed by the professional service and the balance were transcribed by me. As the transcribed interviews provided the primary data source, it was imperative that this step was completed competently. The professional transcriber, who was otherwise not involved with the project and who worked within guidelines for transcription with particular attention to strict confidentiality parameters. The majority of interviews were transcribed in full to arrive at a word processed transcript of each interview. Some interview transcriptions that I undertook towards the end of the data collection process were not transcribed

in full as by this stage it was appropriate to transcribe only that information which added to existing data categories (Corbin & Strauss, 2008).

While not all researchers undertake any of their own transcribing, I found undertaking this task was a useful practice on several levels. This meant immersion in the data through having to closely listen to an interview and capturing words on the computer screen, allowed for a constant touchstone with the data area (Corbin & Strauss, 2008). This often initiated early thoughts on coding areas and allowed for reflection on the interview process.

Undertaking my own transcriptions also provided an opportunity for me to interpret some nuances not captured in words alone. Careful listening of interviews enabled me to hear some nuances that I may not have heard in the initial interview. My listening and transcribing process provided me with a good comparison to the transcriptions completed by the professional transcriber and assisted with ensuring a consistent quality of all transcriptions (Patton, 2002).

As theoretical sampling proceeded, I was able to transcribe those sections of an interview that I was particularly seeking to explore. The professional transcriber always transcribed in full as she was not in a position to make such decisions.

When reading the transcript as provided by the professional transcriber for the first time, the interview was also listened to at various places in order to check accuracy of the transcript, clarify any words that the transcriber was unsure of and to further immerse myself in the data to gain familiarity before open coding (Corbin & Strauss, 2008). Some transcription errors were probably unavoidable. Accuracy was maximised by both checking the transcription against the digital recording and the transcriber indicating phrases and words that she was unsure of. As some interviews took place in public places, notably cafes, background noise was a problem in a couple of interviews. There was also the inclusion of colloquial expressions especially around some lesbian community specific language and smoking behaviour. Again, my sensitivity to the topic allowed me to interpret these. Transcriptions were completed usually within a couple of weeks of each interview.

Field notes made following the interview were generally hand written and then transcribed into a word processed document which facilitated later data analysis. Field notes contained additional information provided by participants either preceding or following the audio recording. There was a subjective element in deciding what to capture in writing this material down. I also made notes on any other interview aspect I thought might have a bearing on the analysis; for example non verbal communication.

Some grounded theory methodology suggests that participants should be given the opportunity to review transcripts of their interview for accuracy and as a contribution to triangulation (Patton, 2002). In this research, participants were not given the opportunity to check the transcripts of their own interviews however all were urged to feel free to contact me with any follow-up information or questions they may have had post the interview. Several participants provided email comments post the interview. As outlined above there was also a formal request for feedback on the interview process.

4.7.3. Constant comparison

Constant comparison is one of the dominant features of grounded theory. This can be facilitated by such tools as memos, diagrams and coding (Boeije, 2002). The constant comparative method allows for the process of theory development and also directs and goes hand in hand with theoretical sampling(Corbin & Strauss, 2008). Such a method allows for the variety within and between participants to be examined (Corbin & Strauss, 2008).

Most grounded theory texts provide little precise direction on how to undertake constant comparison. Boeije (2002) describes a five step structured approach to undertaking a constant comparative method, which although useful also indicates that the approach will be dictated in part by the subject and research question.

The first three steps as outlined by Boeije (2002) provide a good starting point for constant comparison. These are:

- Comparison within a single interview.
- Comparison between interviews within the same group.
- Comparison of interviews from different groups.

In the current research, various groups emerged early which formed the basis of some of the group comparisons. This included groupings based on smoker status such as current versus ex-smoker and number of years of being a smoker. Demographic characteristics also provided groupings for further comparisons such as age; whether participants were mothers, how they identified sexually and year they 'came out'. At a conceptual level, other comparisons could be made on such measures as ease of 'coming out', negative experiences of sexual identity, and level of stigma felt as a smoker. More abstract comparisons can be made at what Corbin and Strauss (2008) refer to as theoretical comparisons. This provides a way of moving from descriptive analysis of the data to moving towards more abstract and less obvious comparative ideas.

Conditional matrixes as described by Strauss and Corbin (1998) and developed by others (Corbin & Strauss, 2008; Miles & Huberman, 1994) were used to help organise and display data during the ongoing analysis. Using these techniques, gaps in data collection and new themes were identified and allowed for further collection of data from the field through theoretical sampling as necessary until saturation was reached (Charmaz, 2003).

Memos, central to the grounded theory methodology, provided the interface that allowed the capture of the relationship between the researcher and the data (Corbin & Strauss, 2008). This process occurred from the commencement of the research, and continued throughout the life of the project. Memos provided a valuable data source themselves and the starting point for me to move from participant descriptions and narratives to conceptualising what the data was saying. Memo writing also provided the opportunity to explore my own knowledge of the field and my own personal understandings (Lempert, 2007). 'Memo writing is a private conversation between the researcher and his/her data' (Lempert, 2007, p. 251). The memo tool in NVivo was utilised to record and assist with analysis of memos. Figure 3 illustrates the data collection and analysis process.
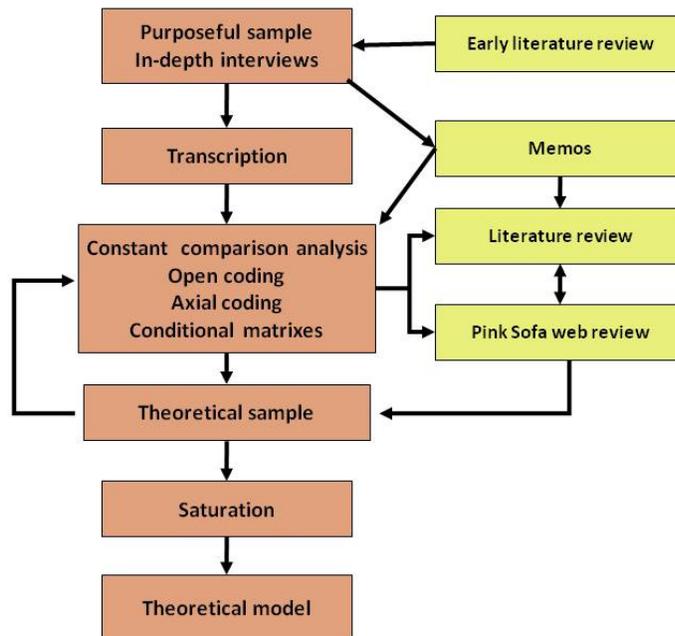
Figure 3. Components of data collection and analysis.

4.7.4. Coding

Open coding

Coding, the act of deriving concepts and categories from the data, commenced early in the data analysis process (Corbin & Strauss, 2008). As interviewing and analysis progressed the coding moved from a dominance of descriptive categories to more conceptual groupings and took into account the growing number of relationships that became apparent (Corbin & Strauss, 2008). Memos were coded, providing a logical area to document early and progressing insights and thoughts on the primary data sources (Corbin & Strauss, 2008). Memos and diagrams contributed greatly to the building of a conceptual framework.

Qualitative computer software, NVivo version 8, was utilised to assist with systematic and ongoing mapping, coding, retrieval and categorisation of data (QSR International, 2008). The NVivo modelling tool allowed for the diagrammatic

representation of coding and relationships and providing a visual shorthand to assist in the ongoing data analysis (Corbin & Strauss, 2008).

Coding was undertaken solely by myself. Although some authors discuss the advisability of multiple raters for data coding and analysis in grounded theory (Patton, 2002), other options exist for contributing to the robustness when only a single rater is used. As new concepts appeared and were coded and deemed worthy of investigation, and were incorporated into subsequent interviews, a feedback and checking mechanism for some initial coding emerged. To assist with consistency of coding a coding description was developed for each code using NVivo (QSR International, 2008). This included where necessary, notes on when to use this code through brief examples and descriptions of any exceptions or directions to more appropriate but related codes. Coding categories and models were also presented to the reference group and supervisor to gain additional feedback and checking on coding decisions and concept development.

Coding followed the Corbin and Strauss (2008) framework of open coding, axial coding and conditional matrixes. Although these sometimes occurred as steps, more often they occurred in a somewhat concurrent manner as described by Corbin and Strauss (2008).

Open coding commenced as soon after transcription of the first interviews as was possible. This was important as it allowed for reflection on both the content and style of interview and meant that I was able to recall the interview setting and reflect and record non spoken cues as well. It also provided quick feedback on interview technique and emerging areas that would benefit from more probing in subsequent interviews. Open coding commenced by reading a transcript quickly in its entirety with reference to the digital audio copy to check for accuracy where appropriate. The transcript was then exported to NVivo, where it was reread along with any associated field notes and then assigned new or existing open codes (termed free nodes in NVivo) as appropriate. Each free node was named descriptively and a working definition provided to maximise consistency in the use of the node and minimise confusion in later coding.

In reading and coding the transcripts, written memos were also generated if the text initiated further thoughts, questions or ideas. NVivo software allows for these to be easily generated and systematically coded and stored for analysis and elaboration. These were dated and coded as open codes. Approximately the first six interviews were handled in this manner and the open coding that emerged is presented in the results chapter.

Axial coding

Axial coding became the next stage where concepts were related to each other (Corbin & Strauss, 2008). Coding moved to being more complex as dimensions and relationships were captured. In NVivo the free nodes were revisited to see if they were related and would better fit into some relational and hierarchical contexts, and where appropriate tree nodes were created. These tree nodes formed the basis of the coding for the remainder of the interviews. Free nodes were still being defined but increasingly these were seen to sit within emerging categories and themes termed tree codes in NVivo. The original list was greatly expanded as sensitivity to the data increased, and interview questions were used to explore areas where I felt that further elaboration and exploration would add to the final analysis. During this process, memoing continued and became an important source of data in itself and also documented my own developing ideas within the conceptual framework about the subject and the research question.

This coding stage required looking for similarities and differences across cases and relationships across concepts (Corbin & Strauss, 2008). This also resulted in questions and ideas that helped direct the stage of theoretical sampling described elsewhere. In other words, the data coding also helped in identifying where gaps in the data existed that needed follow-up. Again, memoing was invaluable at this stage in capturing my own process and thoughts. The results chapter lists the main codes that emerged at this stage, and illustrate a definite move to a more abstract conceptual level.

Matrix building

Conditional/consequential matrixes provide a tool to examine a range of potential conditions and consequences that may affect the interpretation of the data (Corbin &

Strauss, 2008). This often relates to the broader social/political/historical context which helps to answer 'why' questions from the data (Patton, 2002). The current research reflects the personal and social conditions experienced by participants and the effect that had on their behaviour on two important social dimensions; namely smoking and on belonging to a minority sexuality; and what the interplay may be between these. For both of these social phenomena different experiences were also moderated by characteristics of the sample such as the type of smoker they were, their age, and how comfortable they were with their sexual orientation. This led to the bringing together of all data sources, and my own insight and sensitivity of the context to make these connections as provided by the matrix tool.

4.8. Quality Criteria

While there may not be agreement on how to assess the quality of qualitative research, there is little disagreement that it needs consideration (Corbin & Strauss, 2008; Morse, Barrett, Mayan, Olson, & Spiers, 2002; Sparkes, 2001; Whittemore, Chase, & Mandle, 2001). Patton (2002) reminds us that the criteria for judging the quality of any piece of qualitative research must reflect the audience and the intended purpose of the research, however there is no one evaluative tool that can be applied.

A variety of terms and concepts have been proposed to cover this issue. Patton (2002) and others (Corbin & Strauss, 2008) state the importance of achieving reliability in qualitative research. Lincoln and Guba (1985) use the terms 'trustworthiness' and 'credibility'. Trustworthiness of qualitative research is important to demonstrate credibility, dependability and transferability of research findings (Patton, 2002). Credibility is the confidence in how well the data and analysis address the research objectives (Patton, 2002). Dependability refers to the degree to which data changes over the period of research and any alterations to the researcher's analysis decision making (Patton, 2002). Through providing clarity on the distinct cultural context and participant base, issues of transferability can be answered (Graneheim & Lundman, 2004).

Corbin and Strauss (2008) provide a good summary of the different approaches that have been undertaken to achieve quality criteria in qualitative research. However they feel definitions such as the one above from Lincoln and Guba (2004) is too restrictive especially when applied to grounded theory methodology. Hence their discussion on quality, which is defined as "research that resonates with readers" and participants' life experiences, contains a listing of criteria to consider (Corbin & Strauss, 2008, p. 302). Further they emphasise that it is research that offers something that is logical, clear and creative and leads to further discussion and research in the area which is quality research. The approach by Corbin and Strauss (2008) puts the researcher, their skill and approach very much at the centre of these criteria. Hence Corbin and Strauss (2008) outline their criteria as:

1. Methodological consistency (following the conventions that define a methodological approach).
2. The researcher has clarity of purpose (is clear about whether they are working towards a descriptive study or a theory building study).
3. The researcher has self-awareness (understanding they come to the research with their own biases and assumptions that can affect the outcome).
4. The researcher should be trained in qualitative research (qualitative research requires good training and should not rely on the 'anyone can do it' approach).
5. The researcher has feeling and sensitivity for the topic and participants of the research (this involves being able to 'step into the shoes' of the participants).
6. The researcher must be willing to work hard (there are no shortcuts and research is likely to be a long task).
7. There is a willingness to relax and get in touch with the creative self (being able to brainstorm, think outside the box and be open to new ideas).
8. Methodological awareness (aware of the implications of decisions taken through the research process).
9. Desire to do research for its own sake.

When looking at this list it is obvious that these criteria are very much about how the researcher undertook the project in terms of an individual approach, values and awareness. This is difficult for an 'outsider' to judge and hence as Corbin and Strauss (2008) states the research must ultimately speak for itself.

Morse et al. (2002, p. 17) have discussed this as a process of ongoing verification which in qualitative research, "refers to the mechanisms used during the process of research to incrementally contribute to ensuring reliability and validity and, thus, the rigor of a study".

A range of strategies were included throughout the research to ensure that rigor of the study were assured. From the start a clear methodological approach using grounded theory as presented by Corbin and Strauss (2008) and Charmaz (2006) to arrive at a theory on lesbian smoking was adopted.

Throughout the research, I have been aware of both my own biases and the benefits of being an 'insider' in the community under study. I have completed previous research with this community, which has contributed to my sensitivity in the subject and community under study. Corbin and Strauss (2008) state the importance of reflexivity in qualitative research. My own ongoing reflexivity occurred as a way of clearly stating any relevant personal biases and experiences. A written reflective journal was maintained throughout the research, and regular debriefing with both reference group members and academic supervisors provided the opportunity to process ongoing reflexivity.

I have also undertaken several previous qualitative research projects and read widely on the discipline of this approach. I do not therefore come to the area with a lack of experience. Good academic supervision in the area also contributed to my skill level in undertaking this reassess. This included regular reflection with three academic supervisors and note taking at the conclusion of all such meetings.

The provision of a clear audit trail of the research methodology included information that outlined the data collection and analysis process. This provided sufficient detailed information to allow a subsequent researcher to follow the same research approach (Patton, 2002).

Transcripts of interviews whether undertaken by the professional transcriber or myself were checked and proofread against the original digital recording where necessary to ensure accuracy of interview material.

The reference group provided reflection on the direction of the research including such areas as recruitment and interview approaches, coding considerations and theory formulation especially in the early stage of the project. The reference group also provided new ways of looking at both the research process and the data collection and analysis. As there was a diversity of perspectives represented in the reference group this meant my own assumptions were at times challenged in a fruitful and creative way.

NVivo software was used from an early stage to manage data collection and assist with analysis, and reflects both increasing data collection and increasing conceptual understanding; attention was paid to regularly saving the project in NVivo at various stages. In other words, there are different versions of the NVivo data files that can be revisited to show the coding and analysis process. The final working file is just that; the final analysis. The complexity of the coding process of grounded theory makes it difficult for a completely transparent operation, however having maintained snapshots of the coding as it evolved as described above, contributes to this.

Triangulation, the use of different methods to substantiate and reproduce findings, has been used to gain validity and robustness (Burns, 2000). By relying on different data sources namely interviews, field notes, on-line postings, literature, research memos, reflective journal, and the reflection from others, triangulation has been achieved.

The interview follow-up (see Appendix J) also contributed to quality criteria. This provided participants with the opportunity to comment on both positive and negative aspects of the interview process. Feedback generated through this process provided affirmation that the interview process was successful and provided the opportunity to address any criticism of my interview style in subsequent interviews. In all nine respondent's feedback on the interview experience, all stated that the interview experience had been positive. Two common themes that emerged were being able to reflect on their own smoking behaviour and the freedom to discuss a highly stigmatised behaviour. No negatives were reported. That is not to say that there may not have been some negative impact, however if experienced, they were not reported. The quality of the interview process is captured by one respondent who said:

Firstly, I hadn't EVER spoken about my smoking experiences and views in such a focused format previously. This led to considerable ambivalence about continuation of my smoking, which I haven't had for a number of years. Secondly, the interview illuminated the functions of my smoking. Thirdly, I felt able to express my viewpoints without being argued with. P 18

Another participant wrote:

Smoking has become such a shameful and clandestine activity for me that it was kind of liberating to actually be able to discuss it without feeling horrible or degraded...I realise I must quit, but I feel non-judgemental discussion and support will help me get there more than harassment. P 21

In essence, all of the above contribute to a clear audit trail that ensures that as a researcher I have left an open book about how the research progressed both practically and conceptually. This allows for greater evaluation of the research by others and enhances rigour (Bradbury-Jones, 2007; Richards & Morse, 2007). Reflexivity through the use of comprehensive memoing and the maintenance of a reflective journal also contributed to the audit trail.

4.9.   Ethical Considerations

Ethics approval was obtained prior to commencement of the research through the ethics process of Curtin University. Chapter 1 contains details of this.
Interview protocol as stipulated in the ethics approval adhered to the following ethical considerations of:

- The right to **withdraw** at any stage from the interview.
- Written **consent** was obtained after an explanation of the research process using the consent form contained in Appendix K.
- **Confidentiality** was maintained at all stages of the research project. Identifying information has been removed from any analysis or final report documentation.
- The conduct of interviews was undertaken being mindful of the principle of **avoidance of harm**.

A good interview lays open thoughts, feelings, knowledge and experience to the extent that the interviewee may leave the interview knowing things about themselves that they did not know or were not fully aware of prior to the interview (Patton, 2002). Previous qualitative research interviewer experience meant I brought experience to the interview process. At all times during the interview process I was conscious that the purpose of all interviews was to collect data. Inevitably however through this process there are consequences for those being interviewed (Patton, 2002). Interviewees on occasions shared particularly personal aspects of their life especially around their sexuality. Some sought advice around quitting or how to connect to the lesbian community, or my opinion on various issues. I set clear ethical boundaries for myself for the interview process. This included being very clear that I was not actively providing a therapeutic intervention or advice and that referral advice would be provided if required. All participants were given the contact details of several services that offer specialist information and support on either issues of sexuality or substance use (see Appendix H). These agencies would be able to on-refer to more specialist assistance if required and had been made aware of the research being undertaken.

The interview follow-up also provided a safety net for participants if they felt they wanted to discuss the effect, either positive or negative, that the interview had on them. These comments provided another check to the ethical considerations listed above especially the principle of avoidance of harm.

The recruitment strategy had the potential of resulting in interest from potential participants who could be well known to me. To avoid compromise, either from an ethical or personal perspective, I had decided that such people would be precluded from being interviewed. This avoided biases from any existing knowledge I had of them or they had of me as the researcher. This also helped ensure the integrity of interviews and the data collected.

Ethical issues of privacy and consent have also been intently discussed in relation to Internet generated data. While informed consent, i.e. that subjects give their knowledgeable consent to being studied, is a guiding principle of ethical research,

the situation is less clear with Internet based work and compounded by the difficulty in obtaining written consent in an on-line environment (Elm, 2009).

The Association of Internet Researchers has produced guidelines for the ethical use of the Internet for research. They agree that collecting research data without informed consent can be acceptable if; a) the environment was public, and b) the material was not sensitive (Elm, 2009). A public environment in the Internet then is one that is open and available to anyone with an Internet connection, and that does not require any form of membership and registration (Elm, 2009). This is distinct from a semi-public environment where some form of registration is required and which is only available to some people and requires membership and registration. Elm (2009) suggests that researchers using on-line environments be reflexive about the object and process of their research when assessing the publicness of the content in a specific study.

I have never subscribed to the Pink Sofa website and hence I have never been an interactive member who can contribute to discussion themes or make individual contact with other members. The information contained in the forum areas is open to anyone with access to the Internet. On this basis, the forum pages of the Pink Sofa were considered to provide a public Internet data source and that analysis of this in the context of the current research, would not result in ethical compromise.

4.10. Chapter Conclusion

Chapter 3 has provided a comprehensive description of the methodology used in this research. The conceptual framework offered by symbolic interactionism provided the overarching direction to all stages of the research project. Grounded theory was presented as the most appropriate methodological approach for this qualitative research.

Data sources, data collection and data analysis methods were presented following the grounded theory approach of Corbin and Strauss (2008). Issues of quality and ethical considerations were also presented.

Within the framework of symbolic interactionism, society is seen as a dynamic ongoing process where humans both respond to and influence it as active players (Blumer, 1969; Charon, 1998). Underlying assumptions of symbolic interactionism were presented along with reasons for the appropriateness and usefulness of this as the conceptual framework for the research. Such an approach assists with understanding the complexity of the participant experience and in addressing the research question.

The following chapter presents the results of the research.

Chapter 5: Results

5.1. Introduction

Chapter 5 presents the findings of the research allowing for the voice of the participants to be clearly reported. This results chapter makes sense of the data through reporting on patterns and themes and presenting the conceptual mapping of the ongoing coding process. Firstly, the sample characteristics are described followed by the process of open coding, axial coding, core categories and theme identification. The results draw on data from the qualitative in-depth interviews, field notes and memos and the Pink Sofa data. The conceptual framework of symbolic interactionism guided the results while the use of grounded theory allowed for flexibility within the research methodology to respond to changing ideas that emerged from the data collection and the analysis process (Avis, 2005).

While there were a range of responses indicating a diversity of experience of both being a smoker/ex-smoker and a lesbian/bisexual woman, there were also many factors that may be considered as being similar influences on all women who were smokers regardless of sexuality. This illustrates the complexity of unravelling influences that are at play to explain the higher prevalence of smoking of lesbian/bisexual women, which is the underlying research question. Looking at the interplay of three core categories of dissonance, resolution and redefinition that relate to both smoking status and sexual orientation, suggests these are areas of specific influence on smoking within the study population.

As this chapter presents the results of this qualitative research, I have adopted the approach of including some discussion and interpretation when presenting the results. This is not an uncommon convention with qualitative data reporting especially when results are presented thematically (Liamputtong & Shields, 2010). The main discussion however is reserved for Chapter 6 when the categories and themes are brought together for more general interpretation and to address the research aims and objectives.

Throughout the chapter illustrative quotes have been included, and indicated by italics, to allow the participants' voice to be heard, an important advantage of this research methodology (Patton, 2002). Participants have been identified by unique numbering from P 1 to P 28 and comments from Pink Sofa data are identified with PS. Where necessary I have added words to the transcribed text to make the context clear. The choice of representative text extracts to illustrate codes and themes was an active decision, as termed by Braun and Clarke (2006). Data is primarily presented from interviews and the Pink Sofa website (The Pink Sofa, n.d.). Other sources including memos, models and current literature are presented as appropriate.

5.2.   Description of Sample

A one page demographic survey was administered at the conclusion of each interview and provided the sample description data summarised in the tables below. Table 9 provides basic demographic characteristics while Table 10 presents information on smoking-related characteristics as provided by participants. A copy of the demographic data collection tool is located in Appendix F. All information was self reported and no cross checking was undertaken. Although this sample does not seek to be representative some comparative statistics are reported to show that in general a range of demographic types were recruited.

Table 9

Description of sample

Characteristic	Number	%
Number interviewed	28	
Mode of interview		
Telephone	1	
Face to face	27	
Recruitment mode		
Community advert/email	12	42.9
Community venue	7	25.0
Snowball	5	17.8
Referred by friend (often a non-smoker)	4	14.3
Length of interview (minutes)		
Mean	60	
Range	26 to 123	
Residential location		
Inner city Perth	4	14.3
Suburban Perth	20	71.4
Regional WA	4	14.3
Age at interview (years)		
Mean age	37.3	
Range	18-61	
Highest level of education		
Year 11 or less	4	14.8
Year 12	6	22.2
TAFE/trade	3	7.4
University undergraduate qualification	10	37.0
Postgraduate qualification	3	11.1
Current tertiary student	2	7.5
Current employment sector (%)		
Professional	7	25.0
Technician & trades workers	2	7.1
Clerical & administration	2	7.1
Manager	2	7.1
Labourer	2	7.1
Sales worker	2	7.1
Community & personal services workers	5	17.9
Machinery operators & drivers	2	7.1
Not in the workforce	4	14.3
Is a biological mother (%)	9	32.1

As the sample is a purposive one it is not expected to accurately reflect the wider study population. However there are several points that can be noted from the above data. It is primarily a Perth sample with only four interviews (14.3%) with women who live outside of the metropolitan area. The sample of respondents from Perth

came from a variety of suburban locations with three participants coming from the inner city suburban area.

It is primarily an older sample (see Figure 4) with approximately 75% of participants being 31 years of age or older. The oldest woman interviewed was 61. The median age of respondents was 37.3 years old which compares to 37 years for WA women (Australian Bureau of Statistics, 2007b).
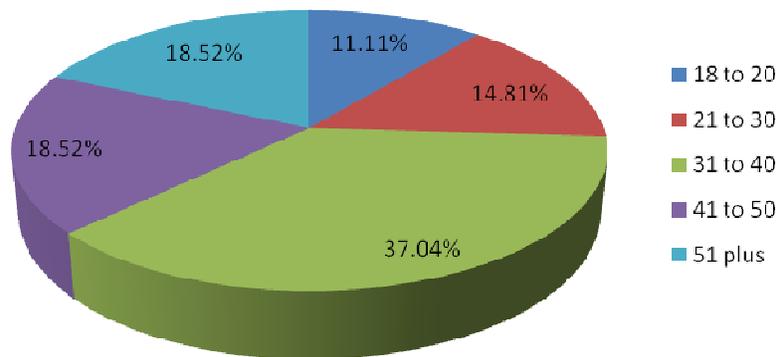
Figure 4. Age at interview (%).

The level of education in this sample is higher than in the broader community with 48.1% of respondents having a university undergraduate or post graduate degree. This compares with approximately 20% of WA women who have a university qualification (Australian Bureau of Statistics, 2007a). This has often been observed in other gay health research. For example in the Private Lives study of over 5,000 respondents, 31.3% had a university degree and 19.4% had a post graduate diploma (Pitts et al., 2006). Research is however inconclusive as to whether there is a higher level of education in this group in general, or research projects are of more interest to those who have higher levels of education. It could also reflect the higher number of non heterosexual people including lesbian/bisexual women who have not had children and therefore may have spent more years studying without the interruption of child rearing (Z. Hyde et al., 2009). This higher level of education is also reflected

in the fact that nearly 25% of the sample were currently employed in professional positions.

Although it was not enumerated, the sample was almost exclusively ethnically of white Anglo European background. This may reflect the added barrier women of colour or minority ethnicity face in being part of the gay community.

Table 10

Smoking-related Characteristics of Sample

Characteristic	Number	%
Smoker status		
Ex-smoker	5	17.9
Current smoker	23	82.1
Daily cigarette consumption smokers		
10 or less	11	47.8
11 to 20	6	26.1
21 to 30	4	17.4
31 plus	2	8.7
Mean age at experimental smoker (years)	13.7	
Mean age became regular smoker (years)	18.0	
Use of other drugs		
Alcohol	20	71.4
Alcohol and marijuana	2	7.1
Alcohol, marijuana and/or party drugs	4	14.3
None	2	7.1

Table 10 indicates smoker status and other drug use. Just over 80% of the sample were current smokers. Mean age of experimental smoking was 13.7 years (15.9 years for women as reported in the National Drug Strategy Household Survey (NDSHS) (Australian Institute of Health and Welfare, 2008a). The age of regular smoking as defined as daily smoking was 18 years (18.1 years for women as reported in the NDSHS (Australian Institute of Health and Welfare, 2008a). Almost half of the sample reported daily cigarette consumption of 10 or less cigarettes or 70 or less cigarettes per week (see Figure 5). The average weekly consumption of cigarettes as reported in the NDSHS is 91 (Australian Institute of Health and Welfare, 2008a). Concurrent drug use was reported by over 90% of the sample with almost three quarters reporting alcohol use. Other drug use was reported less frequently.
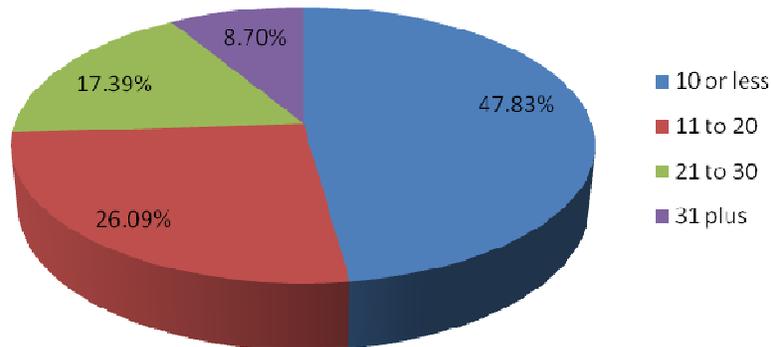
Figure 5. Daily cigarette consumption (smokers only).

Table 11 presents self reported sexuality-related characteristics including sexual identity label use and how comfortable they were with their sexuality.

Table 11

Sexuality-related Sample Characteristics

Characteristic	Number	
Preferred sexual identity (%)		
Lesbian	14	50.0
Gay	8	28.6
Queer	3	10.7
Homosexual	1	3.6
Bisexual	1	3.6
No label	1	3.6
Level of disclosure*		
Mean	9.4	
Range	7-10	
Level of comfort with sexual orientation#		
Mean	9.4	
Range	7-10	
Age 'came out' (years)		
Mean	13.7	
Range	13-52	

* based on a self rated scale of 1 being 'out' only to self to 10 being 'out' to everyone

based on a self rated scale of 1 being very uncomfortable with own sexual orientation to 10 being completely comfortable

Half of the sample identified as lesbian and over a quarter labelled themselves as gay, see Figure 6. Sexual identity. Only one participant identified as bisexual which indicates the potential for bisexual women to be less likely to respond to such a research call. The sample is likely to be drawn primarily from those women who have some connection to the lesbian/gay community as 70% of the sample was recruited through community advertisements and notices or at gay community venues. There was a high level of participants who reported feeling comfortable with their sexuality and how 'out' they felt. A 10 point scale was used to measure both of these indicators. Those women who are less open about their lesbian/bisexual identity or are considered as 'in the closet', are less likely to self identify as a lesbian/bisexual for the purposes of such a study and are unlikely to have responded to a call for participation (IOM (Institute of Medicine), 2011). The use of some electronic recruitment, through the use of email lists, may have assisted in broadening the sample however as with most purposive samples with sexual minority populations, reach was limited.
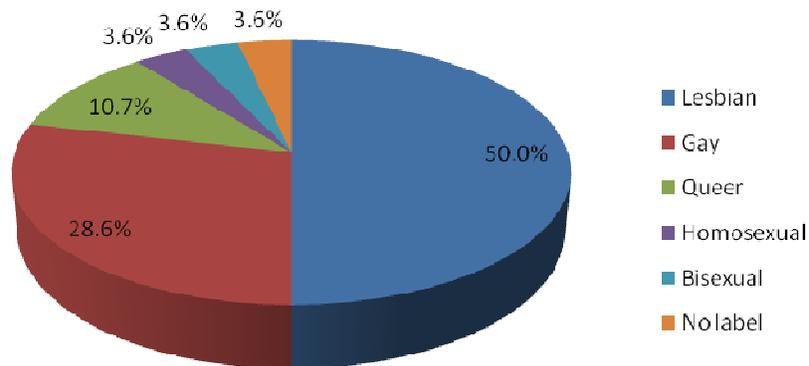
Figure 6. Sexual identity.

There were a number of women who came to their lesbian/bisexual sexuality later in life. This followed a period of heterosexual identity that often resulted in a partnership or marriage, and sometimes children from such a union. These women therefore have had different influences to those women who identified as lesbian/bisexual at a younger age. Approximately one third of participants were biological mothers.

Participants were asked what year they 'came out'. The range was from 1984 to 2008 representing 24 years. This covers a substantial range in terms of the social situation experienced as a newly identifying lesbian/bisexual woman in the early 1980s to the late 2000s.

It was not possible to code demographic data sourced from the Internet Pink Sofa discussion forums as no demographic details are collected from forum participants. While information posted on the Pink Sofa is subject to users upholding a code of ethics[7] and moderation of the site for inappropriate use, information is largely un-moderated. The forum threads that were used for data analysis related to the issue of smoking and appeared to involve either smokers or ex-smokers.

The sample was considered to provide a rich source of lesbian experiences of smoking and a diversity of lesbian lifestyles.

5.3.   Coding

The coding process was outlined in detail in Chapter 4.7. All stages of coding involved active decisions to identify, name and describe codes, patterns and content of interest. A summary of the results of the coding process is presented here. The initial descriptive or open coding stage generated the codes presented in Table 12 below. This provided an initial familiarisation with the data as broad descriptive categories were identified.

---

[7] Full code of ethics is available at http://www.pinksofa.com/ethics.asp and covers issues particularly of Internet safety and etiquette in interactions with other users.

Table 12

Initial Open Coding

Smoking initiation
Experimental smoking
Regular smoking

Coming 'out' process
Age
Year
How easy

Effect of pregnancy/parenting

Current smoking patterns

Social context of smoking
•   Peers
•   Partners
•   Social scene
•   Work environment

Quitting experience
Relapse behaviour
Cues to quit
Cues to relapse

Smoker experience

Lesbian experience

Health issues and smoking

Coding hierarchies and 'tree nodes' or sub-concepts were developed under these open codes utilising NVIVO software. Axial coding, where categories became more conceptually complex was then developed. The axial coding categories are presented in Table 13.

Table 13

Axial Codes

Need for sense of belonging
Societal expectations
Denormalisation of smoking (in both the general community and the lesbian community)
Response to Quit campaigns[8] and quitting
Smoking as addiction
Smoking in relationship to stress
Identity as smoker/ex-smoker
Positives and negatives of smoking
Sexual orientation awareness
Lived experience of being lesbian/bisexual
Stigma and stigma management
Smoker/ex-smoker
Lesbian/bisexual identity
Issues of dissonance
Influences for initiation

This axial coding and further refinement of tree nodes under these became the primary data sorting mechanism from which core categories and themes were developed as reported below.

5.4. Core Categories

The results of this research are presented under three core categories that encompass the broad core theme of self-identity. The core categories encompass concepts that emerged from the axial coding and matrix building (Corbin & Strauss, 2008). Figure 7 presents a summary of the framework of core categories of dissonance, resolution and redefinition factors; and the core theme of self-concept/identity, which guides the reporting of the results. Attached to each core category are a series of

---

[8] Quit campaigns is a general term used to cover social marketing campaigns run by health authorities urging smokers to become ex-smokers. Sometimes participants also saw structural measures as part of this such as tax increases on cigarettes and increasing bans on smoking in public places.

concepts that emerged from the data. A common theme woven through these categories is the tension between how participants view themselves and the how they think others perceive them. This constant negotiation in symbolic interactionism terms is labelled self indication which interplays with ascribed social meaning and personal meaning to arrive at self-identity (Blumer, 1969; Pascale, 2011).
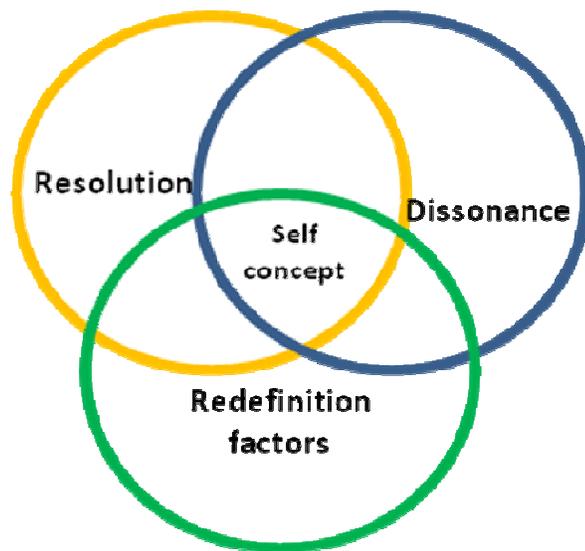
Figure 7. Summary core category and theme development.

These categories, concepts and core theme interact with and influence each other; although the degree of interaction and influence differed for individual participants. These influences are not necessarily unique to lesbian/bisexual women however it is the interplay as represented in the results that begins to offer some explanation for smoking behaviour. In presenting the voice of participants it is also clear that there is a constant interplay of how participants see themselves and the meaning they give things, with how they perceive others see them and socially ascribed meaning. Others can be either people who are very close to participants or how more broadly they think society sees them. This supports the notion of a socially constructed reality arrived at through a constant sorting and interpreting of messages to and about self (Charon, 1998).

5.4.1. Core category – dissonance

An important core category is that of dissonance. I use this to describe a personal conflict or discordance between external evidence/experience and perceptions of how others see personal behaviour and a person's own explanation or storytelling, meaning and/or experience. This emerged as a theme affecting smoker behaviour and identity, sexual identity and sense of self. This was multifaceted and encompassed a number of discrete but interrelated concepts that are presented here under the category of dissonance. This included dissonance related to knowledge, expectations, stigma, loss and sense of fitting in.

Knowledge

Knowledge dissonance emerged as a strong theme in several key areas. For most participants this took the form of incongruence between "I know this however I still choose to do this". Most notably this was demonstrated around knowledge of smoking harms and current behaviour. It was also expressed around minority sexual identity.

Participants discussed their knowledge of the negative health consequences of smoking and their current smoking behaviour and were able to clearly point out the dissonance of this. Most, while seeing this incongruity had also arrived at some resolution, at times uncomfortably, of accepting that they were smokers and this is explored under the category of resolution. This included discussing concepts of justifying beliefs and the positives of smoking.

Dissonance of the knowledge and experience of smoking appeared as a strong and ongoing theme for many participants when they reflected both on smoking in the past and their current smoking and for the four non-smokers, reflecting on their recent experience of smoking. All participants clearly knew that smoking was a health risk, were knowledgeable of the risks associated with smoking and experienced the social message that smoking was 'bad'. This was not new knowledge and most participants had struggled with this for some time. Information on the negative health effects is widely available and is frequently encountered by smokers, for example the graphic health warnings that by law must illustrate all cigarette packs sold in Australia

(Scollo & Winstanley, 2008). Other sources of information included Quit campaigns, smoke-free areas, retail restrictions on cigarette sales, health professionals, and the views of family, friends and society at large. Younger respondents reported growing up in an environment when anti-smoking information was prevalent including within the school curriculum. It would be difficult to find many Australians who could not state some of the adverse health consequences of smoking as illustrated by this participant:

> *Yes with all the information and the media the warnings on the smoke packet you really have to turn the other way and say 'I am not going to look at that'. Because all the information is out there. P 5*

There was almost total agreement that smoking had negative health consequences. The exception being an on-line participant who stated that there was scientific research that supports the benefits of moderate smoking but other forum members quickly challenged this assertion.

Knowledge dissonance was also apparent when participants relapsed and recommenced smoking after a period of being a non-smoker as stated by this participant:

> *When I sit down reasonably and think about it, it's, I know that it's* (smoking) *not the right thing to do and I know that I shouldn't be doing it and that I should be planning to stop it. But then you get to the point and it's like, you know it's all great until I want one and then it's like too hard. P 6*

The other area of knowledge dissonance was illustrated when several participants stated that they knew that there was nothing wrong with being lesbian/bisexual woman, which was not an abnormality, yet their behaviour was one of having had times of struggling with self acceptance of this sexual identity. Even if some of the actual episodes of this were in the past for many there was at some level ongoing negotiation with self about sexual identity and the experience of living as a lesbian/bisexual woman today. There was often a period of knowing that they were lesbian/bisexual woman but not yet ready to accept or declare their minority sexual identity.

An extreme situation of knowledge dissonance occurred for those who grew up with the influence of religious teaching which on the one hand taught acceptance of others yet also taught that homosexuality was wrong. For several participants this was seen as having to make a choice between the church and their same sex attraction. They *didn't want to believe* they were a lesbian/bisexual woman because to do so was to *completely reject the Christian view of homosexuality* and by implication the church.

Expectations

Social expectations emerged strongly as participants discussed the messages they had received from others and their own self talk about both their smoking and their minority sexual identity. Societal expectations and expectations expressed by friends and family were often dissonant to participant's own beliefs and/or behaviour. This reflects the social environment that has increasingly become a no-smoking one and one that is heteronormative. On two fronts, participants were outside the social expectation norms of the broader community.

The majority of participants reported early messages, particularly from parents, that smoking was an undesirable or forbidden behaviour. There was a clear expectation that they should not smoke. Such messages may have been in the face of contradictory evidence especially where parents were themselves smokers.

> ... [the parental message was] *definitely that it was bad and I think I already knew that 'cause I was the one, my brother and I were the ones that wanted and… pushed my mum to give up smoking so we knew it was bad and er, yeah she used to tell us it was bad. P 2`1*

Rebellion was cited by several participants as a reason to start or continue smoking at an early age. This can be seen as dissonance between expected social behaviour and actual behaviour, which was often labelled by both participants and others as a rebellious act.

> *At that age* [when first tried smoking] *I definitely think it was just the rebelliousness, I was, I felt pinned down at that stage with school and the family and everything else. P 19*

Also this participant who said of her early smoking experience when at school:

Yeah trying to be a bit of a rebel, yeah trying to you know oh we're so different from you and we've got our little thing. Yeah I think it was more of rebellion, my way of rebelling because I was not particularly a rebel, I was a very good student and yeah. P 18

A heteronormative environment has strong overtly and covertly expressed expectations of the social position of women and expected behaviour. For the majority of participants, especially older participants, this may have resulted in the adoption of a socially sanctioned heterosexual lifestyle in an attempt to fit this. The majority of participants regardless of age had entered into some form of heterosexual relationships even if for a very short time. While not all of these were stressful relationships, they became stressful when participants confronted the issue of their sexual attraction for women.

All participants discussed growing up in an environment where it was assumed that they would be heterosexual and for many this included marriage and children. Participants discussed in detail their awakening realisation of their minority sexual orientation, which for all participants involved a level of questioning of the wider heteronormative society. This was often accompanied by a strong denial or dissonance about their same sex attraction in the face of social expectations around presumed heterosexuality.

> *You spend your whole life conditioned… when are you going to get married and have kids… when you were a little girl Barbie did not have sex with Barbie she had sex with Ken… the examples on the television are heterosexual. P 17*

The social expectation of heterosexuality was reinforced with family, peers and societal representations of relationships that are almost universally heterosexual. This participant reflected on her mother's expectations thus:

> *To have her daughter walk down the aisle, get married… the whole wedding thing would have been huge for her, she would have loved it… they saved for it for all their lives too but she didn't get that with me. P 15*

Many participants tried to fit the heterosexual norm by ignoring or suppressing personal feelings for other women and *married a man.*

> *I had had a relationship with a female when I was a student nurse and I basically wasn't bringing that into my very dysfunctional family… So that was not going to go anywhere so I married a man; had two children um and of course that didn't work. P 22*

This participant like others married young to conform to the social stereotype of heterosexuality. However as she states:

> *I told* [my husband] *that I may be gay, I may be bi I don't know… It did not go away. … It's always going to be… And we had two kids together by that stage so it was just a matter of me getting the guts to… explore who I am or decide to carry on as normal and play happy families. So I decided to do the most difficult thing in the world at the time and yeah… I can't keep pretending. P 13*

Participants from a religious background or who were currently involved in the church[9] also contended with the weight of church teachings and expectations. Gay people are often portrayed negatively with consequences such as *going to hell* as illustrated below:

> *My background was such that homosexuality was completely wrong. I was a Baptist. So homosexuality was completely wrong. I never believed that it was a sickness or any of that crap but that it was an abomination and you would go to hell… I went home and got under the sheets and said "I am a lesbian, I am a lesbian. Oh God. I will go to hell". P 17*

Expectations were a powerful area of dissonance reported, especially around issues of minority sexual identity.

---

[9] The only religions discussed by participants were Judeo Christian religions however this is likely to be true of other religious groupings many of whom do not accept homosexuality (R. Crooks & Baur, 2010).

Experimentation

Experimentation with behaviour and identity is a common occurrence at an early age and part of the process of attaining a sense of self. For most participants an experimentation stage occurred for smoking and to a lesser extent for sexual identity. While in this experimental phase there was often dissonance due to previously stated concepts of knowledge and social expectation.

Early experimental stages of smoking were commonly reported as being a physically unpleasant experience, and yet all respondents *persisted* to become regular smokers as quoted below:

> *I remember hating it* [first cigarette]. *I remember absolutely hating it. Obviously not dragging back properly, and coughing myself almost sick, and yet I persisted. Persisted until I had it. P 19*

It was acknowledged by most participants that there were many factors at play at this experimental or initiation stage of smoking. It was for some a response to the smoking behaviour of others close to them. This included parental smoking, often seen as a strong predictor of becoming a smoker, or friends and peers particularly at school. The median age of experimenting with cigarettes among participants was 13.7 years with a range of 8 to 22 years of age. School experience, notably the social complexity of being at school, was discussed as an important influence by many participants in smoking initiation.

Many participants when asked to reflect back on early experiences of smoking discussed this teenage period as a time of increasing independence, identity formation and social awkwardness. Dissonance manifested with the knowledge that smoking was unlikely to be approved of by others, especially parents, nor would it necessarily be a pleasant experience. There were however perceived rewards from this behaviour such as achieving a sense of belonging. There are likely to be many factors at play at this time although rarely clearly articulated at the time.

While participants in this research went on to become regular smokers other young people also faced with these feelings decided to either not experiment with smoking or did not go onto become regular smokers. At this experimental stage a complexity

of influences were reported, many of which overlap with other concepts reported under the core category of dissonance. Identified influences included:

- Feeling that smoking would ease social belonging to desired social group.
- Smoking because of feeling different or not fitting in well socially.
- Smoking as assisting in identity issues.
- Smoking as the norm for a particular social group.
- Smoking with the knowledge that it was a forbidden activity i.e. smoking was a hidden or closeted behaviour or as an act of rebellion.

The following participant's words represent their experience of the interplay of influences at this experimental stage:

> *I think well for a start it was cool to smoke… I would smoke in social situations but not at home… and I guess it got to the point if I was going out, and quite often I was going to have cigarettes it was easier to buy them myself even though I would not go through a whole packet. I would take that pack home and not smoke. And I might not use them again till I went out drinking again. But it was just the image the pressure to be cool. P 7*

In discussing their early experiences with cigarettes many respondents said that they did not think they would go on to become regular smokers and that there was often little thought about how addictive nicotine and smoking would become. Most could however reflect back to an early experimental stage that was distinct from being a regular smoker.

> *Well it just kind of added up a little bit and eventually it went from like one a day, up to two and so on and so forth and eventually I was going for walks to try and hide it from my parents, stuff like that. And then one day I tried to stop and I couldn't. P 9*

Although participants did not use the term experimentation (they used words such as *exploring, finding out who they were* etc), when referring to exploring their sexuality, for many there was a sense of acting on their same sex attraction to women initially in a bid to clarify their questioning. Again there will be many young people who do

experiment sexually however do not go on to identify as same sex attracted. This cohort did, and for most although there was universally a period of confusion and denial of their same sex attraction, all went on to identify as lesbian or bisexual women.

> *Yeah, it's just like, so yeah went… Ahm, er met a girl and was very much aware of what I was doing was not where I should be ahm, and so that all was, that was difficult, that was difficult for me. P 61*

As illustrated, a period of experimentation was common for both same sex attraction and for smoking behaviour.

Denial/Closeted

Part of the complexity of coming to terms with smoker status and sexual identity often involved an element of denial that could then manifest as 'closeted' behaviour. The length of period and the degree of denial or 'closeted' behaviour varied within the participant group and was influenced by other factors such as messages around social expectations and level of perceived or anticipated stigma.

This participant illustrates well the 'closeted' behaviour at the experimental and early stages of becoming a regular smoker but also with a positive edge:

> *I used to sneak out and hide under the house to have a fag. So there was the secrecy as well. Something I knew about and they didn't. P 27*

For some this 'closeted' behaviour of hiding smoking continues into adulthood. This can be seen as a dissonance of identity resulting in a potentially stressful situation where smoking is a consciously hidden behaviour with minimal revelation to others. As one respondent reported:

> *My family didn't know that I smoked. My Dad's a doctor and very anti-smoking. My Dad still doesn't know that I smoke… if I'm going to see my Dad I will, you know, I will have had a shower before I go and see him. P 3*

For some participants there was simply a denial of their smoking status, which could be very entrenched. For example:

Yeah weird, weird looking back and as a smoker always being in denial that I was a smoker... I was constantly quitting and constantly cutting down, constantly in denial of ever being a smoker, ever being addicted. P 19

Being mistaken for a non-smoker for some participants was seen as positive, in that they had successfully been able to hide a socially unattractive and unacceptable behaviour. So although they may not have actively hidden their smoking, it was seen as a positive not to have been identified as a smoker. The act of hiding was also reported for sexual identity as reported on the following page. This participant said positively of her smoking:

A lot of comments I have had over my life when I pull out a cigarette and light it are 'oh you are a smoker?' So people do not perceive me as a smoker. P 27

Although most participants acknowledged changing social attitudes towards a greater acceptance of diverse sexualities, this did not mitigate the experience of questioning, denial or 'closeting' of same sex attraction for most participants, at times of struggling with their own sexual identity issues. This is closely linked to heteronormative expectations discussed earlier and was universal across all age groups.

One participant said she knew she was gay from aged six, however decided not to come 'out' until she was 17 because she had fears about how it would be received especially at school. She, like some others, said that 'coming out' was not as difficult as she had anticipated and she feels *really lucky* that she had a relatively easy time. This scenario overlaps with both the concept of (anticipated) loss and social expectations. As she said:

I just knew that I liked girls. I never thought much... until I was about thirteen, until I started realising, oh hang a second I might be gay and then I was in a bit of denial... I started dating boys just to make my parents happy. P 9

This confident young woman, who didn't think her attraction for girls *was an abnormal thing,* still ended up dating boys and making a deliberate decision on when

to 'come out' and was concerned about her parent's reaction. She said that her mother had made it clear that she still had an expectation of grandchildren when she was eventually told.

Others told themselves and had others believe that their feelings for women were just a type of friendship as a way of denying their same sex attraction. As the following quote illustrates:

> *I just kept believing that no* [I was not attracted to women] *it was just,… it's a friendship, you'll get over it. You'll find a nice man some day and get married, have two children, live in the suburbs. P 4*

The time between questioning and accepting a self-identity as a lesbian/bisexual woman and moving from the knowledge to the experience of this new sexual identity varied considerably. Most participants described a time of hiding this emerging identity and lifestyle first from self and then from others especially from those perceived to be important people but who were likely to be unsupportive. This often led to a period of highly 'closeted' behaviour. Most participants talked about this as a time of knowing they were a lesbian/bisexual woman but not yet ready to accept or openly declare their minority sexual identity which overlaps with the concept of knowledge dissonance. The different levels of 'coming out' are captured in the following quote:

> *There is 'coming out' and then there is after 'coming out' and being accepted by your family your peers and the people surrounding you, pretty much that you are comfortable with. P 13*

Many participants reported keeping secret that part of their life, especially from their parents and/or significant other family members and friends and making a very deliberate decision when to finally 'come out'. They clearly perceived that some of these people would be disapproving, not understanding or not accepting of their minority sexual orientation. Illustrative quotes include:

> *Mum didn't find out for another two years or so… So to keep something like that from her was awful. P 19*

> *I mean it's something that I knew since I was about fourteen or something but*
> *yeah I didn't tell my parents until I was twenty one. P 3*

Several participants were asked to keep their sexual orientation a secret from others such as this participant:

> [Mum] *asked me not to tell my Dad so I didn't… She did not tell anyone for*
> *years. She had a sister in law and a brother who had a queer daughter and*
> *she did not even talk to them. P 26*

Denial of same sex attraction was for some also driven by the perception that although they did not necessarily understand what homosexuality was they knew it was not socially desirable. Such as this participant:

> *I did not really know what it* [lesbian] *meant… It wasn't good; no. No it*
> *wasn't good. It was completely… I had never known of a lesbian. I didn't*
> *think I had ever seen one. I must have seen representations of lesbians… So I*
> *knew that it was bad. So I put it out of mind and I really did forget about,*
> *repressed it but I did not have boyfriends. I knew I did not like boys. P 26*

Denial and 'closeted' behaviour did not only occur at the time of initial same sex attraction. This participant talks about being with her partner for nine years yet her *partner was not a lesbian*:

> *And meeting my partner I was with her for eight, nine, nine years which*
> *ended maybe three or four years ago. No my life was with her and we didn't*
> [socialise on the 'scene']*,* ***'cause she wasn't lesbian****… we eventually had*
> *some lesbian friends. P 3*

Many participants saw this 'closeted' time as necessary in the face of anticipated negative reactions from family, friends or society as described elsewhere. A lack of self acceptance around sexual identity for some participants resulted in living 'closeted' lives. Several participants are still 'closeted' about their sexual orientation in certain situations despite the high level of self reported openness about their sexuality.

One participant stated clearly that she tried to deny her same sex attraction and that smoking played a part in that. As she says:

> *I think that I probably took up smoking in London to disguise having fallen in love with someone* [woman] *yeah who was heterosexual. P 1*

Here she smoked so as to fit into the heterosexual group. Also as she later discusses, to cope with the pain of coming to terms with her emerging same sex attraction she smoked.

Aspects of denial and or 'closeted' behaviour around both smoking and sexual identity was widely reported and is likely to be a strong driver of behaviour.

Questioning identity

All participants experienced a period of questioning their identity and although the level, intensity and timing of the questioning varied, identity dissonance did occur. This was reported for both smoker status and more strongly for sexual orientation identity.

For some there was a period of confused identity as a smoker including denial of smoker status – a stage some participants periodically return to. Many participants were able to name an event that changed their identity from a non-smoker to an experimental smoker to becoming a regular smoker. For several participants this was the act of purchasing a packet of cigarettes for themselves, which changed their smoker identity. As one participant put it:

> *If I'm not actually buying a packet then I'm not really a smoker. P 3*

Some participants were able to deny that they were a smoker despite evidence to the contrary. For one participant it was not until she finally quit that she identified as someone who ever smoked even though she smoked regularly for many years:

> *You can delude yourself… I never really thought of myself as a smoker even though on all my insurances it said I was a smoker. And I paid those increased fees… until I had given up. That's just how that goes. P 24*

Or this statement from a participant who saw herself as somehow different from smokers:

> *I never could see myself as actually holding a cigarette and smoking so it was really weird to think of myself as a smoker… my friends that smoke regularly and people that I'd bum one off them, and it'd be yeah but I'm not you. So it was a big denial like you know separating myself from it* [smoking]. *P 19*

Dissonance of smoker identity extended to participants who discussed wanting to quit smoking, sometimes quite passionately, and disliking the feeling of being *ostracised* by their smoking yet stating they found it *hard to imagine myself as a non-smoker*.

Sexual identity was the other pronounced area of identity questioning.

> *It was very traumatic* [accepting my sexual orientation]. *I thought well who the hell am I, you know? All these things that I thought I was, are not right. P 17*

This participant discussed her denial and her lack of self acceptance of her same sex attraction which she had *managed to do… quite a number of times successfully until* as she said *it becomes a reality and you say I am not doing that anymore.* This period of non-acceptance of her sexual orientation was a stressful time.

In general, participants moved from a position of questioning their sexual identity to moving towards a confidently and more publicly declared lesbian/bisexual identity. As discussed in the literature this process was not necessarily linear or resulted in a clear declaration of minority sexual identity in all situations (Mayer et al., 2008; Sophie, 1986). The process of achieving acceptance of minority sexual identity was reported by most participants as being stressful.

There were a minority of participants who reported that the identity or 'coming out' process was relatively simple, however when questioned more fully there was invariably a period of uncertainty and questioning. A participant who said 'coming out' was not difficult still talked about the period of questioning her sexuality as a

struggle saying *I don't know where I got that strength from but I was OK with it* [being a lesbian].

Some participants were told quite clearly that same sex attraction was a phase, something that was not a real identity. This often contributed to the confusion and dissonance of sexual feelings and identity as illustrated below:

> *When I was about 16, I said to my mum I think I am gay. She goes 'no no, no it's just a phase. We have all gone through this before'… So I just thought it was a phase. OK I'll get over it. P 14*

The theme of rebellion has been touched on previously. However the following quote illustrates how being rebellious could manifest in the adoption of extreme behaviour as a way of making a statement about identity, where smoking was perceived as part of what it was to be gay:

> *So I think I used to have a bit more of a, you know fuck you attitude and I'll do what I want,… at that kind of time of 'coming out' and wanting to be really you know, kind of gross out and in people's faces and you have a shaved head and that kind of thing. You know being that kind of super gay stage of just having 'come out' and being like a rebellious teenager. P 3*

Questioning of identity, especially that of sexual orientation identity was almost universally reported across the participant group and can be related to several other concepts most notably expectations.

Stigma

Stigma as defined in the literature review in Chapter 3.5, relates to the negative attitudes and actions held by those who consider a group's behaviour or membership is socially unacceptable (Stuber, Meyer et al., 2008). This can be experienced at many levels from overt violence to more subtle but no less stigmatising behaviour (Bayer, 2008). Stigma was reported for both smoking and same sex attraction behaviour. For most participants there was a very real experience of stigma on both counts although the intensity of the experience and the stigma management practices varied. Most participants reported that the stigma around smoking was now-a-days far more overt and intense than that around sexual minority status. This reflects the

widespread social unacceptability of this behaviour at this point in time (Chapman & Freeman, 2008). Both same sex attraction and smoking have been subjected to changing levels of social acceptability over time as reported in the core category 5.4.3.

Stigma and prejudice is experienced where a behaviour or identity is considered deviant or marginalised from the predominant culture and may result in feelings of diminished self worth or self hate and lower self-esteem (Phelan et al., 2008).

Smoking has not always been a stigmatised behaviour; however as the prevalence of smoking has decreased in the face of concerted and comprehensive public health actions, smoking is now a minority behaviour within most communities and settings and is generally experienced as a heavily stigmatised behaviour (Chapman & Freeman, 2008). The majority of participants stated that they wished they did not smoke, eliciting feelings of self hate or shame as one participant put it:

> *I hate myself for smoking. P 1*

This rapid change from when smoking was socially desirable to the current levels of decreased social acceptability and the related stigma of this as expressed by this participant:

> *So it's, in fact I find it more of an antisocial behaviour now because we, you know we have to remove ourselves from the group, we have to go outside. Yeah it's more antisocial than social smoking these days and I think that's part of the stigma that makes me feel bad about it. Ah. P 21*

Stigma maybe related to feelings of deviancy (*you feel like a criminal out there smoking)*. As social acceptability changes then stigma experiences also change. As this participant states:

> *I do not feel like a deviant around my sexuality. But I do feel a deviant around my smoking yes. But even the students comment on it… I have become a deviant around smoking but that has been a gradual thing. P 28*

All participants were very aware of how negatively smoking was broadly viewed even when overt stigmatising behaviour was absent. For example this smoker said:

Just you know like a leper. I go and stand out the front and sort of hide
around the corner and have a cigarette. P 16

From this participant:

Socially it does not feel good [to smoke], *I feel like an outcast. I am afraid*
someone is going to tap me on the shoulder and go 'excuse me, you are not
allowed to smoke here'. P 18

Work places were discussed by many participants because of the impact of smoke-free areas on their smoking habits. However this can also lead to negative encounters, such as this:

Everyone hates a smoker… at work… they're very, very strongly anti-
smoking but almost discriminatory in the way that they go about it and
they're always talking about filthy smokers and you stink and very, very
aggressively nasty and that sort of makes… I don't know it's really hard to
deal with that. P 21

Stigma resulting from expression of same sex attraction was reported both by participants reflecting back on experiences over their lives and currently. While there was an element of changing social acceptability around sexual diversity, as discussed in 5.4.3., even younger participants reported stigma. Some level of current stigma was reported across all age groups.

One of the outcomes of stigma is a questioning of concepts such as self belief that you are a good, worthy or a 'normal' person when society often uses the opposite of these words to discuss same sex attracted people. Such negative feelings about being same sex attracted came from a variety of sources including, but not restricted to, parents. Peers such as school *girls tease each other* and contribute to the message *that being gay wasn't good.* Stigma due to sexual attraction manifested in many different ways from overt acts, such as being thrown out of a taxi, to more subtle insults or feelings of being judged negatively, to work place episodes.

Feelings of being a stigmatised minority was discussed by some participants as an everyday stress *because of what we have to deal with every day* or as one participants said dealing *with just the usual:*

> *Mainly people being nasty and viscous and just the usual talking behind your back and if they did not know the truth they would make something up to make it sound good. P 11*

This participant while acknowledging that there has been some change in social attitudes towards homosexuality is here referring to a lifetime of stress that manifests in a stressful lifestyle:

> *But you get a lot of the older lesbians like me and we have grown up in a society which was not so accepting, we had a lot of discriminations, also with I think with even 'coming out' to their relatives and all that it's a stressful lifestyle. I would say that it is a stressful lifestyle. P 8*

The lack of recognition of same sex relationships results in both stigma and stress. While relationship stress is also experienced by heterosexual women, there are added stresses due to the minority status and lack of same sex relationship recognition (Australian Human Rights Commission, 2011). For example, this participant reporting how the breakup of a 17 year long relationship with another woman was received by her work mates:

> *I worked with a great bunch of guys… I actually had some of them come up to me after* [the breakup] *who said, I didn't ever think that you would have the same feelings... like it's only like a friend, it's not like a real relationship, it's just a friend. P 1*

This was expressed by another participant:

> *There's always that stigma of, that same sex relationships aren't as valid, or as I don't know, recognised as heterosexual relationships. So you sort of feel that, I mean I'm pretty lucky because the friends I have aren't like that. P 6*

This participant sees the importance of government's permitting same sex marriage as it would contribute to greater social acceptability:

… if, say if you're allowed to get married to your partner because the government isn't seeing it as such a big deal then people won't see it as such a big deal like, it'd just be a lot easier for people to… I know that's why my dad judges gay people because he says that it's unnatural and that it's different and that if God created females to have babies with other females, lesbians would be able to get pregnant. That's why he's so against it. P 25

Approximately half of the sample could report specific episodes where stigma was acted out sometimes in a violent manner as illustrated by the quotes below:

Like I refuse to walk around Warwick shops by myself because I get a lot of abuse from the kids that go to school around there… They're always like oh look at that fag over there and they're all standing in their groups and they laugh and that was when I was with my girlfriend. P 24

I have had ex-relatives abuse me in the street, spit at me, um drive past me calling me all sorts of names… Um it's a very small town. Occasionally I will get… walking in the street [with my partner] *and I get that slight feeling of being uncomfortable. I will stick them* [sunglasses] *on my eyes. Um and then I seem to be fine. P 14*

The fact that for some participants some level of stigmatising behaviour *could be shrugged off* perhaps shows that these are not necessarily isolated incidences. For example:

We were in Melbourne and we had some kids taunt us quite nastily. It was throwing rocks and yelling shit and stuff like that on the jetty so we couldn't quite get away and she [partner] *didn't handle it very well. I don't think she'd been subjected to such homophobia or any phobia before so it was pretty upsetting. I was ready to shrug it off but it really upset her. P 18*

Or that the level of abuse is minimised by saying it is not physical abuse such as:

Yeah I mean you get it occasionally on the train or if you're out walking in the streets, just slander or verbal abuse. Like it's just words so long as they don't lay a fist on me they're alright. P 10

Having self worth eroded with threats of actions even if never seriously carried out, reinforce a position of belonging to a stigmatised group. Parental reactions can be particularly judgemental and threatening as illustrated below:

> *But ahm, yeah the last thing Mum told me was at my uncle's funeral that if she had a gun she'd shoot me. P 15.* And:

> *I wish you were, I wish someone knocked on the door and said you were dead rather than that* [be a lesbian]… *It was like oh, prefer I was dead, like that's a harsh statement… I mean she'll never accept it but I love her. P 4*

Several participants who were mothers were concerned about the impact of stigma on their children and were very clear that at times it felt like an issue of safety for their children, especially school aged children, because of people's reaction to their sexual orientation. This participant who says she is *'out' and proud* yet:

> *… we have three boys so we have to consider them always. One of them has been hassled at school because his mum was gay and he wouldn't admit that. His teacher actually told me what was happening at the time. So we always have to consider that. P 13*

This participant confronted the parents of her daughter's friends because they had stopped her visiting because she had a lesbian mum. She accepted that it was the *parents that have had a problem* nonetheless she still had to endure:

> *… to stick his finger in my face and go 'you know the way that you live up there' and my ex husband said 'you mean the fact that she is gay?' And he said yes. And I did not want her coming up there because of that… And I hate that. I get really riled up inside. I don't say anything. P 16*

This participant lost her job in a school environment because of her sexual orientation. She did not know about unfair dismissal protection and hence walked away from this job. Even though this happened some years ago, it seemed a deep hurt that this participant still had. As she says:

> *I was asked into the principal's office and I was asked to resign. It was incredibly traumatic at the time and probably took three or four years to get over it… I said, this is what this is about so by making it overt* [that it was due

to her sexual orientation]. *I did not have to own it as much in the sense that this is something about me I can't change. P 17*

The subtlety of the expression of stigma can result in quite covert ways, such as the sense of social exclusion as expressed for example in a work place setting by this participant:

Just in exclusions from conversations. Um… If people find out if you are lesbian they don't ask you more questions any further to find out if you have a partner, if you have kids, do you have a life anyway?... They do not know where to take the conversation… and you know whether that is discrimination or naivety. P 26

For some participants it is these *subtle things* that impact more than overt stigma. This can often manifest in heteronormative assumptions that need constant challenge and at the same time to do so is to decide to 'come out' in a new environment. As this participant said:

… everyone always assumes that you have, when you say 'partner' they always assume that you have a boyfriend and so. Yeah I don't know it's more, it's more the subtle things that get me than overt things… I feel like society out there, policy and government shit, that really pisses me off; I don't feel supported by that at all. P 18

Stigma also manifests in the anticipation of adverse treatment or outcome from others due to belonging to an identified minority group. This participant said:

*I think there is a lot of women out there who are still afraid with their jobs and everything about 'coming out'. You fear retribution in some form or another and it does undue stress on you. And god almighty being a lesbian aint easy man (*laugh*). It is not an easy choice. P 8*

The lack of social acceptance may also be the result of others being concerned about their own social standing or how others will view them. For example:

The great majority think of their social standing. Everyone is going to find out I have a gay daughter or son. Keep it to yourself. Act normal around the

family, and that still goes on because people can't… people can't accept that
someone is gay in their family. They are treated like a disease. P 8

Some participants discussed that heterosexual friends and the media glamorised minority membership in the gay community as something that was very identifiable, cohesive, vibrant and fun to be part of. Yet the reality for many was that this has not always been a positive experience of feeling connected to the gay community. There is dissonance as they are being told that they are part of a desirable community yet their personal experience of minority membership was far from this, for example the experience of stigma.

And so yes I think they [straight friends] *do have a notion of what gay*
community is about and I think they think it is a good thing that we have a
community. And I think in some ways they are quite envious of this because in
some ways they lead quite an insular life. P 1

An interesting sub-theme to the concept of stigma and minority membership was that some participants did not want to ostracise non gay people from the gay community, yet they themselves have so often had that stigmatising experience of being ostracised from mainstream community. As described by this participant:

I don't particularly want to be part of one community… I guess that
reinforced that belonging to the gay community in [regional city] *that we*
need to be more balanced than just that community. Like it is sort of like
um… ostracising heterosexuals you know; that you should only be in your
[gay] *community but when we want to go into their community it's OK and if*
they want to come into our community they can't. P 28

Minority membership is related to the broader concept of stigma as participants struggled with the experience of belonging to a minority group due to both their smoking behaviour and their sexual orientation. Minority membership by definition means that participants belong to a numerically smaller group where the majority of society identifies in this case as non-smokers and heterosexual. Minority membership may bring with it some positives and these are discussed in the core category of resolution.

Loss - anticipated and experienced

Adding to the experience of dissonance was often both the anticipated and the real experience of loss around declaring sexual or smoker identity. For most participants these issues were more pronounced for sexual orientation identity, however even for smoking behaviour social loss was experienced. This is further discussed under the concept 'minimising social loss' within the core category resolution, as this appears to have been how many participants came to resolve this situation.

The fear of 'coming out' and *the fear of the repercussions* from significant others was often worse than the reality of 'coming out' which also contributed to extending the period of dissonance. As one participant said: *it was a lot easier in the end than I thought it was going to be and I think the tension of the not knowing how it was going to be* was worse. The anticipation of loss was very real for many participants and contributes to a sense of stigma and non-acceptance. For this participant anticipated loss was expressed around whether she would still have friends:

> *I was just thinking about people around me and what they might think and would I still have my friends and you know it was a real dilemma for me* [whether to 'come out']. P 18

Although participants emphasised that 'coming out' was an ongoing process not a single event, declaring a lesbian/bisexual sexual orientation to people of significance, such as parents or children, was often a difficult undertaking with anticipated negative consequences. This younger participant is not 'out' to her parents as she states she is *scared* of telling them. The attitudes of her parents particularly her father is clear:

> *When I was a child Dad used to always say if my kids ever turned gay I'd kick them out of the house. That's also another fear point of being kicked out of the house… I don't want to be kicked out… I want to grow up with my parents being happy with who I am not, you know denying that I'm gay and trying to ignore that. P 24*

This younger participant also is not 'out' to her parents. She says of her father:

> *He's very homophobic and I'm very close to my Dad so I'm afraid of telling him in case I disappoint him and I will disappoint him so I'm scared of telling*

him. But I don't feel that I should tell them for a little while longer, until I'm a bit older, until they're like OK well I believe you that when you say that you are that you actually do mean it. P 25

The participant below struggled with her sexual identity for 25 years in large part due to anticipated stigma of this and not wanting to hurt her parents. Parental influence and attitudes emerged in several concepts reported in the results:

I didn't come 'out' until I was thirty nine. I was determined that I wasn't going to ever. The stigma attached to it ahm and how much it would probably hurt my parents or I just didn't want to be like this. At that time I was thirteen through to thirty eight. P 1

This participant talks about the lack of acceptance by her mother as grieving. *She* [mother] *did the whole grieving for a straight daughter.*

Even participants who were very 'out' in many situations could still anticipate loss in other situations. This school teacher was concerned that by not declaring her sexuality to the School Chaplain on an overseas study tour, led to a continuing concern several years later that she hadn't *kind of been completely honest,* stated:

What if he found out [about being a lesbian] *tomorrow or in two years time or in ten years time, would that be just completely… would I have completely let him down and deceived him and would he just be feeling really shit about me? P 19*

The social losses experienced at the time of declaring minority sexuality were for some participants of significant consequence, despite the majority of participants when first asked if there were negatives to 'coming out' as a lesbian/bisexual woman, said there were no negatives. Upon further questioning, many participants reported quite profound losses of important friendships and family connection as a result of declaring their sexual identity.

The dissonance between acknowledging that significant loss had occurred, as illustrated below, was clear to me while listening to participant's stories. Hence the reason this concept is grouped under the core category of dissonance.

For example, this participant said that her 'coming out' was very easy yet she has lost her brother through this process, someone she was close to. She dismissed this in a throw-away line. Her commentary suggests very clearly that she expected to lose friends and family and hence she could dismiss this relationship loss. Yet when probed she discussed this at some length as something that was in fact of importance to her. I interpret this as a minimisation of the loss of this family connection. As she states:

> When I came out… I only lost one friend through it… and a brother and his wife and children. And that was not very much for me. You know it was not like I was thrown on the rubbish heap so um yeah I thought that was very minimal… The brother issue is still an issue yeah so he has never quite come around. P 28

The most extreme case of loss reported was a participant who when her mother found out about her daughter's lesbian orientation disowned her. She was 'outed' by a friend and hence was not responsible for telling her parents, although she stated she was not sure how she would have handled this situation herself. As this participant bluntly put it:

> My old house mate, we had an argument, she said I'm going to ring your Mum and tell her you're gay and I said 'go ahead' not thinking that she'd actually do it and she did. Mum's disowned me now for twenty years; she hasn't spoken to me for twenty years. P 15

This woman has maintained 'closeted' contact with her father but her mother has never accepted her sexual orientation or contacted her in twenty years.

The reaction of participants when losses were further investigated showed that far from being minor losses they resulted in feelings of rejection and hurt even when they may have occurred many years ago. Some of this rejection has continued for lengthy periods of time and may contribute to ongoing stress and a questioning of self and reduced self-esteem.

Not everyone's story was of non-acceptance, however there was inevitably the stress of accepting a self-identity as a lesbian/bisexual women and then testing the response

from others in declaring this. Some participants found the actual result of this was unexpected acceptance such as this participant who 'came out' later in life:

So I was brave enough to accept that that was what I was [lesbian] *and I told my children. And they were both very supportive and encouraging. P 22*

This participant talked in general terms about what she saw as the general loss particularly of family connections that have been experienced by many in the gay community. Lack of family connection and support may also be the experience of heterosexuals in the broader community, however it is unlikely to be as widely experienced (Fredriksen-Goldsen et al., 2010):

I mean a lot of our community don't have the same support structures and networks because that's been taken away from them. P 6

Anticipated loss around smoking behaviour was only discussed by a few participants in reference to thoughts about quitting smoking and usually revolved around friendship groups. As stated by this participant:

… and I often have thought you know, what if I quit smoking and go and see these two friends of mine who have been long-term smokers with me, I'm just going to feel really odd and maybe I shouldn't see them anymore you know. So it would almost be like giving up people. P 18

Loss, whether experienced or anticipated as reported above, was widespread especially in relation to the more public stating of a minority sexual identity. The impact of parental response, again real or anticipated, was for some very powerful.

Fitting in and acceptance

Participants discussed the importance of the concept of fitting in and being accepted. This was often linked to having a sense of social belonging, which is discussed more fully in the final dissonance concept of minority membership.

For participants in this research the issue of fitting in was predominately about early feelings of being 'different' which on reflection most participants put down to a realisation that this was due to being same sex attracted. This resulted in feelings of social awkwardness particularly in their teenage years when they did not think they

fitted in. Smoking was often used as a way of trying to fit in and emerged as an experimental behaviour which for this participant group transitioned to regular smoking. At the time of this stated difference, it was rarely articulated as sexual orientation difference. Striving to fit in at school was widely reported during this time for example, as illustrated by these two quotes:

> *I never got to make friends* [at school] *and if you did I always did with people who were on the outer. The ones who were different, the rebels. I was not a rebel just an 'outsider'. One that could never fit in anywhere. P 8*

> *Yeah well you've got to try extra hard I guess if you're kind of having a hard time in high school you just want to try and fit in because you're different to other people. P 9*

These like many participants, reported growing up feeling socially on the outer, feeling different and not fitting in. Smoking was often used as an attempt to overcome this especially at school and while still questioning their sexual identity. As this participant reported:

> *Sounds so silly now because I wish I was not a smoker. I don't know but I guess the people who were considered accepted, cool had that in common; they were smokers and doing stupid things. P 7*

Some capitalised on not fitting in at one level but there was often also a sense of wanting to fit in. As this participant said:

> *I never felt like I fitted in but I also liked not fitting in because it became my thing, you know. Like being alternative and you know people were attracted to that. I felt like god I'm such an 'outsider' and so crazy. But you know there's parts of me that wants to conform too, so yeah. P 18*

For many participants stress around fitting in continued past initial sexual identity questioning and formation to issues of finding and fitting into a gay/lesbian community and also relating to the wider heterosexual community.

For the majority of participants once they accepted that they were not heterosexual it became important to seek belonging and acceptance into the gay community. While

many stated a desire to achieve this, it was not always easily achieved especially at the time when sexual orientation identity was being established. Having social connection or belonging especially in the gay community at this time could have been one way of lessening the identity dissonance discussed earlier (Rothblum, 2010). Some also reported dissonance of feeling finally that they had sorted out identity issues and yet there was not automatically a sense of acceptance or belonging to the gay community.

Smoking was seen by many as a behaviour that would help with a sense of belonging to the gay/lesbian community as a 'new' lesbian. This explanation of early smoking initiation and continuation of smoking in the following examples illustrates its use to fit in to the new social situation of the gay/lesbian community:

> *Sometimes felt like that you stood out. One doesn't, but you know I am sure it is common among dykes* [lesbians] *or if you are different. Um… so I suppose* [smoking] *is a way to have something to do to make it socially feel easier. P 26*

For another:

> *Well kind of trying to fit in I suppose when you first 'come out' when you're a teenager, you maybe you might start smoking to sort of fit in with the crowd a little bit more. Yeah. P 20*

It was not just younger women who sought out the gay community. For many women who 'came out' later in life being involved in the 'gay scene' was also important. As this participant reported:

> *When I 'came out' I used to be on the 'scene' a fair bit. I did not go to that many straight places. It's all mainly night clubs I guess. I probably did go to places where there would be beer gardens and smoking. I mean I hate the Court* [gay hotel] *but I'll go there and be stuck out in the beer garden and smoke. P 8*

While the desire to achieve a sense of gay community connection was especially important in the early stages of sexual identity as a lesbian/bisexual women, for

many this extended past this initial period. Fitting into the lesbian/gay community was for some participants equated with smoking behaviour.

Although participants may have been primarily attracted to fitting into a 'gay scene' there was also a need to work out how to respond to and fit into the broader heteronormative world. This overlaps with concepts of expectations and questioning identity previously discussed. While struggling to fit in is not a unique experience to lesbian and bisexual women, especially as a teenager/young adult, the manifestations of fitting into a heteronormative society exacerbates this experience for this group.

Figure 8 summarises the concepts presented in this section that lead to the core category dissonance. While these all contribute to the core category dissonance, there can be interplay between concepts. For example experimentation and questioning of identity could be operating together as could stigma and anticipated loss. In an example of the latter, a person may have witnessed or experienced sexual identity stigma which then informs their perceptions of what anticipated loss may result from a personal disclosure of sexual identity. Resolution is presented as the next core category.
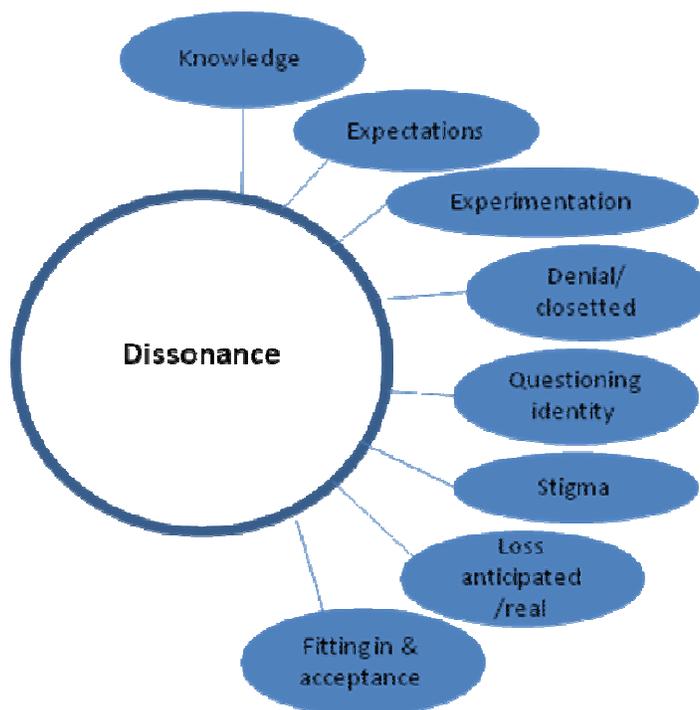

Figure 8. Dissonance concepts.

5.4.2. Core category – resolution

As presented in Figure 7 resolution was one of the three core categories to emerge. I define resolution when someone arrives at a point where they have been able to move from a place of dissonance to a more comfortable place. It is rarely a fixed position and may be challenged by changes in patterns of self belief or in response to how others are perceived to react to that person. As the interview data presents a snapshot of a point in time for each participant, then at this point most participants reported a state that could be called resolution or acceptance on the parameters of smoking and/or sexual identity had been reached. The level and stability of this point of resolution varied across the participant group and many participants commented on the fluid nature of this resulting and the changes over their life which also relates to redefinition factors discussed as the next core category. Resolution factors included justification and minimising of social loss.

While there were some common threads from participants that led to a point of resolution, the experiences reported illustrate that this was a varied journey. For example while early cigarette smoking was an unpleasant experience for most participants, it was not the universal experiences as illustrated below:

> … all those horror stories of people coughing up and things like that. I didn't cough [after my first cigarette] and it wasn't horrible and I went mmm, yeah that's alright… of course I don't think I inhaled, I don't quite remember… so I went oh that's alright, that's not too bad. P 21

This participant reported fewer struggles arriving at a point of accepting her identity as a smoker. Various strategies were often actively chosen to maintain or manage resolution of dissonance in relation to both smoking status and sexual orientation identity. These concepts often intersect and work together to arrive at a point of resolution and are explored below.

Justification

Participants openly discussed a range of justifications that they relied on to overcome aspects of dissonance previously reported. Most notably justifications were used to explain their smoking behaviour to minimise their stated knowledge of the adverse

health consequences of smoking. These could be seen as strategies by which they justified their smoking behaviour to both themselves and others in the face of overwhelming negative consequences to both their health and socially, from continuing to smoke. Most were aware of these justifying behaviours as stated by this participant:

>*Smokers will always find someone doing something that they consider worse to their health than smoking. PS*

The justification or rationale for smoking took different themes. Some participants expressed this in terms of compensatory healthy activities undertaken to counter the health risks of smoking. Most often this was about dietary and physical activity regimes. As one participant said:

>*I know I have high cholesterol and I know the smoking contributes towards that. I love animal fat and I have actually cut that out so I can smoke basically. One of the two evils has to go. I chose the smoking. Because I thought animal fat, I can go with lean meat but I do not know if I can go without cigarettes and I have not had my cholesterol checked again I'm too scared. P 8*

Others compared smoking to a range of other risk taking behaviours or situations as a way of justification.

>*Every time I have a cigarette… I rationalise it away. I go well you could die of anything, I could walk out on the road, get hit by a bus or I could have some kind of genetic flaw and you know why not just let me do what I want to do? P 18. And:*

>*I'm a volunteer fire fighter and I get that much carcinogens from one big fire. P 17*

This participant framed her justifications in reference to much larger issues and problems in society:

>*I was challenged somewhere* [about my smoking]… *my response was… look, when the world deals with all the other issues like how easy it is to over*

drink, wife bash, paedophiles, da da da then I will think about the issue of

smoking. You can justify things by finding bigger things. P22

Smoking was often compared with the scale of other personal issues as a justification for continued smoking. This participant considered smoking to be a minor issue compared to the struggle she had around her sexual identity. While she came to a point of self acceptance of her identity as a lesbian she still struggles with the conflict of being a smoker:

I think in the scheme of things, it becomes less important in the sense that

look I am trying to come to terms with who I am right now, do you think I

care that I am smoking? I can deal with that later. It becomes a smaller issue

in the big scheme of trying to become honest with who you are. I mean I

found it incredibly traumatic; it was very traumatic. I thought well who the

hell am I, you know. All these things that I thought I was are not right. You

know so the fact that I am having a cigarette on the side became so

unimportant… maybe it is a way of saying, stuff you! I'm a smoker and stuff

you. I am a gay woman and proud of it. P 17

Or as expressed by this participant:

No it doesn't make it better but it's like well you feel shit in your head, you

may as well shit in your body… and have cigarettes. P 19

There were also many participants who put the view that "you have to die of something" as a justification for continued smoking and yet when questioned, most acknowledged little basis for this, such as this participant who said:

… people who live a really healthy life end up dying at a young age and

people who live an unhealthy life die at an old age like. You know you can't

really change what ends up happening so there's no point in trying to. P 25

Several participants could distance themselves from their smoking by discussing how disgusting other people's smoking was, as illustrated by the quote below from an ex-smoker:

I used to talk about how disgusted I was with smoking while I had a cigarette in my hand. Just go it's so disgusting, I can't believe people would smoke, ra-ra-ra… that's what we used to talk about while we were smoking. P 19

For others there was a sense of hanging onto smoking as a behaviour even though this conflicted with the intellectual knowledge of the harms.

Conflicting because there is a part of you, the intellectual side that says you need to be doing something about this [smoking] *and then there is the emotional you, or the other part of the child in you or whatever it is, that is saying this is mine and no one is taking it away from me. P 22*

For some, smoking was seen as a personal risk taking decision made in the full knowledge of the risks and as such was something they felt should not be under scrutiny by others. For example:

It's my educated choice. I enjoy it. I don't hold anybody responsible for my choices and the thing that absolutely does my head in is people that spout off what I can and cannot do to my body. Having said that I consider myself a responsible smoker. PS

Participants discussed their addiction to cigarettes, again this often included commentary on how this was contradictory to an intelligent understanding of the behaviour. This participant also acknowledged that there was a positive to smoking and even though she saw herself as addicted there were returns from smoking. For her it was comfort:

But I am hooked [on cigarettes]. *So what? I need an excuse for that because I am an intelligent person? I don't have a drinking problem; I don't have a drug problem. So what is my justification for that? I get comfort from it. P 22*

Addiction to cigarettes was also perhaps seen by some as a way of having to avoid criticism of continued smoking. Such as this participant:

It's just a shame that I am addicted to these horrible cigarettes. My choice to throw them away would be instant if I could give them up. P 8

Another justification is to recognise there are risks in smoking but that these have been overstated:

> *Oh I mean it's everyone's mentality that it won't happen to them but I know it could easily happen to me. I do think they're* [risks] *exaggerated a lot though, a lot of the campaigns. P 10*

For this participant managing the dissonance around continued smoking was simply to deny the risk at this point in time and as she openly says she is currently ignoring acknowledging there are risks to smoking:

> *Intellectually I know that that could be me* [in the Quit advertisements] *but obviously I'm in some state of denial. But I know I'm not stupid. I know I could well die from some disease related to cigarettes but I think as long as I have made the choice to smoke I may as well ignore the warnings because I know better, so I should quit and heed the warnings or ignore them all together. Currently I'm ignoring them. P 7*

While justification was not used to support the decision to live a lesbian/bisexual lifestyle it was used by some participants to justify the adoption of a heterosexual lifestyle rather than accept that they may be of minority sexual orientation. Several participants said they had married heterosexually because that was an easier option than to be socially rejected by family, friends and society. It was also used as a way of excusing homophobic attitudes and behaviour. While this is also discussed under managing stigma, several participants thought that:

> *They can't help how they feel* [that is, homophobic] *so I'm not going to judge. P 25*

Justification was also used by several participants when discussing the church's response to homosexuality which allowed them to remain in the church. Although for others the resolution of such church doctrine was to leave the church. This participant put it like this:

> *I believe who I sleep with is between me and God and it has got nothing do with anyone else. And church doctrine, I don't support that one way or the other… while I might practice my devotion within those manmade rules but in my head I know it is between me and God. And I know God did not make me*

> *lesbian by mistake. That's the way it is... I don't think I am going to burn in*
> *hell. P 22*

Participants were able to articulate justifications for their behaviour especially smoking which was universally reported as having negative health consequences. Justifications although seriously reported where acknowledged by many as just that; a line of reasoning to justify a health compromising behaviour.

Identity

Questioning of self-identity as a smoker and a lesbian/bisexual woman involved some period of dissonance as previously presented. Resolution however for the majority of participants was reached, although the journey to reach and maintain this point may have been similar, they were not identical. Identity for both that of smoker and for sexual orientation did not necessarily mean a single fixed point was reached. As discussed in the literature review, declaring a sexual identity is not always a linear process and is often fluid, while most smokers have experienced a cycling through different smoking patterns and times of identifying as an ex-smoker following a quit attempt, often relapse and return to smoking. Different self-identity labels may be used through these different stages.

Self-identity, especially as a smoker, intersects with the previous concept of justification. Preferred smoker identity was usually one that minimised the level of smoking and the resultant health risk. This included self identifying as a social smoker, opportunistic smoker, responsible smoker (e.g. not smoking around children), binge smoker (only smoking in certain situation such as the weekend where they would smoke heavily) and a chipper (only a few a day). This participant explains:

> *... the chippers, you know the ones who can, you know never smoke up a full*
> *pack a day. They might smoke three or four a day for a long period of time.*
> *They're not super, super addicted but they're not super, super not addicted.*
> *P 3*

For some, being a smoker was seen as an important part of their identity, *smoking has become part of my life and part of who I am,* although no one reported that they wanted to be known solely as a smoker.

Those who arrived at a minority sexual identity quickly and easily tended to come from particular situations where it *just never seemed like a big deal.* One participant's *mum had heaps of gay friends* and another participant had gay parents and considered herself *really lucky in comparison to some of the stories* she has heard about 'coming out', especially to parents. This experience was definitely the exception within this sample.

All participants had reached a point where they accepted their sexual attraction to other women and had acted on this. This was usually followed by a point at which they were happy to identify more publicly first to close friends and family. This was often phrased as being true to themselves. As one participant said:

>*I can't keep pretending* [that I am a lesbian]*. P 13.* Or:

>*So I was brave enough to accept that that was what I was and I told my children. P 22*

In other words they had 'come out' which was usually the defining moment of identity especially when received positively by others. The 'coming out' process again is not a single entity, nor a linear progression and involves different situations of needing to do this. After self acknowledgement, 'coming out' usually then extended past close friends and family to wider circles, for example in the work place.

For some the act of actually telling others was a defining identity moment such as this participant:

>*It was just that I had 'come out', I have DONE IT. I have told everyone. And I can't take it back. P 16*

For some, but not all participants, identity resolution was assisted by finding gay community, a sense of belonging and actively putting themselves in an environment

where *they feel comfortable* and *surround yourself with people who are in the same mindset.* For this participant this included living in the Mt Lawley area, part of the identified 'pink triangle'[10] and also working in the inner city where she was very much a part of *a queer culture.* Although she did admit that perhaps in a way this was a *cocooned* environment that consolidated and affirmed her sexual identity.

Minimising social loss

Minimising social loss whether around being a smoker or around declared sexual minority status provided one strategy for reaching resolution. This could also be seen as overlapping with the concept of justification. Minimising the impact of social loss or accepting behaviour that to others might be clearly homophobic or stigmatising may provide an avenue for resolution and is captured in the concept of managing stigma. This is especially the case on the issue of sexual identity.

The loss and anticipated loss reported earlier provided some examples of situations where there has been a minimisation of the loss of family and friends because of declaring same sex attraction. For some this extended to being able to excuse this behaviour usually saying *that is just how it is.*

Many participants when discussing the behaviour of family and friends who had disowned or distanced themselves at the time of sexual orientation disclosure, were able to minimise this, through justifying or accepting this behaviour. It was rare for a participant to say outright that they felt the behaviour of disowning or distancing was wrong or hurtful. For example, in discussing her mother's response to finding out her daughter was a lesbian, this participant says:

> ***I'll give her credit for standing by her morals*** *and her beliefs* [non-acceptance of her lesbian daughter]. *I'll give her that 'cause she's given me that… I believe I'm gay and that's it. I'm happy with that. It sucks* (mother's response). *P 4*

---

[10] See page 63.

The bold above emphasises this minimisation as this participant turns her mother's non-acceptance into a positive statement about *standing by her morals*. This participant has a relationship with her father which is highly constrained by her mother's non-acceptance and hence her sexual orientation has severely affected the type of relationship she has with both her parents and her siblings, but again she accepts this as *just how it is*. Her mother has not spoken to her since she was 'outed' 20 years ago.

In another case the participant says *it wasn't that difficult* ('coming out') however on further questioning this was largely due to the fact that all of her family was in South Africa. She further states:

> *My mother was absolutely devastated… and my mother said, Oh my God. I did not think there was anything else you could do to devastate me… It was OK because of the distance. P 16*

It later emerged that she had also *lost some very close friends who could not accept* her sexual orientation. These had been lifetime friends and again she stated that it was their decision but she was clearly upset by this loss.

Another extreme example of accepting homophobic reactions of others is illustrated by this participant when a friend had said:

> *I could not sit at the table with you and your partner and socialise with you knowing you were going to go home and get into bed with that person* [female partner]. *And I said **well fair enough that's your call and I can't change your mind on that**. P 16*

The bolded text above and below provides excellent examples of this minimisation of loss. For some they are prepared to be *tolerated* or have their same sex partnerships tolerated. This participant did not sound angry about this and considers her father has been pretty good in accepting her sexual orientation and her partner. As she says:

> *I mean he started off just with his back you know, doesn't give the time of day but he's been pretty good and tolerated that person* (her partner). *P 19*

This participant in discussing her parents' reaction to her sexuality stated they:

> *… didn't agree with it but I had to respect them too… It's just their culture and how they were brought up. P 20*

The majority of participants strongly indicated they would not put up with behaviour that was discriminatory or prejudiced against gay people and yet when this behaviour came from close friends or family members they were prepared to accept it. For example, crass homophobic jokes can be dismissed because *you know that's my Dad*.

The minimisation of loss, perhaps could be seen as a coping strategy of not having to confront such hurtful behaviour. However as stated earlier, listening to these stories their loss was very real and for some still very hurtful.

Another form of minimising loss that several participants spoke of was to say they did not have any family. As this participant says of her partner:

> *Like the woman I am seeing at the moment, her parents disowned her completely… when I met her she said she did not have any family… someone saying they do not have family, usually means they have been separated from their family because of their sexuality or separated from their church or that type of thing. P 23*

Some participants expressed a lack of understanding of other people who had struggled with non-acceptance of sexual identity and minimised this experience. For example, one participant who had suffered great estrangement from her family due to her declared sexuality said:

> *The whole gay thing to me was, that was OK. I didn't think I had to be anything different than who I was. I didn't think I had to be strong to be gay or anything like that… gay's being gay; be happy with it. If you want to make a song and dance about it then don't be gay. P 15*

For several participants the loss was around their church relationships and again is often initially spoken of in a dismissive way. At the point when this participant accepted herself as a lesbian she just *walked away* from the church she had been actively involved in for many years including the position of music coordinator. Here

is another type of loss, where the participant felt she could no longer be with this group and withdrew herself to the extent where:

> *For most of them* [church membership] *I just disappeared off the face of the earth and for most of them they don't know what happened to me. I just walked away. P 17*

Through minimising what had been a large part of her life to arrive at a point of acceptance and resolution of her sexual identity she was able to say that she was not particularly upset about this.

The stated losses that resulted from smoking were rare. However several participants did acknowledge that their smoking behaviour did result in lost time with non-smoking friends or lost time due to having to hide their smoking behaviour or missing out on social invitations. Again, this was expressed as a minimal impact such as this participant:

> *I think people who don't like smoking are a bit hesitant inviting me; I do feel that on occasions yeah. P 1*

Minimising social loss because of stated identity and behaviour was commonly reported. These statements illustrating minimisation were perhaps a form of justifying what are often painful situations.

Positives of marginalised behaviour
While it is easy to concentrate on the negatives of participants' current smoking behaviour and their minority sexual identity, participants also reported positives of the two behaviours being researched. This emerged as an important concept and contributes to the resolution of dissonance. The positives of smoking can be broadly grouped as being pleasurable, used to handle emotionally stressful times, achieving some 'time out' and to socially connect to others. For sexual identity, the positives were expressed broadly as finding resolution and self acceptance of same sex attraction and no longer struggling to fit into a heteronormative mould. Participants indicated that they had rarely if ever been asked what the positives were of being lesbian or bisexual or of smoking.

Respondents usually prefaced remarks by saying *there is nothing positive about smoking* but when probed most could identify several positives. Smoking was widely reported as being a pleasurable activity:

> *My morning cigarette is just, I love it, I look forward to it so much... as soon as I lie there I just think ah that's so nice and you know it goes with my morning coffee as well and you know it's just my little, it's my little ritual and I get pleasure from that you know. P 18*

Smoking was almost universally reported as a positive way of handling stressful situations. Participants talked at length about how smoking helped these situations. This was from everyday stresses, to larger issues around sexual identity or relationship issues where smoking could be seen as medicating emotional distress.

A number of participants specifically discussed the stress of their work environment and that smoking was used to cope with this. This did not mean that they considered their jobs necessarily stressful, but under particular circumstances, it was perceived to be stressful. Smoking was often seen as providing a *little 'time out' to walk away from work* and, *stress relief;* a way of stating; *'leave me alone and don't talk to me' to handle these work situations.*

Responding to relationship stress by smoking was commonly reported. This was often in reference to a primary relationship, i.e. a partner situation, or relationship with immediate family (usually family of origin, although family of choice was also mentioned). It could also revolve around the stress of parenting which for this participant meant:

> *A cigarette solves my boys' bum being black and blue definitely. I am a pretty patient sort of person (laughs). I am usually pretty patient so it takes a lot for me to actually smack one of my children… would rather go out and have a smoke rather than smack… Yeah. It calms me down calms them down and then we talk about it and carry on. P 13*

Break ups of primary relationships were cited by the majority of women as a time of great stress when smoking was seen as providing a positive way of easing this situation. This was often a trigger for more intense periods of smoking or of

relapsing after having quit. Smoking was seen as a positive way of handling this period of emotional stress. Such as:

> *I made a conscious decision to go back to smoking when I broke up with X. And it was better than other options I am... doing something destructive may as well do something that is not too destructive. P 12*

And as expressed by this participant:

> *A stressful situation came along. There is probably break ups with a girlfriend. Those times when you think what the hell, life sucks and I'm not happy you might as well smoke. Might as well die of smoking. P 5*

This participant put it strongly when she said:

> *... smoking was actually still helping myself heal and stick together and communicate properly and not look tortured* [following a relationship break up]. *P 1*

Handling emotional times was often expressed as needing to *suppress* these difficult feelings. This was usually done very deliberately as indicated by this participant who stated:

> *I have tried to medicate my emotions with a smoke. PS*

And from this participant:

> *I know it helps you suppress emotions. If I get really emotional then the thing I want is a cigarette. P 27*

For this participant emotional stress was also expressed in terms of a cigarette providing company:

> *I think it was company… I think it was, ahm it's like switching on television, you're taking yourself away from everything. Lighting up a cigarette for me was my company, my friend yeah it was, it was company for me and I know that's weird. P 15*

Many viewed cigarettes as a way of positively easing socially awkward moments, and providing a crutch. As this participant discussed when thinking about if she

could quit she was concerned about how she *would be able to cope socially* if she quit. *Not having* a cigarette as *a crutch to* fall back on *to feel more at ease* socially, and as expressed by this participant:

> *You know it's like you've got a drink in your hand or you've got a cigarette in your hand you don't feel as awkward, you don't feel as like you've got glaring signs that you're by yourself or that you, you know you don't know anyone... P 6*

For some this was expressed as giving 'comfort', but that was the only positive this participant could say about smoking:

> *For me personally it's a comfort, it's a lot of comfort in that. But that would probably be about all* [the positives]. *Comfort, familiarity, you know and that's emotionally 'cause logically I know there's really no benefits. P 21*

The positive of being able to use smoking to achieve some *time to get myself away* or 'time out' was widely reported. Such as:

> *I get 'time out'. Um people generally don't follow you if you have a cigarette. Um there are not many places or times where you get to yourself necessarily. P 23*

The last area that was widely reported as being a positive from smoking was to do with enabling social connection and group belonging. Smoking was reported as one way of resolving issues around fitting into a group or gaining social belonging to the lesbian community and/or the broader community, as this participant put it:

> *I guess as for meeting other lesbians at the smokers' corner comes into play. It's not really kosher to go up to a table of people and you know* [say] *'can I sit with you'. However if you are going over to the smokers' corner and asking for a light, it's a way of starting up a conversation. P 12*

This comment is about smoking in the gay community:

> *Smoking is definitely more prevalent in the* [lesbian] *population and yeah it does give you a sense of belonging that you can fit into that group. So you are a smoker like they are so you have something in common, something to talk about. P 22*

Some participants reflected that smoking was a way of gaining entrée to lesbian social environments. Participants reported that they remember seeing lesbians smoking and saw this as a role model particularly at a time of struggling to find their own sexual identity. As this participant reported:

> *So ah my partner introduced me to a lesbian community and they were all smokers. Yeah I don't think there was one non-smoker amongst them. P 1*

For this participant her smoking was a way of trying to fit into a particular heterosexual social scene, one that she reported feeling disconnected from but wanted to connect with in the face of not wanting to accept her lesbian self:

> … [smoking] *did help me feel like I fitted in, yeah with the heterosexual community that I was with…* [it was] *socially good, yeah I probably felt like I fitted in more, you know. I'm cool, yeah. P 28*

The following quote is from a participant who was not 'out' in her immediate work area, which was at times stressful, however she found others in the building but not in her immediate work area who are smokers. Smoking provided connection and social support while at work:

> *I have got girlfriends who work down stairs. Girls that are smokers and we actually became friends because we found each other downstairs smoking. P 16*

This smoker reported positive work connection gains which she saw as opening up promotion opportunities:

> *It's actually been good for networking. I'm actually in the job I am in probably because my last director was a smoker and so we spent time together and got to know each other and the next thing you know I have got this opportunity. P 5*

Connecting to other smokers was often seen as more open and less judgemental, *they do not have the attitude of I am better than you because I do not smoke,* or more interesting and being part of a *social micro culture* was reported by quite a few; such as this participant:

It just seemed to cut through boundaries. You know someone you wouldn't normally talk to maybe a guy with tattoos and a goatee you would not normally talk to. I don't know you are outside having a smoke. You stand there and have a smoke and have a chat. P 24

Other positives gained from continued smoking, but only reported by one or two participants, included:

- Smoking to ease boredom.
- Smoking to maintain weight i.e. not putting weight on.
- To counter withdrawal symptoms.

Positives noted by participants on being lesbian/bisexual revolved around being comfortable with who they were and being true to themselves. There were several participants who did put in a throwaway line such as:

It would be easier; it would be a lot easier to be straight [heterosexual]. *P 22*

There was a sense of yes this is where I want to be but it does not mean that it is always easy. There were less stated positives of being lesbian and bisexual than for the reasons given for smoking.

Managing stigma

As discussed under the core category of dissonance, stigma both overt and covert was experienced by many participants around issues of smoker identity and sexual orientation identity. Managing stigma in order to cope with life and maintain a sense of self, emerged from the data. Management strategies around stigma often overlap with previously discussed concepts of justification and minimising loss.

Stigma, experienced in a range of settings, was often managed through minimisation, deciding not to challenge acts of stigma or being dismissive of stigmatising behaviour. This participant is discussing a work place environment where she does not feel confident to be 'out' about her sexuality. Her approach is to keep quiet, despite the homophobic attitudes she reported in her work place:

... [if I came 'out' as a lesbian at work] *they would not see me, you know be not quite a female. I don't know how to put it. I just feel I would not be*

accepted in the old boys' club as I am now. I keep quiet. I do what I need to
do and I get on. And everyone is happy. I feel fine. P 18

This participant reported being abused verbally, and her response:

It hurts, it hurts a bit but I guess I do what I do with other homophobic people
and I'm like well that's your view to it and it's not going to affect me like
ahm... even at school when kids were homophobic and they'd be like that's
really disgusting, I wouldn't be like well fuck you, I hate you, like get lost. I'd
be like that's cool, that's your view but hopefully you can get to know me and
not judge me on it. P 25

Feeling safe was important and managing potentially stigmatising situations could
mean adopting a heteronormative position to avoid adverse judgement. Such as this
participant who said:

I'd be like I have a boyfriend instead of saying a girlfriend until I felt
comfortable with them that they wouldn't judge me on what I said. P 25

Dismissing negative opinions is also a management strategy as illustrated by this
participant when she said:

If you don't like who I am, then don't bother having a conversation with me...
I don't walk around with a big sign on my head saying oh I'm gay respect me.
P 15

This participant reported responding to young men who said negative things about
lesbians in a street situation by dismissing them as *I did not really like those people*
anyway.

Some participants were quite strident in responding to stigma in terms of seeing it as
not their problem. For example from this participant:

I don't, I don't particularly give a shit what people think [of my sexuality]. *I*
don't; I really, you know if they're going to hold that against me or treat me
differently because of that, then they lose out. P 18

There can be a difference with ways of handling stigma in the early stages of identifying as a lesbian/bisexual woman which then moves to a place of more confidence and dismissal of this behaviour. The following participant captures two modes of managing stigma; firstly through trying to blend into mainstream appearances and then to not caring what others think stage:

> *So when I first 'came out' I did, I was afraid like I made sure I dressed the way everyone else dressed. Like I stuck to the mainstream of straight girls so people wouldn't judge me and then in the end I kind of was like I don't really care what you think and why should I care because you know, I don't know you. P 25*

Managing stigma associated with smoking behaviour revolved around two main strategies; restricting where smoking occurred and smoking with other smokers. Often smoking was restricted to private areas or in secret. In other words participants removed themselves from areas of potential active stigma.

> *I guess it becomes the choice to isolate yourself or, and I do isolate myself a lot because of it* [smoking]. *I am very conscious of that I may smell of cigarette smoke so yeah. P 28*

Observing signed no-smoking areas was another way of restricting smoking activity. Conversely defending their right to smoke if there were no declared no-smoking areas was also important. There was definite support for most no-smoking public areas which was rarely seen as stigmatising in itself. Some commented that it encouraged them to smoke less and may support quit attempts. For example as this participant said:

> *So if there is an area that says you can't smoke I wouldn't be going there. I would go somewhere else... or if I could sit there for a while and then go around the corner for a cigarette. P 20*

However the right to smoke in a smoking area was clearly defended by this participant:

> *If there is a smoking area outside and you can smoke there and the people there don't like it, well too bad they will have to move. And vice versa if you can't smoke there you will have to go around the corner. P 20*

Smoking in public in the company of other smokers was seen as providing a supportive environment rather than an antagonistic one, a *safety in numbers* approach. For example as this participant put it:

> *... you'll notice that everyone sort of, all smokers congregate together. It's you know, it's pretty much, you're not going to be, you're not going to feel the brunt of someone you know 'cause if somebody does dislike you smoking there and they've, you know, got every right to say something. It's, yeah safety in numbers I guess, yeah really. P 6*

Being dismissive of abuse was a strategy also used to manage stigma around smoking. Although this participant acknowledged she was hurt by someone's aggressively negative comments about her smoking, she managed this by walking away:

> *Yeah it was an insult* [about being a smoker] *but I kept walking it's actually her issue. I try not to take it personally. P 1*

The ambivalence about how to seek acceptance as a smoker is captured well in the following quote:

> *I think we are always going to be a fringe population and I guess I don't want to be accepted as a smoker maybe because I want to give it up. So maybe there is a bit of selfish bit or self hate to that and it is OK to beat me up because I need to be beaten up. Does that make sense?*

Bringing stigma management to both smoking and sexual identity is nicely illustrated by this participant:

> *It doesn't bother me* [anti-smoking behaviour]. *I'm part of a minority group anyway being gay so I think once I got over that, nothing really fazes me anymore. P 10*

Participants had arrived at a point of resolution through a number of different avenues which have been discussed in this section as summarised in Figure 9. This may however not be a comfortable or stable place for some, and the effect of factors which called for redefinition occurred. Two major themes of this changing social

acceptability and life-course are discussed under the final core category of redefinition factors.
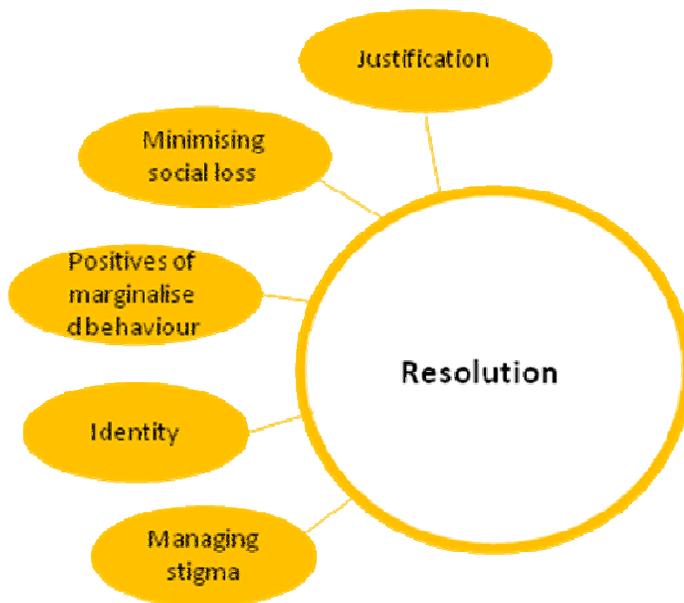

Figure 9. Core category resolution.

5.4.3. Core category – redefinition factors

The results presented in this section relate to the core category named redefinition factors. While there is likely to be interplay between some of the concepts discussed above in the core categories of dissonance and resolution, these have been impacted on by two dimensions of time. The first is the rapid social change over approximately the last sixty years around both smoking and homosexuality (Chapman & Freeman, 2008; Flood & Hamilton, 2008). This has led to one behaviour slowly gaining some social acceptability while the other has become socially unacceptable in most circles. The other dimension of time that has influence on the previous core categories is that of life-course. In other words changes that are experienced as part of growing older and having more life experience (Laurier et al., 2000).

While some of these impacts have been captured within the concepts discussed above they are also being treated separately here because all participants touched on the influence of time on their smoking behaviour and their sexual identity.

Changing social acceptability

> *It's like, oh of course you're gay. We were completely unaccepted and we've*
> *slowly becoming accepted. Whereas smoking was accepted and it's slowly*
> *become unaccepted. P 10*

Social acceptability of a behaviour is rarely a fixed entity as the dynamic process of social action, knowledge dissemination, legal change and increasing visibility challenge and redefine norms and social mores. Within this research two areas of social change have been captured – smoking and minority sexual identity as illustrated in the quote above. As social acceptance of diverse sexualities has been slowly increasing the social acceptability of smoking and smokers has been rapidly decreasing. Participants were acutely aware of and have been impacted by these changes – not necessarily uniformly and acknowledging that different social circles may have different social mores. Older participants, but also younger participants, discussed these changes and the impact on their own behaviour and self-concept.

Figure 10 diagrammatically represents this movement which has an almost mirroring effect of increasing acceptance versus decreasing acceptance. The experience of this while not uniform due to other influences, was nonetheless widely reported. Both situations however still left participants as belonging to a minority membership group. The exception being those smokers who had quit and who now called themselves non-smokers.
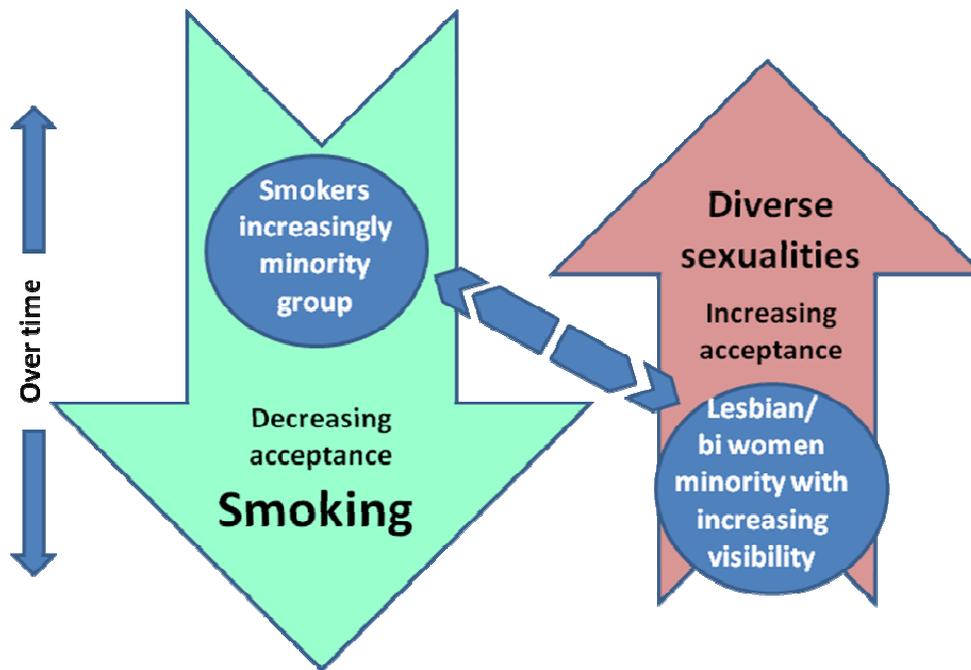
Figure 10. Changing social acceptability: sexual diversity and smoking.

The social change towards both smoking and sexual diversity has been relatively rapid over the last 60 years and some of the milestones of these changes have been reported in the literature review in Chapter 2 and 3. The age range of participants, 18 years to 61 years, mean the results reflect experiences that spanned a number of years during which fundamental social shifts occurred.

The substantial change in the social desirability of smoking was mentioned in many contexts. Young experimental smokers in the 70s or 80s wanted to be 'seen' as smokers which was widely socially acceptable and desirable. This was a time of tobacco advertising and only the start of widespread smoking control interventions (Scollo & Winstanley, 2008). Thirty years later at the time of this research no participant discussed smoking without reference to the social marginalisation they felt. Many wished they had never started and most wished they were not still smoking. Those who had quit worked hard at remaining ex-smokers and talked about how glad they were not to still be smoking and were now part of the majority i.e. non-smokers. Many smokers actively sought to minimise their smoking consumption and often hid their smoking. No participant ever wanted to be considered as smoking more heavily than they did or being mistaken for a smoker when they had quit.

The *romance* and glamour of smoking was mentioned by several older participants as influencing them to start. As this 61 year old participant reflected:

> *... I do think that it was a bit glam in those days because it was quite glamorous to smoke. The ads were glamorous... I think and it was nearly all* [television] *supported by cigarette advertising and it was pretty glamorous. Men were men and smoked men's cigarettes and women smoked women's cigarettes. And they all did it so beautifully. P 22*

Most participants discussed the changes and impacts as smoking became socially undesirable. This was not merely attitudinal change but structural change occurred such as increasing smoking bans and more widespread and graphic Quit smoking campaigns. Even if participants did not report being impacted by Quit campaigns, they acknowledged that this had contributed to smoking increasingly becoming a denormalised activity in Australia. This participant experienced this movement as:

> *A bit weird; a bit opposite to when I was saying it was stigmatised not to smoke* [when she was younger] *and now it is the opposite... there is a lot of pressure on people not to smoke. And health and doing healthy things is becoming more of a fashion if you will. So yes I feel like it's not really acceptable in a lot of places or its acceptable but not approved and you have to be quite a strong smoker to not be affected by that. P 22*

The ambivalence of this denormalisation of smoking was touched on by many participants and is captured in this quote:

> *I can be grateful because it* [smoking bans] *helps me when I am trying not to* [smoke]. *It almost helps me along by saying you can't or you have to walk all the way over there... yeah but then at the same time like when they said you can't smoke in covered areas like beer gardens that really got to me... But it still does not stop me. The whole public you know, general public saying you can't smoke here, it does bug me sometimes. P 16*

This participant summed up how smoking was now something she has to *hide* from society. This quote also illustrates that although there have been advances made in greater acceptance of lesbians, she feels she still often has to hide that part of herself too.

It felt like you're trying to hide a part [being a smoker] *of yourself from the rest of society, like another part of that makes sense, 'cause we already hide parts* [being a lesbian]. *P 18*

This smoker identified that smoking in the past helped her fit into a heterosexual environment, says of this now:

Does it, does it make us fit better into the broader community? Like by smoking do we fit better, and maybe that was so in the past but it's alienating, you know. Anybody who smokes now feels quite alienated. P 28

Social change was also experienced in the area of increasing social acceptance and visibility of minority sexuality groups. No participant said that as a group they were completely accepted but that change had on the whole made this aspect of their life somewhat easier. Difference of experience was reported across the participant group reflecting in some cases an age dimension in terms of the era a woman 'came out' and also the age when someone identified as lesbian woman. Several respondents said they *did not know any other gay people*. There was an invisibility around gay people. As this participant said:

I did not know any gay people either. But it's a funny thing that many families had this like the maiden aunt or the odd uncle or whatever um yeah lots of families had them but they never had a label so you didn't really know. P 22

Participants who had grown up in a time of less acceptance of minority sexualities could reflect back on this time. As this participant summed up:

In the beginning in the 80s ... I think it was a lot more closed doors in those days compared to now you know, as time has gone by. It's the media like Madonna and a lot of other people who have 'come out' and stuff. But back then in the early days in the early 80s I mean you were not sort of going open so much. P 20

And from this older participant:

But you get a lot of the older lesbians like me and we have grown up in a society which was not so accepting, we had a lot of discriminations, also with

> *I think with even 'coming out' to their relatives and all that it's a stressful lifestyle. I would say that it is a stressful lifestyle. P 2*

Several older participants referred to the fact that there are a great many more social supports in place for younger people who are coming to terms with their sexuality today than they ever dreamed of:

> *They are more fortunate because they are coming through in a more supportive* [environment]*, there are so many places* [they] *can latch on for professional support that just weren't there. P 22*

Younger participants on the whole found greater acceptance especially with their peers when they declared same sex attraction, than older participants, such as this participant who said:

> *All my friends are very accepting. I am very open about my sexuality... I've never been really picked on or abused so I don't see stigmatisation towards me or... but I can certainly see that it is the case in society sometimes. I think it has become more acceptable now especially for gay women than gay men. P 7*

This did not extend to all participants and it is a mistake to consider that younger people do not have any issues and conflicts about declaring their sexuality. The participant who made the above quote also stated that she did not *know where I got the strength from* to declare her lesbian sexuality. Two young participants were not 'out' to their parents and were concerned about how that would be received when they eventually had to tell them. However the majority of participants acknowledged the social changes that had occurred around the acceptance of sexual minorities.

Life-course

The second major time influence reported by participants was the effect of life-course on both behaviour and identity as a smoker and lesbian/bisexual woman. While the interview data collected a snap shot of a particular time in a participant's life they talked openly about what had occurred to that point in their life and also in some cases projected how they may respond differently in the future. Participants acknowledged that their responses to social and other situations now were often

different from earlier in their lives. This is the influence of life-course that is being captured here (Mayer, 2009).

All participants discussed the changes that happened during the transitioning from school years through to the stage where as they got older they had become surer of their identity. This may have happened quickly or through a prolonged process. Many participants discussed the impact on their life-course on 'coming out' and at what stage of their life they were at when they did this. Whether they 'came out' in their teens or early twenties, or whether they 'came out' later in life. For most participants teenage years were about trying to fit in and an awakening sexuality. Peer pressure, social expectations, parent influences were all strong at this time and played a role in smoker initiation and maintenance and with sexual identity issues.

'Coming out', regardless of the age when this happened, usually involved socialising on the 'gay scene'. This could be a short period of time or a sustained continuing period or as previously reported by one participant, an intense time of an early *super gay* period. For some this is still an ongoing and important part of their life. But generally older women were now less involved in the 'scene'. This participant echoes this common experience:

> *When I 'came out' I used to be on the 'scene' a fair bit. I did not go to that many straight places. It's all mainly night clubs I guess... I just don't really like to go out all the time, not like the old days when you lived in the place* [gay night club] *basically. Ah and again I think it is the age thing you have got other things that you are more interested in doing, instead of going out to the pubs and nightclubs. P 20*

Although not all women remember this time so positively and may see the 'gay scene' as a *ghetto* as put by this participant:

> *Just happens that I don't see the gay life as one of being a fantastic life to live in. In the gay scene... I like to fit in just normal society, well not normal I just want to fit into society. Back in those times it was like the ghetto. I still don't see the 'scene' as anything. P 2*

Several participants 'came out' much later in life, when they felt more secure in their own identity and stronger to face potential negative social reaction. They discussed having reached a point in their life where they could not hide their same sex attraction any more. This may also have been facilitated by the increasing social acceptance of homosexuality as discussed above. As this participant expressed:

> *Of course it takes a lot, a bit of age and a bit more experience and self confidence and then you do deal with them in a more appropriate way... Basically I did not have the confidence to deal with it* [attraction to women] *earlier. P 22*

Becoming pregnant and having children was seen as a potential modifier to smoking behaviour and many of those participants who were mothers did quit while they were pregnant. One participant was clear that she saw pregnancy as primarily an influence on heterosexual women:

> *I think they* [straight women] *have got the added incentive when they decide to have babies they quit smoking. P 17*

Although another participant who would like to be a mother one day also acknowledged this as a potential life-course influencer on her smoking when she said:

> *Yes well because I've always, whenever I think about it and I think oh one day I'll have kids but I want to give up smoking first. P 21*

As identified by many participants the kind of stress experienced and the role of smoking is likely to change over time through adulthood. In the quote below smoking was seen initially as a way of fitting in and then later used as a stress relief:

> *It's* [smoking] *kind of about rebelling but also trying to fit in with your peer group. But as time's gone on it's like well you know I do it* [smoking] *probably for, more to relieve my stress and to feel more comfortable in social situations. But I did that in the beginning. P 18*

The different expectations, role models and lifestyles that lesbians/bisexual women have about behaviour at an older age was commented on by several participants. For some this included partying due to lack of parenting responsibilities or the

community culture that involves identified social events involving night clubs. The lesbian/bisexual woman's lifestyle that some experience which was not tied to heteronormative expectations meant that several participants in their forties and fifties saw this as something unique. For example this participant talks about being active in the gay night club 'scene' and how this is different to heterosexual women:

> *They* [straight women] *are home with the kids. Yeh I think there it's just an age thing. I don't think at my age that I could be out in the clubs* [if I was straight]... *But because we are gay and there is less age discrimination you can still go. I think; I'll go down to the pub on a Saturday night and there will be a variety of ages. Quite unique. P 5*

For many women the health impact of smoking became more pronounced as they got older and may act as an incentive to quit or cut back on smoking. This participant saw this as related to being more positive about herself especially around issues of her sexuality, greater maturity and taking responsibility for her life which all contributed to re-evaluating smoking. As she says:

> *It'd be really sad, I'd be really disappointed in myself* [if restarted smoking again] *and now, I mean it takes a long time for you to realise from the early twenties I think until the late twenties and now early thirties that you've only got yourself to look after and while there was always a reason, yeah but I don't like myself, now I'm getting a bit more mature and going well you know. P 3*

Another participant in discussing the effect of her age on how she views her health and the impact of life-course: relates specifically to having turned thirty by which age she had hoped to have stopped smoking. However as she said:

> *I think that's what bothers me most now is my health, simply because of the fact that I have been smoking for such a long time and er, and turning thirty was a big thing. I thought shit. Getting a little bit older and smoking for such a long time it worries me now... Only in the last year or so I started to go shit, I really, really don't want lung cancer. P 21*

Despite changes in acceptance of diverse sexualities several participants did talk about how young women often had stereotypes of what being a lesbian/bisexual

woman meant and may not have had that sense of self yet to break out of a stereotype they saw in the 'scene'. This participant put it is this way:

> *I mean you see the younger kind of toughie kind of dykes and they're all smoking... Yeah, and the smoking it's a kind of a sign of toughness. You know like it's, like yeah tough, we smoke and we have cool hair and tattoos and piercings... I think it's an image thing. Like I think it's about being tough and not giving a shit about the mainstream I think. P 3*

Participant responses to what have been labelled here as redefinition factors illustrate changing pressures both internally and externally generated, which require participants to re-evaluate behaviours within their lives. Smoking and minority sexual identity have both been subject to ongoing social change in a relatively short period of time that may exacerbate these responses (Chapman & Freeman, 2008; Flood & Hamilton, 2008). Life experience over the life course also impacts as a redefinition factor.

The core category of redefinition factors places participants' experiences within the broader changing social context. It also reports on both the impact of this in terms of participant's response and society's response to these behaviours. Figure 11 summarises the core category of redefinition factors.
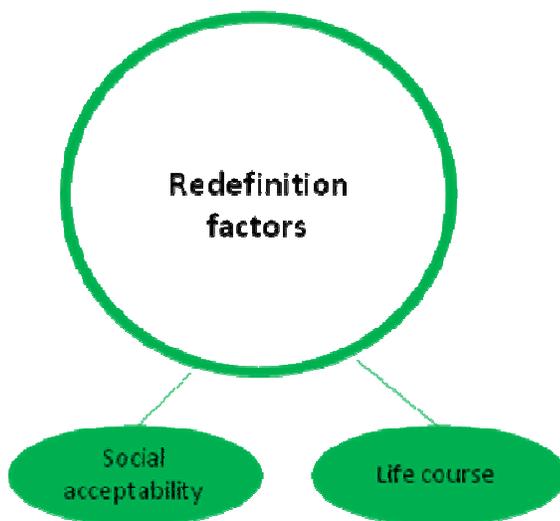

Figure 11. Redefinition factors.

5.5.   Core Theme – Self-concept

The interplay of the core categories of dissonance, resolution and redefinition factors all work to define self in relation to the behaviour of smoking and sexual orientation identity which emerged as significant parts of identity. Figure 7 illustrates self-concept as the point of aggregating the interplay of the three core categories. This is unlikely to be a fixed entity and the concepts presented throughout this chapter operate dynamically over time through evolution, change and resolution, redefinition, re-evaluation and resolution again for each participant.

Participants arrived at identity from a range of influences capturing the interplay of both how they saw themselves and how they thought others saw them. As smoking and sexual identity have increasingly been in the public arena, in legal, policy and public discussions, the social impact of wider views has impacted on previously discussed concepts such as questioning identity, stigma, finding belonging and social expectations.

It was acknowledged that smoking and sexual identity was an important contributor to self-identity these are not the sole contributions to a broader self-concept. Several participants discussed that smoking and sexual identity was just a *part of who I am*, yet both were also a significant part of who they were.

Although not specifically asked in the interview there was a sense that most participants had reached a place of self acceptance but this was not always an easy place. This was put strongly by one participant who said *I hate myself for smoking* a sentiment echoed by several other participants. Or another participant who said *it would be a lot easier to be straight.*

Self-concept does appear to underlie the feelings participants shared about their journey to be both a lesbian/bisexual woman and a smoker/ex-smoker and hence will form the basis of the discussion in the next chapter.

5.6. Lesbian Perceptions of Smoking and Community

Participants were asked to reflect on their perceptions of smoking within the lesbian/bisexual community. This provided the opportunity to authenticate and enhance the credibility of the reported experience of individual participants. This question was asked at the end of the interview after exploring their own smoking experience. I was interested in finding out if participants had any explanation for the higher prevalence of smoking among lesbian/bisexual women. A wide range of perceptions and explanations were provided and the quotes presented although lengthy, provide valuable insights from participants. Support for the core categories as reported earlier in this chapter were found.

Almost universally participants were surprised when told that research, both in Australia and overseas, had established that smoking rates were higher in lesbian/bisexual women. For some this may also reflect their own social circles where there may be higher than average prevalence and perhaps a lack of knowledge about how marginalised smoking has become in the wider community. It may also reflect a lack of discussion of this topic within the target community. This is illustrated by a participant who reported that smoking in the *normal* (heterosexual) *community, the percentage is higher* than the lesbian community. She then went onto say:

> ... *that just under half the women I know as part of LSN* (large country social lesbian group)*, half of them don't smoke. P 13*

By implication 50% do smoke which is well over the rate for the wider community.

This participant in commenting on smoking amongst gay people generalises and says:

> *Ahm, all the gay people I know smoke, not many of the straight. Like there'd be about five straight people that I know of that smoke and like there's quite a lot that would like occasionally have a smoke like when they're at a party. But yeah all the gay people I know do have a smoke, they smoke when they're*

all around each other or just when they're bored they'll have a smoke like yeah. P 25

Some participants when asked were happy to provide their thoughts on an explanation for this. Quite a few participants commented that they thought the higher smoking rate was related to higher levels of mental health issues in the lesbian community, some of which was related to being of minority sexual identity. This is illustrated by quotes from three different participants:

There are a lot of troubled lesbians out there which you know could be a lot of the reasons why they smoke. I'm sure if you looked at surveys you would find higher levels of mental illness. I think there are a lot of unhealthy lesbians out there. P 2

I think difficulties. A lot of people cope, use cigarettes as a coping mechanism and when you've got a lot to cope with, you need more coping mechanisms. Maybe that's why I would tend to think that more lesbians smoke; especially if they've had trouble 'coming out' or if they've faced discrimination and if they get stressed out about that and yeah. P 21

It might also be that you know we don't feel particularly great about ourselves and you know it's one of the ways we soothe ourselves or you know. That and I see a lot of alcohol too. Yeah I don't know actually, it's interesting now I think about it. P 18

For this participant, related to above broader mental health issues is what she considers the social isolation that many gay people experience which helps account for higher smoking levels:

I think a lot of people in the gay community are isolated you know. I think that's, I think that's a big, a big thing in any addictive behaviour whether it's smoking, whether it's drugs. P 6

Several participants discussed smoking as being part of and a response to a lesbian stereotype, especially for younger women. The first quote is from the on-line forum the second from an interview participant:

I think in the community a lot of smoking starts off as an image thing. The tough girl bad boi [boy] *image portrayed in the stereotyping phase of development. Some peeps just smoke cause they can't look honestly at a particular emotional issue. They use smoke to hide behind. PS*

I'd say smoking's on the rise only 'cause of the youngsters following behind us more so than anything else. Especially the young little, little whipper snipper gays 'oh I want to be gay'. They go out, they have a smoke 'cause they think it's cool... I think that's their idea of culture. Oh if you're gay you've got to smoke. P 15

This participant saw higher rates as the outcome of her perception that many lesbians lead a hedonistic lifestyle. This is hinted at in the second quote which mentions the partying lifestyle which is an important element for some members of the gay community:

I think gay people are, obviously speaking in general terms here, but are quite hedonistic... Life is actually quite short to pretend to be something that you are not, so you begin to live life much more for yourself and that the whole smoking thing is... it is fairly hedonistic. It's doing something even though you know you probably shouldn't. P 17

Because there are more [lesbian/bisexual] *women who are not settled out there going out partying and of varying ages. P 5*

This participant discusses mainstream Quit campaigns as often using themes that do not speak to the majority of lesbians/bisexual women. She first mentions that she thinks lesbians/bisexual women are less vain and therefore messages that relate to smoking as being unattractive are unlikely to impact, before discussing those aimed at parenting roles. Such messages have little resonance with this group. As she says:

Well I have not met a lot of gay women who are terribly vain so that particular social message that they have used in advertisements, is not going to work. Those that have not had children using the 'I have to be around for my children to go to school', that is not going to work. It needs to be a completely different approach to that. P 17

For another, smoking amongst the lesbian community was a way of marking difference and as an act of power or defiance in the face of minority status:

> *I would relate that back to lesbians and smoking is that it's some sort of power, it's some sort of identity, yeah. Does that make sense? P 1*

Not all participants could articulate any reasons for the higher smoking. As this quote illustrates from a younger participant who had a relatively easy time of declaring her sexuality and did socialise on the 'gay scene':

> *I don't know. I don't think it is the pressure of 'coming out' or being openly gay because I think if you are in that environment* [gay 'scene'] *anyway you are fairly open anyway. So I don't think it is that type of pressure. I honestly don't know. I do not know if the social pressure is any more. Yah couldn't tell you. P 7*

This is snapshot of some of the participant views on lesbian/bisexual women's smoking which particularly reflect earlier themes around acceptance of sexual identity at both an individual and a societal level and the impact of minority stress of belonging to a minority sexuality group.

5.7. Chapter Conclusion

Chapter 5 presented the results from the collected research data. Firstly the sample was described in detail before the outcomes of the coding and data analysis were presented. This started with descriptive open coding which moved to the identification of more conceptual coding using NVivo to assist with organising data through axial and 'tree nodes'. Grounded theory provided the methodological framework while symbolic interactionism provided the conceptual framework. Grounded theory required an immersion in the data which was achieved through a careful coding process and a constant and multiple revisiting of the transcript data from which conceptual ideas were delineated (Corbin & Strauss, 2008). Not all individual concepts were reported on as these were then collapsed back to core categories in order to make sense of the breadth of experiences reported by participants.

What emerged was a complex interplay of the core categories of dissonance, resolution and redefinition factors. Within each of the core categories further clustering of data around concepts emerged. These contributed to a core theme of self-concept. Although the data collected captures one point in time, this was a dynamic interplay resulting in a constant renegotiation of what it means to be both a smoker and a lesbian/bisexual woman. A final section reported on some explanations given by participants on the reasons for higher smoking prevalence in lesbian/bisexual women, which also overlapped with some of the concepts and categories that had previously emerged from the data.

It was clear that self-concept of smoker and sexual orientation was influenced by both how someone sees themselves, the personal 'I' in symbolic interactionist terms, and how they perceive others to see themselves, the social 'me' in symbolic interactionist terms. This also interplayed with meaning that was both self generated and socially generated. The results show a unique set of influences, experiences and self-perceptions around such issues as social expectations, knowledge, stigma, fitting in, seeking belonging etc., which participants used to negotiate a position as a smoker and a lesbian/bisexual woman.

The results chapter has presented the voice of participants. Chapter 6 will now present a discussion of these results with reference to the research objectives.

Chapter 6 Discussion

6.1. Introduction

Chapter 6 provides a commentary on the results presented in the previous chapter with reference to the research objectives, conceptual framework and the literature. The conceptual framework is restated before providing comment on each research objective with reference to what the research found, how this related to the literature and what conclusions can be drawn. The last research objective – the provision of recommendations for approaches to reduce the prevalence of smoking among lesbians, is addressed in the concluding chapter.

The chapter concludes by presenting an explanatory model that was developed from the first five objectives. The explanatory model shows the impact of smoker identity/behaviour and sexual orientation identity on self-concept as a result of the dynamic and complex interplay of self-perception and the interpretation of the perception of others.

The conceptual framework chosen for this research was symbolic interactionism, which as Crotty (1998) emphasised allows the actor's (participant) view of actions, objects and society to be studied, especially with reference to meanings that have been generated. The current research has captured the participants' views on being a lesbian/bisexual woman in a fundamentally heteronormative environment and a woman who smokes at a time when smoking has become socially unacceptable and is a minority behaviour. In so doing there is the opportunity to explain actions by understanding individuals' responses to the world around them (Chenitz & Swanson, 1986; van Krieken et al., 2000). The results presented a snapshot of participants' understanding at a particular point in time. Their reflection illustrated that this has evolved over their life and will continue to evolve in response to both internal reflection and experience, and an externally changing world.

The discussion confirms the choice of symbolic interactionism as the appropriate and well matched conceptual framework for the research. This guided the grounded

theory methodology that allowed for the actions of participants to be captured and interpreted within an interactionist framework, which illustrated the concept of self, and identity issues to provide a lens of understanding. Charon (1998) outlined five core ideas of symbolic interactionism that contributed to interpreting participants' responses (see Table 14).

Table 14

Symbolic Interactionism Core Areas

Symbolic interactionism core ideas (Charon, 1998)	As illustrated by participant responses
Social interaction is the result of dynamic social activities taking place among persons.	All participants discussed social aspects of relating to others and the relative importance given to certain people and situations and the impact of those people's own views and values e.g. parents, friends, community members.
Human action is caused by not only social interaction but also results from interaction within the individual – the thinking process.	All participants clearly negotiated with themselves in a thinking sense around many issues but particularly for this research, how they thought about their sexual and smoker identity, and how this identity operated with reference to others in an ongoing process.
Humans do not sense their environment directly but rather define their situation as they go along in their actions, reacting to a reality they have defined.	All participants defined and operated in their own reality, one that they had an active part in defining. For example, relationship to the gay community, relationship to the wider community.
Individuals respond to the present situation as defined in the present. The past may influence this definition; it does not determine current actions.	All participants discussed at length the influences of the past particularly around issues of smoking initiation and sexual identity formation however this was not a deterministic pathway. For example while all participants grew up in a heteronormative environment, not all went on to have heterosexual experiences.
Humans take an active part in the cause of their own actions – they are not passive actors.	All participants gave examples of active decision making on how they chose to be in the world. For example there were many examples of stigma management that were actively employed.

The insights gained from a symbolic interactionism conceptual framework have helped in framing the discussion of the research objectives that are stated and discussed in the following subsections.

6.2. Smoking amongst lesbian/bisexual women

Objective 1 was to synthesise a coherent description of the social activities and social interaction of smoking behaviour among lesbians. In describing smoking amongst lesbian/bisexual women, it was important to note that this was a minority behaviour in this group. The majority do not smoke. Those that do, smoked in a variety of circumstances and illustrated a variety of smoking patterns influenced by such things as the experience of minority membership, age, life-course factors (discussed in 6.6.), smoker status of partner, peer, friendship and community group association, socialising activities, work place impacts and smoker identity to name a few.

No single pattern emerged either for the initiation of a smoking career or for current smoking/quitting behaviour. Lesbian/bisexual women are not a homogenous group either in their smoking or in their experience or definition of minority sexuality. One of the strengths of this research is that a diverse group of participants were interviewed as distinct from a more homogenous sample.

The participant group ranged from several ex-smokers, women who had been smoking regularly for as little as two years, to one participant who was a heavy smoker (over a pack a day) and had smoked for over thirty years. For most participants the way they now smoked differed to earlier periods of smoking. For example they had moved from heavy smoking to greatly reduced consumption or self labelled 'social' smoking. Smokers responded to a range of cues that influenced their behaviour and while there were individual responses in part driven by beliefs and experiences explored in the next section, there were also common elements.

Negotiating being a smoker at a time in Australia when smoking had become a denormalised behaviour was a common element. All accepted that there were negative health and social consequences of their smoking. Participants also defined positives of smoking. Participants reported smoking consumption varied depending on the social setting and whether they were making a conscious effort to quit. Smoking behaviour was rarely a fixed entity but changed throughout a 'smoking

career' in response to much more immediate influences of the social setting and emotional factors, and could vary on a daily basis.

Self-description of smoker types helped illustrate the diversity of smoking behaviour. Participants described their own and other smokers' identity and were often critical of the way smokers were considered to be a homogenous group of 'smokers' by others. Identity labels often used language not generally used by the broader community of non-smokers and showed an in-group understanding of the complexities of smoker identity. Smoker types as described by participants are captured in Table 15.

Table 15

Smoker Identities

Identity	Description
Addicted smoker	Acknowledge that the main reason they smoke was that they are addicted to nicotine in cigarettes and crave them. This was often used as justification for difficulty in quitting.
Heavy smoker	Acknowledge that they smoke a pack or more a day, a higher consumption than many other smokers. Little attempt to restrict cigarette consumption.
Binge smoker	Smoking associated with particular social environments or occasions, often on the weekend where extremely heavy smoking occurred in a very different pattern to week-day smoking. Sometimes followed by days of no-smoking.
Habitual smoker	Smoke regularly and habitually often in response to other behavioural clues e.g. always has a cigarette first thing in the morning, smokes when on the phone, when in the car etc.
Chipper	Smoke only a few cigarettes a day and generally do not consider they have a 'smoking problem'. Non dependent users.
Responsible smoker	Very careful to smoke in a way that does not affect others especially children or people they know have health problems. Smoking is not necessarily a shared activity and they may often smoke by themselves.
Opportunistic	May not purchase cigarettes but will smoke if offered or can gain cigarettes from others. Do not always consider themselves to be a smoker.
Social smoker	Rarely consider they have a daily smoking habit but rather smoke when in a social environment where there are other smokers. Often however this is in fact daily smoking.
Occasional smoker	Similar to social smoker however may not require a social situation to smoke but will smoke occasionally.

Other authors have also differentiated smoker types. Tobacco 'chippers' have been defined by Scollo and Winstanley (2008) as non dependent smokers for whom

smoking is associated with relaxation rather than stress management. While the work of Ryan (2010) grouped smokers based on behaviours, attitudes and needs and identified seven archetypes of smokers: young socialites, rejectors, anxious, agnostics, hedonists, dogmatics and defeatists (R. Ryan et al., 2010). Choi et al. (2010) report on 'phantom smokers' characterised as those who report smoking cigarettes but do not view themselves as smokers (Choi et al., 2010). These terms which described types of smoker may not be used by smokers but confirm, as does the table above, that smokers are not a homogenous group but displayed different smoking behaviours and are likely to be motivated by different factors.

While all participants clearly stated the adverse consequences of smoking, they could also report the positives of smoking, although often this required further interview probing as many initially stated there was nothing good about smoking. This assisted in understanding smoking behaviour and cues to smoking patterns. The main positives discussed were stress relief, emotional management, pleasure and social connection.

Providing relief from stressful situations was a widely named positive of smoking. Primarily these were reported as intimate relationship/partnership stresses especially following a relationship breakup. Work-related stress was also noted. Smoking also allowed for time alone as a form of stress relief in both family/intimate relationships and in the work environment as this could actively keep others away. Having a cigarette was also seen as helping to alleviate socially awkward situations.

One positive noted by almost all participants was the social connection with other smokers: close friends, family, work colleagues, members of the universal group of 'smokers'. Sometimes this could be a particular lesbian/gay community setting or event. Smoking also provided an entrée into some of these social settings, a finding reported by others who have looked at gay substance use (Gruskin, Byrne, Altschuler, & Dibble, 2008; Parks, 1999; Remafedi, 2007). Smoking provided what Ryan (2010) called a 'social glue' between smokers; a positive noted by many participants.

Smoking was reported by many as being a pleasurable activity; both the act of smoking (lighting a cigarette, inhaling etc.) and the 'hit' of nicotine. It was often habitually associated with other pleasurable activities e.g. drinking alcohol and talking on the phone. Continued smoking dealt with otherwise unpleasant nicotine withdrawal symptoms. Positives have been reported by other authors (Laurier et al., 2000) yet rarely addressed adequately in smoking control interventions. As Laurier et al. (2000) discussed the habitual or ritual aspects of smoking serve as important and pleasurable parts of most smokers' days.

Smoking, either consciously or unconsciously in response to a stressful life situation or event, was commonly reported by participants. The term 'self medication' was used by several respondents to describe smoking for emotional management. The stressful events experienced by lesbian/bisexual women were often qualitatively different to that of heterosexual women in both frequency and cause. For example, high interpersonal relationship stress resulting from a relationship breakup could be exacerbated because the relationship was not recognised or had not been openly discussed with family or 'straight' friends due to anticipated homophobic response. Such a situation was often reported to result in a return to smoking if the participant had been in a quitting phase, or to a higher level of daily smoking. This increased smoking is different to binge smoking described below as it was not stimulated by social activity and often persisted for extended periods of months. The use of smoking during such times was accepted by other smokers and many friends as an acceptable response. Once the stressful period had passed most participants reported reverting to reduced consumption.

Smoking to handle stressful situations has been reported in other contexts for example Siahpush's (2004) work with single mothers, Nichter et al.'s (2007) work on the role of smoking for stress management amongst college students and Laurier et al.'s (2000) work which showed smoking as both habitual and helpful in coping with everyday struggles. Self medication to handle stressful situations has been reported as an explanation by lesbians for alcohol and illicit drug use (Corliss, Grella, Mays, & Cochran, 2006; Gruskin et al., 2008). Todd (2004) looked at daily patterns of cigarette consumption and found that consumption increased in response to times of increased negative events and higher levels of perceived stress. Several

participants specifically discussed episodes of depression and increased consumption of cigarettes at such times. This is supported by the literature linking smoking and depression and higher rates of depression amongst lesbians than heterosexual women (Hughes & Jacobson, 2003).

All participants discussed different smoking patterns as defined by the social setting which included whether the setting was private or public and the impact of smoking bans and/or the views and behaviours of others in that setting. There was a distinction between smoking in their own domestic environment and smoking in a social setting whether a public or private environment. All participants indicated that they had some pattern to their smoking whether this was a regular pattern of daily smoking and could recite at what time of the day or what activity they associated having a cigarette with. For some this was largely unaffected by the influence of other social events.

Most reported having an 'at home' pattern of smoking that included their own guidelines (only smoking outside, not smoking around children, not smoking in the car) and habitual cues (smoking while talking on the phone, always one cigarette with the first coffee in the morning, smoking after a meal). Social situations that involved others resulted in constraints or promoters for their smoking. Certain cigarettes were also seen as having different functions for example the habitual morning cigarette was very different from that used for stress or emotional management. While there may be many habitual cues to smoking there was also the pharmacological impact of a highly addictive substance which resulted in withdrawal symptoms within two to three hours of the last cigarette (Jarvis, 2004).

Other authors have commented on the complexity of understanding daily smoking where cigarettes can have a different meaning and purpose throughout a day (Laurier et al., 2000). Smokers were found to be able to differentiate between habitual cigarettes for example and those used to manage emotions (Bancroft, Wiltshire, Parry, & Amos, 2003). Motivation that drives cigarette consumption especially of dependent smokers is equally complex (Piper et al., 2004).

The majority of participants indicated that their social activity and social connection was not limited to gay or lesbian social settings and the level of active involvement in the 'gay/lesbian scene' varied considerably. Any social event that involved other smokers usually resulted in higher consumption. Participants generally had friendship groups that included smokers and for some this involved a high prevalence of and acceptance of smoking within their groups whether they were gay or mixed groups. This illustrated the influence of the immediate social context and social group on smoking behaviour.

Smoking for many participants was associated with socialising within the lesbian community or smoking with lesbian friends. The prevalence data confirms higher smoking rates for non heterosexual women and anecdotally smoking is commonly associated with gay night club environments. Many participants reported that their smoking tended to be higher when in this environment. Even though licensed premises in WA have been smoke-free since 2006, most premises have well established outside areas for smoking either as part of a venue or in an adjacent street area.

All participants reported that being in an environment where others smoked including at gay events, resulted in a greater likelihood of their smoking. This ranged from a moderate increase in usual smoking consumption to a marked increase in smoking. Many also stated that there were so many occasions when smoking was not permitted that being with other smokers, a 'safety in numbers' aspect, contributed to the freedom to smoke where smoking was accepted.

There was a lack of consistency about whether participants thought that the denormalisation of smoking had spread to the lesbian/gay community. While many thought this was the case, others thought it was still widely accepted. The majority also reported that smoking was not important compared to other issues confronting the gay community e.g. illicit drug use and fighting for same sex marriage. This also reflected a general lack of knowledge of the higher smoking rates amongst lesbian/bisexual women.

Alcohol consumption was reported as a major trigger for smoking and higher consumption patterns, at both night club and licensed premises or private socialising. Several studies confirm that lesbian/bisexual women were more likely to drink at risky levels (Hughes, Szalacha, & McNair, 2010; Z. Hyde et al., 2009; Pitts et al., 2006). Risky alcohol use amongst lesbians has been associated with higher levels of stress (Hughes et al., 2010). Both stress and alcohol use were named by quite a few participants as related to their cigarette use. The importance of gay bars and nightclubs also meant that alcohol was likely to have social definitions within the lesbian community (McDermott et al., 2002; Pride History Group Sydney, 2009).

Weekend 'binge smoking' was noted by several participants and was closely associated with social context. Binge smoking was characterised by extreme cigarette consumption in a defined time and place, usually associated with socialising with others and often associated with other drug use notably alcohol. Binge smoking resulted in unrestrained smoking such that over twenty cigarettes could be consumed in a single social evening. The following day often involved adverse effects of such concentrated consumption and resulted in either a period of no-smoking or severely restricted smoking for several days or until the next social event, often the next weekend.

There was a group of participants who acknowledged they were smokers, but defined themselves as social smokers. Cigarettes were smoked very much as a social activity and involved smoking when others smoked and was rarely a solo activity. Consumption was often modest perhaps smoking several cigarettes in the company of other smokers whether through a feeling of comradeship or as a way of self-limiting smoking consumption. They had less daily habitual cues to smoking and were likely to be less addicted to cigarettes than those with higher daily consumption patterns.

Participants changed consumption patterns in response to different social settings as has been noted by other authors. This fluidity of smoking behaviour though was rarely found to influence overall consumption but rather redistributed consumption through a day or a week to include periods of heavier smoking and other times of reduced smoking as has been reported by others (O. Carter, 2008; R. Ryan et al.,

2010). Smoking restrictions were found to influence how and when smoking occurred but rarely influenced decisions to quit. Ryan et al. (2010) have also discussed weekend 'binge smoking' although the term is not defined, as one manifestation of this redistribution of cigarette consumption.

Christakis and Fowler (Christakis & Fowler, 2008) have discussed the importance of social networks which both encouraged and normalised smoking and also potentially impacted on quitting behaviour. The current research illustrated the smoking behaviour of a minority group with individual variations and the important influence of social group smoking behaviour and norms. It is therefore not surprising that all smokers discussed the importance of having friends who smoked and the social returns from being part of a 'group of smokers'.

Important and immediate personal connections also influenced smoking behaviour. Several participants discussed partner effect on their smoking. Those who were in a partnership were likely to have a partner who also smoked. It was not always clear whether entering into a relationship with a smoker was the result of wanting to be with a smoker, wanting to do everything to help a relationship and avoid conflict, peer pressure of new social groupings or the dissolution of resolve if they were a recent quitter. Certainly, with a higher prevalence of smoking among lesbian/bisexual women there is a higher probability of meeting a woman who smoked. Conversely, some participants were in a partnership with a non-smoker and this was generally challenging as they often felt pressure to quit smoking. Although several acknowledged the support of partners in this, it did not guarantee success or a true appreciation of how difficult it was to quit nor the positives that came from continued smoking.

Most participants discussed that they had experienced a series of relationships. This potentially impacted on smoking behaviour in two ways. Firstly, there were potentially more stressful life events around the number of relationship breakups and secondly it could lead to exposure to more potential partners who were smokers. This is borne out by several participants who made statements to the effect that all the women they have ever been with were smokers. There was also an indication by many participants that the times when they sought to find a new partner were the

times they were more active in the 'gay/lesbian scene' where smoking was more prevalent.

Having children, especially younger children, modified smoking consumption and behaviour. Most wanted to avoid exposing children to passive smoking and/or wanted to avoid their children seeing them smoke as this was seen as poor role modelling. They also wanted to reduce the opportunity of being subjected to their children's disapproval for their smoking. As the majority of lesbian/bisexual women were not parents this was not an influence for all women, many of whom would be less likely to have their smoking subjected to the scrutiny of close family members. Although some did discuss that they experienced the disapproval from their parents even as adults.

Discussions of smoking behaviour inevitably included discussions of quitting and quitting attempts. For all participants, apart from the two youngest, long periods of constant smoking were interspersed with periods of non-smoking, which could last from a day, a month, to a year or more. Triggers for a quit attempt included renewed concern about health consequences of smoking and internal conflict or dissonance of continued smoking. The majority of participants had quit multiple times which meant that they had also relapsed and returned to smoking multiple times. Relapse was often accompanied by feelings of failure and regret, often reinforced by views of others who may have been supportive of a quit attempt but were unsympathetic or lacked understanding of relapse. Older smokers in general had more regrets about continued smoking and had attempted to quit more often than younger smokers.

Younger participants rarely considered themselves as being lifetime smokers. They gave the impression that when they no longer wanted to smoke they would quit and expressed confidence in quitting without having tested this.

Participants clearly identified situations that led to relapse. Risky situations that challenged their resolve to remain a non-smoker rather than reinforcing a long-term identity of being a non-smoker emerged. The two commonly reported risky situations were the stress associated with an emotionally challenging time especially associated with a relationship breakup and the peer influence of other smokers

usually in a specific setting e.g. party. For some the ongoing exposure to minority stress may make the motivation to quit difficult.

Self-efficacy, or confidence in an ability to remain a quitter, has been researched however the literature does not address how this may relate to lesbians. Gwaltney et al. (2009) have suggested while self-efficacy is important for successful quitting it may be more important to understand and identify within-person changes that are likely to challenge this.

Many of the reasons given above for continued smoking by participants were not dissimilar to reasons discussed in the literature for heterosexual women including depression, stress, weight control, other drug use, reduction in withdrawal symptoms and conditioned responses (Baker, Brandon, & Chassin, 2004; Gruskin et al., 2008; McDermott et al., 2002). Gruskin et al. (2008) reported three main reasons for women's smoking: emotional regulation, stress management and enhancement of social relationships, regardless of sexuality. However they proposed that lesbian respondents' experience of sexual stigma resulted in additional and unique negative emotions which resulted in stigma vulnerability, a "heightened susceptibility to the temptation to smoke as a result of the experience of different types of stigma" (Gruskin et al., 2008, p.172). Reasons for initiation in the participant group often related to seeking belonging and smoking was seen to assist this process as well as specifically addressing the stress of declaring minority sexuality.

Summary
Several conclusions can be drawn from the above. Foremost this was not a homogenous group with homogenous smoking behaviours. Individuals had particular smoking patterns and it was difficult to describe group-smoking norms. Too often however smokers are addressed in public health interventions as a single entity. It is also clear that the reasons women started to smoke and continued to smoke were different. Smoking behaviour was not static or unchanging but fluid with changed patterns dependent on the social situation and an individual's own circumstances, and changed over time. Most smokers had a history of quit attempts and articulated triggers to relapse which illustrated smoker understanding. All smokers acknowledged that their smoking behaviour was influenced by the denormalisation

of smoking in Australia with the implication that they felt part of a minority and maligned group in society. Some noted this was a familiar place due to their sexual minority status and lived experience in a heteronormative environment. All participants defined positive aspects of smoking and thought that most non-smokers did not understand this.

The denormalisation of smoking also influenced reported differences between smoking in private versus smoking in public places, most of which were now smoke-free. Smoking behaviour was influenced by the behaviour of others in both spaces. The higher level of smoking prevalence amongst lesbian/bisexual women meant they were more likely to know other smokers and other smokers would more likely be present at social occasions, which could validate their own smoking behaviour. Social connection with other smokers was seen as a positive and was not restricted to the 'gay/lesbian scene' but was often associated with this.

The lesbian community and 'gay scene' was seen by many as a place where smoking was less likely to be challenged and was more likely to be normalised. While it is simplistic to suggest that this is the prime explanation for higher smoking prevalence in this group, gay/lesbian social events do have an important influence on smoking behaviour for many lesbians at the point of sexual orientation transition, smoking initiation or continued smoking.

The diversity of participant experiences illustrated that influences on smoking behaviour were not as closely linked to a common experience of socialising amongst the lesbian/gay community as earlier research has suggested. There was however greater commonality in the experience of sexual minority membership and the role of smoking in the early clarification of sexual identity. These are discussed more fully in section 6.5.

6.3.   Individual smoking beliefs and explanations

Assessing individual explanations and beliefs about smoking behaviour was the second research objective. All participants had explanations and beliefs about their

smoking behaviour and identity. All accepted that there were adverse health consequences of smoking, a response due in large measure to the widespread anti-smoking public health messages and campaigns in Australia. Many individual explanations for smoking were therefore couched in terms of justifying their smoking at a time in Australia when smoking had become increasingly denormalised. Most acknowledged the contradiction in their knowledge of health consequences and their continued smoking.

Regardless of smoking behaviour it is clear that participants had their own script to describe and explain their smoking to themselves and when necessary to others. This script, like smoking behaviour, changed over life-course and showed significant age influence. It was also influenced by different social settings and the views of other people, both smokers and non-smokers, either stated or implied. The majority wished they did not smoke, however only a minority were currently motivated to consider a serious quit attempt as being imminent although most had tried to quit at least once. Older participants, who also made up the small group of ex-smokers, were more likely to regret their smoking while the younger cohort was less likely to have regrets about smoking.

Most had an explanation for their smoking initiation. The major theme to emerge was related to seeking a sense of belonging at a time in their lives when they felt they did not fit in. On reflection, many named being same sex attracted had resulted in them feeling different and not fitting in during their teenage school years. Most could not name this as such at the time. Initiating smoking was for many a way of connecting to others at this time.

Explanations that justified their continued smoking served both to counter challenges by others and to resolve dissonance about smoking to self. Common themes included taking healthy actions that countered the negative effects of smoking such as a good diet or being physically active. There was a strong belief that this provided protection and a rationale to continue smoking. Quite a few participants believed that smoking needed to be considered within the broader context of how many other circumstances could result in poor health and/or death, many of which they had no control over and

this then justified their continued enjoyment of cigarettes and reduced the need to consider quitting.

Smokers' justification of smoking has been documented by other authors. Kleinjan (2006) used Bandura's term 'disengagement' to describe those beliefs used by smokers to deny or justify smoking. Strong disengagement beliefs were found to inhibit successful quit attempts (Kleinjan et al., 2006). Oakes et al. (2004) arrived at 4 broad categories of self-exempting beliefs about smoking: (1) sceptic belief e.g. smoking cannot be all that bad for you as many smokers live long lives, (2) bulletproof beliefs e.g. you can overcome the harms of smoking by doing things like eating healthy food and exercising regularly, (3) 'worth it' beliefs e.g. you have to die of something so why not enjoy yourself and smoke, and (4) jungle beliefs e.g. it is dangerous to walk across the street. Many participants described these four beliefs.

However there were two unique justifications not captured in Oakes et al.'s (2004) classification above. These can be grouped as: (1) I feel so bad/stressed/depressed that smoking is a helpful/less harmful response than other options such as illicit drug use or self-harm, and (2) to be a lesbian is to be a smoker and I am a lesbian and therefore I smoke. The latter was a belief currently held by two young smokers but was also a belief previously held by several older participants when reflecting on their early smoking careers and their early sexual orientation identity.

The first response related to being overwhelmed by feelings of despair about other aspects of their life, which were seen as a greater priority to resolve than to act on the adverse effects of smoking. For many participants this referred to sexual identity issues or the experience of a period of intense emotional vulnerability that often followed a relationship breakup. This could have resulted in depression or other mental health problems which other authors have found related to greater smoking (Jarvis, 2004; Jorm et al., 1999). Several studies have confirmed higher levels of mental health problems in lesbian/bisexual women (McNair, Tong, Kavanagh, & Agius, 2005; Pitts et al., 2006). The higher prevalence of other drug use notably alcohol, by lesbian/bisexual women has been associated with the higher levels of reported mental health and minority stress by this group (Hughes et al., 2010; Lehavot & Simoni, 2011). Several participants discussed the interplay of other drug

use, mental health, stress, stress management and cigarette use. Smoking as being part of lesbian identity is discussed in more detail in 6.5.

A large proportion of participants reported increased smoking consumption or smoking relapse related to relationship breakup. In a London study of 1,085 non heterosexual women, (mean age 32.8), 51% reported over a lifetime they had six or more female sexual partners and 39% had six or more male sexual partners (Bailey, Farquhar, Owen, & Whittaker, 2003). A Western Australian study found that of those with a regular female partner 62.7% reported this was of three years or less duration (Z. Hyde et al., 2007). While this does not conclusively show that lesbian/bisexual women have more partners, it does illustrate that multiple relationship breakups over a lifetime are common in this group.

Older participants reported more regret about being a smoker and more impact from the denormalisation of smoking and yet they often had sophisticated rationales for continued smoking. Yong et al. (2005) have discussed the age effect of self-exempting beliefs of smokers. They noted that such beliefs can be very entrenched in older smokers and could be harder to shift.

Participant beliefs and justifications altered over time responding to life-course and social acceptability changes. The majority had experienced a relapse following a quit attempt. This participant group was not unique in struggling with the inconsistency between beliefs and behaviour as previously discussed under the core category of dissonance. Dissonance and its effect on behaviour has been described by others (notably in the Theory of Cognitive Dissonance (Festinger, 1957)) and psychological tension due to this was reported by many participants. While some participants reported behaviour change when quitting, for the majority as predicted by Festinger (1957), beliefs were altered more readily than behaviour.

All participants acknowledged that smoking had become unacceptable in Australia. There was variation in the extent of this unacceptability that reflected individual friendship groups and to some extent their beliefs about prevalence of smoking amongst lesbians. The majority of participants thought that smoking rates amongst lesbians was no higher than the wider community. Some participants reported that

the majority of their friends smoked and were equally surprised that this was greater than the broader community.

All participants were aware of ongoing public health interventions that sought to encourage quitting behaviour such as television advertisements, billboards and other visual campaign materials including graphic health warnings on cigarette packages. Universally these were dismissed as having no immediate effect on any quitting decision. Campaign material was reported as not 'talking to' them as lesbian/bisexual women, whether participants identified strongly with the gay community or not. Although intellectually there was a logical understanding that the smoking risks portrayed did in fact apply to them, for the majority of participants the social marketing messages were interpreted as showing little understanding or engagement with non heterosexual women.

Summary

Individual explanations and beliefs about smoking were often framed in terms of justifications for continued smoking despite having the knowledge that smoking carried with it many adverse health consequences. The response to this knowledge and the negative portrayal of smokers within Australian society meant all participants had well developed justifications for their continued smoking. Descriptions of smoking behaviour often sought to minimise their consumption to convince both themselves and others that their smoking was 'not really that bad'. While many of these strategies are not dissimilar to those reported for the population at large, two unique factors emerged. The first was a belief that other issues that negatively impacted on a person's life could be far larger and pressing than the issue of smoking. For many this involved stressful life events and smoking was justified as a useful coping strategy. The other was the belief that smoking was somehow related to what it is to be a lesbian. These beliefs were not held by all participants, but emerged as an important theme.

Reported beliefs and individual explanations for smoking were not fixed, but changed over time, for example explanations for smoking initiation and continued smoking were often very different. There was also universal disdain for social

marketing campaigns, which were not seen as being inclusive of lesbian/bisexual women, many of whom felt marginalised by these campaigns.

6.4. Minority membership

The impact of belonging to a marginalised group on smoking behaviour was the third research objective. Participants discussed the experience of minority membership including identity issues, stigma and consequent stigma management. Participants felt that they distinctly belonged to two minority groups: non heterosexual women and smokers. It was clear that the experience of minority membership was not restricted to sexual orientation and that for some smoker identity was a greater stigma than that of sexual orientation.

Participants reported that the experience of minority membership changed over time, reflecting broader societal responses to both sexual identity and smoking, and that their own self-efficacy and circumstances may have changed. Same sex attraction is a minority behaviour (15.1% of women reported some same sex attraction or experience in a large Australian survey (A. Smith et al., 2003)). A lack of demographic information means it is inconclusive whether this figure has changed over time. However it is likely that this is a conservative estimate as women may be uncomfortable declaring minority sexuality. In Australia in 2010, 13.9% of women reported being daily smokers, a figure which has declined over the last 25 years (Australian Institute of Health and Welfare, 2011).

The experience of belonging to a minority group was defined and reinforced by the social acceptability/unacceptability of these behaviours. All participants acknowledged the pressures of minority membership however this was not a fixed or unchanging pressure but changed over time and also changed in response to specific situations. There were self-identity issues for both of these behaviours. Self-identity was related to several factors including participants' perceptions of how others responded to this minority behaviour, group participation, wider social support and individual and societal meaning given to these behaviours.

The process and experience of sexual orientation identity varied and took from a short time of months to many years. Once adopted, this identity had remained stable for all participants. None of the participants had changed their lesbian or bisexual identity once established. While there is evidence that sexual identity is not necessarily fixed but maybe fluid (Diamond, 2005; Sophie, 1986), it is also unlikely that women who were less secure about their minority sexual identity or who later adopted a heterosexual lifestyle would be captured in the respondent group.

All participants discussed an earlier time of uncertainty and coming to terms with identifying as non heterosexual. The majority arrived at a minority sexual identity after a period of non-acceptance or self-denial of their emerging sexuality. This impacted on how they perceived others and how society would respond to their non heterosexual identity and presented for the majority a period of internal struggle. There was early acknowledgement that to adopt this identity would result in minority and marginalised group membership. For some participants anticipated rejection due to declaration of a non heterosexual identity resulted in self-doubt and denial of same sex attraction which for a few lasted many years through a period of dissonance, stress, diminished self-esteem and continued self-questioning. As reported by others, the level of distress of participants around declaring minority sexual identity varied from several participants who said it was 'no big deal' to others who found it resulted in high levels of stress (Kaminski, 2000).

All participants discussed the social pressure and social expectations on them as women to marry and have children. Quite a few participants embarked on a heterosexual lifestyle before they declared a lesbian/bisexual identity. This varied from a short time to many years and was more pronounced in the older cohort. Although coming out later in life, in retrospect many of these women could reflect on early indicators of difference and questioning of sexuality, but barriers such as heteronormative pressure, prevented the adoption of this lifestyle earlier (Kitzinger & Wilkinson, 1995).

The reported experience of minority sexual orientation identity was not dissimilar to that reported by other authors. For the majority of participants this was an ongoing process of coming out initially to self and then to others and involved progression

and regression as described in the literature by Sophie (1986). Many participants, although saying they were secure in their sexual identity, described how they were constantly reminded of being a minority in a heteronormative environment. Decisions were made, sometimes on a daily basis, about whether to be 'out' or not as has been described by Morris et al (2001) and termed the revolving closet by Johnson (2008). Although disclosure of sexual identity has often been associated with increased emotional wellbeing (Beals, Peplau, & Gable, 2009) it can also have negative consequences (Beals & Peplau, 2001). It is often an everyday decision that emphasises minority status. The lack of legal recognition of same sex couples was reported by several participants as one constant reminder of minority status. Solomon et al. (2004) discussed this as not solely due to legal discrimination but also due to homophobia (external and internal), a lack of a social norms and lower levels of family social support for same sex partnerships. Despite the increased social acceptability, even younger participants struggled with self-acceptance of minority sexual identity as reported by Savin-Williams (2005). Several participants had not come out to their parents. Meyer (2003, 2007) discussed the stress impact of this lack of self-acceptance and/or acceptance by others of declared minority sexual identity which fitted the experience of participants in the current research.

Smoker identity was subject to change over time most obviously as participants moved from smoking experimentation to initiation to regular smoker and during quit times when they may have identified as a non-smoker. Most had a history of periods of quitting although, consistent with the literature, quitting was often followed by relapse. Becoming a regular smoker usually involved a period of uncertainty about smoker identity during experimental smoking. For many participants they received negative messages about being a smoker particularly from family, in some cases even where a parent smoked. Seeking a sense of belonging and peer influence from other smokers often countered this. The majority experienced their current smoking as a deviant, minority behaviour although this was not fixed and altered depending on the situation and whether there were other smokers present. All had experienced pressure to join the non-smoking majority. Smoker identity and/or behaviour also changed over time and in response to particular settings. For example several participants reported reduced cigarette consumption and now termed themselves a 'social smoker' rather than a heavy smoker although if they were in the company of

other smokers or at social event where smoking was more acceptable their consumption increased.

Participants defined their experience as a smoker and a lesbian/bisexual woman as deeply influenced by the social norms set by the dominant, majority group. This included the wider societal response to same sex attraction that had slowly, although not universally become more acceptable and smoking which had become increasingly unacceptable. All had experienced stigma and discrimination due to smoker and sexual identity. Older participants reported greater stigma associated with both of these behaviours, which reflected longer exposure to these social changes. Although smoking amongst women even at its peak prevalence, unlike men was always a minority behaviour (Scollo & Winstanley, 2008).

The minority experience of sexual identity and smoker status in this research echoed that of other researchers who have discussed the effect of a dominant majority group on minority groups (Phelan et al., 2008). Non heterosexual women as a minority group have been subjected to sexual stigma, the term used by Herek, Chopp and Strohl (2007), which manifests in homophobia and heterosexism in such areas as job discrimination; lack of promotion; unfair treatment by family, friends and peers; verbal abuse or violence and observing/hearing heterosexist jokes (Selvidge, Matthews, & Bridges, 2008; Weber, 2008).

Not all homophobic acts that were reported were overt acts of sexual stigma. Several participants discussed the more subtle aspects of sexual stigma including being socially marginalised by heterosexuals, lack of positive media representation, and comedy and humour that made fun of gays. As discussed in the literature, this can result in the stress of everyday stigma including the constant decisions about whether to come out or not (Baernstein et al., 2006; van Dam, 2008). Beals and Peplau (2005) found that the majority of lesbians have endured the social stigma of having a sexual identity at odds with the mainstream cultural values. Lewis discusses 'stigma consciousness', the anticipation of prejudice and discrimination which affects even those minority sexuality identified women who are comfortable and relatively open about their sexuality (Lewis, 2006).

Despite increasing acceptance of minority sexual identity by society as evidenced by greater visibility and more positive portrayal of LGB public figures, media coverage, and in limited legislative support, the majority of participants were emphatic that complete acceptance or legal equality had not yet been achieved. They also reported that certain settings or environments were more homophobic than others, which contributed to selective socialising either within the gay community or with their own family and friends who were accepting of their sexuality.

In addition to reported instances of stigma and discrimination that resulted from their sexual identity, all participants reported intense negative attitudes and discrimination directed to their smoking behaviour. This reflected the perception that, in many social circles, it was socially accepted to exclude or discriminate against an individual's smoking behaviour. In many social circles this was more pronounced than sexual stigma and resulted in overt stigma, for example people who openly commented on how disgusting smokers were. Chapman and Freeman (2008) reported similar experiences of smokers who have been labelled litterers, selfish, unattractive, uneducated, addicts, high health care consumers and an employer liability. The denormalisation of smoking is illustrated in the strengthening views of non-smokers towards smoking. Mecredy et al. (2011) have shown that the number of 'adamant' non-smokers had doubled in the 10 years to 2005/06. Many participants reported negative actions and labelling by non-smokers. Even ex-smokers could clearly articulate negative feelings of both self and others towards them when they were smokers.

Experiencing minority membership and variable levels of stigma and discrimination towards smoking and sexual identity resulted in a range of stigma management strategies being reported. This is summarised in Table 16, which illustrates that similar strategies were used for both minority behaviours.

Table 16

Stigma Management Strategies

Strategy	Description
Passing	Pretending or passing as a non-smoker or a heterosexual woman was used by some participants. This was either a deliberate act or being mistaken for this. Passing as a non-smoker was seen as definitely desirable and was rarely challenged. Being assumed to be heterosexual had been used by most participants at some time when disclosing sexual identity was anticipated to be negatively received or it was 'just easier'. Passing has been reported by others[11].
Concealment	Hiding minority behaviours was reported by many participants particularly for stigma management at a younger age. Most participants had actively hidden their sexual identity particularly from parents until they felt more confident. Most reported hiding smoking at some stage in their life. Several still actively hid their smoking from identified individuals who were important to them e.g. parents or partner.
Finding same	Smokers and sexual minority women often sought out others who belonged to these groups to avoid being challenged and to reduce exposure to stigma. Smokers sought out other smokers in social settings ensuring 'safety in numbers'. The gay/lesbian community provided similar levels of group support.
Minimisation	Being able to dismiss or minimise stigma was used by many participants for both smoking behaviour and sexual identity. This was done through a variety of techniques which included turning a negative comment into a joke, ignoring the impact of the stigma, dismissing what has been said with statements such as 'they are entitled to their opinion', 'that is the way they were brought up', 'that is their loss if they end their friendship with me'.
Forgiveness	Sometimes stigmatising behaviour was forgiven especially when it occurred from a close friend or family member often to ensure that the behaviour did not upset the relationship. For example. 'that's just my Dad' in response to homophobic comments.

Stigma management strategies similar to the above have been noted by other authors (Beals et al., 2009; J. Kaufman & Johnson, 2004; Lasser, Ryser, & Price, 2010; Swim, K., & Pearson, 2009). Fine (2011) reported that college students sometimes used minimisation as one coping mechanism for homophobia and in so doing sought to minimise differences with the broader community.

Despite well developed stigma management skills most participants recounted instances of non-acceptance and rejection due to their declared sexual identity which had resulted in loss of friends or family and in some instances ongoing hurt from these situations. Most participants expressed a deep desire to be accepted for who

[11] (Haines, Oliffe, Bottorff, & Poland, 2010; Morris et al., 2001)

they were. Acceptance was seen as a positive reaction from others to their stated non heterosexual orientation and most participants reported many examples of this. It was acknowledged that anticipated rejection was often worse than the reality and that this resulted in stress, inaction and concealment of their sexual identity. Many participants also discussed instances where self-stigma or internalised homophobia had contributed to eroded self-esteem and similar feelings from external sources of stigma. For most this was most pronounced when they were still defining their same sex attraction.

Stigma management of 'seeking same' had manifested for most participants in seeking out and participating in the gay/lesbian community. The experience and level of involvement varied widely across the participant group. The community provided important support and identity validation especially at the time of initial minority sexual identification, which for most participants involved a time of inner turmoil. Smoking was commonly reported as one way of assisting early entry to this group. Some participants perceived smoking as a normalised behaviour amongst lesbian/bisexual women. Quite a few participants consolidated their smoking at this stage and smoked more consistently and at a higher consumption. For many there was less intense participation in the 'gay scene' as they became older or moved into permanent partnerships however by then most had a highly addicted smoking habit. For some there was re-engagement with the 'gay scene' when they found themselves single following a relationship breakup. Some reported that being outside heteronormative constraints such as parenting responsibilities and heterosexual social norms, enabled participation in the 'gay scene' at an older age than heterosexual women in a mainstream nightclub scene. Participation in the gay/lesbian community was important for most participants, but with changes in intensity throughout their life.

The importance of support and connection to the gay community and its contribution to a sense of wellbeing for lesbian women has been found by others (Mulligan & Heath, 2007; Riggle et al., 2008) and supports the notion of 'seeking same'. Acceptance by others outside of the gay community has also been shown to be important for sense of wellbeing (Beals & Peplau, 2005).

Conversely heterosexual women rarely experience having their sexual identity challenged or not accepted by others. As the majority of heterosexual women are non-smokers they also have not experienced the negative response to the habitual behaviour of smoking.

The literature on the role of minority sexual identity, group identity, community participation and substance use has resulted in differing interpretations illustrating the complexity of defining these associations. Meyer's (2003, 2007) minority stress model proposes that the unique, chronic and socially based stress of minority sexual identity results in higher levels of health issues especially mental health which can lead to higher levels of substance use.

This is supported by a Victorian report which attributes higher substance use in LGB populations as linked to four related factors (Leonard, 2002). These were firstly confusion around sexual orientation or gender identity; secondly the stress associated with coming out to family, friends and work colleagues; thirdly the ongoing threat of violence and abuse faced by those who are open about their sexual orientation or gender identity and fourthly low self-esteem, depression, anxiety and feelings of guilt and paranoia (Leonard, 2002).

Some research has found that adopting and declaring a sexual identity can mean less negative impacts of minority stress (Herek & Garnets, 2007). Overwhelmingly participants rated themselves at a high scale in terms of being comfortable and being very open with their identity as a lesbian/bisexual woman. Despite this all could relate recent instances of feeling marginalised for belonging to a minority sexuality group and experiences of non acceptance. Family acceptance and support for minority sexuality has been found to have a positive effect on self acceptance of sexual orientation and contributed to mental health resilience especially during adolescence (Shilo & Savaya, 2011). Many participants reported episodes of family rejection due to the sexual orientation. The majority started smoking cigarettes, a highly addictive substance (Jarvis, 2004), at a time when they were questioning their sexual identity and were not as comfortable with their sexual identity as they were at the time of the interview. A minority stress model may not adequately accommodate the use of such an addictive substance over a life-course.

While not all authors support the minority stress model or the possible consideration of minority sexuality as a social determinant of health (Gay and Lesbian Medical Association, 2001; McNair, 2003), other research supports that minority sexuality results in poorer health outcomes for GLBT people related to belonging to a marginalised group (IOM (Institute of Medicine), 2011; Meyer & Northridge, 2007). Savin-Williams (2001) suggests that there is a danger in pathologising minority sexual identified youth through accepting a minority stress model and in so doing ignores the fact that not all gay youth are at risk and that struggles of gay identified youth are not dissimilar to heterosexually identifying youth. While this may be true for many young people, most participants discussed a time in their youth of struggling with sexual identity that often coincided with initiation to smoking. Smoking amongst LGBT people is a minority behaviour however one that is at a considerably higher prevalence than heterosexual people.

Some authors have discussed the effects of multiple minority identities (Herek & Garnets, 2007). In the current respondent group participants were members of at least two minority groups (sexual identity and smokers) and hence likely to feel cumulative stigma on both counts. It was outside the scope of this study to look at the effect of other minority group membership for example race, low socioeconomic status or disability. The work of Hughes (2008) has explored multiple minority membership parameters on lesbian smoking and reported higher smoking rates amongst Afro American lesbians than white lesbians and found that lower levels of education were also associated with higher smoking levels in this group (Hughes et al., 2008). There may be layers of minority membership that impact on lesbians who smoke. Although not all authors support an additive stress model stating that some minority memberships may result in community resilience for example in particular racial/ethnic groups (Lewis, 2006).

Summary
In conclusion, all participants experienced minority membership however the experience and impact of this was variable. While all were acutely aware of living outside the heteronormativity of the wider community, many found that smoker minority membership had a more overt impact. This reflected the social sanctioning of anti-smoking by the broader majority and the consequences of public health

success in the area. Older participants particularly provided commentary on the changes they had experienced over time with the denormalisation of smoking and conversely more visibility and acceptance of gay people.

Minority membership based on sexual identity, although not always comfortable, was not something participants felt they could or wanted to change. Minority smoker status however was seen by the majority of participants as socially undesirable and something they wished they could change. Stigma and discrimination had been experienced due to minority membership on both counts. Most participants had highly developed responses to manage this stigma.

While participants wanted acceptance of their sexual identity this was rarely stated as desirable for smoker identity. The majority of participants declared a wish that they did not smoke. All participants identified adverse consequences from their smoking and hence lack of acceptance by others of their smoking was rarely challenged, while non-acceptance of sexual identity was often challenged.

6.5.   Social definitions of smoking among lesbians

The fourth research objective was to generate social definitions of smoking among lesbians. The participant group demonstrated the diversity of lesbian/bisexual women's identities and experience in contemporary Perth. This diversity made it difficult to arrive at any one social definition of smoking among lesbians/bisexual women. The difficulty is compounded by the rapid social change that has occurred in Australia where smoking has become socially undesirable and subjected to stigmatisation in many social situations, (Chapman & Freeman, 2008; Kim & Shanahan, 2003). Despite these challenges, it has been possible to make comments on the social definitions of smoking.

Smoking for many participants was associated with socialising within the lesbian community either currently or at the time when participants defined their sexuality and often consolidated their smoking habit. While it is recognised that there is no single 'lesbian community', many referred to the influence of gay venues on

smoking. Many acknowledged that even though they may not be regularly engaged with the 'gay scene', most had been. For many, active involvement had been especially important at the time of wanting to connect with other lesbian/bisexual women when they first declared their sexual orientation. The majority of participants referred to smoking as a way to connect to the lesbian/gay community.

Many older participants talked about the high levels of smoking in gay venues when it was still legal to smoke inside. There appeared to be a very entrenched culture of smoking among certain groups within the lesbian/bisexual community particularly associated with those who were on the 'scene' and frequented gay venues. There is certainly historical precedent for smoking being seen as a statement of rebellion against traditional roles of women however whether this was a current driver was less clear (Banwell & Young, 1993; Elkind, 1985). Gay venues, bars and nightclubs have long been an important place for lesbians to connect socially and emerged in the 1920s in the USA (Gruskin et al., 2006), and more widely in the 1970s and 1980s including in Australia (Pride History Group Sydney, 2009). Originally this was in an era when there were few other identified safe places and when the level of societal smoking was higher (Pride History Group Sydney, 2009; Sell & Silenzio, 2006). Several participants discussed that 'everyone smoked' in these venues and in order to fit in meant to smoke. Parks (1999) also found the importance of lesbian bars in building community and connection. This could explain in part the view held by some participants that to be a lesbian was to be a smoker and why smoking was normalised in some groups of lesbian/bisexual women. It was considered beyond the scope of the current research to explore what drives this culture.

Gay bars and nightclubs have continued to be an important social outlet for lesbian and are not just an historical artefact. They have continued to help define and identify community and have provided a place of acceptance and connection for many lesbian/bisexual women at different times in their lives (Gruskin et al., 2006). Research confirms that alcohol consumption and the use of illicit drugs, which is higher amongst lesbian/bisexual women (Hughes et al., 2010; Z. Hyde et al., 2009; Pitts et al., 2006), is also often associated with participation in the 'gay scene'. Participants reported low levels of current illicit drug consumption however most reported alcohol use which was often associated with cigarette smoking at social

events, notably in the 'gay scene', and was when cigarette consumption increased. Part of the social definition of smoking therefore relates to the association more broadly with drug use, a finding supported by other research (Hillier et al., 2003).

Most participants remembered using smoking to overcome the social awkwardness of exploring the new world of a gay identity and gay venues and discussed the influence of stereotyping and role modelling of smoking by other lesbians. For many smoking was used as a way to connect to the gay social community as smoking was seen by many as a lesbian trait and eased social entry especially when women were first coming to terms with their sexual orientation as a lesbian. This was true for both younger and older participants. Smoking allowed for a valid and comfortable form of social interaction by asking for 'a light', asking for a cigarette or just being able to 'hang out' with other smokers. Younger respondents who grew up in a time of anti-smoking education at school and limited exposure to cigarette advertising also used smoking in this way. Two younger participants stated that to be a lesbian meant that you had to smoke, even when smoking has largely become denormalised. The majority of lesbians/bisexual women do not smoke (Lee et al., 2009) therefore this perception is a stereotyped view of lesbian/bisexual women.

The younger cohort was more likely to rely on gay nightclub venues for their socialising and smoking was reported as being more accepted by their peers who were often smokers themselves. At the age of around 20 years, they had not had a history of failed quit attempts or wished they had never started. Smoking for this younger group appeared normalised especially in a nightclub environment, whether gay or straight venues. It was often associated with other drug use notably alcohol.

From the on-line environment of the Pink Sofa there was an obvious network of smokers attracted and identified with each other via a forum. While many of the comments discussed and supported each other with quit attempts they also discussed that being part of the lesbian 'scene' had often reinforced their smoking behaviour.

Several authors have suggested that the socialising of lesbian/bisexual women in a bar or club environment contributes to higher levels of smoking, (American Lung Association, 2010; Eliason, 2010; Gay and Lesbian Medical Association, 2001;

Gruskin et al., 2001; Kerby et al., 2005; Remafedi, 2007). Australia has some of the strictest legislative controls on smoking in public places including all licensed premises. In WA from July 2006 these premises went smoke-free (The Cancer Council Western Australia, 2008). Gay clubs are subject to the same smoking bans and while several participants alluded to times when smoking at gay venues was "*so thick you could not see across the room*" all conceded that this had changed dramatically. Many participants reported smoking as still being associated with gay clubs and venues with smokers having to move outside to smoke. As Carter (2008, p. 26) stated "It appears that going outside to smoke in 1984 was a near-alien concept, but in 2007 it appeared an accepted part of most smokers' lives". Hence, although nightclubs were smoke-free they were still associated with high levels of smoking which contributed to the perceptions of the norm of lesbian/bisexual women smoking.

Greig (2010) has contended that the greater acceptance of gay people has led to a dilution of the gay community/'scene'. The majority of participants reported that the gay community was still an important mainstay for finding initial connection and belonging. Younger participants reported the coming out process as an anxious and self-questioning one and were very aware that they would be a minority within a heteronormative environment. Some older participants insisted that young people today had "*nothing to worry about*" with many social supports now in place. This dismissed the struggles of younger LGB people and the fact that for some the 'gay scene' and cigarettes were still used as a tool of connection.

For many participants the gay community and 'gay scene' were still important however were not necessarily the primary or only place of socialising, a finding of other research (Rothblum, 2010). Many said they no longer regularly went to these but preferred to socialise in private places. There was insufficient data to answer the question whether they preferred private socialising because of smoking bans. However many did comment that the need to smoke outside at bars had marginalised their behaviour even more although it did not necessarily lead to diminished consumption, a finding also reported by Carter (2008) in a study with WA smokers.

Christakis et al.'s (2008) network analysis of smoking and cessation provided useful insight into the social connection of smokers (Ivers, 2001). Where the prevalence of smoking is high within a group then there is more network reinforcement for this behaviour to continue. Most participants when asked about the percentage of their friends that smoked gave figures that were much higher than the 17% national average and considered it not unusual to have half of their friends as smokers and illustrated a network influence on smoking. Several referenced that they had spent much of their life on the 'outer' and that to be part of a group of smokers was a way of being socially 'inside'. The fact that the majority of lesbian and bisexual women do not smoke does not diminish the network influence for those who have friendship/network circles where smoking prevalence and acceptance is high. Ivers' (2001) work with Aboriginal women, another minority group with high smoking prevalence, found that smoking promoted bonding, social cohesion and reinforced relationships. This would also seem to hold for many of the research participants.

Smoking therefore was likely to have a special meaning to younger people who are struggling with sexual identity issues and looking at a way to connect to the gay community. Smoking prevalence was higher in young people who are same sex or both sex attracted. From a large New Zealand study of secondary school students, for example, opposite sex attracted students had a weekly smoking rate of 7.4%, while same/both sex attracted youth reported weekly smoking rates of 16.5% (Rossen, Lucassen, Denny, & Robinson, 2009). There is also reported higher use of alcohol and illicit drugs in young same sex attracted people (Corliss et al., 2010; Hillier et al., 2010; Rossen et al., 2009).

Smoking for younger lesbians/bisexual women could have a social definition driven by feelings of difference, rebellion and role model perceptions that smoking was related to a lesbian/gay identity and gay social venues. Several participants discussed smoking as part of being rebellious in their adolescence and may resonate with other risk taking behaviours including exploring and or declaring minority sexuality. Hughes and Jacobson (2003) note that smoking is also associated with social deviance and negative attitudes towards conventional institutions (Hughes & Jacobson, 2003). A study by Remafedi (2007) looking at tobacco use in LGBT youth found that stress, fitting in, peer pressure and perceptions that LGBT people smoke,

were all important influential smoking reinforcers. Tobacco use was seen as mitigating stressful life situations and was seen positively as both a normalising behaviour, and a means of sharing, and socialising (Remafedi, 2007). Kaminski (2000) found that the lesbians in her qualitative study who came out in a more hostile environment often reported poorer health at this time and an initiation to drug use. Some of these reasons were given by participants when describing smoking in their youth. The Freedom Centre, the prime youth focused LGBT agency in Perth discourages smoking however the coordinator reported that smoking still occurred and that often youth had other pressing concerns that were seen as a higher priority such as parental issues and homelessness (Wright, personal communication, August 30, 2011).

Several participants reported that smokers as a group were more fun and interesting people than non-smokers. It is unclear if this is a widely held view however one study found adolescent girls saw smokers as more fun loving and less sensible (Lloyd, Lucas, & Fernbach, 1997). This may be another social definition given by some to lesbians/bisexual women who smoke, and may act to reinforce smoking.

Although no couples were included in the current research the influence of partners was mentioned by several participants. Many had partners who were also smokers and smoking was an important shared experience. Several participants said that even if they had given up smoking if they got together with a smoker they were likely to commence smoking again in a very short time. A non-smoking partner resulted in either a stressful situation or a supportive environment for quit attempts. As found by Bottorff et al. (2005) in their study on couples smoking was an integral part of the interaction for both smoking congruent and smoking non-congruent partners.

Summary
In conclusion, despite reduced smoking prevalence at a societal level, smoking still retains a greater cultural acceptance amongst many groups of lesbians. It was a minority behaviour within this group however lesbian/bisexual women who were non-smokers were not interviewed to gain a perspective on how they viewed and defined smoking in this community. It was clear from participants that for many smoking is or has been associated with lesbian identity. This was not a fixed entity or

reason for continued smoking however as smoking was seen by young lesbians women as something that 'all' lesbians do, and obviously not all young lesbians do believe this, then it could be an important cue to smoking initiation. Historically the gay bar scene was almost exclusively where community connection was made. Even though this may have become more diluted with greater acceptance of same sex attraction and more social avenues where this can be expressed, it still provided an important community focus especially for younger and questioning lesbian/bisexual women.

Where a higher prevalence of smoking existed in this group there was a network effect that reinforced this behaviour. Even where socialising occurred outside gay community or nightclub environments socialising for many participants revolved around lesbian/gay friendship circles with higher smoking prevalence which also provided a more normalised acceptance of smoking.

6.6.   Life-course impact on sexual identity and smoking

The impact of life-course on sexual identity and smoking was the fifth research objective. The term life-course is used here informally to consider the reported effect of experiences at different ages throughout an individual's life. This research was not longitudinal in nature as true life-course research is (Mayer, 2009), and hence is reliant on participants' recall and reflection of early life. A life-course perspective provided a framework for looking at behaviour, attitudes, values, health concerns and other issues over an individual's life. It assumed that earlier experiences were built on and informed subsequent life decisions and experiences. This assisted in the understanding and explanation of gay health outcomes. This approach was used in the Institute of Medicine's (IOM) LBTI report which recognised life events as part of a person's overall trajectory within an historical context as two interlinked influences which helped to provide an exploratory framework (IOM (Institute of Medicine), 2011).

Participants discussed the effect of life-course on both behaviour and identity as a smoker and lesbian/bisexual woman. The interview data reflected a snap shot of a

particular time in participants' lives however they all talked openly about what had occurred to that point in their life in relation to their sexuality and their smoking behaviour; and social and individual influences on these. In some cases there was also projection of how they anticipated they may respond in the future. Life-course was apparent both from individual participants who reflected on their life and also through comparing information from participants of different ages. Although the reported lived experience was unique to each participant, common threads emerged especially related to smoking initiation and to sexual orientation identity. The age range of participants from 18 years to 61 years, presented a range of age-related experiences for both smoking and sexual orientation.

The chronological stages during the life of participants were set within a changing socio-historical setting. The social context of smoking and minority sexuality has changed over time both at an individual level and at a societal level. Below general comments are made along age and social time trajectories. This is not a prescribed sequencing but rather illustrative of experiences of participants at different points in their lives.

Adolescence

Adolescence for all participants except one was when smoking experimentation and initiation occurred. The mean age of experimental smoking was 13.7 years while the mean age for regular smoking was reported as 18 years. Australian data reports females who had ever smoked had their first cigarette at 16.1 years and daily smokers had their first cigarette at 15.9, approximately 2 years later than reported by participants, and daily smoking commenced at 18.1 years, similar to participants (Australian Institute of Health and Welfare, 2008a).

Several influences that led to smoking initiation were reported. Seeking belonging and to fit in socially with peers was the most commonly given reason. This was rarely termed peer pressure but rather seen as a way to find and connect with a particular social group. This was often expressed as a deep desire exacerbated for the majority of participants because they reported a feeling of being on the 'outer' or feeling different. There was often a stated desire to find others who were similarly

'on the fringe' i.e. 'seeking same' which has also been reported by others (Booth-Butterfield, 2003).

For some at this stage there was uncertainty about whether to identify as a smoker, especially when their smoking was often still a closeted behaviour with low consumption. Others clearly remembered an event that marked a change of identity to that of smoker such as when they purchased their first packet of their own cigarettes. Most participants moved quickly from experimental to regular smoking with little reflection on what the long-term implications of this were. Many reported that at this early stage even if they identified as a smoker, they thought they would give up whenever they choose to and did not remember thinking they would be lifetime smokers. The majority had not tried to quit during adolescence. Greater understanding of smoking initiation at a young age is important. Research has reported adolescents have a poor understanding or concept of tobacco addiction and a belief of the ease of quitting (Leavy, Wood, Phillips, & Rosenberg, 2011).

The vast majority of participants clearly stated that they did not feel like they fitted in at school and smoking was often referred to as a tool to assist in fitting in with a particular peer group or as a rebellious act. About half of the participants articulated that the feeling that they had not fitted in at school and the use of smoking as a tool to assist this, was due to their emerging sexuality. For some this was seen as an act of rebellion. Approximately half of participants were unable to articulate at the time of adolescence that their feeling of not belonging was related to their emerging sexuality; however many reflected back on this time and considered that was probably the case. Several participants who did not come out until later in life and resolved to fit in to social expectations of marriage and children also reflected back to adolescence and felt that they did not really fit in.

Younger participants reported that their smoking was seen as a minority behaviour at this time and illustrated exposure to anti-smoking education and growing up in an era essentially without tobacco advertising. For older participants smoking was recalled as being common at this age. Several participants discussed that smoking during adolescence was seen as a way of 'acting out' what they perceived it was to be a 'lesbian'. There was a lack of clarity about where this perception came from. In 2010

smoking during adolescence in Australia is very much a minority behaviour with 3.2% of 12 to 17 year old females reporting daily smoking which increased to 12.8% of 18 to 19 year olds in (Australian Institute of Health and Welfare, 2011). Adolescence was the critical age for smoking initiation (Scollo & Winstanley, 2008).

Late adolescence was reported by many participants as the time of finding themselves, establishing social networks with greater opportunity to socialise without parental supervision and for when some participants moved out of the parental home and had increased independence. Smoking was often reported as a way to help signal this transition, a finding of McDermott et al.'s (2007; 2004) longitudinal study looking at young women's smoking.

The work of Remafedi and Carol (2005) on smoking in LGB identified youth reported that smoking in adolescence was often a response to stress, fitting in and peer pressure. While these could be considered common influences to adolescence the authors argue that LGB youth are exposed to unique stressors as they come to terms with their minority sexuality and the impacts of declaring this. Smoking was used to mitigate this stress by providing a way of affiliating and socially connecting with others (Remafedi & Carol, 2005), sentiments not dissimilar to those made by a proportion of participants and as reported by others as a response to dealing with discrimination and feelings of exclusion as a result of their minority sexuality (Easton et al., 2008).

Several authors have cautioned that adolescence for non heterosexual youth should not be automatically considered as a time of identity angst but could be interpreted as part of the broad adolescence experience of identity formation and as such there may be rebellion against more traditional narratives that being a gay young person is stressful (Cohler & Hammack, 2007; Savin-Williams, 2001). While adolescence can be seen as either a time of struggle or resilience, prevalence data shows that same sex attracted youth are more likely to smoke at this stage and many participants, particularly older participants reflected that adolescence was a difficult time. This time of early social uncertainty was not unique to LGB questioning youth as most adolescents experience a similar stage regardless of sexuality, but the drivers of this uncertainty may be unique for LGB youth.

The complexity of understanding the drivers behind youth smoking prevalence is illustrated in Pollard et al.'s (2011) longitudinal work. They report that higher smoking prevalence and same or both sex attraction is restricted to adolescent women and not men and that the period of transition to LGB attraction status is particularly linked to smoking. With a more stable LGB identity smoking status may not persist. It was however smoking initiation in adolescence that caused elevated smoking rates reported for adult LGB women (Pollard et al., 2011). Smoking acted as both a coping mechanism for additional stresses experienced by LGB youth, as reported by others however it was also likely to reflect LBG socialisation where LGB youth are involved in social environments where smoking is more normative (Pollard et al., 2011).

Feeling different at school was a common experience reported by participants, although the articulation of this and why they were different was less clear. For most there was a gradual awareness of same sex attraction. Not all participants acted on this at adolescence and a minority of participants actively repressed this and it could take many years to accept their sexual orientation. Participants clearly recalled that when they started to realise that they may be same sex attracted, this came predominantly with negative associations that to act on these feelings was somehow wrong, and/or that they would be marginalised by their family and society.

The majority of participants reflected on the stress of accepting, denying or being unsure about their sexuality when there were clear heteronormative expectations from their peers and families. Other researchers have reported the embedded nature of heterosexuality where peers, parents, mass media and schools all promote heterosexuality, traditional gender roles and make homosexuality invisible (J. Hyde & Jaffee, 2000; Kitzinger & Wilkinson, 1995). Many participants adopted heterosexual expression at this time, which for several clarified that they were same sex attracted. Younger participants grew up in a time when homosexuality was likely to be discussed at school and they knew other same sex attracted youth. Older participants rarely had this information or opportunity and sexuality was not discussed openly. Within the participant group a minority reported that they had been bullied at school because of their same sex attraction, as reported in other studies of

same sex attracted youth (Henrickson, 2007; Hillier et al., 2010; Rivers, 2004; Rossen et al., 2009).

Participants discussed the difficulty of talking to their parents about issues of sexuality at this age and almost universal anticipation that declared same sex orientation would result in a lack of support or acceptance. Two younger participants had not disclosed their sexuality to their parents because they felt they would not be accepted and they would disappoint their parents. Although it is undoubtedly easier to declare minority sexuality today, as illustrated by these two participants it is not always so.

Other research suggested that youth who identify as LGBT are more likely to participate in risk taking behaviour such as substance use including smoking (Hillier et al., 2010; Remafedi, 2007). Several younger participants reported being very clear about their sexual identity at this age and were exploring gay community options. Smoking was often used to help this situation either consciously or unconsciously because it provided a social entree and/or they were influenced by the lesbian stereotype of smoking.

Young adulthood

Young adulthood was often a time when identity both as a smoker and as a lesbian/bisexual women was consolidated. For those who came out later in life their smoker identity was likely to have been embedded at this age and their sexuality was expressed as heterosexual. For some this sexual identity was a conflicted existence but for many they reflected back to being relatively content during this time. Smoking for most had become an embedded part of their life.

As with most young adults this was a time of independence. Some who were unsure of their sexuality at school came out at this time. Many participants reported they accessed and socialised gay venues, which included bars and nightclubs. Smoking became an activity related to high levels of socialising either in the 'gay scene' or non 'gay scene'. Some participants discussed having had their first quitting attempt and a realisation that they were addicted to cigarettes.

It was often reported as a time of few responsibilities, increased economic independence and a desire to socialise especially at nightclubs or parties where there was exposure, access and experimentation to drugs both licit and illicit. Smoking for many at this time was a normalised activity, reinforced by the establishment of significant friendship groups. Smoking generally became a more entrenched and habitual behaviour. Few participants reported attempting to quit during young adulthood. A few participants discussed the social activity of smoking that revolved around these events and it was not embedded into everyday events. For some this manifested in what has been called binge or weekend smoking. The 'gay scene' was also seen as a place to find partners and as reported by many participants, being involved in the 'gay scene' was more intense when they were single – a pattern that persisted for some into much later life.

By early adulthood most had joined the workforce which exerted an important influence on smoking behaviour. Even though work place smoking bans are virtually universal in Australia now, this has not always been the case. Even with smoking bans various smoking cultures existed in a work place with smokers as an identified group with ritualised times and places for smoking. Many participants discussed the influence of the work place as either a promoter of continued smoking and they wanted to belong to and participate in the smoker group, or conversely work place bans made smoking difficult and a marginalised behaviour. For some of the latter group smoking took on vastly different consumption patterns during the working week as compared to the weekend. Some reported this as patterns of heavy or binge smoking on the weekends and minimal weekday smoking.

Participants, who were young adults at the time of the interview, were less concerned about long-term effects of smoking, which was similarly reported by older participants reflecting back on their smoking at this stage of their lives. Despite younger participants being exposed to quit smoking campaigns most dismissed these campaigns as not applying to them and further beliefs that they were still young and they were confident they would quit at some time in the future. Most did not see themselves as lifetime smokers. Younger participants were on the whole more 'confident' smokers in their claiming a smoker identity and reporting it was an active choice and dismissed pressure to consider quitting.

Smoking and participating in active social lives that revolved around licensed premises was not unique to minority sexuality young adults. As reported by McDermott et al. (2007) in their study of young women's smoking, this was a widespread behaviour of this group. They commented that women may quit as they matured out of this single partying phase especially when there was a move to serious partnerships and potential parenting.

Some participants, particularly young smokers put predictors on when they might quit smoking which was usually related to reaching a particular age (30 and 40 years old was reported by several participants) or if they were thinking of becoming pregnant. This was usually expressed as a belief that they would give up when they were 'older'. Only a couple of the very young participants indicated they had no intention to quit now.

The literature has suggested that younger women were more likely to participate in the lesbian bar culture as a primary source of socialising and hence were more likely to smoke (Gruskin et al., 2001). The current research showed that women of all ages including older women participated in the gay nightclub scene. While this was more pronounced in younger participants, it appeared related more to being involved in the nightclub scene to socialise when a woman was first exploring issues of minority sexuality and coming out rather than related solely to age. For some this happened at a much later stage of life. Many participants returned to the 'gay scene' at times of being single for example after the breakup of a relationship.

The important role of the gay/lesbian scene in early adulthood has been found in other studies (Gruskin et al., 2006; Parks, 1999). Older participants reminisced back to a time when there were very few places for lesbians to socialise or connect with other lesbians when smoking inside nightclubs and licensed premises was accepted behaviour. This resulted in many venues with "*smoke so thick you could not see the other side of the room*". Smoking was accepted and normalised more broadly in society, while homosexuality was a far more hidden and closeted behaviour. More recent smoking bans in licensed premises have still resulted in a smoking culture that operates in very identifiable outside settings.

Several participants reflected back to early adulthood as a time of self-denial of their same sex attraction and the overwhelming expectation of heteronormativity led them to live heterosexual lives. Although they did not come out in their teens or twenties the stage of growing clarity about their sexuality and the final step to clearly acknowledge this to self and then to others, resulted in feelings of uncertainty, self-questioning and concern for the views of others regardless of what age this happened. It could also be a time of perceived stress and depression which have been found to be influences on smoking adoption at this age (McDermott, Dobson, & Owen, 2009).

Early adulthood for some participants was a time when they become pregnant and took on a parenting role. All participants who were mothers talked about the pressure to quit smoking at this stage. Many but not all did give up smoking during pregnancy however this was rarely maintained.

Adulthood

Several common experiences impacted on smoking behaviour as participants matured. Many had been smokers for a considerable time – up to 30 years. Most had experienced multiple quit attempts and were often disappointed that these had not been sustained, although several had quit smoking for extended periods of time. Older participants had also lived through the immense change in the acceptability of smoking, which had moved from a glamorised widely advertised behaviour to a marginalised and stigmatised behaviour. The majority of participants who were in their mid 30s or older wished they had never started smoking and were often disappointed they were still smoking. Not all could imagine being a non-smoker.

The stated reasons for smoking maintenance were very different from those given for initiation. Although it was for most still a social activity, either within a group or partnership setting, smoking was no longer a way to gain acceptance, belonging or as a result of peer pressure. The smoker identity was securely in place in adulthood and was an addictive behaviour. This was rarely a comfortable place, with an internal voice that said "I really should quit", reinforced by the increasing denormalisation of smoking in society. Smoking in adulthood was an addictive habit with well developed habitual and social cues for smoking. The age factor on changed reasons

for smoking has been noted by other authors (Booth-Butterfield, 2003; Scollo & Winstanley, 2008).

Adulthood was the time when pregnancy and parental roles were experienced by some participants. Consistent with the literature, the majority of these participant's pregnancy was an important trigger to give up smoking (Bottorff et al., 2006; Giglia, Binns, & Alfonso, 2006; McDermott, Dobson, & Owen, 2006). Many declared that they hoped not to smoke post birth however in this group they all relapsed. Those with multiple pregnancies often repeated this pattern of quitting during pregnancy and then restarted following the birth of the baby. Some authors have postulated that this could be in response the stress and uncertainty of this new role (McDermott et al., 2009; Polanska, Hanke, Sobala, Lowe, & Jaakkola, 2011). Some reported that giving up smoking while pregnant was not an active decision but rather one that was brought about because they physically reacted badly to cigarettes while pregnant. For most though an active decision was made to give up cigarettes because of the adverse effects on the foetus and the great social pressure not to smoke while pregnant. Pregnancy provided a high motivation for most to quit.

Some also talked about the pressure from their children to give up cigarettes and those participants who had young children were aware of the negative role model of being a smoking mum. Lesbian/bisexual women have lower rates of pregnancy than heterosexual women and hence this trigger to quit is likely to be less pronounced at a community level. Participants who were mothers reported different socialising during the period of having young children that was more likely to be home based however could still involve friendship groups that included smokers.

Smoking behaviour was usually reinforced in social settings where other smokers smoked. For some this meant the 'gay scene', particularly at times of being single or when seeking a new partner, a finding also reported by Gruskin, Byrne et al (2006). For others who were not involved in the 'gay scene' smoking reinforcement came from having a partner who smoked or other friendship and social groups who smoked including identifying with smokers in the work environment. Smoking in adulthood was therefore marked by embedded behaviours with habitual elements. As reported by Booth-Butterfield (2003) this embedding occurred through relationships,

culture and individual psychological needs and was integrated into social circles. This was illustrated by the many participants who reported far higher prevalence levels of smoking amongst their friendship groups than the Australian rate, for example, several reported that half of their friends smoked. It was not always clear whether these friends who smoked were solely lesbian/bisexual women however it illustrated perhaps a network effect of smoking (Christakis & Fowler, 2008). Not all participants lived near or accessed the 'gay scene' or only interacted with the 'gay scene' for special events such as the annual Pride Parade, hence the network effect extended outside of the 'gay scene' but often represented friendship groups of lesbian/bisexual women.

Smoking was often reported as a shared social activity where a partner was also a smoker as reported by others (McDermott et al., 2006). Several participants who had entered into a new partnership with a smoker usually returned to smoking themselves when they had been an ex-smoker at the point of relationship initiation.

Adulthood was also a time where some participants reported more serious quit and multiple quit attempts. Most could recall quite clearly that when they quit they were in a 'good' space and generally quit attempts had relapsed in times of stress, which was often recalled in some detail. For some older participants they reported that for the first time they had experienced the adverse consequences of smoking and had medical advice directed individually, as distinct from social marketing messages that they should give up smoking. While this could trigger a quit attempt with this participant group, this was rarely sustained. The National Drug Strategy Household Survey (2010) reported that 41.7% of women changed their smoking behaviour because of concerns about the effect on health (Australian Institute of Health and Welfare, 2011). This report also showed that unsuccessful quit attempts had been made by almost a third of smokers in the previous year (Australian Institute of Health and Welfare, 2011). Smoking uptake following a period of quitting was identified by many participants as being a habitual response to managing a particularly stressful situation especially after a relationship breakup. Invariably a return to smoking was seen as a failure, a finding reported by others (Laurier et al., 2000).

The dissonance of continued smoking became more pronounced for most participants as they got older. The internal struggle between the intelligent self, reinforced by wider social norms that smoking was a health limiting behaviour and the desire to smoke and the positives that accrued from this, often became more affirmed. Some smokers moved from smoking as a shared social activity to smoking alone in response to this.

Some participants had seen close family members become ill or die from smoking-related health consequences and acknowledged the pain of witnessing this. For a very few this was a trigger to stop smoking. Others who continued to smoke expressed almost disbelief that they were still smoking despite having witnessed this. A proportion of the participants were estranged from their families and hence even if this was part of their family history the impact of this may have been minimal.

The effect of age on smoking as outlined above has also been reported by others. For example Ryan et al.'s work (2010) found younger smokers experienced smoking as important in social situations and were more accepting of the restrictions on smoking while older smokers felt more strongly about the active stigma associated with their smoking. Gruskin et al.'s (2001) work reported higher rates of smoking (and alcohol use) in younger lesbian/bisexual women who had less regret about their smoking and less desire to give up and a lack of experience of failed quit attempts.

While there were some young participants who were very confident about their sexual identity, adulthood was for most participants a time of increased clarity and less concern about social consequences of declared minority sexual identity. This was at odds with the often reported increased dissonance and ambivalence about smoking behaviour. Many discussed that as they got older they had less concern about what others thought about their lifestyle choice. Within this participant group only one reported being insecure in their sexual identity in adulthood.

Adulthood was for many participants a time of settling into a primary relationship that was often followed by less intense socialising at public venues and increased socialising with established friendship circles often in a private capacity. This could

either be same sex partner or heterosexual partner. Smoking for many at this stage was still a normalised activity within those social groups.

Some older participants who had embarked on a heterosexual life of marriage and children commented that for them adulthood resulted in them making 'the hardest decision in their life' by declaring their same sex attraction and identity as a lesbian. This was followed by a time of renegotiation of their life to accommodate a new sexuality, dealing with the response of family and friends, having to negotiate custody, new living arrangements, formation of 'new' family structures, property and finances. All said this was an extremely stressful time yet one that resulted in them being true to themselves and ultimately being in a much more fulfilled stage of their life. Rickards and Wuest's (2006).work on women who came out later in life illustrated the dissonance experienced at this time and that such women had to re-establish credibility as a non heterosexual women. Participants of Rickards and Wuest's (2006) study and this research uniformly reported that declaring a lesbian identity later in life although challenging, none regretted.

Several of these women discussed that despite being in their forties they felt they had gone through a type of relived or second adolescence on declaring their sexuality and this was often a socially exciting time and involved as has been discussed earlier, connection with the 'gay scene' including the nightclub scene. Smoking often increased in response to being involved in this environment where smoking was often seen as normalised. This could also be a time of seeking a new partner and often resulted in more intense interaction with the 'gay scene'. Returning to the gay nightclub scene when single and looking for a partner was reported by many participants.

There has been very little research on women who come out later in life. For some women who did declare their same sex attraction in midlife this could be seen as part of a more widespread identity struggle that many women face in midlife when parenting roles change and relationships may flounder. However a more accurate interpretation of this participant group is that many of those who came out in mid to older life had struggled all their life with who they were and hence the final declaration at midlife was part of a larger struggle and once children were at an older

age it became easier to act on this. Either way the enormity of leaving a heterosexual relationship and identity cannot be underestimated.

Minority sexual identity women were less likely to experience conventional milestones that have been reported to provide important points of health behaviour assessment including quitting smoking (Fredriksen-Goldsen et al., 2010). It has been postulated that many lesbian/bisexual women do not have life-course markers of pregnancy, being a mother, marriage and closeness to family (IOM (Institute of Medicine), 2011), which have conventionally been seen as triggers to quitting in adulthood.

Summary

In conclusion the life-course of an individual and the impact of social change over time exerted both an influence and an explanatory framework for understanding how participants viewed and responded to their sexual orientation and their identity as a smoker. This section has emphasised the importance of both self-concept and the perceptions of others and society at large to these two minority behaviours. These were dynamic responses to life-course and changing societal norms.

Different influences, functions and meaning of smoking at different life-course stages were reported. This included smoking during experimentation and initiation phases where seeking social belonging was an important driver to behaviour, to smoking becoming a habitual behaviour. The influence of family changed at different times from younger age when parental attitudes and behaviour were more influential for most. Becoming a parent themselves also resulted in different behaviours. Social drivers for smoking included the importance of smoking in certain social settings whether in the 'gay scene' or not. Increasing age in general resulted in increased feelings of being comfortable with sexual identity and less concern about how others viewed this. At the same time there was often increased concern about how their smoking was negatively viewed by society and sometimes by non-smoking friends and family.

As women aged their outlook on their smoking often began to include greater concern over adverse health effects of continued smoking and a regret that they

continued to smoke. Consumption often declined with age but this was not universal. The feelings of stigma associated with being a smoker were felt by all participants with older participants having experienced the rapid social change of the denormalisation of smoking. Younger smokers experienced the stigma of being a smoker but appeared less concerned about this and less concerned about health effects of smoking. Although all participants reported more acceptance of homosexuality today all acknowledged that they still made many ongoing decisions about how open they were. Older participants often reported less concern about this however this could also be seen as having had many years of learning how to adapt and respond to this on a daily basis.

It was also apparent that minority sexuality women do not necessarily share the same life-course markers that may be common for heterosexual women for example having children or getting married. The impact of declaring and becoming confident in sexual identity appears to impact on smoking prevalence in both uptake and maintenance. Smoking continued to be used at different life stages for stress management.

6.7. Explanatory model

Addressing the above five objectives led to the development of an explanatory model for lesbian smoking. The explanatory model draws heavily on the conceptual framework of symbolic interactionism which gave direction that "make(s) that world-view explicit" and "also provide(s) the tools in terms of concepts and models for structuring the investigation" (Merriam, 2006, p 36).

As stated by Crotty (1998) one of the basic tenets of symbolic interactionism is that the actor's view of actions, objects and society should be studied seriously with an emphasis on the origin and development of meaning. The current research has captured the participants' views on what it is to be a lesbian/bisexual woman in a heteronormative environment and a woman who smokes at a time when smoking has become socially unacceptable and a starkly minority behaviour. The meaning of these two identities interacts with the important influence of self-concept, which

arises from dialoguing with self and processing the perceptions of others in the wider social setting.

The model has captured a further tenet of symbolic interactionism by emphasising the internal processes by which individuals make meaning of and respond to the world around them (van Krieken et al., 2000). An individual's self-concept is therefore reinforced or modified in the process of interaction with other members of society (van Krieken et al., 2000). The two behaviours researched here; smoking and sexual orientation are the subject of ongoing social commentary at both an internal personal level and a broader societal view with implied values and judgement. While the interviews presented a snapshot of participants' understanding at a particular point in time, their reflection illustrated that this has evolved over their life and will continue to evolve in response to both internal negotiation and reflection and negotiation with an external changing world. It is a dynamic model with active rather than passive actors.

The explanatory model (see Figure 12) describes an individual process for lesbian/bisexual women in negotiating both their identity and behaviour as a lesbian and as a smoker. The model attempts to arrive at an in-depth explanation for the behaviour of a group of lesbian/bisexual women who are smokers recognising the immense individual variation. Common elements in the process of self-identity and the response to the gay community, broader community and wider societal expectations are captured within a constructivist socially constructed world (Charmaz, 2003; Crotty, 1998).
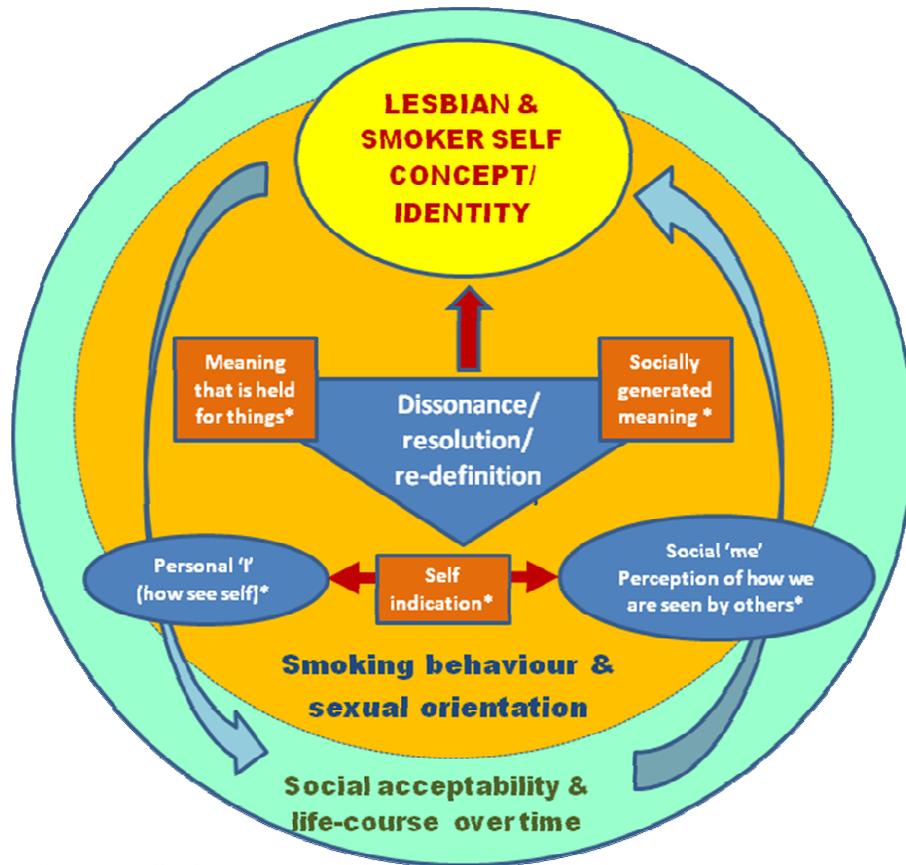
Figure 12. Explanatory model.

Several key constructs make up this model:

- **Lesbian and smoker self-concept/identity**: This is arrived at from negotiation
  with self, the personal 'I' (how someone sees themselves) and how they perceive
  others see them, the 'me' (Blumer, 1969). Dynamic negotiation is required
  because of potential dissonance and tension between these two views in what
  Pascale (2011) has called 'self-indication'. Meaning which is both personally and
  socially generated, contributes to self-concept. This intersects the following two
  constructs, which leads to behaviour and also recognition of the impact of the
  wider social setting.

The negotiation to arrive at self concept and identity is illustrated in the core
categories reported in the results chapter. While in an interview setting with
careful questioning participants could articulate areas of dissonance, resolution
and redefinition this ongoing process is for most participants an unconscious

process. The fact that several participants commented at the conclusion of the interview that they had not thought about their smoking behaviour in such depth or felt they had previously had the opportunity to explore these ideas also illustrates the unconscious nature of this processing.

- **Social acceptability and life-course over time:** This is represented by an outer ring to indicate that people operate in and interact with a socially changing environment and a socially constructed world. While this contributes to self-concept/identity it is set here as the outer ring because of the dynamic and rapidly changing wider social context of both smoking and minority sexual orientation. Participants clearly felt the impact on their minority behaviours, which had changed over time and continue to change within specific social settings. This emerged as a powerful influence on identity issues.

  The core category of re-definition factors included participants' reference to the influence of changes over time both through life course and the wider social acceptability towards lesbian/bisexual identity and the decreasing acceptability of smoking. Participant references emphasised these as dynamic influences on their own experiences and captured the rapidly changing social values on these two areas of behaviour.

- **Smoking behaviour and sexual identity:** The above factors led to specific behaviours related to smoking and sexual identity as represented by the inner circle overlaid by self-concept/identity. Sexual identity behaviour includes how confident and comfortable a participant felt about their minority sexuality which may or may not include connection to the gay community. Smoker behaviour manifested in how and when a person smokes.

While the model can be used to present a particular point in time for an individual, it is more useful to show the complex and constant interaction between self-concept/identity and socially and personally generated meaning within the influence of an ever changing social world. The ongoing reappraisal of self-concept manifests in changes to identity and/or behaviour of both smoking and sexual identity throughout and within a life-course. It revolves around push pull factors of

dissonance, resolution and re-definition, the core themes to emerge from the data, within a socially constructed world.

Individuals are unlikely to be conscious of the social and self-negotiation that is implicit in such a model however as illustrated in the results and discussion all participants described their minority status as a lesbian/bisexual and smoker and their negotiation of this both initially in establishing these identities and in managing these minority identities.

A further word on identity issues is required. Identity and especially the resolution of identity as a smoker and also as a lesbian/bisexual woman were widely reported in the results. Identity provided a perceived social location, and forms part of the concept of self (Charon, 1998; Holstein & Gubrium, 2003). Arriving at a comfortable social location involved levels of dissonance and a need for resolution. Identity within a heteronormative environment provided challenges and uncertainties that participants dealt with both internally and in presenting to the world and has been reported by others (Balsam, 2003; Kitzinger & Wilkinson, 1995; Rickards & Wuest, 2006). The identity and behaviour of smoking also presented for most participants a negotiated space, which resulted from resolving both internal and societal dissonance. Many participants reported that the dissonance of being a smoker was higher than that of belonging to a minority sexuality identity.

Identity negotiation is a fundamental concept within a symbolic interactionist framework for understanding human behaviour. The model illustrates the interaction of meaning and self-indication, the term used by Pascale (2011) to capture the constant negotiation between views of self and how we think others view us. Participants were constantly negotiating identity on both dimensions of smoking and sexual identity. It is accepted that a person has multiple identities some of which are constants such as race and others that are fluid such as health or employment status. Smoking status and declared sexuality are only part of a person's overall identity, however for this participant group they emerged as important areas that contributed to self-concept. It was accepted that these could be fluid. An individual's defined identities importantly respond to changing social realities (Charon, 1998; Vryan, Adler, & Adler, 2003).

The level of dissonance experienced by participants varied greatly within the group and varied at different times and settings within a participant's life. For example for some participants, dissonance about their smoking behaviour was currently stronger now than when they were younger. Dissonance around minority sexual identity was strong for some but on the whole had reached a point of resolution. However either of these behaviours could be challenged by others and society at large often on a daily basis. Dissonance sometimes reflected anticipated responses of others to their identity/behaviour. Part of the dissonance, resolution and re-definition was the expressed positives of these different behaviours.

In conclusion, the explanatory model presented in this chapter illustrates the complex interplay of the core categories of dissonance, resolution and re-definition, which emerged from the results and which led to the core concept of self-concept/identity. The model captures this interplay as experienced by participants from the actor's perspective set within the influence of a changing wider society.

6.8. Chapter conclusion

The discussion chapter has drawn together the results of the qualitative data, the literature and the conceptual framework to revisit the research objectives before presenting an explanatory model of lesbian/bisexual women's smoking. The findings of this study are confirmed by those of other researchers whose work has been cited. The research provides new insight into the complexity of factors at play that influence smoking amongst individual lesbians.

The discussion has described lesbian smoking behaviour, considered the range of individual explanations and beliefs about smoking before considering the impact of minority membership as both a smoker and a lesbian/bisexual woman. Social definitions of lesbian smoking have been explored before looking at the role of smoking across a life-course.

Participants told their own story of their experiences and behaviour as a smoker and lesbian/bisexual woman and commonalities were drawn from these stories. There

was overlap for both behaviours under consideration including early uncertainty and feelings of difference due to sexual orientation and the role of smoking as a way of initially connecting to the gay community. The importance of 'seeking same' i.e. socialising with other smokers and lesbian/bisexual women and the experience of belonging to a minority group resulted in the experience of sexual and smoker stigma. Finely tuned stigma management strategies were employed for both behaviours. Smoking also played a unique role within certain parts of the lesbian community.

There has been limited discussion on the effect of the increasing stigma associated with smoking behaviour which has resulted from persistent public health campaigns and a falling smoking prevalence (Bayer, 2008; Bayer & Stuber, 2006; Stuber, Galea, & Link, 2008). Yet for this group the stigma of being a smoker was for many participants highly felt. This group therefore carried the double stigma of being a smoker and belonging to a sexual minority marginalised group.

The research has outlined the importance of understanding the social context of smoking and in so doing recognised the great variability of experience of what it means to be a lesbian/bisexual woman. If smoking prevalence is to fall within the study group then specific as well as mainstream quit smoking public health interventions are required that show greater understanding of the target group including the impact of stigma and minority membership. Recommendations for practice and concluding remarks are presented in the final chapter.

Chapter 7 Recommendations and Conclusions

7.1.   Introduction

The final chapter will draw the research to a conclusion by summarising the main findings, discussing the limitations of the research, presenting recommendations for practice and outlining areas for future research.

The issue of smoking amongst lesbian/bisexual women is an important public health issue as prevalence rates are higher than that of the wider community. Despite this it is an area that has received little attention. Through this qualitative research the voice of these women has been presented in order to try and understand the context of smoking with the aim of being able to use this information for more effective interventions to address this high prevalence.

Smoking and non heterosexual identity are both minority behaviours/identities and hence were subject to the stresses of minority membership. Stigma and discrimination were reported on both of these measures. Both have been subjected to rapid social change, which has seen smoking become a denormalised and marginal behaviour while there has been a slow increase in the social acceptability of same sex attraction. At a personal level, participants reported a variety of struggles and challenges on both of these issues.

A comprehensive raft of smoking control measures in Australia has resulted in a decline in smoking prevalence and the denormalisation of smoking. This effect has not however been uniform. National prevalence figures often hide that smoking in general has become concentrated in several minority groups including lesbian/bisexual women and the gay community more widely.

There were several unexpected findings from the research. For many participants the stigma currently experienced as a smoker was greater than that from their minority sexuality. In addition socialising in the so called 'gay scene' was not a majority

behaviour and hence does not solely explain the reason for higher levels of smoking. While the role of the gay community is important in understanding higher prevalence it is the ongoing impact of belonging to a minority group that may have more explanation, especially for initiation to smoking.

I was surprised that several of the younger participants who presented as confident young women who willingly participated in the research, still struggled with sexuality disclosure issues. Several older participants commented that today's young people had it so easy in coming out in an accepting society yet the reality was that not everyone felt this way at all. The time of exploring and claiming a minority sexual identity is generally one of vulnerability and uncertainty and can be pivotal for smoking initiation.

It needs restating that the majority of lesbian/bisexual women do not smoke and that the majority live happy and healthy lives. However prevalence of smoking and several other poor health indicators are higher in this group. There are still lingering stereotypes of lesbians being smokers. Despite the prevalence data smoking within the lesbian/bisexual women's community is not an issue of concern within the community or within the mainstream smoking control agencies. This chapter provides recommendation for health promotion practice that may usefully address this issue.

7.2.   Conclusions of research

Set within the conceptual framework of symbolic interactionism a grounded theory qualitative methodology was undertaken to develop an explanatory model of smoking behaviour within the lesbian community. Participants represented a wide range of experiences and ages and although this was a non-probability sample, it was not a convenience sample drawn from a single lesbian entertainment venue like much of the early research on lesbian/bisexual women's health.

Responses from interview follow-up as reported in Appendix J illustrated the appropriateness of the research methodology, which validated the participant voice.

The research question was answered by the completion of a comprehensive literature review and completion and analysis of in-depth interviews with 28 participants, and one lesbian social networking forum which allowed for the six research objectives to be addressed. Throughout the research, my own reflective practice was undertaken and captured in a reflective journal and written research memos attached to the collected data.

The theory, which explained lesbian/bisexual women's smoking, emphasised the dynamic nature of self-concept and identity, which involved a constant redefinition and challenging of self-concept of lesbian/bisexual women's identity and smoker identity related to internal dialoguing. This incorporates the perceptions on how others were seen to respond to an individual and the broader social context of changing social norms over time and life-course.

Summary of research findings

Poland et al. (2006) has called for a consideration of the importance of the social context of smoking in order to understand the growing concentration of smoking among socially and economically marginalised groups and to examine why these groups have been resistant to tobacco control measures. Broad based tobacco control measures such as mass media quit smoking campaigns, increased cigarette taxation and legislated smoke-free public spaces have been successful in achieving a reduction in overall prevalence (Chapman et al., 2003). However tobacco control will continue to fail marginalised groups unless such issues as the power relations, collective patterns of consumption and the social role of smoking are addressed (Poland et al., 2006). While there has been an attempt to describe and understand women's smoking there is a paucity of research in understanding lesbian/bisexual women's smoking from a social context (Elkind, 1985).

This research addressed some of these shortfalls through examining the experiences of 28 lesbian/bisexual women smokers using a grounded theory qualitative approach set within a symbolic interactionism conceptual framework. The literature review contributed to the research and confirmed the starting position of accepting that lesbians/bisexual women smoke at a rate that is considerably higher than the wider

female population. They are therefore considered to be one of the marginalised groups with high prevalence that Poland (2006) discussed above.

In seeking to understand the unique drivers behind this higher prevalence, the research found that lesbian and bisexual women were engaged in dynamic and continuous identity negotiation as both a smoker and a lesbian/bisexual woman in a heteronormative world that has increasingly denormalised smoking. They belonged to two significant minority groups based on sexual orientation and smoker status. This dynamic identity negotiation is influenced by a range of factors that are often interrelated. Three core categories; dissonance, resolution and redefinition factors informed identity negotiation, which was an ongoing process, and provided an understanding of lesbian/bisexual women's smoking.

The majority of participants reflected that they had experienced feeling 'different' from their peers at a point in adolescence. Most in retrospect named this as the experience of same sex attraction whether they acted on this at the time or some later time. For many this was a time of trying to fit in and find belonging and was also a time of early cigarette smoking experience. While adolescence is often a time of identity formation and vulnerability regardless of sexuality, same sex attracted youth are subjected to some unique stressors.

Although all participants indentified as a lesbian/bisexual woman and were currently confident and stable in this identity, there was a diversity of experiences captured across the participant group. There was no single journey or stage that could be delineated as the 'lesbian/bisexual woman's experience. This difference was captured in such things as age of declaring minority sexual identity, experiences of disclosing minority sexuality, experiences of stigma, social expectations about a heterosexual identity and past and current engagement with the gay community. There was also a diversity of experiences of smoking although there was some commonality in the stages of moving from experimental smoking to entrenched smoking. Current smoking patterns and smoker identity illustrated the variety of types of smoker and the meanings and reasons these women smoked. Most regretted that they smoked and stated dissonance of smoking while knowing the adverse health

consequences and the stigma of being a smoker. This was more pronounced in older smokers who also had experience of multiple quit attempts.

All participants discussed the rapid social change they had experienced in the acceptability of the two identities being researched. Smoking has largely become denormalised and experienced as a deviant behaviour by the majority of participants. Older participants experienced this change most dramatically from being involved in a behaviour that was socially acceptable and glamorous to one which was now seen by the wider community as undesirable and resulted in the experience of stigma. Younger participants grew up in a time when smoking was already marginalised and generally were less concerned about being stigmatised and were more accepting of the place of smoking today.

The experience of belonging to minority sexuality has also undergone changes in social acceptability over a similar time period. Being a lesbian/bisexual woman is not universally accepted as illustrated in social attitudes and legal status, there is however increasing visibility, positive role models and acceptance within some areas of society. All older participants felt that it was easier being of minority sexuality now than in the time when they came out. Older participants also generally were far less concerned about how other people responded to their minority sexual identity.

All participants reported having been stigmatised for their smoking experience. This ranged from being subjected to widespread no-smoking bans to negative attitudes of non-smokers. This manifested in such acts as being called names for smoking in public, derogative comments and being socially isolated. All participants reported the importance of and attraction of being with groups of other smokers whether this was in the work place, friendship networks or public social venues. The latter included gay venues. Many participants reported relatively high smoking prevalence in their immediate networks and were not always cognisant that this was a far higher prevalence than the wider community.

Although not initially reported, on further questioning all participants had experienced homophobia or sexual stigma. This included verbal and physical attacks, social isolation, lack of acceptance by family and friends and other more subtle but

no less hurtful homophobic acts. There was a great range in the intensity of these acts with younger participants often reporting fewer experiences.

Management skills were well developed for handling both smoker stigma and sexual stigma and revealed overlap. This included concealment, minimisation of the hurt, dismissal of event, passing, finding people who were the same and forgiveness of stigmatising behaviour. Minimisation of sexual stigma was aptly illustrated by the large number of participants who initially said that they had not experienced negative behaviour due to their sexual identity although their subsequent reporting of events, for example the loss of close friendships, had long-term impacts.

The 'gay scene' is usually considered to revolve around the gay nightclub scene however as reported there were in fact many aspects that made up the 'gay scene' and gay community making it hard to define or describe this as a single entity. There was a very wide variation in the reported interaction and participation in the 'gay scene'. While many participants would not consider themselves to be active members in the 'gay scene', this was a dynamic situation and greater participation often coincided with periods of early exploration of sexuality and when not in a primary relationship. While higher smoking rates in lesbian/bisexual women may be reinforced by greater acceptance of smoking in the 'gay scene' this offered only a partial explanation for these higher rates.

All participants had justifications for their continued smoking. Despite reported high awareness of anti-smoking social marketing campaigns, these rarely resonated, or 'talked to' the participant group. Justifications for continued smoking included undertaking compensatory healthy lifestyle behaviours to counter the harms of smoking, minimising danger through reduced consumption, and a belief that 'you have to die of something' so 'you might as well enjoy a cigarette'. These are shared beliefs of many smokers regardless of sexuality however two unique justifications emerged. Some participants reported that smoking was a tactic for stress management and was helpful and a less harmful response than other options such as illicit drugs or self harm. Some had the belief that to be a lesbian was to be a smoker.

Participants ranged in age from 18 to 61 years and brought to the interviews a range of perspectives on the influence of their own life-course, some of which extended over several decades. It was clear that earlier experiences and critical life events influenced current identity, lifestyle choices, attitudes and future intention on both measures under consideration. In simplistic terms this generally manifested as feelings of more security in sexual orientation identity with less concern over what others thought of this choice as women got older, while at the same time experiencing greater dissonance and distress about their continued smoking. There were exceptions to this including some participants who came out later in life. Age effect was also evident in reported quit attempts with older participants having significantly more quit attempts, including those surrounding pregnancy for those who were mothers, and a greater desire to one day be a non-smoker.

Despite the denormalisation of smoking at a wider community level, most participants including the younger cohort discussed a stereotype that lesbians smoked. This was expressed clearly by one participant who said that to be a lesbian was to smoke. Clearly, with the majority of same sex attracted women not smoking this was an entrenched but inaccurate stereotype for this group.

Self concept for lesbian/bisexual women who smoke involved perception and reflection of the interplay of unique influences experienced over their life course. Heterosexual women do not face minority stress or sexual stigma based on their sexual identify, nor is sexual identity perceived as tied to a smoker identity which is reinforced through group settings where smoking is common. Life course markers for heterosexual women and non-heterosexual women are often different. The former fits more readily into a heteronormative model of partnering, marriage and children and extended biological family. These differences have also resulted in less engagement with mainstream quit campaigns for lesbians/bisexual women.

Figure 13 summarises the interrelatedness of key themes from the research. Participants discussed the influence of and response to different and changing settings. This included an ongoing processing of how they thought others perceived them. Socially and personally generated meanings impacted on internal processing

which was set in a changing world and influenced how they felt and responded to being a smoker and their sexual identity.
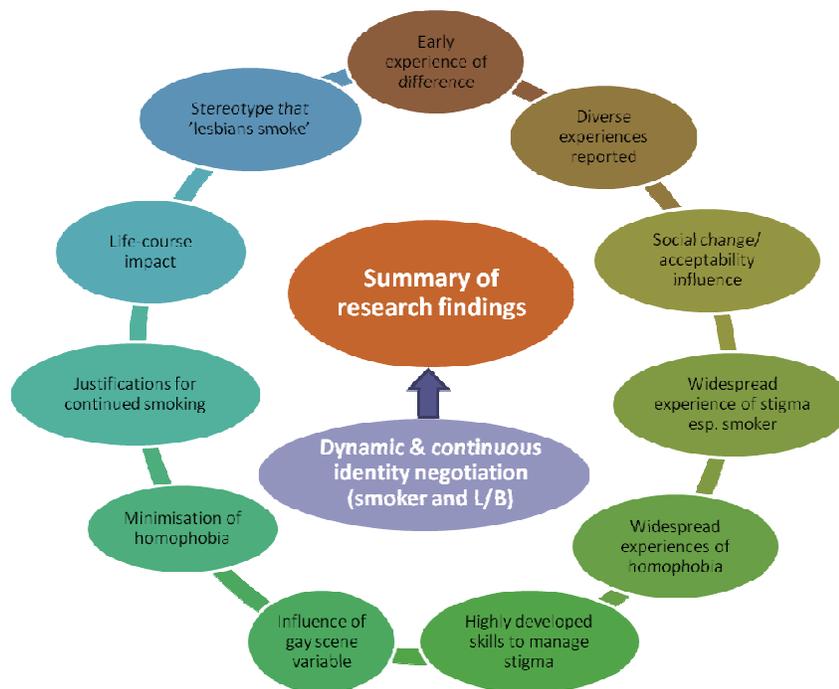

Figure 13. Summary of research findings.

7.3. Research limitations

While every attempt was made to ensure that this research was robust, like any research there were also limitations. Qualitative research methodology does not aim to arrive at generalisable results however the non probability sample recruitment did have some limitations. Recruitment is likely to have only attracted those women who were already connected to the lesbian/bisexual women's community and relatively secure in their sexual identity and hence as noted by others there was probably an under representation of lesbian/bisexual women who do not openly identify as such (Diamond, 2005). Sexual identity, for the purposes of research inclusion, was not defined by the researcher but left to self-definition by participants. This is a common limitation in much of the research in the LBGT health area and has been extensively discussed (Binson et al., 2007; Brogan et al., 2001; Malterud et al., 2009).

Being 18 years of age or older was an inclusion criteria. It is acknowledged that women younger than 18 identify as lesbian/bisexual and may smoke (Austin et al., 2004). Younger women may be coping with their emerging sexual identity and/or smoking experimentation and initiation. The majority of women interviewed for this study were comfortable with their sexuality and had been out for some considerable time resulting in a somewhat homogenous sample on this measure. They also identified as regular or ex-smokers and were not in the initiation phase. The majority of smokers commence smoking during their teenage years when a range of environmental, sociodemographic, behavioural and personal psychosocial factors are likely to be at play (McDermott et al., 2002). Psychosocial factors could encompass issues of emerging minority sexuality. The Freedom Centre, the peak gay based youth organisation in Western Australia is seeing an increasingly younger cohort with an average age of 16 even though people up to 24 years are welcome (Wright, personal communication, June 14, 2009). Therefore this research does not adequately capture this sexual and smoking experimentation of people younger than 18 years of age, which undoubtedly affects later smoking behaviour. This is a limitation of the research.

Non-probability sampling biases when researching a group that is not characteristic of the wider population was another potential limitation of the research. Regrettably with poor general research about what constitutes the population of lesbian/bisexual women made it difficult to ascertain how characteristic the research sample was. The demographics of the sample did show diversity on several measures for example age (18 to 61 years of age); location (inner city and regional residence); occupation (student, employed, retired); type of smoker (long-term highly addicted, short-term habit, 'social smoker', ex-smoker); age of coming out (13 to 52 years of age) and education level (less than year 11 to postgraduate qualification). On the measure of being comfortable with a minority sexual identity as noted above, there was however a general homogeneity which may be a limitation. Meyer and Wilson (2009) contend that depending on the research question and the community of interest, recruiting from the LGBT community may in fact be the most appropriate approach and hence it should not always be seen as a critique or limitation.

This research was limited by the lack of representation of bisexual women or mostly heterosexual women. This limitation applied to much research in the area (Diamond, 2008; Heath & Mulligan, 2008; Hughes et al., 2010). It is acknowledged that there are additional and unique influences at play with this group and emerging research is indicating that bisexual women are likely to have poorer health outcomes than lesbian women on many indicators (Beatty et al., 2006). A limitation of the research is that for the purposes of this study lesbian and bisexual women have been grouped together.

The recruitment information used the terms 'lesbian and bisexual women' and hence may have resulted in women who do not use these identity labels but none the less are non heterosexual not participating in the study. However when asked in the interview what label if any participants used approximately three quarters of the sample used the term lesbian or bisexual. It is therefore difficult to clearly state the impact of this limitation.

The sample relied on volunteer participation which presented a further limitation as recruitment is likely to have attracted a particular type of participant (Meyer & Wilson, 2009). It may be that only those smokers who were interested in exploring their own smoking behaviour responded to the recruitment strategies. Some insight into the self-selection of participants could be gained from the reasons given by those women who when approached declined to participate in the research. This meant that women who held these beliefs are less likely to be represented in the study and yet would have made a valuable contribution. Participation refusal could also represent reasons of stigma either due to sexual identity or smoking status although this was never stated as a reason for refusal which are described in section 4.6.2. A further limitation was the small number of ex-smokers in the sample.

The sample was not ethnically diverse and was almost exclusively ethnically of white Anglo European background, a further limitation. This may reflect barriers women of colour or minority ethnicity face in being part of the LGBT community and additional challenges to being open about their sexual orientation identity. A smaller percentage of culturally and linguistically diverse LGBT people has been reported in most research in this population (Bye et al., 2005; Pitts et al., 2006).

An early and unseen challenge was the difficulty in recruiting participants for the research. The stigmatised nature of the behaviours and identities being researched were a barrier and may account for some of the refusal responses noted above. Others have reported difficulties in recruiting smokers for qualitative research (Bottorff, Kalaw, Johnson, Chambers et al., 2005). Emphasising that the interview was not about encouraging participants to quit but to capture their experiences and feelings about smoking was obviously an unfamiliar concept. For most participants smoking was a very private matter because they 'knew' they should not smoke and there was a degree of guilt around being a smoker. No incentives were given for interview participation, which may have improved participation rates but may have resulted in other biases.

Two limitations were inherent in the literature on lesbian/bisexual women's smoking. Firstly, tobacco smoking is often not included or separately reported within broader studies looking at drug use in this community. This could indicate that tobacco smoking is not considered a 'serious' drug of concern or that its use is pervasive in this group. Secondly, some studies while reporting on drug use in the gay community did not report gender and hence separate figures for lesbian/bisexual women was not presented. For example, the Australian National Drug Strategy Household Report in 2010 reported on sexuality however this was grouped as 'heterosexual', 'homosexual/bisexual' and 'not sure/other' with no gender breakdown (Australian Institute of Health and Welfare, 2011).

A single interview was conducted with all participants except one. This has been seen by some as a methodological limitation because of the degree of unfamiliarity and lack of trust. Being an 'insider' contributed to an early level of trust and as reported in the interview follow-up received, lack of trust was not reported; instead there was an overwhelming response of having been heard and understood. As all interviews were conducted by me, there was also the opportunity to learn from each interview and incorporate lessons learnt to maximise trust and understanding in subsequent interviews and to achieve saturation. With greater resources in undertaking a similar project in the future a re-interview strategy could be developed to counter any limitations of a single interview.

Being an 'insider' at one level was declared to participants and resulted in many participants stating "you know what I mean"; "you know how it was in the old days". After review of an early interview, I ensured that such statements were followed by further probing to elicit participants' own views. This potential pitfall of 'insider' status has been discussed by lesbian woman of colour researcher, Kanuha (2000). Although beyond the scope of the current study comparative qualitative information from heterosexual female smokers may have contributed to greater clarification of the issues. Lack of appropriate control or comparison groups in lesbian health research has been noted by other researchers (Solarz, 1999).

7.4.   Recommendations for practice

Having discussed the research results and presented the theoretical model the final research objective, the development of recommendations for approaches to reduce the prevalence of smoking among lesbian/bisexual women, is addressed.

Prevalence data shows that smoking in Australia is increasingly concentrated in minority groups including that of gays/lesbians (Australian Institute of Health and Welfare, 2011). Many national tobacco control strategies such as taxation measures, plain packaging and smoke-free policies impact on all smokers and contribute to overall falling prevalence and the denormalisation of smoking (National Preventative Health Taskforce, 2008b). There are also state and national social marketing anti-smoking campaigns. There are few objective measures however of the impact of any of these measures on specific minority groups, especially those known to have high smoking prevalence. The participant group reported universally being disengaged with mainstream quit smoking campaigns, despite high knowledge of the adverse health consequences of smoking.

There are several organisations and authors who acknowledged the high prevalence of smoking in the LBGT community and have presented potential approaches to reduce this which involve greater engagement with this target audience (American Lung Association, 2010; Gay and Lesbian Medical Association, 2001; Leibel, Lee, Goldstein, & Ranney, 2011) and there have been several gay specific interventions

(Schillo & Willoughby, 2007). These have responded to the call by Greenwood and Gruskin (2007) for LGBT people to be identified as a priority population for tobacco policy. These approaches have been almost exclusively based in the USA.

There has been a lack of acknowledgement of the problem of LGBT smoking and a lack of approaches to address this in Australia. An illustration of this is the work of the National Preventative Health Taskforce where neither their report 'Australia: the Healthiest Country by 2020: a discussion paper' (National Preventative Health Taskforce, 2008a) nor the specific tobacco control document (National Preventative Health Taskforce, 2008b) makes any mention of LGBT as being a high prevalence minority group. In this same report, specific mention is made of other high prevalence groups, Indigenous Australians and low socioeconomic Australians, with targeted tobacco control recommendations. Approaches were made to several leading tobacco control agencies (Cancer Council Australia, Cancer Council Victoria, Cancer Council WA, Australian Council on Smoking and Health) in order to ascertain if they had been involved in or knew of any specific LGBT targeted tobacco programs. No one was able to name any project or expressed an interest to put this on their agenda. Even the GLVH (Gay and Lesbian Health Victoria) Clearing House, with its extensive collection of resources was unable to locate any tobacco control initiatives with the gay community (A. Mitchell, personal communication, September 22, 2011). ACON (AIDS Council of New South Wales) had produced one brochure to encourage quitting within the lesbian community but its use had not been evaluated (ACON, 2006). Within its lesbian health strategy, smoking is subsumed under the broad heading of alcohol and other drugs (ACON, 2008).

The previous chapter indicated that there are multiple and complex reasons behind the higher prevalence of lesbian/bisexual women's smoking. The discussion has also highlighted that while public health often deals with the single entity of 'smokers', this group is unlikely to consider itself a single group or respond uniformly (Scollo & Winstanley, 2008; Sorg, Xu, Doppalpudi, Shelton, & Harris, 2011). There are different reasons, meanings and self explanations for smoking across smokers which have been captured in the explanatory model; illustrating for example the impacts on early smoking behaviours which are likely to be very different to drivers for smoking maintenance behaviour. There is also the added complexity that public health interventions tend to deal with broad communities or settings and again the

discussion has shown that there is no such thing as a single gay or lesbian community and individual sexual orientation identity, behaviour and attraction is also varied and potentially fluid. Any successful intervention will require multiple approaches at both a lesbian/gay specific level and a mainstream level. The recommendations made here are informed by both the National Tobacco Strategy and the Ottawa Charter for Health Promotion (Ministerial Council on Drug Strategy, 2005b; World Health Organization, 1986). Many of these strategies also reflect recommendations of the National Preventive Health Task Force (National Preventative Health Taskforce, 2008b).

The National Tobacco Strategy recommend four objectives that tobacco control initiatives need to address to reduce smoking prevalence (Ministerial Council on Drug Strategy, 2005b):

1. Preventing the uptake of smoking.
2. Assist those who do smoke to quit as soon as possible.
3. Eliminate exposure to passive smoking.
4. Reduce harm associated with continuing use of tobacco.

The WHO health promotion charters provide clear direction on areas for action (Ottawa Charter), priority approaches (Jakarta Charter) and expanded action areas (Bangkok Charter) (World Health Organization, 1986, 1997, 2005). These seek to maximise improved health, addressing the social determinants of health to reduce health inequity within a human rights framework. This provides an additional appropriate framework to discuss recommended approaches to reduce smoking in the target population.

The recommendations contained in Table 17, Table 18 and Table 19 list potential approaches to reducing the prevalence of smoking among lesbian/bisexual women and are grouped according to the first three National Tobacco Strategy objectives.

Many of these recommendations are framed as involving the whole LGBTI population as their implementation and impact will go further than that of lesbian/bisexual women. Caution however is needed in generalising results from this research to all minority sexuality groups. There is a need for research which

interprets the drivers for smoking for gay/bisexual men, trans and intersex people which may require different interventions. It also becomes clear where smoking rates for subgroups within LGBTI populations have been disaggregated that some groups within this population have higher smoking rates than others. Smoking in males of minority sexuality appears to be less than females (Pizacani et al., 2009; Sell & Dunn, 2008). There are indications that smoking rates in bisexual and mostly heterosexual women are higher than in exclusively lesbian women (Fredriksen-Goldsen et al., 2010) yet these subgroups are often considered together as a single group. Care also needs to be used when labelling the gay community to avoid excluding certain sections (Scheer et al., 2003). The diversity of individual experience and the diversity of what constitutes the 'gay community' must be acknowledged.

Recommendations address both gay/lesbian specific interventions and mainstream approaches to work towards greater resonance with this target group. Full health promotion implementation and evaluation plans need to be developed for these recommendations; however this is beyond the scope of the current research.

Table 17

Preventing Smoking Uptake

Approach	Description	Rationale
Improving social inclusion of LGBT teenagers and young people	• Tobacco control agencies to acknowledge that smoking initiation is higher in minority sexual identity youth and hence require targeted messages. • Tobacco control agencies actively add their voice to support programs that address social inclusion for LGBT youth. • Acknowledge the importance of the school setting in this.	Research has shown that young people questioning or coming to terms with minority sexuality often feel different and/or lack a sense of social belonging and connection. There is a higher prevalence of substance use including tobacco in this group. Social inclusion measures may decrease smoking initiation in this group.
Working with non-smoking LGBT champions to promote the 'don't start' message especially with younger community members	• Identify non-smoking champions with community connection and appeal; both younger never smoked and older LGBT members who have quit or wished they never started. • Utilise in a variety of messages and mediums to promote the 'don't start' message. • Primarily directed to younger cohort.	The majority of LGBT people do not smoke, yet smoking is often seen as associated with the gay community. There is a need to inform younger people that the majority of LGBT people do not smoke with an emphasis on the benefits of never smoking. Additional research required to explore stereotypes around smoking and to better understand resilience factors of young LGBT people who do not smoke.
Targeted social marketing messages in the gay press supporting the stay smoke-free message	• Resource the development and placement of social marketing messages that can be used in gay media including print and radio to promote the 'don't start' message. • Development of youth targeted social media interventions e.g. Facebook, MySpace and other on-line environments to promote smoke-free messages • Ensure targeted LGBT youth focus.	Despite the government commitment to social marketing to promote the non-smoking message there is currently a lack of anti tobacco messages within the gay media. Mainstream messages have little resonance for LGBT people therefore a targeted social marketing campaign with appropriate images and messages are required. Investigating the use of social media to promote this message especially to the younger cohort, where use is known to be high.

Approach	Description	Rationale
Working with community groups to promote denormalisation of smoking	• Develop strategies that endeavour to change the social norms and environments to promote smoke-free lifestyle. • Publishing information on the current high smoking prevalence in LGBT population and also emphasising that there is a no-smoking majority in this community.	Social norms affect how smoking is perceived. The gay community is often seen as revolving around a drug culture including the legal drugs alcohol and tobacco. Although smoking is a minority behaviour across the whole community this is rarely advertised or discussed. There is a need to demystify the meanings given to smoking by the LGBT community.
Working with youth focused LGBT agencies e.g. Freedom Centre	• Ensure LGBT youth focused agencies are adequately resourced and trained to promote non-smoking norms. • Ensure that such agencies promote supportive non-smoking environments.	LGBT youth focussed agencies can be an important point of contact with young LGBT people especially at a times of confusion or crisis. This can also be a time of smoking initiation therefore ensuring these agencies can promote effective non-smoking strategies is important.

Table 18

Assisting Smokers to Quit as Early as Possible

Approach	Description	Rationale
Quit resources for lesbian/bisexual women	• Develop specific lesbian/bisexual women's Quit resources. • Such resources to address life-course influences appropriate to lesbian/bisexual women, acknowledge the impact of minority stress, appropriately address the way smoking is often used especially to handle minority stress and other stressful situations and provide realistic alternatives. • Ensure distribution strategy for such resources.	While there are some universal influences on smoking behaviour of all women, there are also unique factors and some unique triggers for relapse among lesbian/bisexual women. Therefore it is unlikely that mainstream Quit resources adequately address these issues. There is a lack of Australian LGBT specific Quit resources that can be used by both community members and health professionals.
Quit line staff to have demonstrated LGBT competency	• Working with community input to develop professional development for Quit line staff using a diversity agenda training framework to ensure an understanding of the unique drivers behind the higher smoking rates in the LGBT community. • Quit line staff able to appropriately and sensitively provide advice where minority sexuality has been disclosed, acknowledging that not all will disclose sexuality. • Ensure comprehensive understanding of the triggers for relapse especially around relationship stresses and that appropriate referral advice is given. • That the Quit line is widely promoted in targeted campaigns that reach LGBT audience and promote services as LGBT sensitive.	The National Quit line is an important part of the National Tobacco Strategy and its use is known to improve quitting rates. It is therefore imperative that if a LGBT identified person accesses the service, they encounter staff that are well equipped in understanding and advising this minority group.
GP resources	• Develop GP resources/communication strategy that discusses the high level of smoking in the LGBT community. • Include comprehensive information on unique triggers for smoking initiation and maintenance and	GPs provide an important and influential source of information and referral. GP knowledge and competency in LGBT health issues is not uniformly high, indicating a requirement for appropriate professional development. This needs to involve cultural competency that supports clients to feel more comfortable in disclosing their minority sexuality to their GPs.

Approach	Description	Rationale
	the impact of minority stress and the resulting higher levels of mental health problems in this group. • Provide practical brief intervention strategies that GPs could use with LGBT identified clients.	This is required before GPs are likely to refer clients to appropriate resources. Ultimately this should be covered in initial training of all health professionals.
Peer based community settings approach	• Develop and pilot a Quit campaign approach that utilises peer-based, gay community settings. • Special focus on youth environment to prevent movement from experimental to full time smoker.	A settings approach utilising gay community venues has been used with some success most notably for the safe sex message. It is worth therefore piloting a Quit message along similar lines.
Mainstream social marketing Quit messages to be inclusive of a LGBT audience	• With community input, test mainstream social marketing messages for resonance with a LGBT audience. • Future mainstream social marketing Quit messages to ensure greater resonance with LGBT audience, which may require the inclusion of LGBT images in marketing material.	Social marketing campaigns that promote the Quit messages have been central to the National Tobacco Strategy. However resonance with LGBT community is poor. Therefore mainstream messages need to ensure an inclusive approach to this minority group. Not all lesbian/bisexual women actively participate in the gay community adding further impetus to ensure mainstream messages are more inclusive of LGBT audiences.
Targeted LGBT social marketing campaigns promoting Quit message	• Develop targeted LGBT social marketing Quit messages for use with gay community media outlets.	In addition to more inclusive mainstream social marketing campaigns, it is also desirable that LGBT specific messages be developed for gay media outlets and events.
Use of LGBT social media for quit messages	• Investigate appropriate use of Quit messages utilising social media. This could encompass social network approaches, which may also allow for individual tailored advice.	Social media and new technologies are well used by LGBT people and therefore provide a potential medium for Quit messages for this community. Social media may also link social networks, which have been shown to spread both preventive behaviours and quitting behaviours.
Lesbian/bisexual women specific cessation programs	• Develop and deliver a lesbian/bisexual women's specific cessation program. • This could be a unique program or a modification of an existing program such as the Cancer Council Fresh Start program preferably using a trained lesbian/bisexual woman facilitator with culturally relevant content.	While many smokers quit by themselves for others the support of a facilitated group approach has been shown to be effective. There is a lack of evidence of how well used existing group approaches are by lesbian/bisexual women. The unique aspects of smoking within this group are unlikely to be addressed in existing programs.

Table 19

Eliminating Exposure to Passive Smoking

Approach	Description	Rationale
Raising the issue at a community level	• Tobacco control agencies to work with community groups to implement a passive smoking campaign.	The higher the level of smoking in the community the greater the likelihood of exposure to passive smoking. If the issue has not been challenged from within the community then it is unlikely that more than legislative minimum requirements will be met.
LGBT commercial and community organisations to be encouraged to provide better smoke-free controls	• LGBT organisations to be surveyed to ascertain if they have a smoke-free policy and policies that ensure no connection with the tobacco industry. • Tobacco control agencies to work with these agencies to assist in providing policy support.	Many events run by and for the LGBT community may not be equipped or aware of actions they could take to minimise passive smoking. Tobacco control agencies have a background of policy development in this area and there is therefore much to be gained by nurturing this partnership and mentoring LGBT agencies to be more proactive in smoking control. Improved control of passive smoking will benefit both smokers and non-smokers.
Passive smoking and babies and young children	• Raise community awareness of the specific dangers of passive smoking to babies and young children either through the modification of existing mainstream campaigns to be more inclusive and/or targeted campaigns utilising the LGBT media.	It is known that passive smoking has particularly severe consequences for babies and young children. A proportion of the LGBT community are parents or prospective parents and hence the importance of ensuring this group understands and acts on these dangers.
Working with community groups to encourage denormalisation of smoking	• Targeted use of social marketing and social media messages to encourage a shift of social norms to non-smoking norms. • Empowering community members to become active non-smoking advocates.	Australia has some of the strictest controls in place to minimise exposure to passive smoking. These benefit everyone. However within particular LGBT social networks or at community events smoking may still be seen as acceptable. An active approach to encourage the denormalisation of smoking targeted at the gay community is required.

This project and other research (Haines et al., 2010; Poland et al., 2006) have demonstrated the importance of understanding the context and meaning of smoking as elucidated by smokers themselves. The strategies recommended above build on a premise of tobacco control organisations and LGBT community agencies working in partnership with the target community to maximise intervention success. It will be necessary to establish this partnership through such strategies as a sponsored roundtable discussion to bring the partners together and to raise the visibility of the issue, identifying key individuals who can champion the issue and reciprocal membership of relevant organisations. There may also be lessons to be learnt from progress made in such partnerships in other countries notably the USA (Sell & Dunn, 2008).

Youth smoking rates in Australia have been declining. Currently 94.6% of 12 to 17 year olds reported having never smoked and 2.5% reported smoking daily (Australian Institute of Health and Welfare, 2011). It is unlikely that these figures are mirrored in LGB youth and hence strategies to prevent smoking initiation in this group are required.

Oakes et al. (2004) has commented that quit smoking messages have concentrated on the negative health consequences of smoking, often expressed in fear campaigns. Although there is evidence that negative messages and high emotional impact anti-tobacco mass media advertising does impact on smokers (Biener, Wakefield, Shiner, & Siegel, 2008; Wakefield, Loken, & Hornik, 2010), as this research has shown, smokers have sophisticated rationales behind their smoking and most can articulate positives including the pleasure aspect of smoking. These are rarely acknowledged in Quit programs and could add to target audience resonance especially when addressed to minority groups. It is important therefore that any initiatives include the voice of the lesbian/bisexual woman smoker (Laurier et al., 2000).

While not all lesbians/bisexual women are deeply connected to the gay community and the diversity of lesbian/bisexual women's experience and lifestyle is accepted, the gay community is for others an important entity especially at the time of clarifying sexual identity. Therefore smoking control measures must have gay community and social group resonance for LGBT people if they are to have impact.

Tobacco control interventions need to engage with the community in the design and development stage of interventions. Increasingly gay community groups have the capacity to deliver programs and this should be considered where appropriate. Adequate resourcing and training for any community based approach is required as smoking control will be an additional and potentially new area of work for most agencies (National LGBTI Health Alliance). The need to work with the community has been emphasised in the Jakarta Charter where two of the priorities for health in the 21st century were to consolidate and expand partnerships for health and increase community capacity; and empower the individual (World Health Organization, 1997).

Smoking is not a priority issue for LGBT community groups. A study in the USA found that from a total of 74 LGBT community organisations only 24% identified tobacco as a priority LGBT health issue (Offen et al., 2008). The majority of respondents saw tobacco as extraneous to their core business and tobacco use was considered by the majority as an individual choice not a systemic problem (Offen et al., 2008). It is likely that a similar situation exists in Australia.

Christakis and Fowler (2008) have shown that networks exert influence on smoking behaviour. This may help explain participants who reported high levels of smoking among their immediate social networks. "People are connected, and so their health is connected" (Christakis & Fowler, 2008p. 2257). These authors suggest that networks can also be used for positive health change such as with the Quit message. Network approaches need investigation with this target group as outlined above.

This can also extend to the use of peers, social networks and gay venues which have been used successfully in other health promotion strategies within the gay community most notably safe sex messages with gay men using peer educators, outreach services and resources in gay venues (Herbst et al., 2007). Leibel et al. (2011) suggest that the lesbian bar should be considered as an intervention site based on this approach and is worthy of investigation but will require the close involvement of the community itself. The impact of community approaches are likely to be limited to those who are involved in the community and hence more innovative approaches are required to target smoking control to non community LGBT people.

There is the opportunity to utilise appropriate social networking, social media and new technologies for interventions. There is evidence for widespread use of social media by young LGBT with 76 per cent of respondents in a large Australian LGBTI study who reported they had used the Internet to explore their sexual identity (Hillier et al., 2010). Social media was also used to provide a safe non discriminatory place of connection and provided access to a community of peers on-line (Cohler & Hammack, 2007) and also provides a potential approach in smoking control especially when targeting youth (Scollo & Winstanley, 2008). Less is known about the use of social media by older LGBT people. These virtual communities of interest connect not just those people in metropolitan areas, but also non metropolitan areas or those who do not actively participate in the inner city venues. The Pink Sofa, and Facebook sites such as Lesbian Space provide specific social media opportunities for lesbian/bisexual women. They potentially could provide cost effective and directed interventions to raise the issue of smoking at a community level as well as provide individual tailored interventions. They may also be used for broader healthy lifestyle campaigns where preventing or reducing smoking is one message.

Although successful smoking cessation may involve the use of pharmacotherapy, individual or group programs, the majority of smokers who quit do not make use of these (Chapman & MacKenzie, 2010). There is some support for the efficacy of low cost interventions such as quitting kits (Ussher, Chambers, Adams, Croghan, & Murray, 2011). Providing supportive environments, including the denormalisation of smoking within the gay/lesbian community, having community organisations prepared to actively support a quit message rather than passively support existing norms are likely to assist quit attempts. The evaluation of such measures will be difficult as the gay community is also influenced by wider tobacco control measures such as taxation. A more active community voice on smoking control may increase quitter motivation.

There is a lack of evaluation of gay community tobacco control interventions worldwide. The Los Angeles County Department of Health Services implemented a gay specific campaign called 'Last Drag', however no evaluation of this could be located (Anon, 2005). In 2004 the Mautner Lesbian Health project announced a lesbian specific campaign 'Delicious Lesbians Kiss' however without published

evaluation (Lunglhofe, 2004). A report of a small 7 week tailored community level intervention for gay men in London showed improved quit rates for those who undertook the entire program (Harding, Bensley, & Corrigan, 2004). The program is also an example of the adaptation of an existing government program, which was tailored for this audience of gay men. This demonstrates that existing programs can be adapted for a gay target audience and the overwhelming need for better evaluation to drive future evidence-based interventions.

Barriers exist to lesbian/bisexual women accessing health services including lack of LGBT sensitive practice and lack of knowledge of preventive health screening guidelines (A. Diamant, Wold, Spritzer, & Gelberg, 2000; McNair, Anderson, & Mitchell, 2001; Owens, Riggle, & Rostosky, 2007; Scout, Bradford, & Fields, 2001). This makes it even more important that GPs and other health professionals are adequately resourced to competently and sensitively raise issues of smoking with LGBT clients to achieve more inclusive practice (Bonvicini & Perlin, 2003; Makadon, 2006). With higher rates of mental health issues amongst gay/lesbian people (Pitts et al., 2006; Siahpush, 2004) and the relationship between mental health and smoking, presents another area for training on the unique influences at play on smoking amongst lesbian/bisexual women. Improving health practitioner gay/lesbian cultural competency is an important issue. Several resources have been developed to ensure inclusive practice (Makadon, Mayer, Potter, & Goldhammer, 2008; Ministerial Advisory Committee on Gay Lesbian Bisexual Transgender and Intersex Health and Wellbeing, 2009). More resources and commitment however is needed to ensure such training is embedded within health professional training.

Although many of these recommendations have been addressed to a broad audience of lesbian/bisexual women and sometimes the whole gay community, there is a need to recognise that the burden for tobacco use is unlikely to spread evenly in this population. Greenwood and Gruskin (2007) suggest there are likely to be multiple minority stressors or disadvantages at play for example socioeconomic status, race and level of internalised homophobia. Little research has been completed to evidence such differentials however tobacco control work in other areas can be used to inform approaches with the gay population and to understand these different burdens. Interestingly education level, an indicator usually related to smoking prevalence has

been shown in several studies provide little protective effect for this group (Z. Hyde et al., 2009; H. Ryan et al., 2001). Research also reports higher smoking levels for bisexual women than lesbians and this needs to explored further to ensure inclusion of this group in any interventions (Eisenberg & Wechsler, 2003).

Smoking initiation and continuation is often influenced by the broader experiences of belonging to a minority sexuality, as described by others (Meyer, 2001, 2007; Pitts et al., 2006) which may also explain other poor health indicators. LGB youth report higher initial use of substances including cigarettes which has long term consequences on their health (Marshal et al., 2008; Marshal, Friedman, Stall, & Thompson, 2009). Smoking initiation that is used by LGB adolescents as a coping strategy therefore needs interventions that are targeted to this end (Pollard et al., 2011). As there is also evidence that higher LGB smoking prevalence is influenced by the normative place of smoking within LGB communities then interventions must also concurrently address this. Root causes require that a human rights, social inclusion agenda is required to provide a supportive framework for real progress in smoking prevalence and improvement in other health outcomes in the long-term (Eliason, 2010; Northridge, McGrath, & Krueger, 2007). This is especially so for LGB youth who are at a vulnerable stage of identity formation and often seeking a sense of belonging to both the gay and the broader community (McCallum & McLaren, 2011).

Underlying principles for practice

Raising the issue of LGBT smoking at all levels, i.e. the gay community, tobacco control service and advocacy agencies, and government, is one of the underlying principles for practice from this research. Figure 14 presents this and six other underlying principles of intervention that need to inform any future interventions to maximise the efficacy of the recommendations for practice listed above.
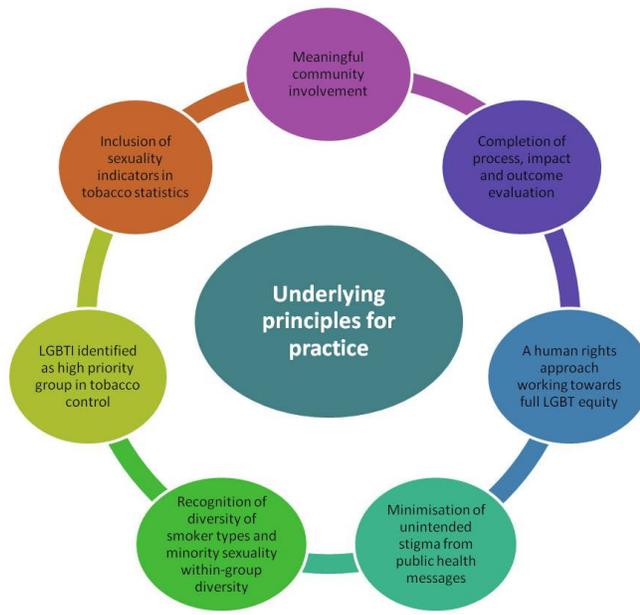
Figure 14. Underlying principles for practice.

LGBT smoking is not currently a priority issue for gay community groups or tobacco control agencies. Advocacy is required to reverse this if there is to be partnership and progress in the development and implementation of strategies to address this issue (Sell & Dunn, 2008). Australia has made significant progress in smoking control and smoking has moved to a minority behaviour concentrated in identified minority groups including LGBT people. It is critical therefore that sexual orientation and gender identity is routinely included in research and epidemiological studies on tobacco use to capture LGBT smoking prevalence and behaviour (Sell & Dunn, 2008). In the USA the National Tobacco Control Network is a partnership of mainstream tobacco control agencies, LGBT community groups and LGBT health centres (The National Tobacco Control Network, 2011) who have shown the strength of such a partnership approach. One of their key aims is to advocate LGBT as a priority group in national tobacco planning documents and this is seen in the USA Tobacco Action Plan which has worked in consultation with the Fenway Institute to include LGBT issues (US Department of Health and Human Services, 2010).

Consultation with the target group is essential to better understand the impact of existing generic anti-smoking campaigns and also to direct future intervention design and implementation. The importance of this is shown in Appendix J when research participants reported they felt listened to and their experiences validated by the

interview process and reflected thoughtfully on the issue of lesbian smoking. There is much to learn from such personal stories and community perspectives. Lessons can also be learnt by examining the small number of lesbian specific interventions that have been implemented to date, particularly in the USA. Any interventions need comprehensive evaluation so that future directions are evidence-based. Evaluation may also provide direction for interventions in other health compromising behaviours that are over-represented in this group such as risky drinking and mental health.

Working towards a more inclusive and equitable society where minority sexuality is no longer stigmatised, where young lesbian/bisexual women are free to declare and express their sexuality will see broad public health returns. Several authors have noted that smoking prevalence is just one of a cluster of other health behaviours and health conditions that have higher rates in the LGBT population including depression, substance abuse, victimisation and childhood trauma (IOM (Institute of Medicine), 2011). As these often coexist and can amplify the effects of each other reducing these other conditions could lead to a reduction in smoking prevalence (Gruskin et al., 2007). Any broad healthy lifestyle programs that are directed to lesbian/bisexual women should include a smoking prevention and quitting message. This is especially appropriate if other drug use is being targeted due to the common concurrence of smoking with these activities.

In the USA several national government organisations have developed resources LGBT health issues (Centres for Disease Control and Prevention, n.d.; IOM (Institute of Medicine), 2011; US Department of Health and Human Services, n.d.). The Australian health agenda to date has virtually ignored LGBT health issues outside of HIV/AIDS for gay men. The National LGBTI Health Alliance in its submission to the National Drugs Policy 2010 to 2015 provided five succinct recommendations that complement the recommendations for practice outlined in this section. Although this submission was in response to a strategy addressing all drug use it provides useful and appropriate direction for tobacco control.

The Alliance recommendations in summary were:

- The need for LGBTI people to be identified as a priority population in the National Drugs Strategy.
- Stigma and discrimination needs to be addressed as underling factors in drug use in this group and social inclusion needs to be promoted.
- The need for ongoing workforce and organisational development on LGBTI issues.
- LGBTI organisations should be supported to deliver interventions.
- The Alliance should receive ongoing funding to provide peak organisation input (National LGBTI Health Alliance, 2010).

The success of smoking control in Australia did not happen overnight and builds on 50 years of history. Even with targeted approaches to LGBT interventions success will not be instant and will require a sustained effort.

Challenges for future action

Five key challenges to progress a reduction in smoking amongst lesbian/bisexual women are discussed below and summarised in Figure 15.

Currently the health system operates from a heteronormative paradigm that assumes everyone is heterosexual. Unless this changes, gay and lesbian people will largely remain invisible and their needs will be overlooked (Meyer, 2001). Examples of professional development training and cultural competency audits that will help address this already exist (Ministerial Advisory Committee on Gay Lesbian Bisexual Transgender and Intersex Health and Wellbeing, 2009). There are lessons to be learnt from successful strategies undertaken in certain states in the USA. Heteronormativity is however deeply embedded in the health system (Rosenstreich, Comfort, & Martin, 2011) and remains a challenge to progress.

There is an increasing body of research in the gay/lesbian health area, however there are still gaps and charges of a lack of research robustness. Without evidence-based practice in the area of gay health the issues will remain fringe to broader health and funding decisions. One barrier has been the lack of large-scale randomised surveys.

As Hughes (2003) and others have commented we need to overcome political and other obstacles that have prevented asking questions about sexual orientation in national health surveys (Hughes & Jacobson, 2003; H. Ryan et al., 2001).

While LGBT smoking control remains a low priority issue for both the gay community and tobacco control agencies it will be difficult to attract the necessary political, community and agency attention and resources to address the issue. This is a major challenge for future action. The 2010–2011 Federal Budget provided funding of $27.8 million for a complementary campaign to the National Tobacco Campaign directed to reduce smoking prevalence among high need and hard to reach groups (Commonwealth of Australia, 2010). Listed groups included pregnant women and their partners, prisoners, people with mental illness, people from culturally and linguistically diverse backgrounds, and people living in low socioeconomic areas (Commonwealth of Australia, 2010). There was no mention of gay/lesbian/minority sexual orientation groups.

The lack of partnerships between tobacco control and the LGBT community in part contributes to the lack of priority of this issue and prevents effective tobacco control with this target group. The Ottawa and subsequent Charters (World Health Organization, 1986, 1997, 2005) emphasises the need for health promoters to engage with the communities they want to work with. There is little evidence of engagement by tobacco control agencies.

Most of the dedicated work in gay health is undertaken by community non-government organisations. Such organisations suffer from a lack of secure ongoing funding which prevents long-term strategic planning and delivery of interventions. The National LGBTI Health Alliance, formed in 2005 (National LGBTI Health Alliance) has been able to provide a national voice on health issues however it suffers from a lack of secure funding. Other minority groups have the benefit of funded peak bodies. If real gains are to be made in smoking control in LGBT communities then community initiatives need to be funded.

Figure 15. Challenges for future actions.

7.5.   Recommendations for further research

This project has raised additional questions, which were beyond the scope of the current research to answer. This includes both identified shortfalls in the literature and ideas generated from the interview analysis, and form the basis for this section on recommendations for further research. These are not necessarily specific to lesbian/bisexual women as it is important that smoking as an issue is raised within the broader LGBT community and certain interventions would be difficult to direct to women only. I start with a need to understand why LBGT smoking control does not appear to be a priority issue.

Tobacco control and public health agencies can claim many successes in smoking control in Australia yet there is a lack of initiatives that tackle high smoking rates in the LGBT community, a community that constitutes approximately 10% of the population (Australian Medical Association, 2002). Research is therefore urgently required to comprehensively assess nationally why this is the case. Information from tobacco control agencies on the perceived barriers to undertaking work in LGBT

smoking and facilitation factors that would increase an agency's commitment is also important. Such research has the potential to raise the issue within the public health sector and provide insight into the reticence to work in this area.

Concurrently research to investigate LGBT community organisations' attitudes and practices in the smoking control area is also required. This includes ascertaining the importance an organisation gives to smoking as an issue within the LGBT community and whether organisations undertake any strategies to actively promote a non-smoking position, or if there are explicit organisational guidance about relationships with the tobacco industry. A study undertaken in the USA showed that LGBT organisations rarely promoted a non-smoking image and many accepted sponsorship from the tobacco industry (Offen et al., 2008). The latter is less likely to be the case in Australia due to strict advertising bans however it is not known if organisations receive any funds from the tobacco industry.

Research with LGBT community organisations into perceived barriers and enablers to smoking control in the community and explanations for higher prevalence rates would provide valuable insight. For advances to be made, the community sector and the public health sector will need to work in partnership. Research can provide valuable insight into both tobacco control agencies and LGBT organisations' attitudes and beliefs into LGBT smoking.

Smoking amongst lesbian/bisexual women is a minority behaviour; the majority of these women do not smoke. Research is required with this group to investigate questions of resilience as these results will provide further insight into what promotes non-smoking within this group especially at transitional times which are likely to be important for understanding smoking behaviour. Such research can operate from a positive paradigm rather than a pathologising one which is often used in gay health issues (Balsam, 2003).

Times of transition whether to different sexual orientation or through life stages are not well researched in relation to the impact these have on smoking behaviour of lesbian/bisexual women. Yet it is an area that research indicates may provide some

answers to smoking initiation and intention to quit (McDermott et al., 2006; Morgan & Thompson, 2011). It is therefore an area of importance requiring research.

The results indicate that there are different groups of lesbian/bisexual women some of whom are likely to have higher levels of smoking prevalence and a more entrenched culture of smoking. This includes women who experience multiple marginalisation of sexual minority status in addition for example low socioeconomic status and ethnicity as found by other researchers (Hahm, Wong, Huang, Ozonoff, & Lee, 2008; Hughes, 2000). Differences between lesbians and bisexual women's health and health behaviours including smoking, report bisexual women are more marginalised and have poorer health outcomes than lesbians (Dilley, Simmons, Boysun, Pizacani, & Stark, 2010; Fredriksen-Goldsen et al., 2010). Exploration of the grouping 'mostly straight', not exclusively heterosexual women is also required as this is emerging as a group with higher smoking prevalence than exclusively lesbian women (Morgan & Thompson, 2011). This may indicate greater levels of marginality and stress (Weber, 2008). Future research needs to be more sophisticated to tease out the differences between lesbian and bisexual women and also include examining the impact of different dimensions of sexual orientation (McCabe et al., 2005). A better understanding of in-group differences within the lesbian/bisexual women group will provide greater understanding of drivers for smoking behaviour.

Chapman and Mackenzie (2010) have commented that the majority of people who quit do so by themselves. Research is required to examine successful quitting by lesbian/bisexual women especially unassisted cessation and whether this is different to heterosexual women. Results of this could inform message development for health promotion interventions emphasising successful quitting strategies. This could also inform the development of appropriate Quitting resources and support group interventions.

The health belief model seeks to assess perceptions of susceptibility and severity of getting a health condition as well as the barriers and benefits of a healthy behavioural change (Glanz, Rimer, & Lewis, 2002). Research is required with an LGBT sample to investigate risk perception and barriers to behavioural change to better understand the impact this has on lifestyle choices including smoking. Such research can inform

targeted health promotion interventions and provide information on differences within the broader gay population of different drivers for both health compromising and health affirming behaviour.

Stigma has been used, often unintentionally, in public health messaging particularly in smoking control. The ethics of such an approach has been discussed (Bayer, 2008; Bayer & Stuber, 2006). Research is required not just with LGBT people but more broadly to examine the potentially adverse effects of this and whether the adverse effects of stigma as acknowledged in many other areas, e.g. in mental health, warrant its use. Potentially, smoker stigma may lead people to quit (Stuber, Galea et al., 2008) however it may also have negative consequences.

This research was restricted to the experience of lesbian/bisexual women who were eighteen years of age or older. It is clear that decisions about smoking initiation are often made at a younger age. Therefore research directed to lesbian/bisexual or queer youth aged 14 to 18 years of age in order to better understand the triggers that lead to smoking initiation are required to inform interventions that seek to delay or prevent smoking initiation. Such research should include approaches that do not rely on a pathologising model to better understand this group (Savin-Williams, Cohen, Joyner, & Rieger, 2011).

There is a lack of targeted smoking control interventions in the gay community in Australia. A range of intervention approaches have been recommended in this chapter which provide the opportunity to design innovative and/or adapt existing initiatives to prevent smoking uptake, promote quitting and reduce passive smoking within the gay/lesbian community. Any intervention requires robust process, impact and outcome evaluation to assist in developing evidence-based practice in the area of LGBT smoking control. Current interventions in this area are stymied by a lack of evidence-based practice even in the USA, the world leader in gay health interventions (Sell & Dunn, 2008).

Networks have been shown to have a powerful effect on behaviour. Research is required to understand the effect of social groups on normative beliefs and behaviours. There is also scope to research an intervention that actively utilises

networks both through on-line social media communities and face to face friendship networks to evaluate the effectiveness of using networks to promote smoking prevention and quitting. This has been used effectively in the sexual health area and it may prove successful in smoking control.

Figure 16. Recommendations for further research.

The eleven areas of further research summarised in Figure 16 illustrate some of the areas that emerged from the research as requiring investigation. One challenge will be in securing resources to support such a research agenda when gay health per se is rarely seen as a priority issue by health funders.

7.6. Concluding remarks

Tackling smoking in marginalised high prevalence groups such as lesbian/bisexual women is essential if the overall target of at least one million fewer Australians smoking by the year 2020, the target of the National Preventative Health Taskforce, is to be met (National Preventative Health Taskforce, 2008b). This represents a national prevalence rate of 9%. While it is difficult to give a definitive smoking prevalence for lesbian/bisexual women, as reported in Table 2 many studies report

higher prevalence. The latest Australian Institute of Health and Welfare (2011) smoking prevalence for heterosexuals was approximately half that of homosexual/bisexual respondents (17.5% compared to 34.2% respectively). Even if as suggested in more recent literature the higher rate of smoking amongst lesbians has been overstated, these figures indicate sexual minority Australians are a group of high smoking prevalence and require inclusive and specific smoking prevention and cessation strategies.

Action will be required to ensure mainstream approaches such as that of the National Tobacco Strategy (Ministerial Council on Drug Strategy, 2005b) are more inclusive as well as considering specific targeted interventions. Any intervention needs to respond to Poland et al.'s (2006) urging that we understand the social context of smoking especially if reductions in smoking rates in marginalised groups are to be achieved.

This research has provided a unique insight into the smoking experience of lesbian/bisexual women by presenting the voice of these women through rich qualitative data. It captured the experience of being a woman of minority sexuality who is a smoker at a particular point in time in Australia. A time when smoking has become a denormalised behaviour and when minority sexuality, despite increasing acceptance, is still a marginalised behaviour.

A comprehensive literature review covering both smoking as a health issue and issues around minority sexuality was presented. The methodology of grounded theory set within the conceptual framework of symbolic interactionism provided evidence of a robust approach to the research. The results chapter gave voice to the 28 individual women who shared their story of being a lesbian/bisexual woman smoker presented under core categories of dissonance, resolution and redefinition factors. The discussion brought together the results and the literature, which led to an explanatory model for lesbian/bisexual women smoking. This chapter concludes the thesis by presenting research limitations, recommendations for practice and recommendations for further research.

The explanatory model illustrates the interplay between lesbian and smoker self-concept/identity the result of negation with self and how others are perceived to see self. This is set within the influence of changing social acceptability and individual life-course influences. These provide unique drivers for smoking initiation and smoking maintenance amongst lesbian/bisexual women.

There is no single entity of 'lesbian/bisexual women smoker' nor is there a single lesbian/gay community. Lesbian/bisexual women smoke for different reasons, with different patterns throughout a life-course and in response to different social settings. The role of stereotypes and the 'gay scene' impacted differentially on individual participants.

Although higher prevalence of smoking is found in minority sexuality groups, as well as higher prevalence of many other health indicators, it is important that this is not equated with pathologised health. Most lesbian/bisexual women do lead happy healthy lives and this may provide further clues to be followed to increase the health outcomes of all LGBT people.

The higher prevalence of smoking amongst lesbian/bisexual women needs to be acknowledged at both a community and a broader public health level as a first step to action. The National Women's Health Policy and others propose that sexual orientation and being of minority sexuality should be considered as a social determinant of health requiring specific and appropriate interventions (Commonwealth of Australia, 2010; Gay and Lesbian Medical Association, 2001; McNair, 2003). This research supports this contention recognising unique drivers behind health compromising behaviours of lesbian/bisexual women.

This research highlights the need to look at smoking amongst lesbian/bisexual women by presenting the complexities that lie behind the numbers. There are many exciting strategies than can be explored to address this issue. I hope some of these are taken forward and the reward will be a decline in the smoking prevalence of this group.

References

Aaron, D., Markovic, N., Danielson, M., Honnold, J., Janosky, J., & Schmidt, N. (2001). Behavioral risk factors for disease and preventive health practices among lesbians. *American Journal of Public Health, 91*(6), 972-975.

ACON. (2006). Become more kissable Quit smoking. Unpublished brochure. ACON.

ACON. (2008). *ACON Lesbian Health Strategy 2008-2011*. Sydney: ACON.

Amadio, D. M. (2006). Internalized heterosexism, alcohol use, and alcohol-related problems among lesbians and gay men. *Addictive Behaviors, 31*(7), 1153-1162.

American Lung Association. (2010). *Smoking Out a Deadly Threat Tobacco Use in the LGBT Community*. New York: American Lung Association.

Anfara, V., & Mertz, N., (eds). (2006). *Theoretical Frameworks in Qualitative Research*. California: Sage Publications.

Anon. (2005, 23 November 2005). Los Angeles County Department of Health Services; 'Last Drag' campaign launched to reach smokers in gay and lesbian community. *Elder Law Weekly*. Retrieved 4 November 2010, from http://proquest.umi.com.dbgw.lis.curtin.edu.au/

Anon. (2009). The L Word.   Retrieved 20 August 2009, from http://en.wikipedia.org/wiki/The_L_Word

Auerbach. (2008). Lesbian, gay, bisexual, and transgender public health: progress and challenges. *American Journal of Public Health, 98*(6), 970.

Austin, S., Ziyadeh, N., Fisher, L., Kahn, J., Colditz, G., & Frazier, L. (2004). Sexual orientation and tobacco use in a cohort study of US adolescent girls and boys. *Archives of Pediatric Adolescent Medicine, 158*, 317-322.

Australian Bureau of Statistics. (2006). *4831.0.55.001 - Tobacco Smoking in Australia: a snapshot, 2004-05*. Retrieved 10 April 2008. from http://www.abs.gov.au/ausstats/abs@.nsf/mf/4831.0.55.001.

Australian Bureau of Statistics. (2007a). 2006 Census Community Profile. *Basic Community Profile*, from http://abs.gov.au/AUSSTATS/abs@.nsf//web+pages/Census+Data#BCP

Australian Bureau of Statistics. (2007b). 2914.0.55.002 - 2006 Census of Population and Housing: Media Releases and Fact Sheets, 2006 Retrieved 14 June, 2010, from http://www.abs.gov.au/ausstats/abs@.nsf/7d12b0f6763c78caca257061001cc588/96e08af8f4178a45ca257306000d4fd4!OpenDocument

Australian Bureau of Statistics. (2009). *A Picture of the Nation: the Statistician's Report on the 2006 Census*. Retrieved 12 November 2010. from http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/LookupAttach/2070.0Publication29.01.096/$File/20700_Population_overview.pdf.

Australian Council on Smoking and Health. (2009). Legislation: Western Australian Smoking Regulations.   Retrieved 11 May 2009, 2009, from www.acosh.org/news/legislation_wa.html

Australian Gay and Lesbian Archives. (2010). Living History.   Retrieved 12 March, 2010, from http://home.vicnet.net.au/~alga/

Australian Human Rights Commission. (2010). *Taking Stock of Australia's Human Rights Record*. Sydney: Australian Human Rights Commission.

Australian Human Rights Commission. (2011). *Addressing sexual orientation and sex and/or gender identity discrimination: Consultation report*. Sydney: Australian Human Rights Commission.

Australian Institute of Health and Welfare. (2007). *Statistics on Drug Use in Australia 2006*. Canberra: AIHW.

Australian Institute of Health and Welfare. (2008a). *2007 National Drug Strategy Household Survey: detailed findings* (No. number 22.Cat. no. PHE 107). Canberra: AIHW.

Australian Institute of Health and Welfare. (2008b). *Australia's Health 2008*. Canberra: AIHW.

Australian Institute of Health and Welfare. (2010). *Australia's health 2010*. Canberra: AIHW.

Australian Institute of Health and Welfare. (2011). *2010 National Drug Strategy Household Survey report*. Canberra: AIHW.

Australian Institute of Health and Welfare & Australasian Association of Cancer Registries. (2008). *Cancer in Australia: an overview, 2008. Cancer series no. 46. Cat. no. CAN42*. Canberra: AIHW.

Australian Medical Association. (2002). AMA Position Statement: Sexual Diversity and Gender Identity: AMA.

Australian Studies Centre Online. (n.d.). The development of homosexuality. Retrieved 12 December, 2009, from www.petra.ac.id/asc/people/homo/development.html

Avis, M. (2005). Is there an epistemology for qualitative research? In I. Holloway (Ed.), *Qualitative Research in Health Care* (pp. 3-16). Maidenhead: Open University Press.

Baernstein, A., Bostwick, W., Carrick, K., Dunn, P., Goodman, K., Hughes, T., et al. (2006). Lesbian and bisexual women's public health. In M. Shankle (Ed.), *The Handbook of Lesbian, Gay, Bisexual, and Transgender Public Health: a practitioner's guide to service* (pp. 87-117). New York: Hawthorn Press.

Bailey, J. V., Farquhar, C., Owen, C., & Whittaker, D. (2003). Sexual behaviour of lesbians and bisexual women. *Sexually Transmitted Infections, 79*(2), 147-150.

Baker, T., Brandon, T., & Chassin, L. (2004). Motivational influences on cigarette smoking. *Annual Review of Psychology, 55*, 463-491.

Balsam, K. (2003). Trauma, Stress, and Resilience Among Sexual MinorityWomen: Rising Like the Phoenix. *Journal of Lesbian Studies, 7*(4), 1-8.

Bancroft, A., Wiltshire, S., Parry, O., & Amos, A. (2003). "It's like an addiction first thing . . . afterwards it's like a habit": daily smoking behaviour among people living in areas of deprivation. *Social Science & Medicine, 56*, 1261-1267.

Banwell, C., & Young, D. (1993). Rites of passage: smoking and the construction of social identity. *Drug Alcohol Review, 12*, 377-385.

Bayer, R. (2008). Stigma and the ethics of public health: not can we but should we. *Social Science and Medicine,* pp. 463-472,

Bayer, R., & Stuber, J. (2006). Tobacco control, stigma, and public health: rethinking the relations. *American Journal of Public Health, 96*(1), 47-50.

Beals, K., & Peplau, L. (2001). Social involvement, disclosure of sexual orientation, and the quality of lesbian relationships. *Psychology of Women Quarterly, 25*, 10-19.

Beals, K., & Peplau, L. (2005). Identity support, identity devaluation and well-being among lesbians. *Psychology of Women Quarterly, 29*, 140-148.

Beals, K., Peplau, L., & Gable, S. (2009). Stigma management and well-being: the role of perceived social support, emotional processing, and suppression. *Personality and Social Psychology Bulletin, 35*(7), 867-879.

Beanland, C., Schneider, Z., LoBiondo-Wood, G., & Haber, J. (1999). *Nursing Research: methods, critical appraisal and utilisation*. Sydney: Mosby.

Beatty, R., Madl-Young, R., & Bostwick, W. (2006). Lesbian, gay, bisexual, and transgender substance abuse. In M. Shankle (Ed.), *The Handbook of Lesbian, Gay, Bisexual, and Transgender Public Health: a practitioner's guide to service* (pp. 201-220). New York: Hawthorn Press.

Benoliel, J. (1996). Grounded theory and nursing knowledge. *Qualitative Health Research, 6*(3), 406-428.

Berman, A. (2008). The repeal of the sodomy laws in Tasmania in 1997 and the status of homophobia in contemporary Australia. In S. Robinson (Ed.), *Homophobia: An Australian History* (pp. 236-253). Sydney: Federation Press.

Biener, L., Wakefield, M., Shiner, C., & Siegel, M. (2008). How broadcast volume and emotional content affect youth recall of anti-tobacco advertising. *American Journal of Preventive Medicine, 35*(1), 14-19.

Binson, D., Blair, J., Huebner, D., & Woods, W. (2007). Sampling in surveys of lesbian, gay and bisexual people. In I. Meyer & M. Northridge (Eds.), *The Health of Sexual Minorities: public health perspectives on lesbian, gay, bisexual and transgender populations* (pp. 375-418). New York: Springer.

Bjartveit, K., & Tverdal, A. (2009). Health consequences of smoking 1-4 cigarettes per day. *Tobacco Control, 14*, 315-320.

Bluff, R. (2005). Grounded theory: the methodology. In I. Holloway (Ed.), *Qualitative Research in Health Care* (pp. 147-167). Maidenhead: Open University Press.

Blumer, H. (1969). *Symbolic Interactionism: perspective and method*. New Jersey: Prentice-Hall.

Boeije, H. (2002). A purposeful approach to the constant comparative method in the analysis of qualitative interviews. *Quality and Quantity, 36*, 391-409.

Bonvicini, K., & Perlin, M. (2003). The same but different: clinician-patient communication with gay and lesbian patients. *Patient Education Counseling, 51*, 115-122.

Booth-Butterfield, M. (2003). Embedded health behaviors from adolescent to adulthood: the impact of tobacco. *Health Communication, 15*(2), 171-184.

Bottorff, J., Kalaw, C., Johnson, J., Chambers, N., Stewart, M., Greaves, L., et al. (2005). Unraveling smoking ties: how tobacco use is embedded in couple interactions. *Research in Nursing and Health, 28*, 316-328.

Bottorff, J., Kalaw, C., Johnson, J., Stewart, M., & Greaves, L. (2005). Tobacco use in intimate spaces: issues in the study of couple dynamics. *Qualitative Health Research, 15*(4), 564-577.

Bottorff, J., Kalaw, C., Johnson, J., Stewart, M., Greaves, L., & Carey, J. (2006). Couple dynamics during women's tobacco reduction in pregnancy and postpartum. *Nicotine and Tobacco Research, 8*(4), 499-509.

Bowen, D., Bradford, J., & Powers, D. (2006). Comparing sexual minority status across sampling methods and populations. *Women and Health, 44*(2), 121-134.

Bowen, D., Bradford, J., Powers, D., McMorrow, P., Linde, R., Cody Murphy, B., et al. (2004). Comparing women of differing sexual orientations using population-based sampling *Women and Health, 40*(3), 19-34.

Bradbury-Jones, C. (2007). Enhancing rigour in qualitative health research: exploring subjectivity through Peshkin's I's. *Journal of Advanced Nursing, 59*(3), 290-298.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77.

Brogan, D., Frank, E., Elon, L., & O'Hanlan, K. (2001). Methodologic concerns in defining lesbian for health research. *Epidemiology, 12*(1), 109-113.

Browne, K., & Bakshib, L. (2011). We are here to party? Lesbian, gay, bisexual and trans leisurescapes beyond commercial gay scenes. *Leisure Studies, 30*(2), 179-196.

Bryant, A., & Charmaz, K. (2007a). Grounded theory in historical perspective: an epistemological account. In A. Bryant & K. Charmaz (Eds.), *The Sage Handbook on Grounded Theory* (pp. 31-57). London: Sage Publications.

Bryant, A., & Charmaz, K. (Eds.). (2007b). *The Sage Handbook of Grounded Theory*. London: Sage Publications.

Bull, M., Pinto, S., & Wilson, P. (1991). Homosexual law reform in Australia, *Trends and Issues in Crime and Criminal Justice* (Vol. 29, pp. 1-10). Canberra: Australian Institute of Criminology.

Burgard, S., Cochran, S., & Mays, V. (2005). Alcohol and tobacco use patterns among heterosexually and homosexually experienced California women. *Drug and Alcohol Dependence, 77*, 61-70.

Burns, R. (2000). *Introduction to Research Methods* (4th ed.). Sydney: Longman.

Bye, L., Gruskin, E., Greenwood, G., Albright, V., & Krotki, K. (2005). *California Lesbians, Gays, Bisexuals, and Transgender (LGBT) Tobacco Use Survey – 2004*. Sacramento, CA: California Department of Health Services.

Carter, O. (2008). Changes in the attitudes and beliefs of West Australian smokers, 1984–2007. In The Cancer Council Western Australia (Ed.), *The progress of tobacco control in Western Australia: achievements, challenges and hopes for the future*. Perth: The Cancer Council Western Australia.

Carter, Z. (2009). Comment on Perth lesbian community. Perth.

Case, P., Austin, B., Hunter, D., Manson, J., Malspeis, S., Willett, W., et al. (2004). Sexual orientation, health risk factors, and physical functioning in the Nurses' Health Study II. *Journal of Women's Health, 13*(9), 1053-1047.

Cass, V. (1979). Homosexual identity formation: a theoretical model. *Journal of Homosexuality, 4*(3), 219-235.

Centres for Disease Control and Prevention. (n.d.). Lesbian, Gay, Bisexual and Transgender Health.   Retrieved 28 August 2011, from http://www.cdc.gov/lgbthealth/

Chapman, S. (2007). Falling prevalence of smoking: how low can we go? *Tobacco Control, 16*, 145-147.

Chapman, S., Byrne, F., & Carter, S. (2003). "Australia is one of the darkest markets in the world": the global importance of Australian tobacco control. *Tobacco Control, 12*(Supp 3), iii1-iii3.

Chapman, S., & Freeman, B. (2008). Markers of the denormalisation of smoking and the tobacco industry. *Tobacco Control, 17*, 25-31.

Chapman, S., & MacKenzie, R. (2010). The global research neglect of unassisted smoking cessation: causes and consequences. *PLoS Med, 7*(2), e1000216.

Charmaz, K. (2003). Grounded Theory: Objectivist and Constructivist Methods. In N. Denzin & Y. Lincoln (Eds.), *Strategies of Qualitative Inquiry* (2nd ed., pp. 249-291). Thousand Oaks: Sage Publications.

Charmaz, K. (2006). *Constructing Grounded Theory: a practical guide through qualitative analysis*. Thousand Oaks: Sage Publications.

Charon, J. (1998). *Symbolic Interactionism: an introduction, an interpretation, an integration* (6th ed.). New Jersey: Prentice Hall.

Chenitz, W., & Swanson, J. (1986). *From Practice to Grounded Theory: Qualitative Research in Nursing*. Sydney: Addison-Wesley.

Choi, Y., Choi, S., & Rifon, N. (2010). "I Smoke but I Am Not a Smoker": Phantom Smokers and the Discrepancy Between Self-identity and Behavior. *Journal of American College Health, 59*(2), 117-125.

Christakis, N., & Fowler, J. (2008). The collective dynamics of smoking in a large social network. *New England Journal of Medicine, 358*, 2249-2258.

Cohler, B., & Hammack, P. (2007). The psychological world of the gay teenager: social change, narrative, and "normality". *Journal of Youth Adolescence, 36*, 47-49.

Coleman, E. (1982). Developmental stages of the coming-out process. *American Behavioral Scientist March, 25*(4), 469-482.

Collins, D., & Lapsley, H. (2008). *The Costs of Tobacco, Alcohol and Illicit Drug Abuse to Australian Society in 2004/05*. Canberra: Department of Health and Ageing.

Commonwealth of Australia. (2010). *National Women's Health Policy 2010*. Retrieved 28 January 2011. from http://www.health.gov.au/internet/main/publishing.nsf/content/A3D713CE1D CD64E5CA257457001D4ED0/$File/Womens_Health_Policy.pdf.

Conron, K. J., Mimiaga, M. J., & Landers, S. J. (2010). A population-based study of sexual orientation identity and gender differences in adult health. *American Journal of Public Health, 100*(10), 1953-1960.

Corbin, J., & Strauss, A. (2008). *Basics of Qualitative Research* (3rd ed.). Thousand Oaks: Sage Publications.

Corliss, H., Austin, S., Roberts, A., & Molnar, B. (2009). Sexual Risk in ''Mostly Heterosexual'' Young Women: Influence of Social Support and Caregiver Mental Health. *Journal of Women's Health, 18*(12).

Corliss, H., Grella, C., Mays, V., & Cochran, S. (2006). Drug use, drug severity, and help-seeking behaviors of lesbian and bisexual women. *Journal of Women's Health, 15*(5), 556-568.

Corliss, H., Rosario, M., Wypij, D., Wylie, S., Frazier, L., & Austin, B. (2010). Sexual orientation and drug use in a longitudinal cohort study of U.S. adolescents. *Addictive Behaviors, 35*(5), 517-521.

Crooks, D. (2001). The importance of symbolic interaction in grounded theory research on women's health. *Health Care for Women International, 22*, 11-27.

Crooks, R., & Baur, K. (2010). *Our Sexuality* (11th ed.). Belmont: Wadsworth.

Cross Campus Queer Network - WA Branch. (n.d.).   Retrieved 11 September 2009, 2009, from http://www.facebook.com/group.php?gid=6706854685

Crotty, M. (1998). *The Foundations of Social Research: Meaning and Perspectives in the Research Process*. Crows Nest, NSW: Allen and Unwin.

Dane, S., Masser, B., MacDonald, G., & Duck, J. (2010). *Not So Private Lives: national findings on the relationships and well-being of same-sex attracted Australians*. Brisbane: The University of Queensland,.

Darbyshire, J. (2008). Unpublished memoir. Northbridge History Project.

Darbyshire, J. (2009). Gay and Lesbian History in Northbridge. Unpublished Paper delivered at Northbridge History Studies Day, 18 May 2009. Northbridge History Project.

Dennis, A., & Martin, P. (2007). Symbolic interactionism and the concept of social structure. *Sociological Focus, 40*(3), 287-305.

Department of Health and Ageing. (2007). Tobacco advertising.   Retrieved 20 January 2009, from http://www.health.gov.au/internet/main/publishing.nsf/Content/health-pubhlth-strateg-drugs-tobacco-marketing.htm

Department of Health and Ageing. (2008). Tobacco Health Warnings.   Retrieved 20 January 2009, from http://www.health.gov.au/internet/main/publishing.nsf/content/health-pubhlth-strateg-drugs-tobacco-warnings.htm

Department of Health and Ageing. (2009). Same-Sex Relationships (Equal Treatment in Commonwealth Laws—General Law Reform) Act 2008. Retrieved 17 November 2009, from http://www.health.gov.au/internet/main/publishing.nsf/Content/samesexbill

Diamant, A., & Wold, C. (2003). Sexual orientation and variation in physical and mental health status among women. *Journal of Women's Health, 12*(1), 41-49.

Diamant, A., Wold, C., Spritzer, K., & Gelberg, L. (2000). Health behaviors, health status, and access to and use of health care - a population-based study of lesbian, bisexual, and heterosexual women. *Archives of Family Medicine, Nov/Dec*, 1043-1051.

Diamant, A., Wortley, P., Spritzer, K., & Gelberg, L. (2000). Health behaviors, health status, and access to and use of health care: a population-based study of lesbians, bisexuals, and heterosexual women. *Archives of Family Medicine, 9*, 1043-1051.

Diamond, L. (2005). A new view of lesbian subtypes: stable versus fluid identity trajectories over an 8-year period. *Psychology of Women Quarterly, 29*, 119-128.

Diamond, L. (2008). Female bisexuality from adolescence to adulthood: results from a 10-year longitudinal study. *Developmental Psychology, 44*(2), 5-14.

Dilley, J., Maher, J., Boysun, M., Pizacani, B., Mosbaek, C., Rohde, K., et al. (2005). Response to letter to: Tang H, Greenwood GL, Cowling DW, Lloyd JC, Roeseler AG, Bal DG. Cigarette smoking among lesbians, gays and bisexuals: how serious a problem? *Cancer Causes and Control, 16*, 1133-1134.

Dilley, J., Simmons, K., Boysun, M., Pizacani, B., & Stark, M. (2010). Demonstrating the importance and feasibility of including sexual orientation in public health surveys: health disparities in the Pacific Northwest. *American Journal of Public Health, 100*(3), 460-467.

Doll, R., Peto, R., Boreham, J., & Sutherland, I. (2004). Mortality in relation to smoking: 50 years' observations on male British doctors. *British Medical Journal, 328*, 2519-2533.

Doll, R., Peto, R., Wheatley, K., Gray, R., & Sutherland, I. (1994). Mortality in relation to smoking: 40 years' observations on male British doctors. *British Medical Journal, 309*, 901-911.

Duffy, K., Ferguson, C., & Watson, H. (2004). Data collecting in grounded theory - some practical issues. *Nurse Researcher, 11*(4), 67-78.

Easton, A., Jackson, K., Mowery, P., Comeau, D., & Sell, R. (2008). Adolescent same-sex and both-sex romantic attractions and relationships: implications for smoking. *American Journal of Public Health, 98*(3), 462-467.

Eisenberg, M., & Wechsler, H. (2003). Substance use behaviors among college students with same-sex and opposite-sex experience: results from a national study. *Addictive Behaviors, 28*, 899-913.

Eliason, M. (2010). *Environmental Prevention Strategies to Address LGBT Alcohol, Tobacco and Drug Use* San Francisco, CA.

Eliason, M., & Schope, R. (2007). Shifting sands or solid foundation? Lesbian, gay, bisexual, and transgender identity formation. In I. Meyer & M. Northridge (Eds.), *The Health of Sexual Minorities: public health perspectives on lesbian, gay, bisexual and transgender populations* (pp. 3-27). New York: Springer.

Elkind, A. (1985). The social definition of women's smoking behaviour. *Social Science & Medicine, 20*(12), 1269-1985.

Elm, M. (2009). How do various notions of privacy influence decisions in qualitative internet research? In A. Markham & N. Baym (Eds.), *Internet Inquiry: conversations about method* (pp. 69-87). Thousand Oaks, California: Sage Publications Inc.

Fassinger, R. (2005). Paradigms, praxis, problems, and promise: grounded theory in counseling psychology research. *Journal of Counseling Psychology, 52*(2), 156-166.

Ferris, J. (2006). The Nomenclature of the Community: An Activist's Perspective. In M. Shankle (Ed.), *The Handbook of Lesbian, Gay, Bisexual, and Transgender Public Health: a practitioner's guide to service* (pp. 3-10). New York: Harrington Park Press.

Festinger, L. (1957). *A theory of cognitive dissonance*. Stanford, CA: Stanford University Press.

Fine, L. (2011). Minimizing Heterosexism and Homophobia: Constructing Meaning of Out Campus LGB Life. *Journal of Homosexuality, 58*, 521-546.

Flood, M., & Hamilton, C. (2008). Mapping Homophobia in Australia. In S. Robinson (Ed.), *Homophobia an Australian History*. Sydney: The Federation Press.

Floyd, F., & Stein, T. (2002). Sexual orientation identity formation among gay, lesbian, and bisexual youths: multiple patterns of milestone experiences. *Journal of Research on Adolescence, 12*(2), 167-191.

Fredriksen-Goldsen, K., Hyun-Jun, K., Barkan, S., Baisam, K., & Mincer, S. (2010). Disparities in health-related quality of life: a comparison of lesbians and bisexual women. *American Journal of Public Health, 100*(11), 2255-2261.

Freedom Centre. (n.d.). Freedom Centre. Retrieved 11 September, 2009, from http://www.freedom.org.au/

GALE, & GLCS (WA) Inc. (2003). *Equality rules: a guide to equality for gay men, lesbians and bisexuals under WA laws*. Perth: Gay and Lesbian Equality, Gay and Lesbian Community Services (WA) Inc,.

Gay and Lesbian Equality. (nd). GALE WA.   Retrieved 11 September, 2009, from http://galewa.asn.au/main.html

Gay and Lesbian Medical Association. (2001). *Healthy People 2010 Companion Document for Lesbian, Gay, Bisexual, and Transgender (LGBT) Health*. San Francisco: Gay and Lesbian Medical Association.

Geiger, W., Harwood, J., & Hummert, M. (2006). College Students' Multiple Stereotypes of Lesbians. *Journal of Homosexuality, 51*(3), 165-182.

Giglia, R., Binns, C., & Alfonso, H. (2006). Which women stop smoking during pregnancy and the effect on breastfeeding duration. *BMC Public Health, 6*, 195.

Glanz, K., Rimer, B. K., & Lewis, F. M. (2002). *Health Behavior and Health Education. Theory, Research and Practice*. San Francisco: Wiley & Sons.

Glaser, B., & Strauss, A. (1967). *The Discovery of Grounded Theory*. Chicago: Aldine.

GLCS. (2009a). About GLCS.   Retrieved 11 September, 2009, from http://www.glcs.org.au/index.html

GLCS. (2009b). Women on Women.   Retrieved 11 September, 2009, from http://wawow.forumotion.com/login.forum?connexion

Glover, J., Galliher, R., & Lamere, T. (2009). Identity development and exploration among sexual minority adolescents: examination of a multidimensional model. *Journal of Homosexuality, 56*, 77-101.

Goffman, E. (1963). *Stigma. Notes on the Management of Spoiled Identity* (Touchstone Edition ed.). New York: Simon and Schuster Inc.

Gordon, L. (2006). Bringing the U-Haul: Embracing and Resisting Sexual Stereotypes in a Lesbian Community. *Sexualities, 9*(2), 171-192.

Goulding, C. (2002). *Grounded Theory: a practical guide for management, business and market researchers*. London: Sage Publications.

Government of Western Australia. (2009). Tobacco Products Control Amendment Act 2009 (Vol. No. 22 of 2009). Perth: Government of Western Australia,.

Graneheim, U., & Lundman, B. (2004). Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness *Nurse Education Today, 24*, 105-112.

Green, J., & Tones, K. (2010). *Health Promotion Planning and Strategies* (2nd ed.). London: Sage.

Greenwood, G., & Gruskin, E. (2007). LGBT tobacco and alcohol disparities. In I. Meyer & M. Northridge (Eds.), *The Health of Sexual Minorities: public health perspectives on lesbian, gay, bisexual and transgender populations*. New York: Springer.

Greig, B. (2010). There's no place like homo the death of the queer ghetto. *Out in Perth,* p. 35,

Grey Literature Network Services. (n.d.).   Retrieved 6 November 2009, from http://www.greynet.org/greynethome.html

Gruskin, E., Byrne, K., Altschuler, A., & Dibble, S. (2008). Smoking It All Away: Influences of Stress, Negative Emotions, and Stigma on Lesbian Tobacco Use. *Journal of LGBT Health Research, 4*(4), 167-179.

Gruskin, E., Byrne, K., Kools, S., & Altschuler, A. (2006). Consequences of frequenting the lesbian bar. *Women and Health, 44*(2), 103-120.

Gruskin, E., & Gordon, N. (2006). Gay/Lesbian sexual orientation increases risk for cigarette smoking and heavy drinking among members of a large Northern California health plan. *BMC Public Health, 6*(1), 241.

Gruskin, E., Greenwood, G., Matevia, M., Pollack, L., & Bye, L. (2007). Disparities in smoking between the lesbian, gay, and bisexual population and the general population in California. *American Journal of Public Health, 97*(8), 1496-1502.

Gruskin, E., Hart, S., Gordon, N., & Ackerson, L. (2001). Patterns of cigarette smoking and alcohol use among lesbians and bisexual women enrolled in a large health maintenance organization. *American Journal of Public Health, 91*(6), 976-979.

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? an experiment with data saturation and variability. *Field Methods, 18*(1), 59-82.

Gwaltney, C., Metrik, J., & Kahler, C. (2009). Self-efficacy and smoking cessation: a meta-analysis. *Psychology of Addictive Behaviours, 23*(1), 56-66.

Hahm, H., Wong, F., Huang, Z., Ozonoff, A., & Lee, J. (2008). Substance use among Asian American and Pacific Islanders Sexual Minority Adolescents: findings from the National Longitudinal Study of Adolescent Health. *Journal of Adolescent Health, 42*, 275-283.

Haines, R., Oliffe, J., Bottorff, J., & Poland, B. (2010). 'The missing picture': tobacco use through the eyes of smokers. *Tobacco Control 19*, 206-212.

Hall, W., & Callery, P. (2001). Enhancing the rigor of grounded theory: incorporating reflexivity and relationality. *Qualitative Health Research, 11*(2), 257-272.

Hall, W., & Gartner, C. (2009). Supping with the Devil? The role of law in promoting tobacco harm reduction using low nitrosamine smokeless tobacco products. *Public Health, 123*(3), 287-291.

Hammond, D., Fong, G., Zanna, M., Thrasher, J., & Borland, R. (2006). Tobacco denormalization and industry beliefs among smokers from four countries. *American Journal of Preventive Medicine, 31*(3), 225-232.

Harding, R., Bensley, J., & Corrigan, N. (2004). Targeting smoking cessation to high prevalence communities: outcomes from a pilot intervention for gay men. *BMC Public Health, 4*(1), 43.

Harland, C. (2002). Drug and alcohol use within GLBTI communities. In W. Leonard (Ed.), *What's the Difference: health issues of major concern to gay, lesbian, bisexual, transgender and intersex (GLBTI) Victorians* (pp. 45-51). Melbourne: Victorian Government Department of Human Services.

Heath, M., & Mulligan, E. (2008). 'Shiny happy same-sex attracted woman seeking same': how communities contribute to bisexual and lesbian women's wellbeing. *Health Sociology Review, 17*(3), 290-302.

Heffernan, K. (1998). The nature and predictors of substance use among lesbians. *Addictive Behaviors, 23*(4), 517-528.

Henrickson, M. (2007). "You have to be strong to be gay": bullying and educational attainment in LGB New Zealanders. *Journal of Gay and Lesbian Social Services, 19*(3/4), 67-85.

Hequembourg, A., & Brallier, S. (2009). An exploration of sexual minority stress across the lines of gender and sexual identity. *Journal of Homosexuality, 56*, 273-298.

Herbst, J. H., Beeker, C., Mathew, A., McNally, T., Passin, W. F., Kay, L. S., et al. (2007). The Effectiveness of Individual-, Group-, and Community-Level HIV Behavioral Risk-Reduction Interventions for Adult Men Who Have Sex with Men: A Systematic Review. *American journal of preventive medicine, 32*(4), 38-67.

Herek, G. (2000). The psychology of sexual prejudice. *Current Directions in Psychological Science, 9*(1), 19-22.

Herek, G. (2007). Confronting sexual stigma and prejudice: theory and practice. *Journal of Social Issues, 63*(4), 905-925.

Herek, G. (2009). Hate crimes and stigma-related experiences among sexual minority adults in the United States: prevalence estimates from a national probability sample. *Journal of Interpersonal Violence, 24*(1), 54-74.

Herek, G., Chopp, R., & Strohl, D. (2007). Sexual stigma: putting sexual minority health issues in context. In I. Meyer & M. Northridge (Eds.), *The Health of Sexual Minorities: public health perspectives on lesbian, gay, bisexual and transgender populations* (pp. 171-208). New York: Springer.

Herek, G., & Garnets, L. (2007). Sexual orientation and mental health. *Annual Review of Clinical Psychology, 3*, 353-375.

Hillier, L., DeVisser, R., Kavanagh, A., & McNair, R. (2003). The association between licit and illicit drug use and sexuality in young Australian women. *Medical Journal of Australia, 179*, 326-327.

Hillier, L., Jones, T., Monagle, M., Overton, N., Ghan, L., Blackman, J., et al. (2010). *Writing Themselves In 3. The third national study on the sexual health and wellbeing of same sex attracted and gender questioning young people*. Melbourne: Australian Research Centre in Sex Health and Society.

Holloway, I. (Ed.). (2005). *Qualitative Research in Health Care*. Berkshire, England: Open University Press.

Holloway, I., & Todres, L. (2005). The status of method: flexibility, consistency and coherence. In I. Holloway (Ed.), *Qualitative Research in Health Care* (pp. 90-103). Maidenhead: Open University Press.

Holstein, J., & Gubrium, J. (2003). The life course. In L. Reynolds & N. Herman-Kinney (Eds.), *Handbook of Symbolic Interactionism* (pp. 835-856). Walnut Creek: Alta Mira Press.

Hsia, F., & Spruijt-Metz, D. (2007). Acculturation and meanings of smoking among Asian-American college students. *Addictive Behaviors, 32*, 2292-2296.

Hublet, A., De Bacquer, D., Valimaa, R., Godeau, J., Schmid, H., Rahav, G., et al. (2006). Smoking trends among adolescents from 1990 to 2002 in ten European countries and Canada. *BMC Public Health 6*, 280.

Hughes, T. (2000). Comparing lesbians' and heterosexual women's mental health: a multi-site survey. *Journal of Gay and Lesbian Social Services, 11*(1), 57-76.

Hughes, T., & Eliason, M. (2002). Substance use and abuse in lesbian, gay, bisexual and transgender populations. *The Journal of Primary Prevention, 22*(3), 263-298.

Hughes, T., & Jacobson, K. (2003). Sexual orientation and women's smoking. *Current Women's Health Reports, 3*, 254-261.

Hughes, T., Johnson, T., & Matthews, A. (2008). Sexual orientation and smoking: results from a multisite women's health study. *Substance Use and Misuse, 43*, 1218-1239.

Hughes, T., Szalacha, L., & McNair, R. (2010). Substance abuse and mental health disparities: Comparisons across sexual identity groups in a national sample of young Australian women. *Social Science and Medicine, 71*, 824-831.

Human Rights and Equal Opportunity Commission. (2007). *Same-Sex: Same Entitlements*. Sydney: HREOC.

Hyde, J., & Jaffee, S. (2000). Becoming a heterosexual adult: the experiences of young women. *Journal of Social Issues, 56*(2), 283-296.

Hyde, Z., Comfort, J., McManus, A., Brown, G., & Howat, P. (2009). Alcohol, tobacco and illicit drug use amongst same-sex attracted women: results from the Western Australian Lesbian and Bisexual Women's Health and Well-Being Survey. *BMC Public Health, 9*(317).

Hyde, Z., Comfort, J., McManus, A., & Howat, P. (2007). *The Health and Well-Being of Lesbian and Bisexual Women in Western Australia*. Perth: WA Centre for Health Promotion Research.

Hylton, M. E. (2006). Queer in Southern MSW Programs: Lesbian and Bisexual Women Discuss Stigma Management. *The Journal of Social Psychology, 146*(5), 611.

International Gay and Lesbian Human Rights Commission. (2008, 19 December). United Nations: General Assembly Statement Affirms Rights for All. Retrieved 12 March, 2010, from http://www.iglhrc.org/cgi-bin/iowa/article/pressroom/pressrelease/826.html

IOM (Institute of Medicine). (2011). *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*. Washington DC: The National Academies Press.

Ivers, R. (2001). *Indigenous Australians and Tobacco: a literature review*. Darwin: Cooperative Research Centre for Aboriginal and Tropical Health,.

Jarvis, M. (2004). Why people smoke. *British Medical Journal, 328*(7434), 277-279.

Jha, P., Chaloupka, F., Corrao, M., & Jacob, B. (2006). Reducing the burden of smoking world-wide: effectiveness of interventions and their coverage. *Drug and Alcohol Review, 25*(6), 597-609.

Johnson, S. (2008). My revolving closet door. *Journal of Lesbian Studies, 12*(1), 59-67.

Jones, T., & Nystrom, N. (2002). Looking Back … Looking Forward: Addressing the Lives of Lesbians 55 and Older. *Journal of Women & Aging, 14*(3-4), 59-76.

Jorm, A., Rodgers, B., Jacomb, P., Christensen, H., Henderson, S., & Kortem, A. (1999). Smoking and mental health: results from a community survey. *Medical Journal of Australia, 170*, 74-77.

Kaminski, E. (2000). Lesbian Health: Social Context, Sexual Identity, and Well-Being. *Journal of Lesbian Studies, 4*(3), 87-101.

Kanuha, V. (2000). "Being" native versus "going native": conducting social work research as an insider. *Social Work, 45*(5), 439-447.

Kaplan, A., & Haenlein, M. (2010). Users of the world, unite! The challenges and opportunities of Social Media. *Business Horizons, 53*, 59—68.

Kaufman, J., & Johnson, C. (2004). Stigmatized individuals and the process of identity. *The Sociological Quarterly, 45*(4), 807-833.

Kaufman, R. (2008). Introduction to transgender identity and health. In H. Makadon, K. Mayer, J. Potter & M. Goldhammer (Eds.), *Fenway Guide to Lesbian, Gay, Bisexual, and Transgender Health* (pp. 331-364). Philadelphia: American College of Physicians.

Kerby, M., Wilson, R., Nicholson, T., & White, J. (2005). Substance use and social identity in the lesbian community. *Journal of Lesbian Studies, 9*(3), 45-56.

Kertzner, R. (2007). Developmental issues in lesbian and gay adulthood. In M. Shankle (Ed.), *The Handbook of Lesbian, Gay, Bisexual, and Transgender Public Health: a practitioner's guide to service*. New York: Harrington Park Press.

Kim, S., & Shanahan, J. (2003). Stigmatizing smokers: public sentiment toward cigarette smoking and its relationship to smoking behaviors. *Journal of Health Communication, 8*, 343-367.

Kimmel, D., Rose, T., & David, S. (2006). *Lesbian, gay, bisexual and transgender ageing*. New York: Columbia University Press.

Kirby, M. (2003). The 1973 deletion of homosexuality as a psychiatric disorder: 30 years on. *Australian and New Zealand Journal of Psychiatry, 37*(6), 674-677.

Kitzinger, G., & Wilkinson, S. (1995). Transitions from heterosexuality to lesbianism: the discursive production of lesbian identities. *Developmental Psychology, 31*(1), 95-104.

Kleinjan, M., van den Eijnden, R., Dijkstra, A., Brug, J., & Engels, C. (2006). Excuses to continue smoking: the role of disengagement beliefs in smoking cessation. *Addictive Behaviors, 31*, 2223-2237.

Klugman, B. (2007). Locating and linking sexuality in development and human rights. *International Journal of Sexual Health, 19*(3), 65-77.

Lasser, J., Ryser, G., & Price, L. (2010). Development of a lesbian, gay, bisexual visibility management scale. *Journal of Homosexuality, 57*(3), 415-428.

Laumann, E. O., Gagnon, J. H., Michael, R. T., & Michaels, S. (1994). *The social organization of sexuality: sexual practices in the United States*. Chicago: University of Chicago.

Laurier, E., McKie, L., & Goodwin, N. (2000). Daily and lifecourse contexts of smoking. *Sociology of Health and Illness, 22*(3), 289-309.

Leavy, J., Wood, L., Phillips, F., & Rosenberg, M. (2011). Try and try again: qualitative insights into adolescent smoking experimentation and notions of addiction. *Health Promotion Journal of Australia, 21*(3), 208-214.

Lee, J., Griffin, G., & Melvin, C. (2009). Tobacco use among sexual minorities in the USA, 1987 to May 2007: a systematic review. *Tobacco Control, 18*, 275-282.

Lehavot, K., Balsam, F., & Ibrahim-Wells, G. (2009). Redefining the American Quilt: definitions and experiences of community among ethnically diverse lesbian and bisexual women. *Journal of Community Psychology, 37*(4), 439-458.

Lehavot, K., & Simoni, J. (2011). The impact of minority stress on mental health and substance use among sexual minority women. *Journal of Consulting and Clinical Psychology, 79*(2), 159-170.

Leibel, K., Lee, J., Goldstein, A., & Ranney, L. (2011). Barring Intervention? Lesbian and Gay Bars as an Underutilized Venue for Tobacco Interventions. *Nicotine & Tobacco Research, 13*(7), 507-511.

Lemon, G., & Patton, W. (1997). Lavender blue: Issues in lesbian identity development with a focus on an Australian lesbian community. *Women's Studies International Forum, 20*(1), 113-127.

Lempert, L. (2007). Asking questions of the data: memo writing in the grounded theory tradition. In A. Bryant & K. Charmaz (Eds.), *The Sage Handbook of Grounded Theory* (pp. 245-264). London: Sage Publications.

Leonard, W. (Ed.). (2002). *What's the Difference? Health issues of major concern to gay, lesbian, bisexual, transgender and intersex (GLBTI) Victorians*. Victoria: Victorian Government Department of Human Services.

Lewis, R. (2006). Stigma consciousness, social constraints, and lesbian well-being. *Journal of Counselling Psychology, 53*(1), 48-56.

LGBT Health Alliance. (2010). Wear it with Pride.   Retrieved 12 March 2010, 2010, from http://www.wearitwithpride.com.au/

Liamputtong, P. (2010). The science of words and the science of numbers: research methods as foundations for evidence-based practice in health. In P. Liamputtong (Ed.), *Research Methods in Health - foundations for evidence-based practice* (pp. 1-27). South Melbourne: Oxford University Press.

Liamputtong, P., & Shields, N. (2010). Presentation of research findings: writing a qualitative and quantitative research report. In L. Liamputtong (Ed.), *Research Methods in Health: foundations for evidence-based practice* (pp. 433-450). Melbourne: Oxford University Press.

Lincoln, Y., & Guba, E. (1985). *Naturalistic Inquiry*. Beverly Hills: Sage.

Lloyd, B., Lucas, K., & Fernbach, M. (1997). Adolescent girls' construction of smoking identities implications for health promotion. *Journal of Adolescence, 20*, 43-56.

Loconto, D., & Jones-Pruett, D. (2006). The influence of Charles A. Ellwood on Herbert Blumer and the Symbolic Interactionism. *Journal of Classical Sociology, 6*(1), 75-99.

Lunglhofe, J. (2004). Put your lips to better use: lesbian health group embarks on anti-smoking campaign. *Washington Blade*.

Maijala, H., Paavilaimen, E., & Astedt-Kurki, P. (2003). The use of grounded theory to study interaction. *Nurse Researcher, 11*(2), 40-57.

Makadon, H. (2006). Improving health care for the lesbian and gay communities. *New England Journal of Medicine, 354*(9), 895-897.

Makadon, H., Mayer, K., Potter, J., & Goldhammer, M. (Eds.). (2008). *Fenway Guide to Lesbian, Gay, Bisexual, and Transgender Health*. Philadelphia: American College of Physicians.

Malterud, K., Bjorkman, M., Flatvell, M., Ohnstad, A., Thesen, J., & Rortveit, G. (2009). Epidemiological research on marginalized groups implies major validity challenges; lesbian health as an example. *Journal of Clinical Epidemiology, 62*, 703-710.

Markham, A., & Baym, N. (2009). *Internet Inquiry: conversations about method*. Thousand Oaks, California: Sage Publications Inc.

Marmot, M. (2005). Social determinants of health inequalities. *Lancet, 365*, 1099-1104.

Marshal, M., Friedman, M., Stall, R., King, K., Miles, J., Gold, M., et al. (2008). Sexual orientation and adolescent substance use: a meta-analysis and methodological review. *Addiction, 103*, 546-556.

Marshal, M., Friedman, M., Stall, R., & Thompson, A. (2009). Individual trajectories of substance use in lesbian, gay and bisexual youth and heterosexual youth. *Addiction, 104*, 974-981.

Mayer, K. (2009). New directions in life course research. *Annual Review of Sociology, 35*, 413-433.

Mayer, K., Bradford, J., Makadon, H., Stall, R., Goldhammer, H., & Landers, S. (2008). Sexual gender minority health: what we know and what needs to be done. *American Journal of Public Health, 98*(6), 989-995.

McCabe, S., Hughes, T., Bostwick, W., & Boyd, C. (2005). Assessment of Difference in Dimensions of Sexual Orientation: Implications for Substance Use Research in a College-Age Population. *Journal of Studies on Alcohol, 66*(5), 620–629.

McCabe, S., Hughes, T., & Boyd, C. (2004). Substance use and misuse: are bisexual women at greater risk? *Journal of Psychoactive Drugs, 36*(2), 217-225.

McCallum, C., & McLaren, S. (2011). Sense of belonging and depressive symptoms among GLB adolescents. *Journal of Homosexuality, 58*, 83-96.

McCann, T., & Clark, E. (2003a). Grounded theory in nursing research: part 1 - methodology. *Nurse Researcher, 11*(2), 7-18.

McCann, T., & Clark, E. (2003b). Grounded theory in nursing research: part 2 - critique. *Nurse Researcher, 11*(2), 19-28.

McCarn, S., & Fassinger, R. (1996). Revisioning sexual minority identity formation: a new model of lesbian identity and its implications for counselling and research. *The Counseling Psychologist, 24*, 508-534.

McDermott, L., Dobson, A., & Owen, N. (2006). From partying to parenthood: young women's perceptions of cigarette smoking across life transitions. *Health Education Research, 21*(3), 428-439.

McDermott, L., Dobson, A., & Owen, N. (2007). Occasional tobacco use among young adult women: a longitudinal analysis of smoking transitions. *Tobacco Control, 16*, 248-254.

McDermott, L., Dobson, A., & Owen, N. (2009). Determinants of continuity and change over 10 years in young women's smoking. *Addiction, 104*, 478-487.

McDermott, L., Dobson, A., & Russell, A. (2004). Changes in smoking behaviour among young women over life stage transitions. *Australian and New Zealand Journal of Public Health, 28*(4), 330-335.

McDermott, L., Russell, A., & Dobson, A. (2002). Cigarette Smoking Among Women in Australia. *National Tobacco Strategy 1999 to 2002-03 occasional paper* Retrieved 19 January 2009, from http://www.wesdarc.org.au/download/breathingspace/ResearchMaterial/Australian%20National%20Documents/National%20Drug%20Strategy%202002%20Smoking%20and%20women.pdf

McKirnan, D., & Peterson, P. (1989). Psychosocial and cultural factors in alcohol and drug abuse: an analysis of a homosexual community. *Addictive Behaviors, 14*, 555-563.

McMillan, D., & Chavis, D. (1986). Sense of community: A definition and theory. *Journal of Community Psychology, 14*(1), 6-23.

McNair, R. (2003). Lesbian health inequalities: a cultural minority issue for health professionals. *Medical Journal of Australia, 178*(12), 643-645.

McNair, R., Anderson, S., & Mitchell, A. (2001). Addressing health inequalities in Victorian lesbian, gay, bisexual and transgender communities. *Health Promotion Journal of Australia, 11*(1), 32-38.

McNair, R., Tong, B., Kavanagh, A., & Agius, P. (2005). The mental health status of young adult and mid-life non-heterosexual Australian women. *Australian and New Zealand Journal of Public Health, 29*(3), 265-271.

Meads, C., Buckley, E., & Sanderson, P. (2007). Ten years of lesbian health survey research in the UK West Midlands. *BMC Public Health, 7*(251).

Mecredy, G., Cohen, J., Ferrence, R., Poland, B., McDonald, P., & Garcia, J. (2011). Typologies of smokers and non-smokers: encouraging changes over time. *Tobacco Control, 2011*(5), 385.

Mendelson, G. (2003). Homosexuality and psychiatric nosology. *Australian and New Zealand Journal of Psychiatry, 37*, 678–683.

Mercer, C., Bailey, J., Johnson, A., Erens, B., Wellings, K., & Fenton, K. (2007). Women who report having sex with women: British national probability data on prevalence, sexual behaviours, and health outcomes. *American Journal of Public Health, 97*(6), 1126-1133.

Merriam, S. (2006). Transformational learning and HIV-positive young adults. In V. Anfara & N. Mertz (Eds.), *Theoretical Frameworks in Qualitative Research* (pp. 23-38). Thousand Oaks, California: Sage Publications Inc.

Meyer, I. (2001). Why lesbian, gay, bisexual, and transgender public health? *American Journal of Public Health, 91*(6), 856-859.

Meyer, I. (2003). Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence. *Psychological Bulletin, 129*(5), 674-697.

Meyer, I. (2007). Prejudice and discrimination as social stressors. In I. Meyer & M. Northridge (Eds.), *The Health of Sexual Minorities: public health perspectives on lesbian, gay, bisexual and transgender populations* (pp. 242-267). New York: Springer.

Meyer, I., & Northridge, M., (eds). (2007). *The Health of Sexual Minorities: public health perspectives on lesbian, gay, bisexual and transgender populations*. New York: Springer.

Meyer, I., & Wilson, P. (2009). Sampling lesbian, gay, and bisexual populations. *Journal of Counselling Psychology, 56*(1), 23-31.

Midsumma. (n.d.). Midsumma: History Introduction. Retrieved 3 September 2010, from http://www.midsumma.org.au/midsumma-history-preamble.html

Miles, M., & Huberman, A. (1994). *Qualitative data analysis: an expanded sourcebook* (2nd ed.). Thousand Oaks, California: SAGE Publications.

Mills, T., Stall, R., Pollack, L., Paul, J., Binson, D., Canchola, L., et al. (2001). Health-related characteristics of men who have sex with men: A comparison of those living in "gay ghettos" with those living elsewhere. *American Journal of Public Health, 91*, 980-983.

Ministerial Advisory Committee on Gay and Lesbian Health. (2003). *Health and sexual diversity: A health and wellbeing action plan for gay, lesbian, bisexual, transgender and intersex (GLBTI) Victorians*. Melbourne: Department of Human Services, State Government of Victoria.

Ministerial Advisory Committee on Gay Lesbian Bisexual Transgender and Intersex Health and Wellbeing. (2009). *Well proud: a guide to gay, lesbian, bisexual, transgender and intersex inclusive practice for health and human services*. Melbourne: Ministerial Advisory Committee on Gay Lesbian Bisexual Transgender and Intersex Health and Wellbeing,.

Ministerial Council on Drug Strategy. (2005a). *National Tobacco Strategy, 2004-2009*. Canberra: National Drug Strategy.

Ministerial Council on Drug Strategy. (2005b). *National Tobacco Strategy; 2004-2009: Meeting the Challenges of the Next Five Years*. Canberra: Australian Government Department of Health and Ageing.

Morgan, E., & Thompson, E. (2011). Processes of sexual orientation questioning among heterosexual women. *Journal of Sexual Research, 48*(1), 16-28.

Morris, J., Balsam, K. F., & Rothblum, E. D. (2002). Lesbian and Bisexual Mothers and Nonmothers: Demographics and the Coming-Out Process. *Journal of Family Psychology, 16*(2), 144-156.

Morris, J., & Rothblum, E. (1999). Who fills out a "lesbian" questionnaire? *Psychology of Women Quarterly, 23*, 537-557.

Morris, J., Waldo, C., & Rothblum, E. (2001). A model of predictors and outcomes of outness among lesbian and bisexual women. *American Journal of Orthopsychiatry, 71*(1), 61-71.

Morse, J. (2001). The cultural sensitivity of grounded theory. *Qualitative Health Research, 11*(6), 721-722.

Morse, J., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2002). Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods, 1*(2), 13-22.

Mruck, K., & Mey, G. (2007). Grounded theory and reflexivity. In A. Bryant & K. Charmaz (Eds.), *The Sage Handbook of Grounded Theory* (pp. 515-539). London: Sage Publications.

Mulligan, E., & Heath, M. (2007, 23 February 2007). *Lesbians and bisexual women are thriving!* Paper presented at the ACON 2007 Mardi Gras Forum, Sydney.

Murnane, A., Smith, A., Crompton, L., Snow, P., & Munro, G. (2000). *Beyond Perceptions: a report on alcohol and other drug use among gay, lesbian, bisexual and queer communities in Victoria*. Melbourne: The Also Foundation.

Murphy, T. (2008). Brief history of a recurring nightmare. *Gay and Lesbian Review Worldwide 15* Retrieved 17 March 2010, from http://www.glreview.com/article.php?articleid=42

National Cancer Institute. (2008). *The Role of the Media in Promoting and Reducing Tobacco Use* (No. Tobacco Control Monograph No 19, NIH Pub. No. 07-6242). Bethesda: US Department of Health and Human Services, National Cancer Institutes of Health, National Cancer Institute.

National LGBTI Health Alliance. (2010). Submission on the Draft 'National Drugs Strategy 2010-2015'. Unpublished Submission. National LGBTI Health Alliance.

National LGBTI Health Alliance. (n.d.). About us. Retrieved 26 March, 2010, from http://www.lgbthealth.org.au/

National Preventative Health Taskforce. (2008a). *Australia: the Healthiest Country by 2020: a discussion paper*. Canberra: Commonwealth of Australia.

National Preventative Health Taskforce. (2008b). *Tobacco Control in Australia: making smoking history*. Canberra: Australian Government.

National Preventative Health Taskforce. (2009). *The Healthiest Country by 2020 – National Preventative Health Strategy – the roadmap for action*. Canberra: Commonwealth of Australia,.

Netzley, S. (2010). Visibility That Demystifies: Gays, Gender, and Sex on Television. *Journal of Homosexuality, 57*, 968–986.

Nichter, M., Nichter, M., & Carkoglu, A. (2007). Reconsidering stress and smoking: a qualitative study among college students. *Tobacco Control, 16*, 211-214.

Northridge, M., McGrath, B., & Krueger, S. (2007). Using community-based participatory research to understand and eliminate social disparities in health for lesbian, gay, bisexual, and transgender populations. In I. Meyer & M. Northridge (Eds.), *The Health of Sexual Minorities: public health perspectives on lesbian, gay, bisexual and transgender populations* (pp. 455-470). New York: Springer.

Oakes, W., Chapman, S., Borland, R., Balmford, J., & Trottera, L. (2004). "Bulletproof skeptics in life's jungle'': which self-exempting beliefs about smoking most predict lack of progression towards quitting? *Preventive Medicine, 39*, 776-782.

Offen, N., Smith, E., & Malone, R. (2005). The perimetric boycott: a tool for tobacco control advocacy. *Tobacco Control, 14*, 272-277.

Offen, N., Smith, E., & Malone, R. (2008). Is tobacco a gay issue? Interviews with leaders of the lesbian, gay, bisexual and transgender community. *Culture, Health and Sexuality, 10*(2), 143-157.

Orgad, S. (2009). How can researchers make sense of the issues involved in collecting and interpreting online and offline data? In A. Markham & N. Baym (Eds.), *Internet Enquiry: conversations about method* (pp. 33-53). Thousand Oaks, California: Sage Publications Inc.

Oswald, F., & Lazarevic, V. (2011). "You Live Where?!" Lesbian Mothers' Attachment to Nonmetropolitan Communities. *Family Relations, 60*(4), 373–386.

Ottosson, D. (2009). *State-sponsored Homophobia: A world survey of laws prohibiting same sex activity between consenting adults*. Brussels: The International Lesbian, Gay, Bisexual, Trans and Intersex Association.

Owens, G., Riggle, E., & Rostosky, S. (2007). Mental Health Services Access for Sexual Minority Individuals. *Sexuality Research and Social Policy, 4*(3), 92-99.

Oyserman, D., & Swim, J. (2001). Stigma: an insider's view. *Journal of Social Issues, 57*(1), 1-14.

Parks, C. A. (1999). Lesbian social drinking: The role of alcohol in growing up and living as lesbian. *Contemporary Drug Problems, 26*(1), 75-129.

Parliament of Australia. (2011). Tobacco Plain Packaging Bill 2011. Canberra.

Parsons, J., Kelly, B., & Wells, B. (2006). Differences in club drug use between heterosexual and lesbian/bisexual females. *Addictive Behaviors, 31*, 2344-2349.

Pascale, C.-M. (2011). *Cartographies of Knowledge: exploring qualitative epistemologies*. Thousand Oaks California: SAGE Publications.

Patton, M. (2002). *Qualitative Research and Evaluation Methods* (3rd ed.). London: Sage Publications.

Perinbanayagam, R. (2003). Telic reflections: interactional processes, as such. *Symbolic Interaction, 26*, 67-83.

PFLAG. (n.d.). About PFLAG. Retrieved 11 September, 2009, from http://www.pflagwa.org.au/

Phelan, J., Link, B., & Dovidio, J. (2008). Stigma and prejudice: one animal or two? *Social Science and Medicine, 67*, 358-367.

Pierce, J. (2007). Tobacco industry marketing, population-based tobacco control and smoking behavior. *American Journal of Preventive Medicine, 33*(6S), S327-S334.

Piper, M., Piasecki, T., Federman, E., Bolt, D., Smith, S., Fiore, M., et al. (2004). A multiple motives approach to tobacco dependence: the Wisconsin Inventory of Smoking Dependence Motives (WISDM-68). *Journal of Counselling and Clinical Psychology, 72*(2), 139-154.

Pitman, G. (2002). Outside/insider: the politics of shifting identities in the research process. *Feminism and Psychology, 12*(2), 282-288.

Pitts, M., Smith, A., Mitchell, A., & Patel, S. (2006). *Private Lives: a report on the health and wellbeing of GLBTI Australians* (No. Monograph Series Number 57). Melbourne: Gay and Lesbian Health Victoria and Australian Research Centre in Sex, Health and Society, La Trobe University.

Pizacani, B., Rohde, K., Bushmore, C., Stark, M., Maher, J., Dilley, J., et al. (2009). Smoking-related knowledge, attitudes and behaviors in the lesbian, gay and bisexual community: a population-based study from the U.S. Pacific Northwest. *Preventive Medicine, 48*, 555-561.

Platzer, H., & James, T. (1997). Methodological issues conducting sensitive research on lesbian and gay men's experience of nursing care. *Journal of Advanced Nursing, 25*, 626-633.

Poland, B., Frahlich, K., Haines, R., Maykhalovskiy, E., Rock, M., & Sparks, R. (2006). The social context of smoking: the next frontier in tobacco control? *Tobacco Control, 15*, 59-63.

Polanska, K., Hanke, W., Sobala, W., Lowe, J., & Jaakkola, J. (2011). Predictors of Smoking Relapse After Delivery: Prospective Study in Central Poland. *Maternal and Child Health Journal, 15*(5), 579-586.

Pollard, M., Tucker, J., Green, H., Kennedy, D., & Go, M. (2011). Romantic attraction and adolescent smoking trajectories. *Addictive Behaviors, 36*, 1275-1281.

Pride History Group Sydney. (2009). *Out and About: Sydney's Lesbian Social Scene 1960s - 1980s*. Sydney: Pride History Group Sydney.

Pride WA Inc. (n.d.). History. Retrieved 11 September 2009, from
    http://www.pridewa.asn.au/pride/index.php/pride/history.html

QSR International. (2008). NVivo 8 (Version 8).

Remafedi, G. (2007). Lesbian, gay, bisexual, and transgender youths: who smokes
    and why? *Nicotine and Tobacco Research, 9*(Sup 1), S65-S71.

Remafedi, G., & Carol, H. (2005). Preventing tobacco use among lesbian, gay,
    bisexual and transgender youth. *Nicotine and Tobacco Research, 7*(2), 249-
    256.

Reynolds, L. (2003). Early representatives. In L. Reynolds & N. Herman-Kinney
    (Eds.), *Handbook of Symbolic Interactionism* (pp. 59-82). Walnut Creek:
    AltaMira Press.

Reynolds, L., & Herman-Kinney, N. (Eds.). (2003). *Handbook of Symbolic
    Interactionism.* Walnut Creek: AltaMira Press.

Richards, L., & Morse, J. (2007). *Readme first for a user's guide to qualitative
    methods* (2nd ed.). Thousand Oaks, California: Sage Publications Inc.

Richters, J., Song, A., Prestage, G., Clayton, S., & Turner, R. (2005). *Health of
    Lesbian, Bisexual and Queer Women in Sydney: the 2004 Sydney Women and
    Sexual Health Survey*. Sydney: National Centre on HIV Social Research;.

Rickards, T., & Wuest, J. (2006). The Process of Losing and Regaining Credibility
    When Coming-Out at Midlife. *Health Care for Women International, 27*,
    530–547.

Ridinger, R. (1996). *The Gay and Lesbian Movement: references and resources*.
    New York: G.K. Hall & Co.

Riggle, E., Whitman, J., Olson, A., & Rostosky, S. (2008). The positive aspects of
    being a lesbian or gay man. *Professional Psychology: Research and Practice,
    39*(2), 210-217.

Rimmerman, C. (2008). *The Lesbian and Gay Movements: assimilation or
    liberation?* Boulder, Colorado: Westview Press.

Rivers, I. (2004). Recollections of bullying at school and their long-term implications
    for lesbians, gay men, and bisexuals. *Crisis, 25*(4), 169-175.

Robinson, S. (Ed.). (2008). *Homophobia An Australian History*. Sydney: Federation
    Press.

Rodriguez, E., & Ouellette, S. (2000). Gay and Lesbian Christians: Homosexual and
    Religious Identity Integration in the Members and Participants of a Gay-
    Positive Church. *Journal for the Scientific Study of Religion, 39*, 333-347.

Rosenstreich, G., Comfort, J., & Martin, P. (2011). Primary Health Care and Equity:
    the case of LGBTI Australians. *Australian Journal of Primary Health Care,
    17*, 302–308.

Ross, L., Dobinson, C., & Eady, A. (2010). Perceived determinants of mental health
    for bisexual people: a qualitative examination. *American Journal of Public
    Health, 100*(3), 496-502.

Rossen, F., Lucassen, M., Denny, S., & Robinson, E. (2009). *Youth '07 The health and wellbeing of secondary school students in New Zealand: Results for young people attracted to the same sex or both sexes*. Auckland: The University of Auckland.

Rothblum, E. (2010). Where is the 'Women's Community?' Voices of lesbian, bisexual and queer women and heterosexual sisters. *Feminism and Psychology, 20*(4), 454-472.

Ryan, H., Wortley, P. M., Easton, A., Pederson, L., & Greenwood, G. (2001). Smoking among lesbians, gays, and bisexuals - A review of the literature. *American Journal of Preventive Medicine, 21*(2), 142-149.

Ryan, R., Hill, W., Rubenstein, L., & Ross, S. (2010). *Tobacco Social Marketing Campaign (prepared for Market Research Unit, Communications Branch, Department of Health and Ageing)*. Australia: Urbis.

Sandelowski, M., & Barroso, J. (2003). Writing a proposal for a qualitative research methodology project. *Qualitative Health Research, 13*(6), 781-820.

Sandfort, T. G. M. (2006). Sexual orientation and mental and physical health status: findings from a Dutch population survey. *American Journal of Public Health, 96*(6), 1119-1125.

Sartore, M., & Cunningham, G. (2009). Gender, sexual prejudice and sport participation: implications for sexual minorities. *Sex Roles, 60*, 100-113.

Savin-Williams, R. (2001). A critique of research on sexual-minority youth. *Journal of Adolescence, 24*, 5-13.

Savin-Williams, R. (2005). *The New Gay Teenager*. Cambridge: Harvard University Press.

Savin-Williams, R., Cohen, K., Joyner, K., & Rieger, G. (2011). Rejecting the refutation that never was: reply to Meyer's (2010) comments on Savin-Williams, Cohen, Joyner, and Rieger (2010). *Archives of Sexual Behavior, 40*, 659-661.

Scheer, S., Parks, C., McFarland, W., Page-Shafer, K., Delgado, V., Ruiz, J., et al. (2003). Self-reported sexual identity, sexual behaviors and health risks: examples from a population-based survey of young women. *Journal of Lesbian Studies, 7*(1), 69-83.

Schillo, B., & Willoughby, D. (2007). Understanding tobacco use in Minnesota: findings from the ClearWay Minnesota research program. *Nicotine and Tobacco Research, 9*(Supp 1), S7-S9.

Schroeder, S. (2008). Stranded in the periphery - the increasing marginalization of smokers. *New England Journal of Medicine, May 22*, 2284-2286.

Scollo, M., & Winstanley, M. (Eds.). (2008). *Tobacco in Australia: Facts and Issues* (3rd ed.). Melbourne: Cancer Council Victoria.

Scout, M., Bradford, J., & Fields, C. (2001). Removing the barriers: improving practitioners' skills in providing health care to lesbians and women who partner with women. *American Journal of Public Health, 91*(6), 989-990.

Sell, R., & Dunn, P. (2008). Inclusion of Lesbian, Gay, Bisexual and Transgender People in Tobacco Use-Related Surveillance and Epidemiological Research. *Journal of LGBT Health Research 4*(1), 27-42.

Sell, R., & Silenzio, V. (2006). Lesbian, Gay, Bisexual, and Transgender Public Health Research. In M. Shankle (Ed.), *Lesbian, Gay, Bisexual, and Transgender Health, in The Handbook of Lesbian, Gay, Bisexual, and Transgender Public Health: a practitioner's guide to service* (pp. 33-58). New York: Harrington Park Press.

Sell, R., Wells, J., & Wypij, D. (1995). The prevalence of homosexual behavior and attraction in the United States, the United Kingdom and France: results of national population-based samples. *Archives of Sexual Behavior, 24*(3), 235-248.

Selvidge, M., Matthews, C., & Bridges, S. (2008). The relationship of minority stress and flexible coping to psychological well being in lesbian and bisexual women. *Journal of Homosexuality, 55*(3), 450-470.

Shankle, M. (Ed.). (2006). *The Handbook of Lesbian, Gay, Bisexual, and Transgender Public Health: a practitioner's guide to service*. New York: Harrington Park Press.

Shilo, G., & Savaya, R. (2011). Effects of family and friend support on LGB youth's mental health and sexual orientation milestones. *Family Relations, 60*, 318-330.

Siahpush, M. (2004). Why is lone-motherhood so strongly associated with smoking? *Australian and New Zealand Journal of Public Health, 28*(1), 37-42.

Silverman, D. (2007). *A Very Short, Fairly Interesting and Reasonably Cheap Book About Qualitative Research*. London: Sage Publications.

Skinner, W. (1994). The prevalence and demographic predictors of illicit and licit drug use among lesbians and gay men. *American Journal of Public Health, 84*, 1307-1310.

Smith, A., Rissel, C., Richters, J., Grulich, A., & DeVisser, R. (2003). Sex in Australia: sexual identity, sexual attraction and sexual experience among a representative sample of adults. *Australian and New Zealand Journal of Public Health, 27*(2), 138-145.

Smith, E., & Malone, R. (2003). The outing of Philip Morris: advertising tobacco to gay men. *American Journal of Public Health, 93*(6), 988-993.

Solarz, A., (ed). (1999). *Lesbian Health: Current Assessment and Directions for the Future*. Washington DC: National Academy Press.

Solomon, S., Rothblum, E., & Balsam, K. (2004). Pioneers in Partnership: Lesbian and Gay Male Couples in Civil Unions Compared With Those Not in Civil Unions and Married Heterosexual Siblings *Journal of Family Psychology 18*(2), 275-286.

Sophie, J. (1986). A critical examination of stage theories of lesbian identity development. *Journal of Homosexuality, 12*(2), 39-51.

Sorg, A., Xu, J., Doppalpudi, S., Shelton, S., & Harris, J. (2011). Hardcore smokers in a challenging tobacco control environment: the case of Missouri. *Tobacco Control, 20*(5), 388-330.

Sparkes, A. (2001). Myth 94: qualitative health researchers will agree about validity. *Qualitative Health Research, 11*(4), 538-552.

State School Teacher's Union WA. (2011). B-Legits: Gay and Lesbian.   Retrieved 8 November 2011, from www.sstuwa.org.au/resources/b-legits

Strauss, A., & Corbin, J. (1998). *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory* (2nd ed.). Thousand Oaks: Sage Publications.

Stuber, J., Galea, S., & Link, B. (2008). Smoking and the emergence of a stigmatized social status. *Social Science and Medicine, 67*, 420-430.

Stuber, J., Meyer, I., & Link, B. (2008). Stigma, prejudice, discrimination and health. *Social Science and Medicine, 67*(3), 351-352.

Suter, E., Daas, K., & Bergen, K. (2008). Negotiating lesbian family identity via symbols and rituals. *Journal of Family Issues, 29*(1), 26-47.

Swann, S., & Anastas, J. (2003). Dimensions of lesbian identity during adolescence and young adulthood. *Journal of Gay and Lesbian Social Services, 15*(1/2), 109-125.

Swim, J., K., J., & Pearson, N. (2009). Daily experiences with heterosexism: relations between heterosexist hassles and psychological well-being. *Journal of Social and Clinical Psychology, 28*(5), 597-629.

Swim, J., Pearson, N., & Johnston, K. (2007). Daily encounters with heterosexism: a week in the life of lesbian, gay, and bisexual individuals. *Journal of Homosexuality, 53*(4), 31-48.

Sydney's Pride History Group. (2009). A chronology of lesbian and gay communities and movements in Sydney.   Retrieved 17 December 2009, from http://www.pridehistorygroup.org.au/

Szymanski, D., & Chung, Y. B. (2001). The Lesbian Internalized Homophobia Scale -- A Rational/Theoretical Approach. *Journal of Homosexuality, 41*(2), 37 - 52.

Szymanski, D., & Chung, Y. B. (2003). Internalized homophobia in lesbians. *Journal of Lesbian Studies, 7*(1), 115-125.

Tabatabai, A. (2010). Protecting the lesbian border: the tension between individual and communal authenticity. *Sexualities, 13*(5), 563-581.

Tang, H., Greenwood, G., Cowling, D., Lloyd, J., Roeseler, A., & Bal, D. (2004). Cigarette smoking among lesbians, gays, and bisexuals: how serious a problem? (United States). *Cancer Causes and Control, 15*, 797-803.

The Cancer Council Western Australia. (2008). *The progress of tobacco control in Western Australia: achievements, challenges and hopes for the future*. Perth: The Cancer Council Western Australia.

The Freedom Centre. (2009).   Retrieved 18 October 2009, from http://www.freedom.org.au/

The National Tobacco Control Network. (2011). About the National Tobacco Control Network Retrieved 10 August 2011, from http://www.lgbttobacco.org/about.php

The Pink Sofa. (n.d.). The Pink Sofa.   Retrieved 5 September 2008, from http://www.thepinksofa.com/

Thompson, E., & Morgan, E. (2008). "Mostly Straight" Young Women: Variations in Sexual Behavior and Identity Development. *Developmental Psychology, 44*(1), 15-21.

Todd, M. (2004). Daily processes in stress and smoking: effects of negative events, nicotine dependence, and gender. *Psychology of Addictive Behaviours, 18*(1), 31-39.

Trocki, K., Drabble, L., & Midanik, L. (2009). Tobacco, Marijuana, and Sensation Seeking: Comparisons Across Gay, Lesbian, Bisexual, and Heterosexual Groups. *Psychology of Addictive Behaviors, 23*(4), 620-631.

Troiden, R. (1979). Becoming homosexual: a model of gay identity acquisition. *Psychiatry, 42*, 362-373.

US Department of Health and Human Services. (2004). *The Health Consequences of Smoking: a report of the Surgeon General*. Atlanta: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.

US Department of Health and Human Services. (2006). *The Health Consequences of Involuntary Exposure to Tobacco Smoke: a report of the Surgeon General*. Atlanta: US Department of Health and Human Services, Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.

US Department of Health and Human Services. (2010). *Ending the Tobacco Epidemic: A Tobacco Control Strategic Action Plan for the U.S.* Washington, DC: U.S. Department of Health and Human Services.

US Department of Health and Human Services. (n.d.). Lesbian, Gay, Bisexual, and Transgender Health. *Healthy People 2020*   Retrieved 30 April 2011, from http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=25

Ussher, M., Chambers, M., Adams, R., Croghan, E., & Murray, R. (2011). Evaluation of a nationally disseminated self-help intervention for smoking cessation ('Quit Kit'). *Tobacco Control, 20*(5), 380-382.

Valanis, B., Bowen, D., Bassford, T., Whitlock, E., Charney, P., & Carter, R. (2000). Sexual orientation and health: Comparisons in the Women's Health Initiative sample. *Archives of Family Medicine, 9*(9), 843-853.

van Dam, M. (2008). A lesbian identity disclosure assessment: ALIDA instrument. *Journal of Homosexuality, 55*(1), 166-182.

van Krieken, R., Smith, P., Habibis, D., McDonald, K., Haralambos, M., & Holborn, M. (2000). *Sociology Themes and Perspectives*. Sydney: Longman.

Vryan, K., Adler, P., & Adler, P. (2003). Identity. In L. Reynolds & N. Herman-Kinney (Eds.), *Handbook of Symbolic Interactionism* (pp. 367-390). Walnut Creek: AltaMira Press.

WAAC. (n.d.). About us.   Retrieved 11 September, 2009, from http://www.waaids.com/About-Us/

Wakefield, M., Loken, B., & Hornik, R. (2010). Use of mass media campaigns to change health behaviour. *Lancet, 376*(9748), 1261-1271.

Walker, D., & Myrick, F. (2006). Grounded theory: an exploration of process and procedure. *Qualitative Health Research, 16*(4), 547-559.

Walsh, G. (2008). Happy days. *Scoop, Summer,* 70-73.

Washington, H. (2002). Burning love: big tobacco takes aim at LGBT youths. *American Journal of Public Health, 92*(7), 1086-1095.

Weber, G. (2008). Using to numb the pain: substance use and abuse among lesbian, gay, and bisexual individuals. *Journal of Mental Health Counseling, 30*(1), 31-48.

White, V., Hill, D., Siahpush, M., & Bobevski, I. (2003). How has the prevalence of cigarette smoking changed among Australian adults? Trends in smoking prevalence between 1980 and 2001. *Tobacco Control, 12*(Supp 2), ii67-ii74.

Whittemore, R., Chase, S., & Mandle, C. (2001). Validity in qualitative research. *Qualitative Health Research, 11*(4), 522-537.

Willett, G. (2000). *Living Out Loud a history of gay and lesbian activism in Australia*. Sydney: Allen & Unwin.

Willett, G. (2003). Social Exclusion and Gay and Lesbian People. In D. Weiss (Ed.), *Social Exclusion - An Approach to the Australian case* (pp. 407-423). Frankfurt: Peter Lang.

Willis, K., Daly, J., Kealy, M., Small, R., Koutroulis, G., Green, J., et al. (2007). The essential role of social theory in qualitative public health research. *Australian and New Zealand Journal of Public Health, 31*(5), 438-443.

Wilson, H., & Hutchinson, S. (1991). Pearls, pith and provocation: triangulation of qualitative methods: Heideggerian hermeneutics and grounded theory. *Qualitative Health Research, 1*(2), 163-276.

Woodward, A., & Kawachi, I. (2003). Tobacco control in Australia. *Tobacco Control, 12*(Supp 2), ii1-ii2.

World Health Organization. (1986). *The Ottawa Charter for Health Promotion*. Geneva: WHO.

World Health Organization. (1997). *Jakarta Declaration on Leading Health Promotion into the 21st Century* Geneva: WHO.

World Health Organization. (2003). *WHO Framework Convention on Tobacco Control*. Geneva: WHO.

World Health Organization. (2005). Bangkok Charter for Health Promotion in a Globalized World

World Health Organization. (2008). *WHO Report on the Global Tobacco Epidemic 2008: the MPOWER package*. Geneva: WHO.

World Health Organization (2010). International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) Version for 2010, Chapter V Mental and behavioural disorders. Available from http://apps.who.int/classifications/icd10/browse/2010/en#/F60-F69

Wright, E., & Perry, B. (2006). Sexual identity distress, social support, and the health of gay, lesbian, and bisexual youth. *Journal of Homosexuality, 51*(1), 81-110.

Wykes, R. (1999). In search of the mythical lesbian community. *Women Out West, 5*, 4-5.

Yong, H., Borland, R., & Siahpush, M. (2005). Quitting-related beliefs, intentions, and motivations of older smokers in four countries: findings from the international tobacco control policy evaluation survey. *Addictive Behaviors, 30*, 777-788.

Young, R., & Meyer, I. (2005). The trouble with 'MSM' and 'WSW': erasure of the sexual-minority person in public health discourse. *American Journal of Public Health, 95*(7), 1144-1149.

Appendix A   Ethics Approval

MINUTE

Curtin
UNIVERSITY OF TECHNOLOGY

To	Jude Comfort
From	Leslie Thompson
Subject	Protocol Approval – SPH – 0041 - 2008
Date	October 16th, 2008
Copy	Associate Professor Jan Lewis

SCHOOL OF PUBLIC HEALTH

TELEPHONE   9266 4346
FACSIMILE   9266 2958
EMAIL l.thompson@curtin.edu.au

Dear Jude

Thank you for your "Form C Application for Approval of Research with Minimal Risk (Ethical Requirements)" for the project titled "Health related behaviour of marginalised groups. Why do lesbians smoke?. On behalf of the Human Research Ethics Committee I am authorised to inform you that the project has been approved.

Approval of this project is for a period from October 10th, 2008 to October 10th, 2010.

If at any time during the twelve months changes/amendments occur, or if a serious or unexpected adverse event occurs, please advise me immediately. The approval number for your project is SPH - 0041 - 2008. *Please quote this number in any future correspondence.*

Leslie Thompson
Coordinator
Human Research Ethics Form C
School of Public Health

Please Note: The following standard statement must be included in the information sheet to participants:
This study has been approved by the Curtin University Human Research Ethics Committee. If needed, verification of approval can be obtained either by writing to the Curtin University Human Research Ethics Committee, c/- Office of Research and Development, Curtin University of Technology, GPO Box U1987, Perth, 6845 or by telephoning 9266 2784.

Appendix B Social and political timeline of women's smoking

Period	Women's smoking
Mid 19th century	Only daring bohemian, avant-garde and fashionable women smoked. Smoking was seen very much as a masculine pursuit and perceived by most as unfeminine.
Turn of 19th and 20th century	Some woman smoked but only in private, either alone or with friends.
World War I	Smoking in public started to became acceptable for women.
Interwar period	Increasing expression of women's emancipation and women's smoking became more open.
Early 1920s	Smoking for women had become accepted by society vogue and bought into the open. It was however still not universally approved. Cigarette advertising started its early targeting of women as smokers.
Mid 1930s	Smoking was seen as a normal means of relaxation for the busy business women but it was still a minority habit taken up mainly in adulthood (compared to men who started in adolescence).
From 1930s	Tobacco company advertising showed smoking related to a life of glamour, romance, sophistication and success. It was also portrayed widely in movies. Smoking advertisements unashamedly target women and many of them are in terms of demonstrating that smoking by women is an act of equality with men who have long been able to smoke with immunity.
World War II	The war bought changes in women's role in society. Women were employed in both civil and military jobs previously only available to men, and this led to greater social and financial freedom for many women. At the same time smoking became widely accepted behaviour. Women's smoking was seen by some as symbolic of independence – this also persisted into the 1970s and 80s. Smoking advertising incorporated with war messages and a nationalistic flavour; for example an RJ Reynolds advertisement featured a woman air force pilot who was smoking while involved in important war work. By the end of the war, more than a quarter of Australian women were smokers, along with almost three quarters of adult males.
1950s	The first confirmed reports linking tobacco use with lung cancer and other negative health consequences.
Post war period	Women's smoking moved towards an earlier age of experimentation and earlier initiation to regular smoking. Women's smoking became ubiquitous in most developed countries with a proliferation of smoking advertisements targeting women and normalising this behaviour.
1960s	The second wave of feminism and a challenging of established gender roles and equality in the workforce and many other areas.
1962	The *Smoking and Health* report issued by the Royal College of Physicians in the UK and in 1967 the US Surgeon General's report saw the start of health campaigns and consciousness around smoking. Smoking rates for women were yet to peak though. Tobacco companies and cigarette advertising sought to discredit these adverse health findings.
Mid 1960s	Smoking initiation in adolescence occurred in both men and women.
Late 1960s	Philip Morris promoted its Virginia Slims cigarettes to women with their targeted 'you've come a long way' text with accompanying lines such as 'we made Virginia Slims especially for women because women are dainty and beautiful and sweet and generally different from men' here showing that women could still be feminine and smoke countering the claim that smoking made women masculine.

Period	Women's smoking
1976	Australia banned television and radio advertising of tobacco products and at the same time there were new women's cigarettes launched such as 'Eve the first truly feminine cigarette'.
Mid 1970s	The peak of Australian women smoking prevalence at 33% while smoking rates in men had started to decline.
1983	State run Quit campaigns commenced in Australia.
Mid 1980s	Increasing evidence on the harmful effects of passive smoking including the NHMRC Australian report.
1986 onwards	Increasing number of legislative tobacco control measures introduced into Australia including in 1986 smoke-free work place policies and stronger health warnings; 1989 ban on print media tobacco advertising; increasing number of public spaces became smoke-free.
1997	The National Tobacco Campaign launched.

Appendix C   Research Reference Group

Sandra Norman
Gay and Lesbian Community Services (GLCS)

Professor Sherry Saggers
National Drug Research Institute (NDRI)

Dr Owen Carter
Centre for Behavioural Research in Cancer Control (CBRCC)

Dr Clare Rees
Curtin University

Community Representatives
Zoe Carter

Are you a
smoker or an
ex smoker?

Are you a lesbian or

If you smoke or quit in the last year, do you have an hour to talk about your smoking experience? A research project through Curtin University is investigating why lesbians smoke at higher rates than the wider community. To arrange an individual

Curtin
University of Technology

Are you a smoker or ex-smoker?
Are you a gay, same sex attracted
or queer woman who wants to
help with a gay health project?
Can I interview you as part of a Curtin University
research project? Please contact me
j.comfort@curtin.edu.au or phone 0422 654 244
or provide your contact details on the back and I
will contact you. Thanks Jude Comfort.

Curtin Health Innovation
Research Institute

Curtin
University of Technology
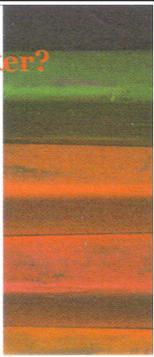
Appendix E Final interview guide

Interview Guide and Prompts (final version 28 January 2010)

1. Can you tell me about your experience of smoking? Maybe your first
    cigarette, how you started?
2. How do you smoke now? (or when you smoked?) What about quitting? Cues
    to quit/relapse
3. What do you get out of smoking? (positives of smoking; how do you use
    cigarettes; why do you smoke)
4. Tell me about your experience of being gay/lesbian? How easy was it
    coming out? What about now?
5. Do you feel a minority in any sense? What does that feel like? (smoking or
    sexuality)

Other

6. Do you feel marginalised from society because of your sexuality?
7. How do you handle this?
8. Do you feel marginalised from society because of your smoking?
9. Can you talk about the difference between your smoking behaviour and
    knowledge of smoking damage?
10. How do you handle this?
11. Do you think others or do you perceive either of these behaviours as
    deviant?
12. Do you think either of the above has resulted in mental stress?
13. How do you handle this?
14. Do you feel you have a community that you belong to?
15. How would you define this community?
16. How would you describe the gay community?
17. How do you rate your health, what part does smoking play in that?

Question 1

- Age? Who gave you cigarettes? Parental smoking? Why did you have first cigarette?
- Experimental versus becoming a regular smoker?

Question 2

- Social/heavy/addicted smoker?
- When/where/who do you smoke with/partner influence?
- How many friends smoke? How many friends are gay?
- Triggers to smoke? Alcohol, drugs, environment?
- Stigma as a smoker?
- Is it part of the gay scene?
- How acceptable is it to smoke? Different social situations. Work environment?
- How many lesbians do you think smoke?
- Have you tried to quit/how many times?
- What happened when quitting? Different for different attempts?
- Would you like to quit smoking?
- Response to anti-smoking campaigns?

Question 3

- Why do you smoke?
- Stress management/self medication?
- Sense of belonging?
- Stigma of being gay, coming out, emotional support?
- Social role of smoking? What about in the lesbian community? Changes over time?

Question 4

- Coming out experience?
- Are you happy with being gay?
- Stigma/discrimination at being gay/lesbian?
- Community identity - straight community, gay community?
- Feel a minority?

Question 5

- Negatives of being a minority?
- Positives of being a minority? Do you feel some solidarity?
- What coping mechanisms do you have?

Appendix F   Demographic data collection tool

Interview Guide - Demographic Information

1. At what age did have first cigarette?   Become a regular smoker?

2. How many cigarettes did you/do you generally smoke?
    a. a day
    b. a week

3. Do you regularly use alcohol or any other drugs? (describe)

4. What is your highest level of education?

5. What is your current employment status/profession?

6. How do you label your sexual identity to yourself?

7. At what age did you 'come out' as a lesbian/gay/queer?

8. How 'out' do you rate yourself? (circle)

    1   2   3   4   5   6   7   8   9   10

    Out only to myself   Out to everyone

9. How comfortable are you with your sexuality?

    1   2   3   4   5   6   7   8   9   10

    Very uncomfortable   Very comfortable

10. Age

11. Postcode

Appendix G   Participant information sheet

Information Sheet
Research project: Lesbian experience of cigarette smoking

My name is Jude Comfort and I am undertaking doctoral research within the School of Public Health at Curtin University of Technology. I am completing research on the experience of smoking within the lesbian community in WA. The purpose of this research is to increase understanding of smoking within this group in an attempt to explain the higher rates of smoking and also to provide some direction to more appropriate public health campaigns.

Interviews are being carried out with WA women who are 18 years or older, identify as lesbian, bisexual or same sex attracted and are also current, regular smokers, or women who have quit smoking in the last 12 months. The interview will be digitally recorded and will take approximately 50-60 minutes of your time. All information provided will be treated confidentially and no names will appear on the transcribed interview. Information gained through these interviews will form the basis for a written report on the experience of smoking in the lesbian community. Extracts of the interview may be used in the research report, but you will not be identified in any way.

All participants do so voluntarily without reward and may withdraw from interviews at any time. It is not envisaged that sensitive information will be collected and there is no known negative consequences for participants.

Information collected and stored on audio files, written notes or computer files will be carefully secured at all times by the researcher. Data will only be accessed by the researcher and by supervised administrative staff involved in the transcribing of audio recordings. All information will be destroyed after five years.

This project has the approval of the Curtin University Human Research Ethics Committee. Further information can be obtained from:

> Jude Comfort (Researcher)
> School of Public Health
> Curtin University
> PO Box U1987 Perth WA 6845
> Phone 9266 2365
> j.comfort@curtin.edu.au
>
> Dr Janice Lewis (Research supervisor)
> School of Public Health
> Curtin University
> PO Box U1987 Perth WA 6845
> Phone 9266 2075
> j.lewis@curtin.edu.au
>
> The Secretary
> Curtin University Human Research Ethics Committee
> Office of Research and Development
> PO Box U1987 Perth WA 6845
> Phone 9266 2784
> hrec@curtin.edu.au

Appendix H   Contact details – specialist referral information

Additional resources

Thank you for your participation in this important social research project. If you feel that this interview has raised other issues that you would like to discuss with someone, you may want to make contact with:

Gay and Lesbian Community Services

Telephone Counselling and Information Line
Phone (08) 9420 7201 or 1800 184 527
Monday to Friday, 7-10 pm

www.glcs.org.au

Alcohol and Drug Information Services

ADIS is a 24 hour, confidential telephone service for people in Western Australia. It provides information, counselling, referral and advice to anyone concerned about their own or another's alcohol or other drug use. Also provides an on-line Directory of Drug and Alcohol Services in Western Australia at:
http://www.dao.health.wa.gov.au/Gettinghelp/ServiceDirectory.aspx

Phone (08) 9448 5000 or Country Toll Free 1800 198 024

www.dao.health.wa.gov.au

National Quitline

Specific assistance for those wanting to Quit cigarettes

Phone 131 848

www.quitnow.info.au

Appendix I   Participant follow-up email

From: Jude Comfort
Sent:
Subject: Interview follow-up

First, I would like to thank you for being involved in the research project looking at lesbians/gay women and cigarette smoking. I appreciate your time and your openness. I am interested to get some feedback on the interview itself. Could you please take a couple of minutes and send me a return email answering these short questions?

1. *Did the interview change your views or understanding of your own smoking or smoking in general? How?*

2. *What were the positive elements of the interview experience for you?*

3. *What were the negative elements of the interview?*

Please feel free to call me on 0422 654 244 if you wish to discuss the interview further.

Secondly, I still need to interview women and I will be interviewing for another few months yet. So please forward my details and details of the research (see below) onto any friends, contacts or networks you have who may be interested in participating in this research. Alternatively you can send me their email details and I am happy to follow-up. The area of gay health is very much under-researched and hopefully this project will help fill a part of that gap.

Appendix J   Interview follow-up

The methodology chapter has details of an interview follow-up protocol that was conducted to report on participants' positive and negatives feelings about the interview (see Section 4.6.4.). This appendix captures some participants' comments in response to the three questions asked via email and provided a measure of the potential impact of qualitative methodologies on participants and the importance of giving validity to the participant voice.

All respondents mentioned that they had experienced many positives as a result of being interviewed as part of the research project. No negatives were reported. Themes to emerge included being able to reflect on their own smoking behaviour, and the stigma of being a smoker. As one respondent put it:

> *Being able to actually talk about being a smoker was really positive because it is generally quite a shamed activity. . . . I think it was also positive to talk about the reasons why I still smoke and what it would take to quit. I can't say that my smoking has reduced since the interview but I have been thinking more about quitting than I had done previously. P 3*

The desire to quit was mentioned by several participants. For example in response to question two, what were the positives of the interview one participant wrote: *How much I want to quit, as it* [smoking] *increases my lack of self esteem, P 1;* while another wrote the positives of the interview were *identifying some of my triggers and once again reinforcing my want to give up. P 16*

All participants commented that the interview did make them reflect on their own smoking behaviour. This did not necessarily translate into any strong feelings that the interview would necessarily change participants' views on smoking; however the following quotes illustrate the reflective outcome for several respondents:

> *I think the interview allowed me to reflect on my smoking history. I think it helped me to identify some of the reasons why I started smoking and to think about why I still continue to do so. P 3*

I now question the validity of my reasons for smoking and ask myself why I smoke when I'm alone and more than when I am in a group. P 1

Yes. I realised I use smoking as an excuse to isolate/remove myself from situations or problems if I don't want to deal with them. P 16

The interview led some participants to reassess their current smoking and whether they wanted to continue to smoke. For example:

I realised that my smoking was enjoyed the most in isolation, especially during the day at work... I am sure initially the 'off to be on my own' behaviour was brought on by my own sense of social-shame at being a 'smoker'... When I realised this, I found it initially very discouraging because it reinforced to me how hopelessly addicted to tobacco I really am. Of late though, it has given me some ideas regarding developing strategies for quitting. P 17

Since the interview I have mostly stopped smoking!!! . . . My Dad died of emphysema and I really knew that I did not want to go the same way . . . perhaps the co-incidence of the interview (and the anniversary of father's death) being at about the same time is not a coincidence???? P 26

Although not all participants fed back on their interview the nine who did found the experience positive and generally reported that the interview provided a powerful reflective experience. It also illustrated the interventionist capacity of an in-depth research interview which for several manifested as moving them from being a smoker towards being more likely to seriously consider quitting. This in itself is an important outcome and provides an area of future research.

Appendix K   Consent form

School of Public Health, Curtin University, Western Australia
Research project: Lesbian experience of cigarette smoking
Consent form

My name is ....

My address is ....

 ....

Email …………...

I understand the aims of this study and I am happy to assist the principal researcher Jude Comfort, from Curtin University, through being interviewed. I understand that I do so on a voluntary basis and will receive no payment for this participation.

I understand that I can stop answering questions at any time.

I am happy for the answers I give in the interview to be used in reports and publications.

I confirm that I am 18 years or older.   Yes ☐   No ☐

I am happy for the interview to be audio recorded.   Yes ☐   No ☐

I am happy to be contacted for follow-up.   Yes ☐   No ☐

Signed

Date