

Personal and professional choices, tensions, and boundaries in the lives  
of lesbian  
psychiatric mental health nurses

by

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## **Abstract**

This study breaks new ground in articulating how sexual identity impacts on the therapeutic relationship between the client and the lesbian nurse in psychiatric mental health nursing. There is little consideration given in the literature or in research as to how sexuality of the nurse impacts on nursing practice. Most attitudes held by the public and nursing staff are based on the assumption that everyone is heterosexual, including nurses.

Fifteen lesbian psychiatric mental health nurses from throughout New Zealand volunteered for two interviews and shared their experiences of becoming and being a lesbian psychiatric mental health nurse. The stories they told give new insights into how these nurses negotiate and position their lesbian identity in the therapeutic relationship.

To work therapeutically with people in mental distress the nurse uses personal information about themselves to gain rapport with the client through appropriate self-disclosure. Being real, honest and authentic are also key concepts in this relationship so the negotiation of reveal/conceal of the nurse's identity is central to ongoing therapeutic engagement.

One of the most significant things arising from the research is that participants are able to maintain their honesty and authenticity in the therapeutic relationship whether they self-disclose their lesbian identity or not. This is because the experiences in their personal lives have influenced how the participants 'know themselves' and therefore guide how they 'use self' in their therapeutic nursing.

The concept of a 'licensed narrative' has also been developed during this research reflecting the negotiated understandings between the researcher and the participants. Further, the use of NVivo a qualitative software package helps to track and make transparent the research processes. These two aspects make a unique contribution to the field of narrative inquiry.

Key words; lesbian, mental health nurse, narrative inquiry, therapeutic relationship.

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## Glossary

These definitions are compiled from my own knowledge and experience over the years working in mental health services rather than those from any specific text book. They are included here because the reader may not be familiar with some of the language and terms specific to psychiatric mental health nursing and to the New Zealand context. They have been used by the participants in their stories and are important to understand.

bipolar disorder	A medical term given to someone who has mood swings from times of elation to times of low mood.
borderline personality disorder	A medical term used to describe people who have maladaptive coping patterns, are emotionally unstable and have unstable interpersonal relationships. Women are much more likely than men to be given this diagnosis.
client, consumer, patient, service user	A person who is or has been in mental distress and has experience of using mental health services.
coming out, to come out, self-disclosure, 'outed'	These terms collectively refer to the acknowledgement and sharing of a lesbian/gay/queer identity, usually by a previously heterosexual person to themselves and/or to those around them.
cultural safety	A term that acknowledges and respects the cultural identity of the person seeking health services and the responsibility of the nurse to ensure they understand and work safely with that person's or their family's culture.
counter-transference	A term used in the therapeutic alliance to describe an unconscious response in which the therapist or nurse over-identifies with the client.
Maori	The indigenous people of New Zealand.

psychotic, psychoses	A medical term used to describe various mental disorders whereby a person has varying degrees of personality disintegration. It is often associated with a loss of contact with reality, distorted perception and hallucinations and/or delusions.
seclusion, secluding	A procedure adopted (in mental health facilities) when a person who is in mental distress is assessed to be at risk to themselves or others. The person is usually isolated in a single room for a period and monitored until they are assessed to be safe enough to leave the single room.
tangata whaiora	A Maori term to describe a person who is or has been in mental distress and has experience of using mental health services.
transference	A term used in the therapeutic alliance to describe an unconscious response in which the client projects their thoughts, feelings or emotions onto the therapist or nurse. This is sometimes attributed to the client's past dealings with someone with whom they have unresolved issues.
Treaty of Waitangi	New Zealand's founding document between Maori and the Crown.

# **Chapter One**

## **Introduction to the Study-Background and Positioning**

Little is known about what it means to be a lesbian psychiatric mental health nurse and how being lesbian influences nursing practice. This thesis explores the stories of fifteen nurses who self-identify as lesbian and work in mental health settings. The purpose of the study was to gain an understanding of the experiences the participants shared about being lesbian and how these experiences shaped their nursing practice.

This research is positioned politically and socially in New Zealand where the rights of lesbians are monitored and protected under legislation. However, despite this protection some lesbians are reluctant to self-disclose their identity because of societal homophobia and heterosexism. Homophobia is a term used to denote anti-gay feelings and heterosexism, is the “belief that heterosexuality is the only acceptable form of sexuality” (Gruskin, 1999, p.29). Both of these occur at individual, group and institutional levels. Because of the possible exposure to homophobia and heterosexism the lesbian nurse faces daily uncertainty about whether she should disclose her lesbian identity in the work environment. Risks associated with the nurse self-disclosing her lesbian identity to the client may include rejection or abuse from the client. As a consequence of this rejection or abuse the nurse may feel less confident in her nursing ability and feel ashamed of being lesbian. Therefore it is important that the nurse is comfortable being lesbian, and with the decisions she makes about self-disclosing this in her practice.

It is my belief that sexual identity is an integral part of the practice of all nurses but lesbian psychiatric mental health nurses need to negotiate the disclosure about their identity much more thoughtfully and carefully than non-lesbian nurses. They need to be more careful because emphasis is placed on the ‘use of self’ as an accepted therapeutic intervention in psychiatric mental health nursing. Using this intervention requires the lesbian nurse to consider the impact that personal disclosure has on the client. Given that the ‘use of self’ usually requires revealing some personal information and is integral to establishing therapeutic nursing care with people in

mental distress, I wanted to find out how lesbian nurses working in mental health decide about what to disclose and how they reveal themselves in their therapeutic interventions.

I also wanted to explore if the fifteen lesbian psychiatric mental health nurses in this study offered something unique to their practice because of their position of marginality and their journey to becoming and being lesbian. I use the term 'unique' based on the assumption that as Barker and Kerr (2001) suggest "the world of personal experience is a unique world" (p.36). I add to this that the personal and professional world of lesbian psychiatric mental health nurses is unique. Further, that all nursing practice is unique, we are all unique, but a major challenge for this research was to reveal this uniqueness through the stories of the participants.

Through sharing the participants' stories I hope to make known how the 'use of self' unfolds in the therapeutic relationship for the nurse who identifies as lesbian. Broadly, I wanted to use the stories and experiences shared by the participants to add to knowledge about the therapeutic relationship in psychiatric mental health nursing. But I was uncertain about how to add to knowledge by theorising about these experiences. Flax (1993) argues that the relationship between theorising and experience is not straightforward and experience does not necessarily inform theory. I agree with Flax about the relationship between experience and theory and believe that experience informs understandings. By theorising and using existing knowledge about the therapeutic relationship, I hope to gain more understanding about the practice of these lesbian psychiatric mental health nurses.

Understanding the 'what' and 'how' of being a lesbian nurse working in mental health adds to the knowledge of nurses seeking to understand some of the more commonly asked questions about psychiatric mental health nursing practice. Questions like what is it that psychiatric mental health nurses actually do, how do they do it? These questions have dominated the debate around psychiatric mental health nursing practice for some time (Altschul, 1972, 1973, 1997; Barker, 2003; Barker, Jackson, & Stevenson, 1999; Bazley, Cakman, Kyle, & Thomas, 1973; Forchuck, 1991; Horsfall, Stuhlmiller, & Champ, 2000; Horvath, 2002; O'Brien, 2000; Peplau, 1987, 1992; Reynolds, 2003; Simpson, 1991; Walsh, 1997). While

articulating that the ‘what,’ why’ and ‘how’ of practice is important we also need to articulate ‘who’ we are as nurses and how this makes a difference to the person in mental distress.

The assumptions that support this study have been formed on the basis of my own experience as a lesbian psychiatric mental health nurse. I believe that lesbian psychiatric mental health nurses add a unique perspective to the therapeutic relationship. Their perspective has been shaped by their experiences of living as lesbians outside the so-called ‘normal’ discourse of heterosexuality and also because of their experiences working in mental health services, a ‘marginalised’ area of health and nursing (Prebble, 2001; Walsh, 2002).

## **Study aim and research questions**

The methodology used for this research thesis is narrative inquiry. Narrative inquiry provides a framework for understanding experiences through story. Fifteen lesbian psychiatric mental health nurses living in New Zealand have shared their experiences in two interviews- one face to face and the other by telephone.

The overall aim of this study was to explore the experiences of lesbian nurses working in psychiatric mental health nursing. Two questions frame this study:

- What is the experience of lesbian nurses who work in psychiatric mental health nursing?
- How does identifying as lesbian influence the practice of psychiatric mental health nurses?

This research makes an important contribution to reframing thinking about how sexual identity and the ‘use of self’ influence the therapeutic relationship in psychiatric mental health nursing.

In this chapter I provide background to the study and explain why this research is necessary. Importantly, I describe how working in mental health has influenced my nursing and how my university study has shaped and guided this study. Justification

for using narrative inquiry is introduced and more detail of this is covered in Chapter Three. Further positioning and framing of the study is addressed with respect to language and terms used, issues about heterosexuals doing research on lesbians, the context and environment in which the study takes place, and finally introducing the therapeutic relationship as a key tool in practice.

## **Background**

### ***Rationale for this study***

The purpose of this research was to hear from women about their experiences of being lesbian nurses working in mental health and how becoming and being lesbian shapes their nursing practice. Over the last twenty years there has been a growing interest and therefore more information about lesbians and their experiences as consumers of health services. Some studies about consumers have revealed the discomfort that lesbians have with seeking health care (Stevens & Hall, 1988), while others have focused more on how discrimination and homophobia influence the health care of lesbians (Hitchcock & Wilson, 1992; Rankine, 1997).

While information and research about experiences of lesbian health care consumers has developed there has been little research about how being a lesbian nurse in health services influences their practice especially those working in mental health services. Studies on nurses self-disclosure of their lesbian identity in the workplace have revealed that good working relationships with colleagues impacted on whether or not they self-disclose (Hansen, 1992), and stressed the relevance of the self-disclosure to their work (Thurston, 1993). While these studies are on nurses, and sometimes involve nurses who work in mental health services, no study either nationally or internationally has been conducted exclusively with psychiatric mental health nurses who identify as lesbian.

Further, no specific research has been conducted on the issue of self-disclosure in the practice of psychiatric mental health nurses who identify as lesbian. The therapeutic relationship, arguably the cornerstone of psychiatric mental health nursing practice, stresses the importance of the nurses' self-awareness and knowing how their own



personality influences the therapeutic encounter (Altschul, 1997; Barker & Kerr, 2001; Peplau, 1952). Self-awareness and ‘appropriate’ self-disclosure for the lesbian nurse necessitates consideration of how disclosure or non-disclosure of her sexual identity will impact on this therapeutic encounter. How the decision to self-disclose impacts on the lesbian nurse working in mental health services is therefore an area needing investigation and is one of the focal aspects in this thesis.

### ***Rationale for the methodology***

It has been my experience that nurses, particularly psychiatric mental health nurses, enjoy a good yarn. Nurses have spent many hours sitting around yarnning about encounters and experiences with people with mental illness, exploring the various nursing strategies undertaken in these situations, and reflecting on the best and worst of these encounters. As a basis for contemplating my approach to this study, I was clear that talking with psychiatric mental health nurses and listening to their stories would be the main source of information gathering. This at least gave me a starting point for exploring specific details about the qualitative research methodology that is best suited to gathering and understanding these stories.

In writing this thesis I have tried to portray the process of gathering the stories and how the stories were created to become licensed narratives. The story of the research process is important to convey because the process undertaken to conduct this research involved working closely with the participants. Transparency adds to the credibility and trustworthiness of the research process which is explained further in Chapter Three. Essentially, this thesis conveys multiple story lines. There is a story within a story conveying the different and yet complementary processes that have emerged throughout my research journey.

Narrative inquiry seeks to add to human understanding by exploring human experience. Clandinin and Connelly (2000) identify how a narrative is “a way to understand experience” (p. 21), adding that “narrative inquiry is stories lived and told” (p. 20). In giving voice to participants I asked them to tell stories about their experiences of working in psychiatric mental health nursing and to reflect on how their identity as lesbians influenced their nursing practice. An unstructured interview

using reflective questioning was used to assist the participants to share their experiences. This approach gave participants an opportunity to share their experiences by telling their own stories, as well as encouraging them to think about and reflect on the meaning of those stories for their practice.

Some of the principles embedded in feminist research processes such as reciprocity and negotiation are important to my undertaking this research. In this research I have engaged in with full participation and collaboration with the participants. I have been mindful of the need to represent, respect and value their subjective experiences. More description about how feminist research processes have influenced this thesis is covered in Chapter Three.

The narrative inquirer needs to keep research processes transparent, which necessitates acknowledging how personal perspectives have influenced and contributed to the study. Clandinin and Connelly (2000) suggest that when undertaking narrative research, “we start with ourselves” (p. xiii). I interpret this to mean that the researcher explains how their personal journey has shaped their engagement with the participants and their narratives.

I have not embarked on this study devoid of experience and knowledge. My past experiences contribute to a set of beliefs and assumptions that have informed and guided this research. Exploring the development of my thinking in preparation for this study is one way of explaining how my personal journey has helped to shape the narrative. Being transparent about my thinking sits alongside feminist research processes.

## **Positioning the thesis**

### ***Developing my thinking in preparation for this study***

The idea of working with women to do research, of talking to women, and of being able to include myself subjectively in the research appealed to me. Interest in this research began initially through my experiences of working as a psychiatric mental health nurse. I ‘came out’ as a lesbian early in my training at the age of 19

encouraged by the freedom to express myself and within an accepting mental health environment. There were many lesbians and gay men working in the hospital and I noticed even then the personal, relaxed, and informal relationship that existed between lesbians, gay men, and patients. I also realised that being a 'psych nurse' was somehow less acceptable than being a general nurse and we were 'fringe' nurses; something that I was comfortable with even then.

Exposure to academic and scholarly work at university where I read about how women are positioned in society, provided the beginnings for developing my thinking and preparing for this research. A women's studies paper exposed me to the writings of New Zealand feminists who wrote about power and gender (Bunkle & Hughes, 1980; Craven, McCurdy, Rosier, & Roth, 1985; Dann, 1985; B. James & Saville-Smith, 1989; Waring, 1985), and revealed the impact of oppression of women such as: inequalities in the workforce, politics and society in general. In my reading I explored these issues further, particularly in education (Barrett, 1980; Clark, 1981; Mahony, 1985; Middleton, 1988; Spender, 1980, 1982; Weiner, 1985) and mental health (Bachrach & Nadelson, 1988; Chesler, 1972; Dowling, 1981; Haines, 1987; Matlin, 1987; Mowbray, Lanir, & Hulce, 1984; Robbins & Siegel, 1985; Walsh, 1987). Much of this new knowledge resonated with me as a woman, a lesbian and a psychiatric mental health nurse. Enrolling in a master's degree in applied social science research enabled me to add a research dimension to my developing interest in feminism.

My master's thesis that explored the relationship between feminism and psychiatric mental health nursing practice using a feminist research approach excited and appealed to me (Walsh, 1995). Stanley and Wise's (1983) text *Breaking out: Feminist consciousness and feminist research* was recommended to me by the late Jane Khull, a lesbian feminist psychiatric mental health nurse, union organiser and educator. Reading this book was the beginning of my interest in feminist research. I was persuaded by the compelling argument proposed by Stanley and Wise that positioned 'the personal' within the research process and their argument that "a feminist social science should begin with the recognition that 'the personal', direct

experience, underlies all behaviours and actions. We need to find out what it is that we know and what it is that we experience” (p. 165).

Other feminist researchers note that there are many different perspectives and a wide range of methodologies used by feminists (Fonow & Cook, 1991; Nielsen, 1990; Reinharz, 1992), hence, the difficulty in defining ‘feminist research’. The term ‘feminisms’ is now widely accepted and seems to capture the different approaches adopted to undertake research and the diverse epistemological standpoints embedded in the research itself. Undertaking research through a feminist lens was influenced by my discovery of a then very popular book by Wheeler and Chinn (1989), *Peace and power: A handbook of feminist process*, and by ideals such as reciprocity in research as described by Lather (1991).

I was becoming increasingly aware of the different worlds that men and women occupy and the need to claim women’s knowledge and experience as part of our unique place in this world. Over a decade later Stanley and Wise (1993) continue to argue that “we need to reclaim, name and rename our experiences and our knowledge of the social world we live in and daily construct” (p. 164). So, while my feminist research awareness was crystallising and my nursing experience a foundation, I had yet to put a stake in the ground with respect to any specific focus in my studies on being lesbian.

The opportunity for developing my thinking further about being lesbian and working in mental health came with two invitations to write book chapters. The first book chapter raised the issue of being different in the context of mental health nursing in New Zealand (Walsh, 1997). I teased out the complexities in the debate among academics and researchers about ‘difference’-but the context in which I explored difference was in relation to culture, gender and sexuality. I argued for the importance of mental health nurses to make a commitment to recognising difference amongst their client group despite attempts by institutions to homogenise care. The process of writing this chapter provided me with my first opportunity to articulate the view that lesbian nurses and lesbian clients are marginalised and further to explain how this marginalisation influenced the care of lesbian clients.

The second book chapter gave me the opportunity to reflect on my career in psychiatric mental health nursing and the changes that have taken place in nursing since my training days (Walsh, 2002). This time I wrote about lesbians and the ‘presumption of heterosexuality’ that many nurses assume when dealing with lesbian clients. My enrolment in doctoral studies further created the opportunity to do research with a lesbian focus. I was keen to do some research that was about and for lesbians. Given that I was working in education the logical step would have meant focussing a piece of research on lesbian nurses in education. However, I was more interested in following a line of inquiry that had a clinical focus and would possibly contribute to nursing practice. And I wanted to do some research that involved lesbian nurses talking about their practice.

As this study has progressed it has become more clear to me that my experiences as a lesbian, a psychiatric mental health nurse, an educator and a student of learning, influenced my thinking about how to interpret and understand the participants’ stories. To begin, feminism(s), as noted, had a profound impact on the research approach. Later, ideas of being ‘different’ and on the fringe provided new lenses through which the participant’s stories could be further understood.

My identity as lesbian and a psychiatric mental health nurse has also influenced the shape and structure of this study. Being open about my lesbian identity is important and I begin to outline the reasons for this in the next section. A continuation of this discussion is in Chapter Two where I discuss the issues around being a lesbian researcher and doing research on lesbians. But first I would like to address concerns I have about heterosexuals doing research on lesbians.

### ***Heterosexuals researching lesbians***

Heterosexual investigators conducting research on lesbians is problematic especially when as Diamant (1993) suggests “lesbianism has largely been unreported by anthropologists as an institutionalized phenomena when compared to the studies on male homosexuality” (p. 4). That is not to say a heterosexual person could not undertake a study with lesbians. They could, but they would get different stories from lesbian participants who may be reluctant to share the depth of their experience

and less tolerant in having to explain the nuances of the lesbian sub-culture. So, how are non-lesbian researchers interpreting the data and information that they have collected? What steps have been taken to ensure their interpretation has been congruent with the participants and the wider body of lesbian knowledge? More importantly, what has influenced their interpretive stances in announcing the results?

According to Rothblum (1994) when doing research on lesbians and gay men the definition of sexual orientation used by the researcher will have an impact on research results about lesbians and this also needs to be taken into consideration in the reporting of research. James and Platzer (1999) refer to a crisis of silence with lesbian representation of experiences in health care and suggest that “there is a pressing need to develop further understanding about the ways in which the dissemination of research can potentially harm already vulnerable research populations” (p. 73). For example, they argue that it is important not to perpetuate negative stereotypes of lesbians or gay men in research findings without discussing the context of these stereotypes with lesbians and gay men to whom the information belongs.

A heterosexual researcher interprets research data having been brought up heterosexual and exposed to this dominant discourse. When trying to analyse and understand research data of a group like lesbians who live outside the dominant discourse the heterosexual researcher is more likely to misinterpret or misrepresent this data. James and Platzer (1999) acknowledge the “need to reflect upon our knowledge of self and our moral development (i.e. how who we are and what we believe in affects how we select, interpret and represent what we see, hear and feel)” (p.77). The motivation of a non-lesbian researcher engaging in a lesbian study should be revealed by the researcher because issues of credibility both of (the researcher and the study) are relevant. Brogan, Frank, Elon and O’Hanlon (2001) note that researchers can be misled when using particular definitions (current self-identity and current sexual behaviour) when researching women’s sexual orientation. They found that combinations of identity and behaviour were common and suggested that care needed to be taken when researchers added items on sexual orientation to new

research. They suggest that more substantive research on the health of lesbians is needed.

I believe that research on lesbians should be undertaken and reported on by lesbians. I agree with Bennett (1996) who comments that gay and lesbian teachers are suited to research on gay writers because:

They are sensitive to the issues. They understand the problems, having lived through them. They are more likely because of their sensitivities to recognize encoding when encoding occurs and to respect the complex validity of such hidden expression. And finally, of course, they care.

(p. 6)

Having argued for lesbians to undertake research on lesbians I have some discomfort about putting this lesbian research out in the public domain. In seeking a resolution to my disquiet I spoke to lesbian friends and colleagues before undertaking this study. I found that they also shared some of my concerns, which were allayed in some respects, by an opportune encounter with a well-known lesbian writer. In May 2003 I interviewed Joan Nestle, a prominent American lesbian femme, prolific writer of lesbian erotica and co-founder of the Lesbian Herstory Archives in the United States of America (US). Joan has been someone I have admired and respected, not only for her outspoken and challenging views, but because she writes with such freedom, vision and commitment. I asked Joan about her thoughts on putting our lesbian lives out into the heterosexual world and having no control over how it would be interpreted and understood. She replied, “I will never live with what men can do with anything because if that were true I’d never get out of bed in the morning” (personal communication, 25<sup>th</sup> May, 2003). I found this statement very liberating and reassuring, especially coming from such a well-known and respected lesbian.

These observations convey and support my reasons for why it is important to this study that I identify as lesbian and am open about this.

### ***Language and this study***

There are a number of ways that words are used throughout this thesis to portray similar meaning. For example the terms client, consumer, patient, person in mental distress, and service user, appear at various times. I use these terms to match the context in which they are situated. There are so many different ways to portray the 'person in mental distress' it seems appropriate to 'go with the flow' and adopt whatever term is being used by the person telling the story, the paraphrasing from other writers, and in my case whatever suited the context.

In this study references are made to being homosexual and at times it is appropriate to use this term rather than lesbian. For example, when referring to the socio-political context the term homosexual refers to both men and women when describing identity. I prefer the terms gay men and lesbians and have used them in the study-terms including non-heterosexual are also used when appropriate.

Another positioning of words includes the use of the term psychiatric mental health nurse. I have chosen this term instead of other commonly adopted ones like mental health nurse or psychiatric nurse because I want to acknowledge both health and illness and their impact on nurses' practice while working with people in mental distress. Finally, throughout the thesis 'story' and 'licensed narrative' are used interchangeably. By this I mean that the word story denotes the participant's transcript before they became licensed narratives.

One of the earliest decisions about the use of terms and language I had to make was in relation to using the word 'lesbian' in recruiting participants for this research.

### ***Language and lesbian identity***

One of the first things I had to consider in recruiting for this research was how to identify participants and how they would respond to the 'naming' used to identify them. I knew there would be diverse opinion about the word 'lesbian' in the lesbian nursing communities from which I intended to recruit. This prompted me to consider carefully how to 'name' the women in this study, so that they identified with that name and recognised it as one that included them; a name that attached an identity



they would be comfortable with; that carried with it the certainty of women loving women.

Language used to identify and describe the sexual identity of non-heterosexual people is often inadequate and offensive and according to Wilton (2000) “members of the lesbian and gay community are often highly sensitised to the significance of naming” (p. xvii). Reflecting on this ‘sensitivity’ I found myself thinking carefully about how to choose language that would not be offensive yet would encourage participation in this study. I was not persuaded by the argument proposed by McNaught (1993) that the word ‘gay’ was adequate as a shorthand for “gay men, lesbian women, and bisexual people” (p. 10), even though he acknowledged the differences among these groups. Nor was I convinced that replacing the ‘offensive slang’ used to describe us was necessary as Zurlinden (1997) suggests when he argues that “for me, *lesbian* and *gay* are the only words that describe us with respect, and I [do] not want to model disrespect” (p. xviii). The 15 women in this study are those who have had intimate relationships with other women and I chose to make a stand and argue for naming based on my own knowledge and experiences in the communities of these women.

In an effort to find language that would resonate with potential participants I considered the use of words like lesbian, gay, queer and homosexual, knowing that these were used in our communities with varying levels of understanding and acceptance. Dyke is also another way of naming women who love women and has preferred status among some of the participants.

To me the word ‘gay’ is used to describe women and men who are attracted to same-sex people. Being gay does not differentiate between women and men. I remember the word ‘queer’ when, as a young child, adults would talk about that ‘queer fellow down the road’, meaning a person who was a bit strange or odd. Today ‘queer’ has been eagerly reclaimed by many non-heterosexuals as an all-embracing identity offering to bridge exclusive margins and provide a platform for debating fringe sexuality (Jagose, 1996). From my experience moving in various lesbian communities ‘queer’ has not been so well received by some older lesbians who prefer to remain true to their exclusive lesbian identity. I have never identified as

homosexual; it seems to apply more to men and also carries with it stigma, prejudice, discrimination and fear. Homosexual is derived from the Greek language, homo meaning same, it carries also the pain of the past—the pathology that was associated with homosexuality and mental illness (Stallworthy, 1963).

I settled for 'lesbian'. There is no mistaking the meaning of this name. It means woman to woman, woman with woman. I was prepared to take the risk in asking for women who identify as lesbian to participate in my study, to accept the critique that this naming offered, and to trust that it engaged rather than alienated potential participants.

The participants' lesbian identity has been influenced and shaped by living in the socio-political context of New Zealand. Further, their nursing identity has been shaped by the psychiatric mental health nursing environments where they have also worked in New Zealand. Therefore it is important to introduce these contexts as a backdrop to this study.

### ***Contexts of the participants***

#### ***The New Zealand context***

The New Zealand context of this study is important to consider at two levels. First, the socio-political environment influences the way lesbians are positioned and live in New Zealand and the way society views and behaves towards lesbians. Informing these attitudes and behaviours is the political climate that dictates legislatively how lesbians are treated and underpinning this is the impact of the ever-present holders of moral and religious ideology. Second, the psychiatric mental health nursing environment had an impact on the way the 15 participants become nurses and under what conditions and circumstances they continue to practise today. The socio-political and nursing environments are not mutually exclusive. Both contribute to the overall positioning of lesbians and lesbian psychiatric mental health nurses living in New Zealand today. These environments have helped to shape the experiences of the participants in this study.

The key question to answer in the examination of the New Zealand socio-political context is how the lesbian identity of the participants in this study was constructed by the events happening in New Zealand at the time participants were becoming and became lesbian. How these events link to their everyday work life as psychiatric mental health nurses is important in understanding the questions posed at the start of this research. Experiences described by lesbians in this study are also shaped by factors such as ethnicity, class, religion, economic status, work position, family background, life experiences, relationship status, and political and personal beliefs. While the participants have had different experiences and changing circumstances, the emphasis that each places on the socio-political environment is different according to those experiences and circumstances.

The environments in which participants in this study were developing their lesbian identity were influenced by societal views and values at the time. Politically the early 1970s saw the first wave of feminism hit New Zealand and the early 1980s was dominated by homosexual law reform. In New Zealand, three major legislative changes have helped to shape the lives of non-heterosexual people: the decriminalisation of homosexuality; the prohibition on discrimination based on sexual orientation; and the recognition of civil unions for same-sex couples. I have included a section on these political contexts in Chapter Two where more attention is given to the complexities of these reforms.

New Zealand has a population of 4.1 million people (Bain, Dunford, Miller, O'Brien, & Rawlings-Way, 2006). We are a small, but very diverse, country. On many fronts, such as human rights, we are seen internationally as progressive. Hogan and Hudson (1998) describe New Zealand as a country with “broad rights protection” and as “at least legally, the most gay-and lesbian-friendly country in the English-speaking world” (p. 418). On other fronts, like involvement in the war on Iraq, we are hardly seen at all. Major political events, such as the declaration of New Zealand as nuclear free, have attracted widespread comment and at times criticism, not only internationally but within New Zealand. The development of lesbian and gay identity and rights in New Zealand has been influenced by many factors including overseas opinion and events. Alice (2004) argues however that “a different political culture,

welfare system and the comparatively early establishment of human rights understanding and legislation mean that the direct action politics of America and Britain have not figured to the same degree in queer Aotearoa/New Zealand” (p. 8). While this may be true, it is clear that social reform in New Zealand has gained momentum from hard-working and committed early activists who have pushed the political agenda and gained support by constantly challenging the social climate of the day.

Like the socio-political context, the psychiatric mental health nursing environment had an impact on the way participants became nurses. The conditions and circumstances they encountered here shaped their practice and in the next sub-section I set the scene for this.

### *The mental health nursing context*

The early practice of psychiatric mental health nurses in New Zealand took place in big institutions commonly referred to as lunatic asylums. These institutions were often placed on the fringes of cities and ‘treatment’ of the mentally ill was administered by untrained attendants providing custodial care (Papps & Kilpatrick, 2002; Williams, 1987). Formal psychiatric nursing training began in 1905 and even though these ‘mental deficiency nurses’ were registered after sitting an exam, according to Papps and Kilpatrick they were not registered in the same way that general nurses were. Today, training and education for psychiatric mental health nurses is included in the 3-year undergraduate degree leading to qualification as a registered nurse.

Reservations have been expressed that the undergraduate degree has insufficient mental health nursing focus or content and does not adequately prepare nurses for working in mental health services (Prebble, 2001; Walsh, 2002). Renowned psychiatric nurse Annie Altschul (1997), argued for psychiatric nursing to be separate from other nursing specialities. She argued against the notion of a ‘unified nursing profession’ (p.2) and that people who wanted to be psychiatric nurses should be able to do so right from the beginning of their training. Altschul also believed that psychiatric mental health nurses have much more in common with professions like

social workers, the police, youth workers and counsellors, than they have with general nurses. In New Zealand psychiatric mental health nursing continues to be marginalised in nurse training and education through minimal content in nursing programmes (Prebble, 2001). Attempts to address this lack of preparation for registered nurses working in mental health have resulted in programmes for newly registered nurses whereby they receive structured support and supervision for a year after their initial registration. However, the issue of training and preparation at an undergraduate level remains an issue of concern especially given that the pathway to become a mental health nurse is through comprehensive nursing training (Mental Health Commission, 2007).

Crucial to the practice of mental health nursing is the concept of the therapeutic relationship. No matter where a nurse working in mental health services works, they will be expected to engage therapeutically with their clients as a major focus of their practice.

### ***The therapeutic relationship***

Psychiatric mental health nursing is primarily about working therapeutically with people in mental distress. To work therapeutically with someone requires the nurse to fully understand the workings of what is commonly known as the therapeutic relationship and how to use themselves as the primary tool in this relationship. Many important concepts underpin the therapeutic relationship but one of the most critical is how the nurse uses personal information about themselves to gain rapport with the client. Appropriate self-disclosure often takes the form, for example of the nurse revealing that they have a partner or have children. As a result of this personal disclosure from the nurse, conversations between the client and the nurse are more likely to be based on mutual understanding particularly if the client also has a partner or children. Opportunities for establishing rapport are increased when the nurse and the client have common ground as a basis from which to engage in the therapeutic relationship.

The therapeutic relationship differs in each encounter between the nurse and the client, which adds to the complexity of understanding it. In psychiatric mental health

nursing the concept of the therapeutic relationship is based largely on the original work of Peplau (1952) who described phases of the interpersonal relationship between the nurse and the patient and roles for the nurse during these phases. The framework, as set out by Peplau, articulates the dynamics of the interaction between the nurse and the client and assists the client with problems in communication and relatedness. The overall purpose of the therapeutic relationship is to support the person in mental distress to overcome their distress and empower them to understand the distress and deal with it more resourcefully. In psychiatric mental health nursing the therapeutic relationship is arguably the most important and dynamic interaction between the nurse and the client.

Although Reynolds (2003) states that the influence of the therapeutic relationship has been documented in the literature for many years and that the therapeutic relationship transcends different nursing specialties, (Welch, 1995) claims it has generally been poorly researched and is not well understood. Geanellos (2002b) adds that “in mental health nursing, inadequate nursing practice research has resulted in a deficit of knowledge concerning the nurse–client relationship; an area seen as the heart of practice” (p. 174). Further, Martin and Street (2003) argue that the therapeutic nurse–patient relationship needs further examination in the specialist forensic setting. Given the importance of the therapeutic relationship to practice it is surprising that such a key tool has been the subject of little research. Therefore, it is also not surprising that lesbians and the self-disclosure of their lesbian identity is not featured in literature on the therapeutic relationship.

## **Overview of the thesis**

The heart of this thesis is the stories of 15 nurses and the interplay between their identity as lesbians and their nursing practice. The interrelationships of the way that practice shapes identity and identity shapes practice are revealed. The stories uncover the intricacies inherent in the way these nurses negotiate decisions about self-disclosure of their lesbian identity constantly in their everyday practice.

There are six chapters to this thesis. Each chapter contributes to the understanding of the thesis as a whole and subheadings assist with the organisation of the material. A

glossary (after the contents and before Chapter One) provides my definitions for specific words and specialist terms.

This chapter serves as an introduction to the thesis and provides background, scene setting, and justification for the study. I describe how my thinking has developed in positioning this study with reference to my nursing and academic careers. The importance of being lesbian and undertaking a study with lesbians is an issue I touch on here particularly in drawing out the complexities when heterosexuals do research on lesbians. Lesbian identity and concerns I had about language to use in this study were addressed. The New Zealand context of the study is introduced here. This context is important because the socio-political climate in which participants' lesbian identities were shaped and developed against the backdrop of the homosexual law reform. The New Zealand mental health context has also shaped the nursing identity of the participants. The therapeutic relationship in psychiatric mental health nursing was introduced in this chapter and is developed further in Chapter Two.

Chapter Two is the literature review. Key literature is addressed particularly in relation to lesbian identity and the therapeutic relationship. There is a notable absence of research on psychiatric mental health nursing conducted by a lesbian or with lesbians or about lesbians. For this reason I have given more specific detail about studies and literature where the focus has been on lesbian identity and nursing.

Chapter Three, the chosen methodology, method and design that informs this research are presented and discussed. I outline my interest in narrative inquiry and the key writers in this field who have influenced my approach particularly with respect to being creative with narrative inquiry. Some of the principles that underpin feminist research processes have been important to how this study has been conducted. Therefore, my understandings and adaptation of some of the main concepts of these principles are discussed. The participants' transcripts were loaded into a qualitative software package called NVivo. I explain here how this software assisted with getting to know and develop a feel for the participants' stories, and how the stories were created. Two poems appear here that I wrote while contemplating how to present the stories and the challenges in interpreting them.

Chapter Four, Research Findings: Part One contains the participants' licensed narratives. These are written in the present tense for all scene setting and mid-interview actions, and the past for everything else. The licensed narratives are presented in alphabetical order, according to the participants' chosen pseudonyms.

Chapter Five, Research Findings: Part Two presents my interpretation of the participants' stories. I theorise about the participants' experiences in the context of the research focus, that is, what have their experiences working in psychiatric mental health nursing been and how does their lesbian identity influence their practice. I explain how the narrative themes arose and use excerpts from the participant's transcripts and from their licensed narratives to support my interpretation.

In Chapter Six, Discussion and Conclusion, I focus on what has been revealed by the participants about their identity as lesbian and how this has influenced their practice as psychiatric mental health nurses. After the discussion I provide some reflections on the research and research processes as a way of acknowledging the challenges and limitations undertaking this research. I then outline some of the key findings that have emerged from this study particularly the way that participants negotiate being both authentic and lesbian in the therapeutic relationship. Implications and research possibilities for the practice of psychiatric mental health nursing are then explored. Finally, in the conclusion, I reflect on whether the research questions posed at the start of this study have been adequately addressed.

It is timely now to review what other writers have contributed to the debate and to knowledge about lesbian self-disclosure and the therapeutic relationship. The next chapter explores the literature relevant to this study.



## **Chapter Two**

### **Review of the Literature**

The literature selected to background this thesis has been guided by the research questions which focus on lesbian psychiatric nurses' experiences of working in mental health and how their lesbian identity influences their practice. Literature on lesbian identity and psychiatric mental health nursing practice was a good starting point for this inquiry. As the therapeutic relationship is the cornerstone of psychiatric mental health nursing practice and the primary tool used in the practice of these nurses is themselves I address general questions about what the therapeutic relationship is, who the key writers are and what they say and what the important aspects of the therapeutic relationship are. These questions lay a platform for understanding how nursing practice in mental health is guided by the nurse interacting with the person in mental distress. Most significantly literature about the 'self' is addressed. Relevant to this thesis is the question about how being lesbian influences the therapeutic relationship and therefore the nursing practice of nurses who identify as lesbian. Of further relevance to the therapeutic encounter is the literature about how other lesbian therapists and health professionals (non-nursing) disclose (or not) their sexual identity. Literature on lesbians in nursing with a focus on self-disclosure of their lesbian identity is also addressed. Research on lesbian experiences of health care (particularly in mental health) is also relevant to this study because lesbian psychiatric mental health nurses will have interactions with lesbian mental health clients. What issues this poses for the self-disclosure of the lesbian psychiatric mental health nurse who works with the lesbian client is also of interest to this study.

The literature and research on lesbian identity is wide ranging. Of note in this literature and research is the propensity to combine studies and writings to include gay men as well as lesbians and other non-heterosexual people. It is therefore difficult at times to unpick the 'lesbian-only' components of these studies and make clear assertions about the findings. Because of this difficulty in accessing specific 'lesbian only' literature on sexual identity development, I have of necessity included

research and literature about sexual identity development of lesbians, people who identify as bi-sexual and gay men.

As set out in Chapter One there are two contexts that are important to the thesis. One is the mental health setting where nurses engage in the therapeutic relationship here in New Zealand. This context sets the tone or atmosphere where nursing identity is shaped and impacts on how the nurse behaves and how the nurse engages with the specialty area of psychiatric mental health nursing. I have included, therefore, a section of literature to help the reader to understand the New Zealand mental health setting particularly with reference to the notion of mental health nursing being a 'marginalised' area of nursing where 'being different' is acceptable. The other context relevant to this thesis is the New Zealand socio-political environment. The identity development and self-disclosure of lesbians in New Zealand has been influenced by societal beliefs and social structure. Some background that underpins what these beliefs and structures are gives a deeper understanding to the experiences and stories told by participants in this study and presented in Chapters Four and Five.

## **Search strategy**

I began with electronic data bases of relevant health and related disciplines to identify relevant literature. The data bases that were searched included Cumulative Index of Nursing and Allied Health Review (CINHAL), OCLC first search (Dissertation Abstracts and MEDLINE), ProQuest and PsychInfo.

Much of the literature search was tailored to focus on lesbians, nursing and health. For example key words used to locate literature for this thesis were lesbian identity, lesbian nurse, lesbian disclosure, lesbian mental health nurse, lesbian patient, lesbian health and lesbian service user. The OCLC FirstSearch (MEDLINE) using the key words lesbian and identity gave me a feel for the scope of the literature. I was able to select those articles that I felt could be relevant to my thesis especially those that focussed on nursing. Key words such as therapeutic relationship, nurse-patient interaction and nurse-patient therapist were used to access literature on the therapeutic relationship. For the purposes of this study my focus on the therapeutic

relationship is particularly about what the literature says about the self, sexual identity, and gender.

I also followed up references from bibliographies and reference lists from journal articles and books. Colleagues and students periodically sent me articles or references they thought might be useful which they had come across in the course of their own literature searches. I searched PhD theses and dissertations internationally through the National Library of New Zealand database Te Puna with key words psychiatric nursing, thesis and mental health.

The time frames for the literature search covered the period from about 1982-2002. However, if there was little material forthcoming I did extend the search time frames. Using this strategy was useful. For example, when looking for research and literature on lesbian identity I extended the time frame and came across a thesis by Moses (1978) - one of the early works on lesbian identity. The first edition of the original book by Peplau (1952) was also important to include because she is one of the most influential writers about the nurse-patient interpersonal relationship.

Another source of information for this thesis is newspaper and magazine articles. These sources may not be deemed 'suitable' for a PhD thesis. They have been useful in tracking the socio-political context of being lesbian in New Zealand. I also had a number of mental health nursing texts and articles that I had collected through my teaching about mental health nursing. Research articles that I had collected over the years also helped to provide background for the subject matter and the methodology.

### ***What the literature offered***

Through the literature search I was unable to find any information about how the identity of lesbian psychiatric mental health nurses influences their practice. The practice of self-disclosure of lesbian identity in everyday life is documented as both problematic (Morris, 1997; Whitman, Cormier, & Boyd, 2000) and positive (Jordan & Deluty, 1998; Levine, 1997). I did find literature relating to lesbian identity defining and naming, lesbian nurses identity and lesbian identity development. These are included because they provide the backdrop for consideration about how

becoming and being lesbian influences the practice of the participants and to reinforce the link between their personal and the professional identities and lives. Research on lesbian psychiatric mental health nurses is nearly always a part of a study involving other nurses (Hansen, 1992; Thurston, 1993) and so it is difficult to draw specific conclusions from these studies. Therefore I concluded that due to the lack of literature related to psychiatric mental health nurse's practice there was further justification for why this study needed to be undertaken.

The following sections form the basis for the structure of the literature review: the context and environment (including the New Zealand socio-political context for lesbians and the New Zealand mental health nursing context), lesbian identity development, lesbians in the workplace; and the therapeutic relationship in psychiatric mental health nursing.

## **The context and environment**

### ***New Zealand socio-political context for lesbians***

The socio-political context of the participants' stories informing this thesis is positioned in the 1970s when social and political change was beginning to influence lesbian lifestyle and choices. Glamuzina (1993) gives a thorough account of the activities of lesbians in New Zealand from 1962 to 1985. Of note in Glamuzina's publication is the reference to the beginnings of lesbian visibility in New Zealand and her observation that the "first known attempt to start a lesbian political group was about 1963 when some Wellington lesbians placed an advertisement in a local newspaper inviting any interested women to contact the Radclyffe Hall Memorial Society" (p. 14). She also acknowledges that lesbians were at the forefront "in forming women's centres, rape crisis centres, sexual abuse help centres and provided much of the energy for anti-abortion law protest groups, domestic purposes benefit action groups as well as a broad range of feminist protest action" (p. 15). The early 1970s was also a time when some lesbians began to organise independently from the feminist and gay rights movements because of their recognition and emphasis on the link between power and sexuality. Feminism had provided a platform from which to launch lesbian visibility. A more recent publication (Laurie & Evans, 2005) details

papers from the first Lesbian and Gay History Conference held in Wellington in 2003. The lesbian papers in this collection provide context for the early lives of different lesbians in New Zealand, through stories from those who came out in the late 1960s, as well as critique on current issues like how lesbians should be represented in the New Zealand census.

The decriminalisation of consensual sex between adult men in 1986 was a huge blow to conservative groups who had petitioned parliament against homosexual law reform. Discrimination based on sexual orientation was banned in 1993 as part of the Human Rights Act (Laurie, 2003, 2004). Finally, on 9 December 2004 the Civil Union Bill was passed giving same-sex couples the option of having their relationships legally recognised, although as Courtney (2005) reports, same-sex couples have been slow to take up this option.

The drive for homosexual law reform is described by Laurie (2004) as a “demanding twelve month campaign to counter the nationwide opposition of conservatives, especially religious fundamentalist groups influenced by the ‘moral majority’ New Right movements in the [United States of America]” (p. 13). As one of the chief campaigners and activists for homosexual law reform, Laurie was heavily involved in the activities and strategic planning at that time. The build up to reform had been a long slow process from the time of the enactment of laws making homosexuality illegal (through implementation of the English Laws Act 1858), to changes in penalties for buggery or sodomy (being death), to amendments over a period of years softening penalties and attempting to decriminalise private homosexual acts.

Lesbians were not recognised by the law, so any new potential laws influencing lesbians’ status were treated with suspicion by some lesbians who wanted to remain independent of the law or at least not further disadvantaged by it. According to Laurie (2004), attempts to change lesbian status “to equate female and male homosexual acts and to provide an equal age of consent” (p. 16), through the introduction of the Equality Bill in 1983, were vigorously opposed by lesbians and radical gay men’s groups. Laurie also noted that Fran Wilde, a heterosexual member of parliament, then in opposition, who had agreed to introduce the bill, was

persuaded to drop it. In 1984 a new bill was drafted and once again Fran Wilde, who was a government member of parliament, agreed to support it.

She agreed to introduce the Homosexual Law Reform Bill, to be drafted in two parts, one providing for decriminalisation of all homosexual acts between consenting males in private, with an age of consent of 16 years, and the other proposing to add sexual orientation as a ground for the prohibition of decriminalisation, as an amendment to the Human Rights [Commission] Act 1977.

(p. 16)

Although lesbians were not directly affected by this bill many saw it as an opportunity to support their gay brothers and were in favour of the human rights focus in the amendment. Some also felt it was an opportune time to challenge public attitudes towards homosexuality and hoped it would lead to lesbians and gay men being more accepted in New Zealand.

In the 1970s and 1980s there was little recognition of other non-heterosexual individuals or of groups such as transsexuals who might nowadays come under the queer collective umbrella. The reason for this is that it may have been a matter of keeping things at a level that the general public of New Zealand, led by its politicians, could handle.

The history of the early lives and struggles of lesbians in New Zealand has not been well documented until the 21<sup>st</sup> century. For example, it is only fairly recently that a New Zealand collection of articles about lesbian studies has been published (Laurie, 2001). In commenting on this inaugural collection, Laurie noted the wide-ranging literature that had historically helped to inform and shape the scope of lesbian studies. Lesbian visibility in mainstream literature has typically appeared in publications under the feminist umbrella through edited texts by Du Plessis and Alice (1998) or through feminist magazine publications (Harrex, 1992) and those relating to women in New Zealand (Cox, 1987).

While progress has been made in raising awareness about being lesbian and giving voice to the experiences of lesbians living in New Zealand, there is still much work to be done. Lesbians are in danger of becoming 'normalised' as evidenced by the decreasing number of 'lesbian-only' groups or activities. The recent disbanding of long-standing groups like Wellington Lesbian Line and social organising groups like DOODs (Dykes Out of Debt) are evidence that the need for women to inquire about their sexual identity and for lesbians to meet in groups socially seems to be declining. Older lesbians may be content to merge into mainstream New Zealand or socialise in their own homes, while younger ones mix much more in mainstream groups. Compared to these earlier times lesbian visibility, so confined and clandestine in the 1960s, 1970s, and 1980s has given rise to more openness and acceptance of what it means to be lesbian in New Zealand today.

As with the history and early lives of New Zealand lesbians there is very little early, or subsequent, New Zealand literature about psychiatric mental health nursing or about how the therapeutic relationship developed and is positioned here (O'Brien, 2000) In the next sub-section I provide an overview of psychiatric mental health nursing in New Zealand related to how homosexuality and lesbians appear in early nursing literature.

### ***New Zealand psychiatric mental health nursing context***

The philosophical and cultural positioning of the systems of nursing in the United Kingdom (UK) and more recently in the US has influenced how we approach nursing education and nursing practice in New Zealand. Nursing theorists from overseas have had a profound impact on the curricula of psychiatric mental health nurse training in New Zealand (Altschul, 1973; Peplau, 1952). It was not until the early 1970s that nurses from New Zealand wrote text books about psychiatric mental health nursing and they were published in New Zealand. Before this nurses had relied on medical texts written by doctors to inform their practice (Sainsbury, 1973; Stallworthy, 1963). The medical texts that psychiatric mental health nurses were exposed to were ones such as a New Zealand medical text that was prominent for a time, *Manual of Psychiatry: A practical guide for practitioners and students of psychiatry* (1963). In it, Stallworthy discussed homosexuality largely under the

section on mental mechanisms where the personality strives to come to terms with conflicting impulses. In the same text lesbianism is mentioned as “sexual activity between two females” (p. 77) and while not a crime, there are warnings against homosexuality because “if there is a latent taste for the unusual there can be no doubt that experience will stimulate it” (p. 77). While calling homosexuality a ‘sexual aberration’, it is surprising that most of the discussion in this text centres on the legal status of male homosexuality, rather than the medical treatment of it. Lesbianism is largely ignored.

The first text book on mental health nursing published in New Zealand, *The nurse and the psychiatric patient* (Bazley, Cakman, Kyle, & Thomas, 1973), emphasised the importance of communication and trust to the therapeutic relationship, and stressed that the nurse should be a mature nurse “who is mentally healthy, who knows what to do and why this is the course to take, and why this assists particular patients. Such nurses understand fully their own behaviour and motives” (p. 14). There is no elaboration on what it means to be “mentally healthy”. It is implied what it might mean to be “mentally unhealthy” as the authors describe homosexuality as deviant, urging the nurse looking after these patients to “be on guard for the intellectual rationalising of patients who frequently are persuasive and seductive in their approach. They depict a colourful, accepting way of life that may attract the naive nurse” (p. 142). Being lesbian and a nurse was counterproductive to good, moral nursing practice in 1973 when this book was published.

In many ways the attitudes portrayed at this time in the literature about nursing and homosexual identity are not surprising. Homosexuality was still categorised as a mental illness and the view that it was treatable and thereby curable was the pervading ideology at that time. Nursing practice was largely directed by medical frameworks and nurses were not inclined to undermine this medical dominance.

Psychiatric mental health nursing is a specialty area of nursing where it is typically hard to recruit nurses (Williams, 1987). Stigma and discrimination against the client group who use mental health services are common issues that they face particularly with respect to stigma around disclosing their past to people (Lapsley, Nikora, & Black, 2002). The nurse working in mental health services also experiences stigma



associated with societal perceptions of mental illness and this can lead to staff low morale, high turnover of staff, and recruitment and retention problems (National Mental Health Workforce Development Co-ordinating Committee, 1999). The psychiatric mental health nurse who identifies as lesbian is exposed to stigma and associated discrimination like any nurse working in mental health. However, being lesbian adds another layer of complexity to the way she experiences this stigma and therefore how it influences nursing practice.

For people in mental distress being different (diagnosed with a mental illness as opposed to being mentally healthy) is accepted in the mental health setting whereas in society people with mental illness are discriminated against because of the stigma associated with their condition. Alongside being different people who are in mental distress often live on the margins of society and face daily struggles in trying to live 'normal' lives. Lesbians also live on the margins because they are different to heterosexuals, the predominant sexual identity in society. Marginality in nursing however, has been identified as useful in valuing diversity (Hall, Stevens, & Meleis, 1994). Further, that 'difference' amongst nurses is not visible thereby limiting the authentic practice of nurses (Giddings, 1997). It seems that being 'marginal' is useful in valuing diversity, but creates tensions when not allowing a space for people to feel that they belong. In psychiatric mental health nursing marginality and being different is a reality for lesbian nurses and people in mental distress. My observations and experiences as a nurse and a lesbian have lead me to believe that lesbian psychiatric mental health nurses practice somehow 'differently' from other nurses who are heterosexual. Their practice is informed by and relational to the marginal context in which they live and work.

In the next section I provide an overview of the literature on lesbian identity with respect to how lesbians are defined including lesbian nursing identity. Literature on stage models of lesbian identity development and self-disclosure is reviewed. This is followed by literature about lesbians in the workplace focussing on the nursing workforce, lesbian experiences of health care and attitudes of health professionals towards lesbians. The section concludes with literature on the therapeutic relationship with reference to the 'self', sexual identity and gender.

## **Lesbian identity**

Erai (2004), (Ngapuhi, Ngati Porou) a Maori and lesbian, reflects on her socialisation as a brown-skinned, then heterosexual girl:

Whether individuals feel that they were born gay or lesbian, or that it is a way of being that they become (or choose), there is some moment or period of cognisance, of realisation, when the idea of gay or lesbian stops being 'other' and becomes 'maybe me'.

(p. 139)

The actual 'moment' when a woman realises she is lesbian can be preceded by an array of complex emotions, thoughts and behaviours. No one theory satisfies lesbian identity development; it is clear the development from heterosexual to lesbian identity is a process, not an isolated incident. However, there are surely 'opportune times' within this process that influence the development of lesbian identity. Some of these 'opportune times' are indeed, moments. Even when that 'moment' is acknowledged by the woman she may not necessarily identify as lesbian and almost certainly will not fully comprehend what it means to identify as lesbian.

### ***Defining and naming lesbian identity***

My own experience and observations over the years have led me to believe that what it means to identify as lesbian is complex and ever changing. Bohan (1996) highlights the tensions, and challenges the assumptions about what is meant by 'lesbian identity'. She cautions about the meaning of the terms 'lesbian', 'gay' and 'bisexual', suggesting that they can be nebulous and that experiences of lesbians are not the same as those of gay men or bisexual individuals. This, argues Bohan, means it is highly unlikely that one single model of identity development takes account of all variations of sexual identity. Wilton (1995) also notes that the definition of 'lesbian' is contentious and adds that even among lesbians there is no agreement on what lesbian identity means. Even Abbott and Love (1985) in their pioneering views on lesbianism commented that "one thing is becoming clear—gay women are too varied and too individualistic to be lumped under any one stereotype" (pp. 13–14). Diversity within the different lesbian cultures and communities has enriched

becoming and being lesbian and if anything this diversity has become more complex and more challenging (Alice, 2004; Butler, 2000; Jagose, 1996; Nestle, 2002; Tripp, 2000).

Some of this diversity is reflected in the language used to describe who we are. As previously mentioned the word 'queer' is a term that has resurfaced and been embraced by some lesbians, discarded by others. The connotations of non-heterosexual identity embedded in terms such as lesbian, gay, bisexual, transgender, and transsexual sitting under the 'queer' umbrella has received both acclaim and criticism from different quarters. Tripp (2000) suggests that "queer theory takes what has been stigmatised by a culture as 'perverse' and uses this as a lever to decentre, deconstruct or 'query' notions of 'the natural' and 'the normal'" (p. 15). Queer theory questions everything in its path while breaking down and rebuilding notions of fixed categories. The definition of the term itself is futile, because as Jagose (1996) suggests, "part of its efficacy depends on its resistance to definition" (p. 1). The reclaiming of the word 'queer' is also problematic according to Butler (2000) who argues that the historical connotations of queer have left a legacy of hurt, and to simply reclaim the word may not be enough to combat the harm its use has caused. Alice (2004) notes the derogatory use of queer, but situates it now as a word that recognises the importance of being proud of who we are and also celebrating our differences.

Nestle (2002) rejects the notion of labels and categories and argues that they are difficult to assign because they no longer fit. She does not necessarily agree, however, that labels are necessarily bad things. Gender for Nestle, is much more a human rights issue and therefore is political, not personal, "gender *is* the civil rights movement of our time, because gender rights are human rights. And I look forward to the day when they are universally recognised and respected as such" (p. 17).

Aside from definitional and naming issues, other writers have drawn attention to lesbian identity, or lack of visibility of it, throughout history (Faderman, 1996; Gowing, 1997; Laurie, 2003; Nestle, 1987; Rupp, 1996; Zimmerman, 1997). Reclaiming lesbian history is acknowledged by Nestle (1987), who notes:

History, like so many other things, has been redefined in the past two decades. More and more we are learning to listen to the individual and collective voices of the people who were once seen only as the victims of history, or as the backdrop for the drama of the rich, the powerful, the heads and tails of state.

(p. 9)

The implications of this invisibility and ‘victim’ label on lesbian identity throughout history is captured by Gowing (1997) who acknowledges that “invisibility is also always part of the lesbian and gay experience, and the secrecy and individualism of sexual experiences is as crucial to the lesbian and gay past as publicity, visibility and community” (p. 63). Given the progress that has been made about acceptance of lesbians there is an opportunity for the identity of lesbian psychiatric mental health nurses and lesbian nurses to be more visible about their sexual identity and their practice as lesbian nurses to challenge and change the notion of sexual invisibility.

The most powerful discourse that shaped understandings about homosexuality as a sexual deviation in the Western world was the American Psychiatric Association’s *Diagnostic and Statistical Manual* (DSM). According to Ussher (1991) this classification, first published in 1883, and a creation of the German psychiatrist Kraepelin, “formed the basis for the description of syndromes and diagnostic categories still used by mental health professionals today” (p. 100). Gruskin (1999) also reminds us:

In 1952, homosexuality was still listed in the Diagnostic and Statistical Manual (DSM) as a sociopathic personality disturbance, along with fetishism, pedophilia, and transvestism. Treatments included psychoanalysis, aversive therapies, surgery, drugs, shock treatments, and even the insertion of electrodes into the brains of gay men. Treatments have been documented primarily for gay men. When treating lesbians, the focus was on teaching them to become more feminine as well as changing their sexual orientations.

(pp. 44–45)

Much of the early ‘pre-lesbian liberation’ identity research and writing that emerged from the US described lesbianism as a pathology. Nowadays there is a shift towards lesbian identity as a lifestyle choice rather than an illness needing a cure (Kitzinger, 1987).

### ***Lesbian nurses identity***

To date, little information has surfaced about how sexual identity, especially lesbian identity, influences nursing practice. While Altschul (1997) acknowledges “that people who take to psychiatric nursing are different from those who want to be general nurses”, (p. 1) she does not expand on this in relation to sexuality. Her focus is more on those who are more mature with a range of life experiences and wide interests. However, she is clear they require different qualities from general nurses. I agree with Altschul that people who take up psychiatric mental health nursing are ‘different’ from general nurses, but also acknowledge that nurses who are ‘different’ do exist in other areas of nursing. Psychiatric mental health nurses are different because they identify in some way with people who experience mental distress. They feel a connection with people who are in mental distress and from this connection want to alleviate this distress. Once again I concur with Altschul that the person who becomes a psychiatric mental health nurse is better equipped to alleviate this distress if they are mature and have a range of life experiences. I go one step further and argue that the lesbian psychiatric mental health nurse draws on her experiences from her lesbian journey to engage with the person in mental distress. This journey, while distressful at times, acknowledges the growth and self-acceptance of her lesbian identity. It acknowledges the pain and distress of many lesbians and gay men in the way they been treated because of their non-heterosexual affiliations. It acknowledges a unique and precious life experience.

I believe that being lesbian, and the experiences on the journey to lesbian identity, influence how lesbian nurses practice. As part of their nursing practice lesbian psychiatric mental health nurses are constantly making decisions about whether or not to disclose their lesbian identity. One nurse, who declined to be named, claimed (Anonymous, 1993):

Lesbian nurses are an invisible minority. Employment equity and harassment initiatives miss this group. Co-workers are not generally expected to be sensitive to homophobia, and nursing education does nothing to teach students to be open and understanding to this group of people. Until we have a work environment which is safe for all nurses, we cannot expect to meet the needs of our diverse client population.

(p. 30)

The possible negative ramifications for self-disclosure are likely to be one of the reasons the lesbian nurse chooses not to self-disclose. Being unsupported in the work environment is another one.

Attention to the environment, to the risks and benefits associated with self-disclosure, to the context of mental health nursing and to the person in mental distress requires that the lesbian nurse knows herself. This self-knowing is critical to the therapeutic relationship and to the practice of the psychiatric mental health nurse.

I have always thought that having a high presence of nurses who identify as lesbian in mental health services adds to the general demeanour of the environment and is important to the therapeutic relationship. This is especially so for lesbians who use mental health services. The visibility of lesbian psychiatric mental health nurses also depends on how the nurse assesses her environment and how she feels about the possible ramifications of her self-disclosure. Deevey (1993) suggests that “nurses who are open about being lesbian can provide healthy role models for their colleagues and patients” (p. 26). There are risks to revealing lesbian identity both on the part of the nurse and the lesbian using mental health services. Similar issues are evident in educational settings where Giddings and Smith (2001) in their study of the life histories of five self-identified lesbian women in nursing found that “all participants agreed that lesbian visibility in nursing education is critical to confronting the homophobia within nursing. Closeted teachers only serve to maintain the status quo” (p. 18). Whatever the environment, these risks or issues undermine the willingness and safety of lesbian nurses to self disclosure their lesbian identity.

Moral values underscored by a heterosexual identity were, and still are, expected features of nurses and their practice today. Once again Giddings and Smith (2001) note:

It appears from this study that hidden criteria may be used to define and measure a 'good' or 'real' nurse. One of these criteria appears to be the need for nurses to be seen publicly as heterosexual. Women in the study were expected by their colleagues to be quiet about their lives and lifestyles, and in so doing contribute to the heterosexual image of the 'nice' and caring nurse. The women who were open as lesbian, no matter how morally and ethically they led their lives, threatened this public image. It appears that lesbianism is contrary to the image of nursing as a humanistic and caring profession.

(p. 19)

So, in this small study the presumption of heterosexuality and the moral attributes deemed appropriate go hand in hand with being heterosexual.

Trust is another expectation that the public have of nurses. A survey of 501 New Zealanders reported by Neville (2005) rated nursing as the third most trusted professionals. There was no mention of whether the sexuality of the nurse influenced the level of trust or no break-down examining trust in the various specialty areas of nursing. The assumption here seems to be a presumption of nursing being more general than specialist. Certainly when members of the public were responding to this survey they would be more likely to have a picture of a general nurse, not a psychiatric mental health nurse. In psychiatric mental health nursing practice trust is an important ingredient to the therapeutic relationship between nurse and client. Sexual identity and lesbian identity in the therapeutic relationship in psychiatric mental health nursing have not to date, been part of the extensive discussion or received serious attention. It is important, because working through issues critical to acceptance of a sexual identity outside of the dominant paradigm of heterosexuality, contributes to self-development and therefore self-acceptance. All nurses should examine and consider how their and others' sexual identity impacts on relationships

with people in mental distress. Further literature and discussion about the therapeutic relationship and being lesbian is covered later in this chapter.

## **Lesbian identity development**

Before the mid-1970s much of the psychological research focused on homosexuality as pathological; it was a sickness and people who were homosexual came from disturbed backgrounds (Kitzinger & Coyle, 2002). More recently, Bohan (1996) argues that psychology has recognised the need to take account of how identity as a lesbian or gay man impacts on individual and group wellbeing and psychological functioning. The relevance of these studies for this thesis lies in the need to understand and appreciate the relationship between becoming and being lesbian and working in a health environment that both rejects and accepts being lesbian. Paradoxically this health environment places emphasis on the ability of the nurse to be 'healthy' and relate 'authentically' with people in mental distress.

Of the studies sourced about lesbian identity most stemmed from the discipline of psychology (Cass, 1979, 1984; Chapman & Brannock, 1987; Stephen Cox & Gallois, 1996; Faderman, 1984; Horowitz & Newcomb, 2001; Kahn, 1991; Levine, 1997; Sophie, 1986; Wells & Hansen, 2003), with one each from nursing (Kus, 1985), sociology (Troiden, 1989) and education (Whitman, Cormier, & Boyd, 2000).

### ***Stage theories and models of lesbian identity development***

Some of the early studies about lesbian identity focused on the stages of lesbian development (Levine, 1997; Sophie, 1986). Subsequent research has developed and challenged early assumptions and findings. Stage models about the development of lesbian identity are useful to consider because of the relationship that some of these models describe between how lesbians became aware of their attraction to women and how they subsequently live their lives.

One of the earliest, and subsequently most influential, psychological studies about homosexual identity was conducted by an Australian clinical psychologist (Cass, 1979) who developed a model for homosexual identity formation over a period of



several years by working with homosexuals. “Taking an interactionist perspective, interpersonal congruency theory is based on the assumption that stability and change in human behaviour are dependent on the congruency or incongruency that exists within an individual’s interpersonal environment” (p. 220). The model comprises of six stages. The six stages of development identified by Cass are identity confusion, identity comparison, identity tolerance, identity acceptance, identity pride and identity synthesis.

The model assumes, first that a person acquires their identity developmentally, and second that the person’s behaviour with all its manifestations, is an interactive process between the individual and their environment. Individuals move through all these stages to acquire a fully integrated homosexual identity. The time taken to proceed through the stages varies for each person, and foreclosure, where the person chooses to go no further in the process, is possible at each stage.

Although Cass (1979) said the model can be applied to lesbians and gay men, there is no indication of how many lesbians or gay men she has worked with clinically. So, it could well be that Cass worked with many more gay men in creating her model in which case the relevance for lesbians is problematic. By her own admission, time and changing societal attitudes will influence the model and it will need to be adapted to take account of these things. However, at the time of her original work (1979) the lack of recognition of the different experiences and lifestyles of gay men and lesbians tends to play down these differences, which were, and still are an important feature of contemporary lesbian and gay life. Today lesbians and gay men hold quite different positions in society and this will impact on individual and group identity formation. Just as it is important not to presume everyone is heterosexual it is important not to presume that lesbians and gay men have the same experiences just because of their sexual identity.

Sophie (1986) described another model with more general stages than Cass (1979). However, in Sophie’s model “as soon as more specificity was introduced, the theory was inaccurate in accounting for development in various individuals” (p. 51). While linearity has some validity, it loses traction for those who have moved past the early stages when there are endless possibilities of change and direction. Sophie suggests:

One option was to continue in the direction of lesbian identity; the general stage description served to describe that process. But other options were also possible in which the individual re-incorporated attractions to men which had become unacceptable while developing a lesbian identity. The notion of a fixed identity, then, had to be dropped in favour of recognition of flexibility in sexual identity.

(p. 51)

Levine (1997) found limited support for Cass's (1979) model and suggested that further research needed to explore the relationship between lesbian identity and other aspects of identity such as ethnicity. New Zealand psychotherapist Suzanne Johnson (2004) too argues for other aspects of identity to be considered and claims that, "[w]hile many lesbians and gay men want to be accepted as homosexual beings, many also describe a broader sense of identity of which sexual orientation is only one aspect" (p. 171). An earlier study by Chapman and Brannock (1987) surveyed 197 women (mostly self-identified as lesbian) and found that the process of self-labelling varies among lesbians, but that the recognition of somehow feeling 'different' in a heterosexual world is the first step to lesbian identity awareness. They further argued that "lesbian identity is present before the individual's recognition of incongruence between her feelings and those of non-lesbians, and that the process of self-labelling occurs through the interaction with the non-lesbian world" (p. 69). So, in becoming and being lesbian there is some support for feeling different yet not being able to pin point what this feeling meant with respect to identity. There is also support for consideration of identities that sit alongside the lesbian identity.

Cox and Gallois (1996) concur with stage models as a way of highlighting milestones in the development of homosexual identity but would like to see more emphasis on the influence of social forces on groups and individuals in this development. Horowitz and Newcomb (2001) assert that there is no end point to identity development and support the consideration of the interaction between the individual and the environment as key to the process of identity development. With more research the complexities of lesbian identity development have become more

transparent but there is not one model or study that satisfies the process of lesbian identity development.

The original model proposed by Cass (1979) is not as flexible as subsequent models, and indeed Cass has further developed her original model to take account of cultural differences and sexual identity development as a process rather than a fixed, stagnant category (Cass, 1996). According to Eliason (1996) gender, race and class should also be considered in lesbian identity development. The social context of coming out is considered to be very important particularly in relation to beliefs, stereotyping and attitudes (Markowe, 1996). Gender, ethnicity, race, age, and health status all braid with lesbian identity development. Also impacting on the process of lesbian identity development is how the woman responds to the fact that she is lesbian and the reaction from other people (Wells & Hansen, 2003; Whitman, Cormier, & Boyd, 2000).

Wells and Hansen (2003) surveyed 137 lesbians and found that while participants were comfortable with their lesbian identity they also had high levels of internalised shame. Further, the authors suggest that one explanation for this could be related to stigma and the impact of the effects of stigma on the self-worth of these lesbians. Whitman, Cormier and Boyd (2000) found in their interviews with 25 lesbians that “some women do reach a point in their development where managing a lesbian identity is no longer a process of managing a stigma” (p. 17). The issue of stigma is relevant to this study because of the stigma associated with having a mental illness and the notion of being a nurse working in a ‘fringe’ health discipline. A strong sense of self and a secure identity are necessary to work effectively in mental health and nurses who are lesbian have unique issues to deal with to ensure they have both these attributes.

In summary, stage models about the development of lesbian identity have proved useful in contributing to understanding about how women become and are lesbian. Subsequent to early stage models other researchers and writers have articulated the importance of the need to have a broader focus on what factors play a part in the development of lesbian identity.

### ***Lesbians and self-disclosure***

Markowe (2002) makes a valid point when she argues, “[i]f we lived in a society in which same-sex relationships were as acceptable, as positively valued and as ‘normal’ as opposite-sex relationships, ‘coming out’ as lesbian would not be an issue” (p. 63). She further argues that ‘coming out’ should be seen in the context of the discrimination suffered by lesbians and gay men in a predominantly heterosexual society. During interviews with 40 lesbians on their experiences of coming out Markowe (1996) noted the contrasting experiences in identity development and coming out for lesbians with heterosexual backgrounds. She distinguished those lesbians who had heterosexual backgrounds and relationships while perceiving themselves to be heterosexual; those lesbians who thought of themselves as possibly lesbian, but having heterosexual relationships; and those lesbians who had not experienced heterosexual activity (the ‘always’ lesbian group). Her research findings suggested that all groups showed some evidence of the negative connotations associated with being lesbian, but the lesbians with heterosexual backgrounds showed the most evidence of this perception. Even though two-thirds of the lesbians with heterosexual backgrounds expressed dissatisfaction with heterosexual relationships they either repressed or denied their lesbian feelings.

Much of the literature detailing the complexities and challenges of how lesbians manage the disclosure of their identity also exposes the difficulties that lesbians have with doing this (Hitchcock & Wilson, 1992; Sophie, 1987; Stevens & Hall, 1988).

Some of this literature is in relation to having to deal with their own internalised homophobia (Sophie, 1987) or in particular health settings (Hitchcock & Wilson, 1992; Stevens & Hall, 1988). In a survey of 134 lesbians, Anderson and Mavis (1996) found that “it is not one’s actual outness that is significant in lifestyle satisfaction, but rather one’s confidence in one’s ability to be out that is more important in providing freedom to chose when or if to come out” (p. 50). According to Esterberg (1997) lesbians who participate in research, are more likely to be out, have a tendency to be “white, middle-class, and highly educated” (p. 178). Wilton (1995) makes the point that:

A common theme in lesbian coming-out stories is that of individuals deciding that they couldn't possibly be a lesbian because they were not what the books available said lesbians were; men trapped in women's bodies, sick, psychotic, sinful, obsessed with sex or driven by the urge to smoke cigars and wear trousers.

(p. 62)

Other studies have drawn attention to the fact that self-disclosure correlates with the length of knowing one's self as lesbian and that self-disclosure is a positive development (Jordan & Deluty, 1998). The link between a stable identity and psychological wellbeing has also been documented (Anderson & Mavis, 1996; Kahn, 1991; Levine, 1997; Morris, Waldo, & Rothblum, 2001).

Thompson (1996) notes the losses associated with coming out, believing from her experience as a psychotherapist that it is important to acknowledge these losses. They include loss of the heterosexual lifestyle that most lesbians have been brought up in, the loss of privileges associated with the heterosexual lifestyle (including social acceptance of the heterosexual relationship), and the loss through isolation from the heterosexual community. Counter to these perceived losses she also notes the gains made by some lesbians as a result of coming out. Women who had never married experienced a sense of power and identity. Those who had been married had a slightly different experience, feeling the loss of their sense of self, as 'wife', and sometimes having to fight for custody of their children.

The management of self-disclosure is still problematic for many lesbians. Whitman, Cormier and Boyd (2000) found that the decision to disclose could still occur at later stages of their lesbian development.

It is clear that, at various points along the developmental process for lesbians and at various times in their lives, decisions are made to maintain a split between private and public selves. Knowing that their decisions are normal, understanding what the mediating factors are, and exploring why it is they have chosen to conceal it at this time and in this particular situation, could serve to empower lesbians and

bolster their self-esteem. It is not always in the best interest of a lesbian client for a therapist to 'push' her to come out, on the assumption that she will be more empowered if she does.

(p. 16)

Therefore, despite the fact a lesbian might be completely comfortable with her lesbian identity, self-disclosure can still depend on the environment in which she lives and works. Preserving self-esteem does seem to be a feature of the decision to self-disclose, or not. Morris (1997) too supports the environment as key to determining whether a lesbian self-discloses, and argues that "lesbians are constantly engaging in a risk assessment of their environment. The possible negative and positive outcomes of disclosure are weighed and decisions are made" (p. 12). So, context and environment are important to the decision to self-disclose. Another key aspect to consider in terms of context and environment is the family.

#### *Families and self-disclosure of lesbian identity*

According to Markowe (1996) research about lesbian self-disclosure to family members is sparse "in spite of the obvious importance of this area to 'coming out' for individual gay people" (p. 40). Information about family reactions to lesbian self-disclosure are often embedded in general research about lesbians, resulting in a lack of real depth about issues and experiences for lesbians. Markowe noted that participants were mindful of negative family reactions and used 'passing' as a strategy to deal with this perceived threat. She also found that most participants had at least one family member they had not come out to and they were more likely to come out to their mothers than their fathers. Chapman and Brannock (1987) found that over three-quarters of their participants said that as children homosexuality was not a subject that was discussed in their families. In the same study nearly half of the women said it was still not discussed, although two-thirds of these women said their families knew about their lesbianism.

In an American study, data gained from individual interviews and a focus group of 11 lesbians aged 25 to 47, Gramling, Carr and McCain (2000) concluded that "to disclose self-as-lesbian is to relate authentically. Acceptance is a validation of self

within the context of the interpersonal relationships of family” (p. 667). The study was framed within a theory of women’s development, called self-in-relation, and proposes that important relationships in a woman’s adult life are critical to how a woman shapes her perceptions of herself. Kahn (1991) found that women who were not intimidated by their parents tended to have more feminist tendencies, expected more positive reactions to their disclosure and were more open about their identity.

## **Lesbians in the workplace**

Much of the literature about lesbians in the workplace is based on the experiences of lesbians living in the US and to a lesser extent the UK. Lesbians in the armed services, educational settings, police and human services have been usefully studied, although many of these studies are not exclusively of lesbians, including gay experiences as well (Anderson & Smith, 1993; Cabaj, 1996; Fassinger, 1993; McNaught, 1993; Savin-Williams, 1993). However, this literature does provide a platform from which to examine the homophobia that still pervades many workplace environments.

The impact of negative attitudes towards lesbians and gay men in the workplace is viewed by some as detrimental to work productivity, promotion, and work satisfaction and poses a dilemma for non-heterosexuals about whether to ‘come out’ in their workplace (Anderson & Smith, 1993; Cabaj, 1996; Fassinger, 1993; McNaught, 1993; Savin-Williams, 1993; Zurlinden, 1997).

Of significance to this thesis are other studies and literature on lesbians in nursing (in management, education and clinical roles) with respect to their lesbian identity in the workplace, including the attitudes of their colleagues towards them.

## ***Lesbians in the nursing workplace***

There are two studies sourced on lesbian nurses and how their identity influences their practice but neither has a specific focus on lesbian psychiatric mental health nurses (Hansen, 1992; Thurston, 1993). Because there are so few studies it is

important to provide more detail about what studies have been sourced and what relevance these studies have to this thesis.

Hansen (1992) conducted in-depth interviews with eight registered nurses, two of whom worked in mental health. This ethnographic study sought information affecting nurses' self-disclosure. Six of the nurses had self-disclosed to varying degrees to their work colleagues and both of the nurses working in mental health were 'out'. Hansen found that "working in a female-dominated, human service occupation, in small, non-bureaucratic environments with adults contributed to greater comfort in coming out at work" (p. 91) and that "three quarters of the lesbian nurses mentioned the importance of having lesbian co-workers yet isolation and a lack of contact with other lesbian nurses at work was mentioned repeatedly" (p. 92). Hansen further argued that "guarding" their lesbian identity inhibited their ability to engage in trusting and genuine relationships with their colleagues, thus influencing their ability to be more effective as professionals. These findings, although from a very small group, do reinforce the importance of trust and authenticity (being genuine) in relationships. If lesbian nurses find this barrier with colleagues it is highly likely that these same barriers exist with their patients.

Using a descriptive exploratory design Thurston (1993) interviewed 20 lesbian nurses for her doctoral dissertation to discover and describe the decision-making process of self-disclosure in their workplace. She found, among other things, that self-disclosure to co-workers occurred in two phases, the anticipatory and interactional phases. These two phases were influenced by the relevancy of self-disclosure, the health care context, the personal attributes of the lesbian nurse and homophobia. Furthermore, the decision to self-disclose is a fluid and complex process influenced by several variables. In her study, younger nurses and those with partners were more inclined to self-disclose. Religious affinity seemed to have little bearing on the decision to disclose, although many of the respondents had changed their religious affinity to one more accepting of homosexuality. In the anticipatory phase respondents spent time assessing the attitudes and behaviours of co-workers before deciding whether to disclose and chose co-workers who were more likely to approve. Job loss or similar consequences as a result of disclosing were not reported



in this study, but loss of professional friendships was reported. The flip side of this was an improvement and opening up of collegial relationships, but above all:

the most important consequence from self-disclosure that lesbian nurse related was how they felt about themselves. Self-disclosing for many was an act of 'freeing' themselves and resulted in them having a more positive view of themselves. They no longer felt as though they were 'lying,' which was emotionally draining on these women.

(p. 162)

Of further note in Thurston's (1993) research was the relevance of the health care environment to disclosure. Nurses working in a psychiatric setting were among those who were less likely to disclose to co-workers. Thurston speculates that this "may be in assuming this role as listener and confidant that little self-disclosure about themselves carries over into their relationships with peers and co-workers" (p. 165). She adds that another reason for this could be that mental health workers are homophobic and cites research from a 1982 study to support this assertion. The implications of the findings for this research may suggest that different perceptions of 'appropriate self-disclosure' or even self-disclosure are dependent on context and environment. But once again because of the small group it is difficult to generalise. What is clear is that more research specifically on lesbian nurses working in mental health is needed where relationships with clients are critical to nursing practice.

Self-disclosure of lesbian identity is a constant concern of many lesbian nurses as they negotiate the implications of whether to tell their colleagues and the people they nurse that they are lesbian. Deevey (1993), a lesbian nurse telling her personal story, found that "my experience of self-disclosing to other nurses has been much more positive than I had anticipated" (p. 21). The fact she was working on a psychiatric unit where nurses are much more used to 'difference' may have contributed to this ease of self-disclosure. Studies focused on lesbian nurses revealed that homophobia affects their emotional health (Glass, 2002) and discrimination and closeting of lesbian identity perpetuates the invisibility of nurses (Giddings & Smith, 2001; Thurston, 1993).

### *Lesbian experiences of health care*

There is a growing interest, and therefore more information, about lesbian experiences of health care as consumers of health services (Hughes, Hass, & Avery, 1997). Because this thesis is about lesbian nurses who work in mental health I felt it necessary to include literature about lesbian mental health consumers. Of necessity lesbian nurses will come across lesbian mental health consumers and I wondered how much literature or research has been done about this. The therapeutic encounters that lesbian nurses have with lesbian mental health consumers might change or be different compared to encounters with heterosexual mental health consumers. Further, lesbian mental health consumers may have different expectations of lesbian nurses in these encounters. They may also have experiences that are different because of their decision to self-disclose, or not.

Research and writings since the 1990s on lesbians and their experiences of contact with mental health services have tended to move away from barriers to health care to focus more on specific mental health issues for lesbians such as alcohol use, depression and abuse (Bradford, Ryan, & Rothblum, 1994; Hughes, Hass, & Avery, 1997; Rothblum, 1990), depression (Williams-Barnard, Mendoza, & Shippee-Rice, 2001), and normal and social health practices of lesbians (Sorensen & Roberts, 1997). Not surprisingly I was unable to source literature on how the lesbian psychiatric mental health nurse and the lesbian mental health consumer engage therapeutically and what issues arise during this relationship. However, more general information about lesbians and health services is available. Stevens and Hall (1988) and Hitchcock & Wilson (1992) found in their interviews with lesbians that they were uncomfortable seeking health care and felt at risk of harm if they self-disclosed. These authors further suggest that this may partly explain why lesbians are reluctant to seek health care.

Willingness to discuss freely and openly their sexual preference remains an issue for a significant number of lesbians. In a New Zealand survey of 229 lesbians nearly one-third of them hid their sexuality from health services (Rankine, 1997). Albarran and Salmon (2000) analysed critical care literature about lesbian, gay and bisexual service users' experiences from 1988 to 1998 and found that "these groups are

invisible in this field of practice and consequently their particular concerns have remained marginalised” (p. 445). According to Williams-Barnard, Mendoza and Shippee-Rice (2001) self-disclosure remains an issue; navigating lesbian identity was perceived to be problematic when presumptions of heterosexuality prevailed and health assessments were structured around this presumption. In another New Zealand study Clear and Carryer (2001) argued that their participants felt that in interactions with health professionals for minor issues they were less likely to disclose their lesbian identity.

As a result of more information becoming available that identifies specific issues and concerns for lesbians seeking health services there is an increasing number of publications seeking to advise on the best ways to work with lesbians and other non-heterosexuals (Ball, 1994; Campos & Goldfield, 2001; Crisp, 2002; Falco, 1995, 1996; Gruskin, 1999; Hardin & Hall, 2001; Hart & Heimberg, 2001; Johnson, 2004; Malley & McCann, 2002; Milton, Coyle, & Legg, 2002; Saari, 2001; J. C. White & Levinson, 1995). One theme throughout many of these publications is the recognition of the impact that occurred when the American Psychiatric Association removed homosexuality from its list of disorders, thus encouraging and enabling a better understanding of homosexuality and a move away from diagnosis and treatment. Issues commonly encountered by non-heterosexual people include: having to deal with the burden of stigma placed on them because they are non-heterosexual; the impact of internalised homophobia when seeking health services; and whether to disclose their sexual identity.

### *Attitudes of health professionals towards lesbians*

In a review of the literature (1970–1990) on research into lesbian health, Stevens (1993) found that health care providers’ attitudes towards lesbians often negatively influenced the assessment and care they subsequently provided. Further, nursing educators were ill-informed about lesbians, and many nursing students had prejudicial attitudes towards lesbians. Stevens also noted that the research revealed: lesbians delayed seeking health care because they feared the consequences of disclosure; many lesbians felt their health care would be of a better quality if they were able to disclose their lesbian identity; and there was a presumption of

heterosexuality on the part of the health care provider. Brogan (1997) in her literature review about attitudes and experiences of lesbians in health care identified damaging stereotypes of lesbians, disclosure of lesbian identity and delays in seeking health care as issues needing attention by health care providers if health care to lesbians were to improve.

Health professionals working with lesbians have a professional responsibility to provide the best care possible to these women. This care and attention can be hampered by the stereotypic attitudes of these professionals. In one of the few studies assessing attitudes of psychiatric nurses towards lesbians and gay men, Smith (1993) found that “nurses may have cognitive acceptance of gays and lesbians and homosexuality yet continue to have negative feelings towards gays and lesbians” (p. 382). He makes the point that life experience is an important part of nurses developing both positive and negative attitudes towards these groups. White (1979) argued that attention to the homophobia of nurses should be given more recognition and attention. More recent research findings suggest attitudes towards non-heterosexual people by registered nurses may have improved (Rondahl, Innala, & Carlsson, 2004) and that health services for lesbian and gay clients have also improved particularly with respect to gay and lesbian satisfaction with their therapist (Liddle, 1999).

Other studies about the attitudes of health care providers have revealed that homophobia in female nursing students is common and a familiarity with lesbian lifestyles is a significant predictor of nurses’ acceptance (Eliason & Randall, 1991).

Kus (1985) claims it is critical for nurses to understand the coming out process and “without understanding this process, nurses and other helping professionals cannot provide adequate care to the gay or lesbian client” (p. 192). Taylor (1999) concurs with Kus and argues that, “[k]nowledge of coming out as a transitional process can help health care providers respond appropriately to gay men or lesbian women who are experiencing feelings of isolation, guilt, anxiety and depression” (p. 523). Polansky, Karasic, Speier, Hastik and Haller (1997) also support the idea that psychiatrists should be familiar with the coming out process for non-heterosexual people and need to be educated about attitudes.

The final section of this literature review provides an overview of concepts of the therapeutic relationship as it relates to psychiatric mental health nursing. The main concepts addressed in this relationship are the 'self', sexual identity, gender and the lesbian 'self'.

## **The therapeutic relationship in psychiatric mental health nursing**

Nurses are not the only health care professionals mindful of the importance of the therapeutic relationship when working with people in mental distress. Psychologists, psychiatrists, counsellors, therapists and social workers also value this relationship and have similar ideals to nurses about how to work therapeutically with clients. Horvath (2002) in a review of the historical and conceptual dimensions of the therapeutic alliance between therapist and client found support for the notion that a good therapeutic relationship correlates with positive outcomes. The client's perceptions of the therapist's qualities were found to be the most significant measure of the therapy outcome, not the therapist's actual behaviour. Further, "the major message seems to be that the development of a good alliance with clients includes not only a positive, emphatic disposition by the therapist, but also a collaborative framework, a partnership in which clients see themselves as active, respected participants" (p. 171). This finding supports the values and understandings that are promoted in the work of the psychiatric mental health nurse. While other health professionals' value this alliance few of them spend as much time with their clients on a day-to-day basis or rely on ongoing daily communication and interaction to the same degree as psychiatric mental health nurses. The opportunities and potential for engaging in therapeutic relationships, therefore, is much more likely for psychiatric mental health nurses. Not only is it likely; it is expected.

As mentioned in Chapter One the therapeutic relationship is widely regarded as the cornerstone of psychiatric mental health nursing. While it is acknowledged that Peplau (1952) made a huge contribution to the idea of the interpersonal relationship in nursing, other nurse theorists discussed and placed a lot of emphasis on the importance of this relationship to nursing, not just mental health nursing (Orlando,

1961; Travelbee, 1971). In one interview Fontaine & Fletcher (1994) Grayce Sills, a prominent psychiatric mental health nurse, captured part of the essence of good interpersonal relationships when she said, “[o]verall, I’ve found good communication skills and comfort with variety and diversity to be the most important skills in mental health nursing” (p. 4).

Unlike other subspecialties of nursing the main tool in the therapeutic relationship is the nurse. The work of Peplau (1952), *Interpersonal relations in nursing: Offering a conceptual frame of reference for psychodynamic nursing*, is the most well known text that set the benchmark for the development and understanding of the therapeutic relationship in psychiatric mental health nursing. Even at the early stages of her thinking and writing, Peplau recognised the importance of the nurse’s personality in the interpersonal relationship with the client.

### *The self in the therapeutic relationship*

A central premise of the early work of Peplau (1952) was “to recognise the importance of the nurse’s personality in interpersonal relations in nursing situations” (p. xiii). In the contacts the nurse has with people in life, no matter what the situation the nurse should strive for common understandings and goals, while at the same time recognising the possibility of clashes in these encounters. Peplau recognised that, “[b]eing able to understand one’s own behaviour, to help others to identify felt difficulties, and to apply principles of human relations to the problems that arise at all levels of experience are functions of psychodynamic nursing” (p. xiii). The theme of the significance of the nurse ‘knowing self’ has continued throughout text books on psychiatric mental health nursing (Fontaine, 1995; Kneisl & Wilson, 1996; Moore & Hartman, 1988; Stuart & Sundeen, 1987).

Similar characteristics and attributes relevant to the nurse ‘knowing self’ are discussed in these texts with varying degrees of emphasis. Fontaine (1995) stresses the importance of self-evaluation of clinical practice to improve your own understanding of yourself. She describes the characteristics of ‘effective helpers’ as having a non-judgmental approach, an acceptance of clients, warmth, empathy, authenticity, congruency, patience, respect, trustworthiness, self-disclosure and

humour. Stuart and Sundeen (1987) focus on self-awareness using the concept of the Johari Window to augment the process of self-awareness. They believe “[a] firm understanding and acceptance of self will allow the nurse to acknowledge a patient’s differences and uniqueness” (p. 98). They acknowledge the effort expended in the process of self-awareness and also the pain it can cause. According to Moore and Hartman (1988) areas that the nurse should explore in their self-development are self-concept, beliefs and values, and life experiences. Further to this are the avenues available to the nurse to gain self-awareness such as involvement in interpersonal relationships (here, the family is the most enduring lesson in self-awareness), reading (formal study and fiction), and writing (a diary or journal). Kneisl and Wilson (1996) say that learning to know yourself is just the beginning of their journey as psychiatric mental health nurses, and to be effective at their job psychiatric nurses need to “[c]onfront their own identity; separate it from another’s identity, which may indeed be dissolving; and finally integrate different values and behaviours comfortably in the therapeutic relationships they develop with clients” (p. 3). There is wide agreement in the literature and among psychiatric mental health nurses that a high level of self-knowing is critical to the development of the skills needed to engage therapeutically with clients.

Further emphasis on the importance of self-knowing on the part of the nurse and/or the therapist in the therapeutic relationship has been established and developed by different writers, theorists and health workers. Caring, as described by Carper (1978) and Watson (1988) recognised the different components that contribute towards the therapeutic relationship: personal, moral, artful and scientific. In psychiatric mental health nursing there is more emphasis on the personal aspects of these components; whereas in other nursing specialties, like intensive care nursing, the scientific component is prioritised. That is not to say nurses in intensive care are not aware of the personal component; they simply need to address the scientific first.

According to Bird (2000) understanding and engaging in the therapeutic relationship requires “a willingness to be transparent to ourselves” (p. 109). Pauly and James (2005) suggest that self-knowing is essential to relations with clients, but it is also important to be open to others’ different values and beliefs. Randle (2002) discusses

the implications of a positive healthy sense of self on the part of the nurse and argues that this leads to sound interpersonal relationships overall. She expands on the characteristics of a healthy sense of self as “use of the authentic-self, empathy, the delivery of individualised, holistic care and continuing in the face of adversity” (p. 88).

McKenzie (2002), a mental health nurse, agrees that self-awareness in the therapeutic encounter is key to the success of the therapeutic encounter. In a narrative study about the loss of his father, he describes the importance of understanding the link between self-awareness and personal and professional experiences. McKenzie concludes that in the process of revealing yourself “you do come to understand yourself in deeper ways and with understanding of self comes understanding of others” (p. 31). The use of narrative in combining the personal and professional experience and knowing self is similar to the way the stories told by the lesbian nurses in this study express their lesbian and nursing identities.

### *Sexual identity and gender in the therapeutic relationship*

Being a lesbian nurse and how this influences the therapeutic relationship in psychiatric mental health nursing is yet to be fully explored. While Altschul (1972) acknowledged that the interaction between nurses and patients of the opposite sex may cause sexual stimulation, her focus was more directed to teaching nurses how to cope with these feelings. Horsfall, Stuhlmiller and Champ (2000) make reference to sexuality as “an aspect of daily interactions” (p. 33), in nursing but little if any reference is made to follow up this observation. Little progress has been made about what the issues might be for homosexuals because the focus seems to be on what nurses’ views are of sexuality (Cort, Attenborough, & Watson, 2001) and what nurses think are the causes of homosexuality. Even a recent psychiatric mental health nursing text, *Psychiatric and Mental Health Nursing: The Craft of Caring* (2003), had little discussion about gender or gay and lesbian sexuality. One of the chapters in this textbook was dedicated to sexuality and gender. However, within this chapter one paragraph referred to lesbian, gay and bisexual users of mental health services and the focus was on the training of nurses to meet the needs of these groups (Grant, 2003).



Even gender as a contributing factor in the therapeutic relationship in psychiatric mental health nursing is seldom discussed in the literature. Because lesbians are women it is useful to understand how gender is positioned in the literature.

Gallop (1997) recognises the part that gender plays in the development of empathy in therapeutic process, but once again the premise for this is underpinned from an assumption that heterosexuality is the dominant discourse. The nurturing role has not shifted markedly from the early writings of Peplau (1952) and Gallop argues:

Women are well positioned, because of their developmental histories, to use their relational skills to enhance their understanding of the clients' experience. As women, psychiatric mental health nurses may be more attuned to the qualities of connectiveness or empathy that are hallmarks of female development.

(pp. 34–35)

Empathy, however, is not the exclusive domain of women, and Gallop adds that “the capacity for empathy can be developed and enhanced in anyone but it cannot be taught in a traditional pedagogical manner. Empathy must be experienced, identified and reflected upon” (p. 35). How does being lesbian inform the notion of empathy as described by Gallop? Do the lesbian psychiatric mental health nurses in this study, have the same or similar empathetic qualities as female psychiatric mental health nurses who identify as heterosexual? The answers to these questions are not within the scope of this study. However, empathy gained from life experience helps nurses to engage with a wide range of clients. Lesbian nurses, because of their journey to being lesbian, are often able to identify and recognise the struggle that many clients have (and thus show empathy) with living in a society that is not always kind to them.

Bird (2000) too argues that the role of the client's and the therapist's gender in the therapeutic relationship is something not often considered by therapists when working with clients. She argues that “gender relations [are] present and influential in every conversation, including every therapeutic conversation” (p. 256). Lack of attention to this, she suggests, leads to domination, exclusion, silencing and

misunderstanding in the therapeutic encounter. For the therapist, acknowledging gender requires reflection and scrutiny through ongoing collegial support and review.

While gender has received little attention in the literature, lesbian identity has received even less. Much of the discussion to date about lesbian identity in the therapeutic relationship has centred on therapists working in private practice or in other disciplines like social work. When the therapist acknowledges her sexual self as lesbian, the therapeutic encounter invites, and has potential for a unique exchange of experiences between the client and the therapist (Hanson & Weeks, 1998; Pearlman, 1996; Sophie, 1987).

### *The lesbian self in the therapeutic relationship*

Sophie (1987) recognises the challenge of how and whether the therapist's sexual orientation should be disclosed. She acknowledges that because society has such a strong presumption of heterosexuality, when the client is heterosexual the therapist's sexual orientation does not seem to be an issue. However, Sophie argues that the lesbian client "is less likely to make this assumption automatically. She may instead be very sensitive to the information revealed by the therapist concerning her or his own sexual orientation" (p. 55). According to Sophie, a therapist's subtle references about a spouse or children may be interpreted by the client as discomfort with the client's lesbian identity or reinforcement of the therapist's heterosexuality. Conversely, an "unwanted revelation of the therapist's lesbian identity may be viewed by the client as a seductive move. In either case, of course, the client may be perfectly right" (p. 55). Further issues are identified by Sophie about the therapist's self-disclosure and how the therapist's refusal to do this can lead to distrust on the part of the client, especially if the client has made a direct request for this information. In considering how to respond to a direct request such as this Sophie argues that:

The client has a right to know, if she so wishes, whether the therapist has experienced the process of coming to terms with a non-heterosexual identity. Crucial questions for the therapist to consider

are whether the client wants this information, and if so, what it would mean to her.

(p. 56)

The client's motivation should, argues Sophie (1987), determine how the therapist responds, but each case should be considered on its own merit. Pearlman (1996), a lesbian psychotherapist, acknowledges that issues like how she manages her disclosure to lesbian and non-lesbian clients are constantly in the back of her mind. Issues include how to broach boundary concerns, the timing and approach of disclosure, social interaction between client and therapist, and transference.

Two lesbian practitioners in private practice, Hanson and Weeks (1998), acknowledge similar issues to those already mentioned, but expand on the management of boundary expectations between the lesbian therapist and the lesbian client. They recognise the common bonds between lesbian client and therapist (for example, shared values, experiences and politics) as possible strengths in building the relationship. They also discuss potential problems with this commonality. Transference and counter-transference, they suggest, may make the therapist uncomfortable and the therapist may feel compelled to set limits and negotiate boundaries much earlier than with a non-lesbian client. If this happens the lesbian client might feel betrayed, thus weakening the therapeutic alliance. They conclude that "[o]ur experience over the past two decades has convinced us of the need for congruence between the openly lesbian therapist's intentions and the actual dynamics that are present in her work with lesbian clients" (p. 54).

The issues and experiences of these lesbian therapists are helpful in discussing how lesbian nurses working in mental health services practise. However, context and environment are crucial to understanding like self-disclosure in the therapeutic relationship and nurses have many factors that influence the way they make decisions about issues like self-disclosure.

## Summary

In this chapter I have reviewed the literature setting the context and environment for this thesis and reviewed literature about lesbian identity development, self-disclosure and the therapeutic relationship.

Notwithstanding the ‘mix’ of research there are some lesbian-only studies that highlight that context and environment should be part of the discourse on lesbian identity development. Self-disclosure of their lesbian identity, whether as a consumer of health services or professional working in the health services, is more often than not carefully negotiated. The ramifications of this disclosure can be liberating, but this is often tempered by a fear of potential negative repercussions. The presumption of heterosexuality pervades the health service despite an increased awareness in understandings about lesbianism as a lifestyle choice rather than pathology.

The therapeutic relationship is central to psychiatric mental health nursing practice. Nurses who have a high level of self-acceptance and self-knowledge are well placed to work effectively with people in mental distress. Much of the literature and research about lesbian identity in the therapeutic alliance while useful, has taken place outside psychiatric mental health nursing where conditions for these encounters are unique to the mental health setting. The identity of the lesbian psychiatric mental health nurse and issues of self-disclosure in her practice have thus far been given little attention in the literature. It is therefore necessary to undertake such research to uncover the unique contribution that lesbian psychiatric mental health nurses make to mental health nursing.

The previous two chapters have set the scene for this study. The next chapter further positions this study and explains how narrative inquiry and feminist research processes have informed and guided the way the study has been conducted.

## **Chapter Three**

### **Methodology Method and Design**

In this chapter I discuss why narrative inquiry is the methodology best suited to answering the research questions in this study. Further, I outline why and how using feminist research processes for this research have underpinned the design and contributed to the integrity of this study. By this I mean that I have adopted the guidelines suggested by different feminist scholars that relate to data collection, researcher declaration and negotiation of making meaning (co-creating the narrative) with participants. These concepts are explored further in this chapter.

The method and research design sections in this chapter outline the ethical considerations in the process of undertaking this study. It also describes how the qualitative research software package, NVivo has been used to work with the interview data and craft the participants' stories into licensed narratives. I use Diana, one of the research participants, as an example of how the original interview transcript progressed through to become a 'licensed narrative'. It is important that the reader understands how the transcripts became licensed narratives through the use of NVivo because a feature of this thesis is the notion of licensed narratives. Individual and collective data analysis is presented in the findings chapters later in this thesis. Chapter Four presents the licensed narratives (individual) and Chapter Five lays out the narrative themes which arise from the licensed narratives (collective).

#### **Why use narrative inquiry**

Discussion amongst writers and researchers about narratives or storytelling (used here interchangeably) is widespread. From its adaptation as a form of therapy (Barker, 2003; Bird, 2000) to its wide-ranging use as a qualitative research methodology (Berger, 1997; Clandinin & Connelly, 1998; Clandinin & Connelly, 2000; Cortazzi, 1993; Currie, 1998; Ellis & Bochner, 1992; Polkinghorne, 1988, 1995; Riessman, 1993; Ronai, 1992) the literature about narrative has found favour among researchers.

Narrative inquiry appealed to me as the appropriate methodology for this study for six reasons. First, my level of personal involvement as the researcher is similar to what underpins feminist research processes as outlined by feminist writers like Chinn (2003) and by those who write about narrative inquiry. In responding to the question about what narrative inquirers do, Clandinin and Connelly (2000) say that a good place to start is with ourselves and how our personal lives influence the research. The way I wanted to conduct the study using my personal experience as a lesbian and psychiatric mental health nurse, and with the engagement of participants, in particular with feedback and comment on their transcripts, are congruent with feminist research approaches. Reinharz (1992) explains:

Personal experience typically is irrelevant in mainstream research, or is thought to contaminate a project's objectivity. In feminist research, by contrast, it is relevant and repairs the project's pseudo-objectivity. Whereas feminist researchers frequently present their research in their own voice, researchers publishing in mainstream journals typically are forbidden to use the first person singular voice.

(p. 258)

In undertaking this research the inclusion of my personal story and experiences have been carefully considered. That is, care has been taken to ensure that the participants remained the focus of the research and not the researcher. Therefore, my story is positioned to demonstrate my authenticity as a lesbian, a psychiatric mental health nurse and my credibility as a researcher.

Second, narrative allows participants the opportunity to share their experiences by telling their own stories, and as Clandinin and Connelly (2000) suggest, experience is central to narrative. It was also important to give voice to and to hear from lesbians, because as a minority group their voices are often not heard or acknowledged. In her positioning of gender as central to feminist research, Lather (1991) argues that "the overt ideological goal of feminist research in the human sciences is to correct both the *invisibility* and *distortion* of female experience in ways relevant to ending women's unequal social position" (p. 71). Nurse scholars of narrative and feminism, Chinn and Watson (1994), say "narratives are the result of explorations of the

personal; and in our language, personal consists of gender” (p. 80). Also Holloway and Wheeler (1996) assert that “the use of narrative is valuable in understanding feminist ontology which is about the theory of being” (p. 140).

Third, by the participants sharing their experiences through narrative, as well as encouraging them to think about and reflect on the meaning of those stories, the knowledge and understanding about how lesbian psychiatric mental health nurses practise will be further developed. Understanding how the personal and professional lives of nurses interplay in psychiatric mental health nursing is critical to working therapeutically. Lesbians working in mental health have different politics from heterosexual nurses to negotiate when deciding how their lesbian identity will be revealed. Interviewing, as the method adopted to collect these stories, is consistent with data collection based on feminist research processes because it allows participants to tell their stories in their own voices and negotiate involvement in data analysis (Reinharz, 1992). Although popular with feminist researchers, unstructured interviewing as utilised in this study, is a method of data collection that has been part of the social science research tool kit since well before feminism became fashionable (Maynard, 1994).

Fourth, nurses historically have used storytelling as a means of conveying, critiquing and exploring their practice (Bailey & Tilley, 2002; Barton, 2004; Frid, Ohlen, & Bergbom, 2000; Gramling, 2004; Leight, 2002; McAllister, 2001; Tilley, Pollock, Ross, & Tait, 1999; Wood & Giddings, 2003). In addition, Wood and Giddings suggest that “an understanding of a person’s health needs, for example, is often gained through the stories they tell. Telling stories is also part of practice” (p. 4). Hearing and telling stories is familiar territory to most nurses, so I expected that asking them to convey stories in an interview for this thesis would appeal.

Fifth, I believed that using narrative inquiry would uncover the complexities embedded in the experiences the nurses in this study have had in their personal and professional lives concerning being lesbian. Telling individual stories and sharing experiences would create the opportunity to reveal the uniqueness of these nurses practice in ways that would contribute towards the national and international literature on lesbian identity in nursing, in particular, in psychiatric mental health

nursing. A further contribution would be the addition of knowledge on lesbian identity with lesbians working in any human service industry, especially with respect to self-disclosure. Lesbians have used narrative to convey the meanings and experiences associated with: lesbian identity (Esterberg, 1997; Maher & Pusch, 1995; Moonwomon, 1995; National Lesbian and Gay Survey, 1992; Stein, 1997); lesbians in long-term relationships (Johnson, 1990; Weinstock & Rothblum, 2004); lesbian adolescence, (Russell, Boham, & Lilly, 2000); growing up lesbian, (Vanita, 2000); older lesbians (Claassen, 2005) oral histories (Kennedy & Davis, 1993; Laurie, 2003) and health care for lesbians (Stevens & Hall, 1988). It is clear that narrative inquiry suits research where information and knowledge is sought about lesbians. However, as mentioned earlier, it is not always easy to identify literature and research using narrative inquiry where the research is by lesbians and about only lesbians.

Finally, narrative inquiry seemed to suit my personality and life experiences. The idea for the way the stories in this thesis are presented emerged from my reflections on my early teenage life to adult experiences as an educator. As a college student I enjoyed reading novels and plays and loved participating in the school drama productions. Later, as an educator I began to realise that teaching is enhanced by the teacher's 'performance' to engage the interest of and entertain the student. In undertaking this thesis it seemed important to engage the reader by creating something with a dash of drama, yet create a fascinating, interesting and compelling read. Reading lesbian fiction has also influenced my desire to bring the research participants alive as characters and create readable stories. Developing these stories as narratives, having received a verbal licence from the participants, has led me to view these stories as 'licensed narratives'. Participants gave me the freedom to co-create their stories. The interview environment, the relationship between the participants and me, and the analysis using NVivo of the interview transcripts all combined to bring the participants' experiences and their personalities to life.

I want now to revisit the positioning of this study with respect to my being a lesbian and being the researcher. In Chapter One I expressed concerns about heterosexuals doing research on lesbians particularly when positioning language and interpreting



data. I would now like to explore how my identity has raised issues about privileged access and declaration of identity.

## **Methodology**

### ***Being lesbian and a researcher***

Positioning this research as a lesbian has prompted me to consider the impact my lesbian identity has on the study. I consider ‘researcher disclosure’ as an important concept to describe and articulate when lesbians are being researched by lesbians or heterosexuals. Narrative inquiry provides a broad framework for understanding experience through stories. It offers a forum for participants from minority cultures to be heard when their voices are seldom heard and even more importantly not understood. The intricacies in understanding participant’s experiences are fraught with competing and complex issues both for the researcher and the participant. For example, there is potential for misunderstanding on the part of the researcher when responding to questions from participants and also to misreading cues during the interviews. When the research is being conducted with lesbians and the researcher does not identify as lesbian the likelihood of misunderstandings and subsequent misinterpretation can raise doubts about the credibility of that research. Similarly when the researcher states that they are heterosexual the same issue can occur, particularly if the heterosexual researcher has not sought the input of lesbians to contribute to the research process.

In reading a variety of different studies about lesbians and gay men I noticed that researchers leading these studies do not always declare their own sexuality when reporting on their research. If the study is printed in the *Journal of Homosexuality* can we assume that the researcher is non-heterosexual? Is it a taken-for-granted assumption similar to the assumption of heterosexuality that we constantly encounter in our day-to-day lives? James and Platzer (1999), in reviewing three aspects of doing research with vulnerable groups (susceptibility to harm, the politics of representation, and the use of self), argue that “it is a sensitive topic, which requires that careful thought be given to the planning, process and likely impact of the research. Voyeurism, misrepresentation and negative stereotyping already affect

individuals from lesbian and gay cultures” (p. 75). In her study of lesbian identity Ponse (1978), acknowledging her non-lesbian identity, found that lesbians in the communities in which she conducted her study were really interested in why a non lesbian was doing research on them:

I was again discomfited by the focus on my identity on whether I was gay or not. I couldn't see why that mattered. After all, I was a researcher—immersed in the ethics of social science, discreet, sympathetic, non-judgmental. What difference did it make what went on in my personal life? Why was everyone so interested in whether I was gay or not? I was miffed, too. I had read about entry; I had followed the rules as diligently as possible; I had been honest; and now everyone was asking *me* questions.

(p. 15)

The potential for misunderstanding the nuances in lesbian identity are increased in this example because the researcher does not understand the interplay between the personal and political. Being lesbian is a political act because it confronts and challenges the so called ‘norm’ of society, which is being heterosexual. Following the rules of research does not guarantee that the participants in the research will be represented accurately or honestly. Being able to convey why a non lesbian undertakes research with lesbians should not be seen as an affront but as a healthy challenge to personal politics.

It is important that I am open about being lesbian and it is important to this study that I am lesbian. Being open acknowledges the privileged access that I have as a lesbian researcher and recognises the importance of building relationships as key to the success of the research. Pitman (2002) notes that:

The identities we claim, the aspects of our identities we choose to highlight or downplay, all have the potential to shift the relationship of power in the research process, increase or diminish awareness, and either uphold or dismantle existing power hierarchies. Clearly, the

question is not *whether* our identities and practices affect these relationships and hierarchies, but *how* they do.

(p. 287)

Being lesbian has allowed me certain privileges in undertaking this study. Participants have been willing to share their stories and their lives with me in ways I doubt they would have if I had been heterosexual. Not only is it important to disclose my lesbian identity it is also important to identify what some of the issues might be for researchers who are heterosexual doing research on lesbians.

Before describing how the descriptor 'licensed narrative' is positioned in this study, a discussion about narrative inquiry and personal experience narratives helps to set the scene. Narrative inquiry is the methodology for this study; personal experience narratives are the specific focus of the narrative inquiry; and 'licensed narrative' is the culmination of the inquiry, its processes and the experiences of the participants as told in story form.

### ***Positioning narrative inquiry for this study***

Berger (1997) traces the use of narrative back to Aristotle who he argues suggested that imitation was central to literary works as they imitated reality by using different mediums, focused on particular objects, and adopted different modes when presenting characters. Another key influence on the nature of narratives, according to Berger, is Vladimir Propp in the 1920s who studied Russian fairy tales in relation to their structure and how they were put together. Propp's work is key in analysing the 31 functions of fairy tales. To derive meaning from stories Berger turns to the work of Levi-Strauss in the 1960s. Levi-Strauss looked for what the text means to people. Berger distinguishes between the wide range of fictional narratives in mediums such as film, radio, television, comics and fairy tales, and stories found in what he calls everyday narratives such as jokes, journals and conversations. Whatever the narrative's form and function, Berger recognises the importance of learning from stories and the need to have them in our lives.

Like Berger (1997), Currie (1998) argues that “the theory and systematic study of narrative” (p. 1), has evolved throughout the 20th century in literary and cultural studies to a burgeoning current day expansion of narrative in everyday life taking the form for example, of films, video clips, comic strips and accounts of daily life. He adds that “in more academic contexts, there has been a recognition that narrative is central to the representation of identity, in personal memory and self-representation or in collective identity of groups such as regions, nations, race and gender” (p. 2). As a lesbian, identity is important to understanding the experiences of the nurses in my study. Thus, the claim as described by Currie, for a growing acceptance of narrative in understanding and representing the complexities of identity fits coherently into the justification for its use in this study.

When trying to understand where narrative is best positioned in the research world, I became bogged down with different terms that underpin both storytelling and narrative inquiry. The language seemed to change depending on what text I was reading at the time and interpretations within the literature varied depending on the writer. This is not surprising as Riessman (1993) suggests in her opening statement, that “[t]he study of narrative does not fit neatly within the boundaries of any single scholarly field” (p. 1) and later that “[t]here is considerable disagreement about the precise definition of narrative” (p. 17). Thus, the different understandings and applications within the broad field of narrative research do offer considerable scope for employing narrative methods in qualitative studies. Given the complexity and diversity of narrative inquiry it is difficult to clearly define. It is clear, however, that its appeal to a wide range of disciplines and its subsequent development within these disciplines has led to narrative inquiry now being an eclectic and versatile methodology. However, to provide some context for how narrative is used in this study it is useful to look at examples of the way it has evolved as a methodology in nursing and some of the associated disciplines linked to nursing such as social sciences and education.

### *Development of narrative in relevant disciplines*

According to Polkinghorne (1988) narrative inquiry can be traced back to several different disciplines including history, literature and psychology. In psychology

people like Bruner (1990) criticised the continued reliance of psychology on objectivism and argued that “the central concept of a human psychology is *meaning* and the processes and transactions involved in the construction of meanings” (p. 33). Narrative inquiry has rapidly evolved in the social sciences in areas such as anthropology (Geertz, 1983), psychology (Bruner, 1990), education (Clandinin & Connelly, 2000), and sociology (Riessman, 1993).

Polkinghorne (1995) argues that narrative has a variety of meanings and within narrative the terms ‘narrative inquiry’ and ‘narrative configuration’ are sometimes positioned. He further distinguishes between narrative as a discourse (any coherent text that can form a statement) and narrative as a type of discourse (the story). I liked the way he describes ‘story’ “in its general sense, to signify narratives that combine a succession of incidents into a unified episode” and that “[s]tories are concerned with human attempts to progress to a solution, clarification, or unravelling of an incomplete situation” (p. 7). This, alongside his views on the place of the plot or plots in a story (which offer possibilities for putting together events to make a story), seemed a way to work that encouraged the freedom to create, but also to adopt and adapt a structure. Further encouragement to use narrative inquiry as a means of conducting this study came from reading about how narrative has informed and guided nursing practice.

### *Narrative and nursing*

Bailey and Tilley (2002) suggest that “the underlying premise of narrative inquiry is the belief that individuals make sense of their world most effectively by telling stories” (p. 575). They further argue that narrative has become more appealing to nurse researchers as a means of exploring people’s health experiences and “the body of nursing literature based on narrative analysis is growing” (p. 575). This view is supported by other nurse researchers Wood and Giddings (2003) who argue that “narrative inquiry is an emerging methodology in nursing and midwifery research” (p. 4).

Philosophically and theoretically narrative inquiry sits comfortably with methodologies commonly used in nursing research such as phenomenology (van

Manen, 1990), hermeneutics (Gadamer, 1976) and grounded theory (Strauss & Corbin, 1997). Feminist scholars also make the argument for narrative inquiry as an appropriate methodology because “it is understandable that work by women investigators and/or about women’s lives has been in the forefront of alternative research paradigms in the social sciences and the humanities” (Lieblich, 1994) p.xii). Further, narrative inquiry offers opportunities to hear and create knowledge about women’s experiences (Chinn & Watson, 1994; Holloway & Wheeler, 1996; Josselson & Lieblich, 1994; Morgan, 2003).

Overcash (2004) suggests nurses are well suited to doing narrative research because of their familiarity with the tools that this research adopts such as communicating, listening and interviewing. Further, in recent years mental health services have adopted narrative as a data collection strategy with nurses, consumers and family members talking about their personal experiences of health services (Barker, 2003; Lapsley, Nikora, & Black, 2002; Mental Health Commission, 2001a, 2005).

### *Creative nursing narrative*

Chinn and Watson (1994) lay the foundation for discussions about the relationship between art, science, the aesthetic environment and therapeutic modalities such as narrative. Vezeau (1994), in acknowledging the struggle that scientists using the scientific method has in conducting research on groups such as women and minorities, argues for nursing to develop aesthetic possibilities consistent with the metaphorical nature of nursing. In this way, she suggests, by avoiding the certainty or probability that science demands, nursing and narrative will combine to provide a forum where education and practice can meet. Her work struck a chord with me as I delved into the reasons a narrative inquiry appealed to me as a way of approaching my study. Vezeau supports the use of narrative as creative fiction to engage the reader with the story they are reading and also to engage them with their own lives. She argues that writing fiction is not something that is done in isolation. The nurse writing fiction writes from an informed perspective and this says Vezeau, is reflected in the writing. However, the main focus she says should be on the person reading the story, not the story itself. And the reason for writing narrative fiction is to gain a better understanding of what that person’s life is about.

This focus on the reader of the story leads me to wonder how the nurse, or anyone else who reads the participants' stories in this thesis, might be influenced by what they read. While creative narrative conveyed here by Vezeau (1994) as creative fiction, can offer possibilities for different understandings, the progress or change in thinking made by the reader during the reflective process of reading these stories depends on the pre-understandings each reader brings with them to the creative narrative. As Vezeau notes, "some stories will not speak to everyone in a group" (p. 168) and "a story teaches possibilities. It can never be generalizable explanation; it is solely exploration and never prescribes" (p. 168). Vezeau also acknowledges that people's cultural beliefs play an important role in how they understand stories.

In this thesis the stories are about lesbian nurses and through their sharing of experiences I may provide some insight into the lives of being lesbian and a nurse especially for nurses who work in psychiatric mental health nursing. Therefore, while the reader may, as Vezeau (1994) suggests, search for personal meaning in these stories, I hope also that these readers will gain unique insights to further their understanding of lesbian lives. But a more important reason for putting our lesbian lives out publicly is so we as lesbians can share and understand the complexities inherent in our own lives. To create our own herstories, so we can not only reflect on and learn from a past, but carry these understandings into the future.

As previously mentioned, one of my reservations about making public lesbian stories and lives is that once in the public arena this information may be interpreted by non-lesbian people in ways that may not be consistent with my and other lesbian understandings. If a function of narrative is to engage people with their lives, can we assume that the narrative will engage them with others' lives? If the person reading the stories is lesbian, they will have their own interaction with the stories, their own reaction and action. The non-lesbian reader's reaction will be based on their personal experiences and encounters with lesbians, whatever these might be.

The 'experience' from reading narrative emerges from the 'experience' conveyed by the person writing about it and the person telling a story about the experience, so, experience narratives have meaning for the reader, the writer, and the narrator. In writing the stories about the experiences of the nurses in my study my aim is not only

to engage the reader to experience the experience, but also to convey the personal experiences of the lesbian nurses. Narrative and personal experience go hand in hand.

### *Feminist research process and narrative*

As discussed, principles from feminist research processes have guided and influenced the way this study has been undertaken. Combining feminist research processes with narrative has not been difficult.

A prominent writer and scholar of narrative approaches, Lieblich (1994) had the following to say about the interface between feminism and narrative:

Women have been storytellers in many cultures, yet their different voices were not heard enough in the public sphere. We do not accept the simple notion that the narrative is a feminine domain or research tool or that women speak in the language of stories. Rather we think that the subjective-reflective nature of the narrative coincides with the feminist ideology of compassionate, unauthoritarian understanding of the Other.

(pp. xi–xii)

The search for understanding and meaning in the experiences of the participants' stories has been one of the most challenging aspects of the study. The responsibility for maintaining the integrity of the participants' stories and conveying them to make visible the participants' personal and professional lives rests with the researcher. Feminist research processes require a working, collaborative relationship with the participants and respect and value for their subjective experiences. In following these principles I sought to interpret and present the participants' experiences, knowing they had given input and were accepting of how their stories were presented and understood. Narrative inquiry fitted feminist research processes like a glove.



### ***The link between narrative and experience***

Various writers have slightly different positions in relation to the link between narrative and experience. Polkinghorne (1988) emphasises that narrative is “the primary form by which human experience is made meaningful” (p. 1); while for Clandinin and Connelly (1998) experience is about how “[p]eople live stories, and in the telling of them reaffirm them, modify them, and create new ones” (p. 155). Telling different stories throughout our lifetime is such an important way to convey how our lives have been shaped and how we have lived and live our lives. I believe we are, after all, the sum of our experiences.

Once stories have been gathered, narrative researchers have the task of analysing or interpreting the stories to understand the participants’ experiences and to try to find meaning in those stories. Josselson and Lieblich (1995) suggest “the ultimate aim of the narrative investigation of human life is the interpretation of experience. But in this postmodern age, what it means to interpret and what it means to experience become highly relative, contextual concepts” (p. ix).

It is not the researcher’s task to impose their own meaning on those stories, but to negotiate understanding and meaning with the participant. In describing what it is that narrative inquirers do, Clandinin and Connelly (2000) argue that “the narrative inquirer does not prescribe general applications and uses but rather creates texts that, when well done, offer readers a place to imagine their own uses and applications” (p. 42). This resonated with me as I worked with the stories and talked with participants about how they understood their own stories and what I had written. I discussed the positioning and the meaning of their stories in trying to make the connections between their experiences and what these meant in the way they lived and understood being both lesbian and a psychiatric mental health nurse. Polkinghorne (1988) makes the connections between meaning and experience by noting that “[e]xperience is meaningful and human behavior is generated from and informed by this meaningfulness. Thus, the study of human behavior needs to include and exploration of the meaning systems that form human experience” (p. 1).

In reviewing some of the historical influences that shaped their views on narrative inquiry, Clandinin and Connelly (2000) discuss the work of John Dewey, a prominent educationalist, who believed experience was a key concept in diverse inquiries. He argued that experience, in this case that of the child, needed to be understood not only from an individual perspective, but from the context in which the experience occurred. The significance of this for this thesis lies in the fact that nurses who identify as lesbian, hold their identity in the context of complex environmental factors that influence their willingness and ability to self-disclose. Their experience of the environment is very important but so too is their understanding of how they position themselves within that environment and how others position them as well. This can change from moment to moment and impacts on their behaviour and relationships with others within that environment. I expected that listening to stories of how nurses made decisions about self-disclosure would reveal another dimension about lesbian nurses' decision making about revealing their lesbian identity, or not, in their relationships with clients and others'.

So far in this chapter I have argued that narrative inquiry has been adopted and adapted by a range of disciplines, including nursing, thereby creating an eclectic and versatile methodology which is also contextually bound and specific. Further to this, narratives that seek to explicate people's experiences offer opportunities to understand and interpret the unique meaning behind these experiences, especially when this is negotiated with the person who has had the experience and within their complex environment. I now move on to the justification for how the participants' stories appear in the thesis and how the term 'licensed narrative' came about.

### **The 'licensed narrative'**

Similar terms to 'licensed narrative' appear in the literature. Eubanks (1997) describes how metaphorically, licensing stories help us to understand the way the world is constructed. McEldowney (2002), in her interviews with six nurse educators used the term licensing stories referring to "giving license to the metaphor of shape-shifting as a new way of thinking about transformation and change" (p.227). The term 'licensed narrative', as described in my thesis, is one that I came to use when I

thought about how the participants and I negotiated and co-created the stories and the processes that we engaged in during the interviews. The word ‘license’ is defined by Fowler and Fowler (1964) as “allow complete freedom to; grant permit; authorize publication of (book etc) or performance of (play)” (p. 699), which resonates with the context in which I use ‘licensed narrative’. Researching for this thesis has created a heightened awareness and sensitivity about the origins of knowledge. I make no claim that ‘licensed narrative’ is an original term or a phrase that has never appeared in the literature before. My naming and use of it came about through reading about narrative inquiry and becoming more confident about the possible ways in which the style of narrative inquiry can be incorporated into research.

### ***Being creative with narrative***

I became interested in the ideas associated with ‘performance’ of story and this has extended to the desire to create stories with characters that could come alive in the pages as read aloud. In writing personal evocative stories Ellis and Bochner (2000) say it is important to capture how people deal with life’s complexities:

The texts produced under the rubric of what I call **narrative inquiry** would be stories that create the effect of reality, showing characters embedded in the complexities of lived moments of struggle, resisting the intrusions of chaos, disconnection, fragmentation, marginalization, and incoherence, trying to preserve or restore the continuity or coherence of life’s unity in the face of unexpected blows that call one’s meaning and values into question.

(p. 744)

Although in this instance the authors are describing a situation where the researcher is the subject of the inquiry, the ideals that underpin the personal story as described by Ellis and Bochner (2000) appealed to me. I especially liked the idea that with personal stories (evocative narratives), “the mode of storytelling is akin to the novel or biography and thus fractures the boundaries that normally separate social science from literature” (p. 744). The authors set out to challenge the genre of writing for handbooks that in the past has mostly used the third person and conformed to a

scholarly discourse of essay writing, not story writing. Art Bochner, in discussing his thoughts with his co-author Carolyn Ellis about how they might write their chapter, explained that:

We need a form that will allow readers to feel the moral dilemmas, think with our story instead of about it, join actively in the decision points that define an autoethnographic project, and consider how their own lives can be made a story worth telling.

(p. 735)

One thing that strikes me about their story is the way it creates a picture of the characters using descriptive details about their mannerisms, their clothing, their voice tone (including conveying things like laughter and surprise), and their feelings and thoughts during and after their interactions with each other. The different environments in which these characters have their conversations and interactions are also described. The reader is not only given information about the subject at hand (which includes references to other writers that, at times, was a minor distraction from the flow of the story), but engages with the characters on a level unlike many of the other chapters in this same book. What I was reading not only resonated with my ideas, philosophy and understandings about research, but also gave me confidence that the way I had written the participants' stories was credible and fitted with other people's approaches.

I have been single-minded about wanting to present the stories in a particular way, a little like a short story in a book of short stories, and I have composed them keeping the research questions at the forefront of my thinking. The participants licensed me to write their personal stories, and the principles of evocative narrative outlined by Ellis and Bochner (2000) have enabled a freedom to write the participants' stories and call them licensed narratives.

Another researcher and writer who advocates creativity in writing stories from research is nurse academic Tina Koch (1998), who argues that "telling a vital story gives context and information that captures and aims to hold the readers' attention. It attempts to recreate the mood of the setting" (p. 118). Part of my goal was to create

stories that would captivate the reader's attention and at the same time gain the participants' approval. A slightly different take on story writing is offered by Ceglowski (1997) who described how to use the writing of short stories and the connection of these to the text during her study about her experiences at Wood River. Ceglowski discovered that:

Short stories can be especially valuable when they are part of a mixed genre text that combines stories with traditional research writing that places the stories in theoretical context. Stories allow readers of research to experience the vivid life of subjects and not view them only from a distant, theoretical perspective.

(p. 188)

Therefore, there are precedents for my application of this version of narrative and presenting the participants' stories as 'licensed narratives'.

Narrative has contributed to the growing collection of information about lesbian history and lesbian 'experience', yet nursing has been slow to embrace narrative as a methodology in exploring and describing the practice and lives of lesbian nurses. My position as an academic has provided me with a unique opportunity to undertake research with lesbians using a methodology and methods suited to both my personality and the lesbian focus of the study, and a methodology that is open to innovative creation. Feminist research process values the subjective experience of the researcher and the participants. What follows now is a description of how the research was conducted.

## **Method and design**

In discussing the methods used in this research consideration is given to the ethical parameters that guided the study, how participants became involved, including who was invited to participate, how the interviews were conducted and how the data is analysed in the thesis. The first deliberation was the ethical issues involved in undertaking it the study.

### ***Ethical considerations***

As with any human subject research the ethics of this study have been considered. This study has the approval of the Human Ethics Committee (HEC) of Victoria University of Wellington (see Appendix A). The only amendment of note was the request for some “starter questions” for the interviews (see Appendix B). Ethics approval for the study was granted on 14 December 2001.

Given the previous discussions in this thesis about power relationships and visibility of lesbian identity, three aspects of this study that warrant mention with regard to ethical issues are the exclusion of potential participants, recruitment and confidentiality.

#### ***Exclusion of potential participants***

Even though I did not specifically deal with the issues of recruiting friends, colleagues or students in the ethics proposal I would like to address this now. Although recruitment for this study was sought through personal networking and personal knowledge I made a decision that there were some people I would not approach. I excluded students who enrolled in my courses and students I was likely to have a close supervisory relationship with while I was undertaking my study. I also excluded work colleagues and my partner.

The main issue with engaging students in my research was my concern that complex and competing power dynamics could emerge to jeopardise the research relationship and the student-supervisor relationship. The recognition of these issues as potential problems is not enough to resolve or avoid the tension that may develop because of these complexities, so it seemed sensible to simply avoid them altogether. However, with the best will in the world I could not predict which research participants would later, after the interview, become students of mine. My strategy for dealing with this when it happened was to give their assessments to another staff member to grade without giving the staff member a reason why I could not grade the assessments. It is not unusual to give assignments to other staff to mark given the internal moderation practices that are used in my workplace. I am confident that by avoiding grading

their work, the integrity of the research and confidentiality of the student was protected.

Interviews with colleagues posed a slightly different set of issues to consider. The working relationship between me and colleagues had the potential to be compromised because of information exchanged during the interview. Sometimes people who are being interviewed give away more information than they realise at the time. Even if they have the opportunity later to retract what they said in their transcript they may feel reluctant to do this. Another risk in interviewing a work colleague was the increased possibility of this person being identified through our day-to-day contact. A 'corridor conversation' between me and the colleague about some aspect of the study (which revealed them as a participant) had the potential to be overheard by another person. The need to 'walk on egg shells' at work did not appeal to me; I am not very light footed at the best of times. The possibility of these issues becoming a problem influenced my decision not to approach students or work colleagues to participate in my study.

Several people were affected by this decision and thereby excluded from this study. I was disappointed not to have the opportunity to interview them, because I knew from previous conversations with some of them that they had much to offer and had expressed interest in being interviewed. However, the risks as far as I was concerned outweighed the benefits.

### *Recruitment of participants*

An important consideration in this study was the way in which participants were identified and approached to contribute to this inquiry. As discussed in Chapter One, lesbian psychiatric mental health nurses, like lesbians in the wider population, have individual ideas about the language they use to name themselves and how open they are about their lesbian identity.

Despite lesbians and lesbian psychiatric mental health nurses being minority, and not always visible groups in New Zealand society, it has not been difficult to find, identify and recruit nurses for this study. I used my extensive networks in the lesbian

community and mental health services to access participants. This included talking to friends and colleagues, advertising on the Lesbian Radio Programme (based in Wellington), putting a notice in the Manawatu lesbian newsletter, and talking to colleagues in mental health services who I knew to be lesbian. As expected, most participants were recruited through personal networking. Even though personal networking was the most common recruiting method I did not know all the participants. Of the 15 who agreed to take part in this study I knew four well, seven vaguely, and four not at all.

Once I received notification from women that they were interested in being interviewed, I posted them an information sheet and a consent form. This was followed up by contact from me, usually a phone call, to establish their commitment to being involved and to set a time for an interview. I was able to have email contact with all but one participant, so this made ongoing contact more expedient. In the process of setting up email contact it was essential I maintain confidentiality, which necessitated working through issues about who had access to their email and if sending information to their work or home address would compromise this confidentiality.

### *Confidentiality*

One consequence of recruiting within a small population such as New Zealand, and a minority group such as lesbians, is that the likelihood participants would know each other, and by default also know those who had agreed to be interviewed for the study, was quite high. From the outset of the study I was very discreet about who was participating and avoided talking about my research in social situations, where at times, two or three participants were in attendance. I carefully followed up contact once people had received information from me or others who had distributed information through their own networks. This way I endeavoured to protect the identity of participants from each other.

In such a small community it was expected that participants would talk among themselves about the study. If I was doing interviews in smaller towns or work areas it was likely those lesbians were more identifiable because they were known in the



service. Thus, it was relatively easy to work out who was a participant in the study. I concluded that ethically it was more important to maintain the confidentiality of the interview information than the interviewees. I discovered in my follow-up conversations with participants that some of them had talked about their interviews and showed their stories to other lesbians, their partners and friends. This was their choice and not something I wanted or needed to control or take responsibility for. I expected that the two sets of couples (partners) who were interviewed would share their written transcripts and stories and was not surprised to discover that this was the case. Once again, the issue for me was about keeping the confidentiality of the participants to the best of my ability. Participants received a participant information sheet so they knew what they were agreeing to by taking part in this study (see Appendix C). They also signed a consent form signalling they were fully informed and had consented to participating in the study (see Appendix D).

### ***Interviews***

The face-to-face interviews took place in April and May 2002. I travelled to four locations in New Zealand and two participants came to me. Women were interviewed at home or work for the first set of interviews. The second round of interviews was conducted by telephone and took place in May, June and July 2003. For the follow-up telephone interviews I used a communication accessory, an inductive telephone line pick-up, which enabled me to tape the interviews by attaching an audio plug suction cup to the phone and the audio plug to the tape recorder. The sound quality was excellent, but the process did require full concentration to ensure the suction cup stayed in place and written notes could be taken at the same time.

Although I believe most nurses enjoy a good yarn I know some nurses spin a better yarn than others, capturing the interest of their audience with their wit and humour, while others struggle to engage their audience. Part of my responsibility in setting the scene for the interviews involved preparing the participants so they had time to consider how best to share their experiences. They were all sent information well in advance about the research focus and the research questions that informed the study.

Given that the interviews were conducted using an unstructured approach with reflective questioning, it was difficult to determine the exact question format or content. I soon realised that the questions I had on the interview schedule needed adjusting. The first question about why participants agreed to be involved in the study did not shed light on any of the research questions; it was supposed to help them feel relaxed about the interview by asking them something they would feel confident about answering; instead it seemed to surprise the first participant.

About the time of the interviews I had been reading a study by Wiseman (1995) where the researcher had asked students to focus on their early memories of experiences of loneliness, expecting that early memories would spontaneously trigger other memories (which it did). After the first interview I revised the questions, preferring to ask participants to tell me how they got interested in nursing and their first memory of the word lesbian. I did this because I realised an easier warm-up opener would be to ask them about their nursing, which I assumed they would all feel comfortable with. At the same time as their nursing story evolved, memories of their lesbian identity would be likely to form part of their nursing story and this would help to trigger their lesbian story. The adaptation of this line of questioning for my study opened the door to, at times, a watershed of different experiences couched in personal and individual stories.

During the interviews we had conversations about participants' nursing lives and their identity as lesbians. We laughed a lot. There have been serious moments as women recalled and reflected on their lives as nurses and lesbians. There have been lighter moments as times of reflection often brought a shared understanding and resolution of past experiences.

### ***Data analysis***

The aim of the data analysis was to create licensed narratives for each participant that addressed some aspect or aspects of the research questions. The process adopted, as described earlier, was underpinned by feminist research processes, particularly in the way the data was collected. What follows is a description of how transcribing,

working with the interview transcripts and using NVivo (a qualitative software package) assisted with the data analysis and the creation of the licensed narratives.

### *Transcribing*

I considered whether to transcribe the interview tapes. Previous experience with interview tapes and transcriptions lead me to believe that the transcribing of audio tapes to written text requires much skill and is a time-consuming process. Silverman (1993) describes this work as “research activities” and I tend to agree that it is part of the research process. One of the arguments for researchers doing their own transcription is that by listening to the tapes repeatedly (how many times depends on your typing skills) they will become more familiar with not only the content but also the way in which participants express their stories. These are important considerations in qualitative research, but the researcher doing the transcribing is not the only way to achieve these milestones.

The decision to contract the transcription of the tapes to someone was based on my desire to have access to hard copy interviews quickly and my planned approach to the data analysis. This approach involved going through the hard copy transcribed interviews, correcting any mistakes, adding or changing identifying information (particularly the names of people and hospitals or wards and geographic names, which, in a small country and specific profession, make it more likely people will be identified), and checking the grammatical details.

According to Tilley (2003) careful consideration should be given to how and who transcribes interview data, because “the transcriber’s interpretive/analytical/theoretical lens shapes the final texts constructed and as a result has the potential to influence the researcher’s analysis of the data” (p. 750). My first priority in considering who should transcribe the tapes was that a lesbian should do it. Therefore, I contracted a woman who identified as lesbian to transcribe the face-to-face interviews. I felt it was important to have someone listening to the interview tapes who had an awareness of issues affecting lesbian identity, and who would understand some of these issues. The transcriptionist had no theoretical lens through which she might influence the data. Her skills in listening to tapes and transcribing

them verbatim, as well as her being lesbian, were the two reasons she was approached to do the transcribing. We met and negotiated the parameters of her involvement and exchanged expectations. Once she was satisfied with her involvement she then signed a non-disclosure agreement form (see Appendix E).

Unlike the face-to-face interviews I transcribed the follow-up telephone interviews myself. It seemed easier for me to do this immediately after each interview when it was fresh in my mind and I could make decisions about what needed to be included and what did not. The purpose of these telephone interviews was different from the face-to-face interviews. In the follow-up telephone interviews I sought feedback from the second draft of participants' stories; how they felt, if anything needed to be changed. I also explained how their stories were shaping up in the thesis, and explored ideas that I had about this with them. Some information in these interviews was used in the findings presented in Chapter Four and Chapter Five..

My comments, which were also recorded during the telephone follow-up interviews, were summarised rather than transcribed. These comments served as a useful reminder of where my thinking was at that time and what contribution I had made to discussions with participants. For example, in these interviews I explained to the participants that I would be reworking their stories to shorten them but would try to capture the essence of their story and their character while keeping the research questions in the back of my mind. I was careful to note any changes they wanted and attend to these as soon as possible after the interview. There were very few changes. Participants were genuinely pleased with their transcripts and the way they had been portrayed in them.

### *Working with participants transcripts*

As part of the data analysis I immersed myself in the participants' stories, listening to the tapes. As I listened to each tape I kept a creative journal, made up of notes to myself, drawings and symbols that reminded me about the participants and their mannerisms, noises during the interview and so on. This creative journal was useful to help me build the unique character of each person while writing the short stories. It served as a useful reminder of the context in which I had formulated ideas about

the stories and also about the participants. The different external sounds such as cars going by, doors slamming, and other noises were also noted in this creative journal. Individual characteristics and quirky habits were recorded in the same way, and these helped to construct context, recreate the atmosphere and capture the uniqueness in each story. The creative journal helped take me back to the interview situation. Re-living the interview was important in assisting to transform the transcripts from text to licensed narratives.

Capturing the way women spoke was an important part of helping to create their character. Other literary techniques commonly used to create a picture in the reader's mind of the person, like describing physical characteristics and other identifying features, were not considered because of the possibility of participants being identified. This process of listening to the tapes, writing in my creative journal, and reading the transcripts ensured I was very familiar with the interview data and at the same time was able to check the transcript matched the tape. Examples of creative journal pages about two of the participants, Jane and Sally, help to show how the creative journal influenced the completed licensed narratives (see Appendices F and G).

### *Working with NVivo*

My experience with qualitative software packages had been confined to using NUD\*IST (non-numerical data indexing systemising and theorising) on a study I assisted with in the early 1990s. My involvement had been minimal but I did get a sense of what was possible using this type of software. I decided to explore the possibilities of using NVivo. Using this software, as Bazeley and Richards (2000) suggest, "it is possible to manage, access and analyze qualitative data and to keep a perspective on all of the data, without losing its richness or the closeness to data that is critical for qualitative research" (p. 1). Its use with narrative is not well known at this stage (personal communication with Pat Bazeley, 2002), so I was interested to see how NVivo could contribute to this narrative inquiry.

I knew that the interviews would generate a lot of written documentation and the management of this would be a nightmare if I did not have a systematic way to keep

track of it. The storage and retrieval of information using NVivo is easier particularly with a study like this one where the time-frame is likely to be 3–4 years. Ideally, and in hindsight, it would have been useful to start using NVivo right at the beginning of my study. This would have enabled me to start recording and setting up project documents in NVivo to record my thinking and research questions, and any other information and ideas about the proposed study.

Once the transcripts had been checked and rechecked I felt confident to load them into the document browser of NVivo which has tools that enable the editing and coding of transcripts. Each transcript was named with the name the participant had chosen. At this stage I decided to take my text out of the transcripts and work only with the text of the participants. I did not want to be distracted by my comments and wanted to focus on the stories from the participants. Besides, I could always refer back to my interview comments if necessary by browsing the document working sets. Each participant was also given a ‘memo document’ linked to their transcript where I could make notes while coding. Therefore, while reading each transcript if anything interesting, or something I was not sure about, came up I could make a note of it in the ‘memo document’ for later retrieval.

Once the participants’ files were set up I started up another journal (as distinct from my creative journal) in the document browser of NVivo. The purpose of this journal was to record my ideas and reflections throughout the research process, including my thoughts on how to analyse and write the stories. Figure 1 is part of the first entry from this journal.

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### **Thoughts on process of Nvivo**

Important to set up files for loading to NVivo to consider the size of participant and researcher texts. The long ones are a pain for retrieval and context because it retrieves the whole paragraph. Also to identify whose speaking. So, paragraphs of transcripts need to be broken up,

Loading the project

If you make a password and later forget the password then you are in trouble.

Memos are reflective documents.

### **Coding**

1 What's interesting about that?-highlight to code

2 Why is it interesting? -code

-memo

3 Why am I interested in that?-code

-memo

Process, quick read through looking for critical issues but coding at the same time.

Use memo process to record useful thinking about particular things.

When coding decisions made about eg the differences or similarities between transition, disclosure and coming out. The question is do we need coming out? A boolean search revealed that coming out covers disclosure, therefore can get rid of disclosure. This was done on the third interview transcript

*Figure 1: First entry from my NVivo journal*

Of note in this extract (Figure 1) is the process of initial thinking about how to use NVivo and an example of how coding decisions were made.

### *Profile of participants*

NVivo also has a system for setting up attributes and this was used to compile a profile of the participants (see Appendix H). Attributes are characteristics about the data that help to describe participants.

### *Attributes*

During the coding process I assigned attributes to each document. I identified attributes of the participants that would be useful for profiling and describing the

group as a whole. These attributes were edited later when I rechecked details with participants. For example, from each document I assigned a numeric value for how many years they had been in psychiatric mental health nursing. When I checked this information with participants, two of them corrected the values I had attributed them. An interesting discovery that assigning attributes revealed was that no in-patient nurses are in this study, although most participants did speak of their past experiences working in the in-patient area. The methodological reflections at the end of this thesis offer my thoughts on why in-patient nurses are not part of this study.

Attributes are assigned for the period when the face-to-face interview took place and these have been adjusted only in certain circumstances. For example, if the participant was in a relationship at the time of the interview but then the relationship broke up, the attribute for that participant did not change. The same principle applied to their work area. Several participants changed their work area between the face-to-face interview and the follow-up telephone interview. However, if the change was relevant I included the information about their change of relationship or work area in their story or as part of the discussion chapter.

At the time of the first interviews participants had a range of 9–30 years of nursing experience. Eleven participants were living in the North Island of New Zealand and four in the South Island. Nursing training and education varied, often depending on where they were living and what nursing programme was being offered at the time. In New Zealand comprehensive nursing training began in 1973, so those who trained before then had only the choice of hospital-based single registration training, in this case psychiatric nursing.

One participant mentioned the fact that she is Maori (and that she does not look Maori). In accordance with my commitment to any participant who self-disclosed their Maori identity, and as outlined in the ethics proposal, I checked out with this participant if there was anything she wanted to discuss about her participation in light of her Maori identity. She said no, she was happy to handle anything that came up without consulting with any other Maori. There may have been other participants who had Maori affiliations but who chose not to disclose this.



Overall, attributes provided descriptive data that helped create a picture of the New Zealand context for the group. In the analysis of these participants' transcripts, individual stories and experiences are the focus, not how the identified attributes might influence others' stories. Therefore, cross-tabulating data was not considered. While participants' attributes were being noted, coding of the transcripts occurred simultaneously.

### *Coding and memos*

As discussed earlier, the purpose of coding the data was to highlight not only interesting pieces of text but why I found them interesting; while at the same time recording my thoughts about this interest in the memo document. Segments of text were highlighted and placed under the code that had been set up.

For the purposes of coding in the node explorer, NVivo allows for the creation of what it calls 'tree nodes', which are categories and subcategories designed to help with the organisation of data. I created several 'tree nodes' for topics I thought would be useful in exploring the research questions. For example, I created a tree node called 'psychiatric nursing'. I expected that this would be a major category that would need to be further refined or broken up. I created three subcategories for the tree node 'psychiatric nursing' (which NVivo calls child nodes). I named these children: 'working with clients'; 'the therapeutic relationship'; and 'offers what'. For example, when participants talked about the therapeutic relationship that text was then coded at that tree node 'psychiatric nursing', in the children node, 'therapeutic relationship'. By coding other information about psychiatric nursing, for example 'working with clients', I was able to easily identify and retrieve participants' stories and experiences about aspects of working with their clients. The child node 'offers what' was created, so when participants talked about what it was that they offered in their practice, these stories were collectively coded for later retrieval. One pre-study assumption I had was that lesbian nurses offered something unique in their practice with regard to relationships they had with clients. Therefore, stories and experiences coded here helped to identify who spoke about it and what they said as well as to explore one of the pre-study assumptions.

Not surprisingly, the tree node coded 'lesbian', had 14 child nodes. All the tree and children nodes are listed in Appendix I.

### *Using the memo document*

As previously stated, memos are reflective documents that are useful for recording your thinking as you work through the data. I thought it might be interesting to see why and how participants became interested in psychiatric mental health nursing to see whether being lesbian or thinking about being lesbian might have some bearing on their choice of career. Figure 2 is an extract from a memo that I made while looking through the child node 'initial interest'. This extract also illustrates the process of thinking that lead to some of the ideas in the creation of the narrative themes and sub-themes. The recognition at this early stage in the data analysis of the importance of the 'self' first surfaced through this process of coding and writing memos.

While the coding helped me to organise information, think about possible narrative themes and stimulate thinking, reflection and writing, I knew I had to decide what to include and exclude from the transcripts when creating the licensed narratives. It seemed important to make connections between, for example, how participants were raised during their childhood and how they managed their lesbian identity as an adult. It also seemed important and interesting to explore why participants were attracted to psychiatric mental health nursing. If participants were lesbian before they went nursing did these participants become attracted to psychiatric nursing because they felt they would be accepted and understood? These questions were at the back of my mind as I began to write the licensed narratives.

**Background influencing decision to go psychiatric mental health nursing:**

Knowing someone who was a psychiatric mental health nurse

Childhood memories of wanting to help/fascinated by the body/mind; growing up around nurses/nursing

Growing up within an environment that challenged thinking and what was normal or usual

Being befriended/liked by people who were different for example, lesbian psychiatric mental health nurses and patients who might have been neighbours or visitors

Being exposed to how creative and challenging psychiatric mental health nursing could be, the possibilities

Own life experiences of challenging the system and exploring the possibilities through social activities, that is, drug taking leading to different perceptions of reality

Feeling that they had a knack for psychiatric mental health nursing in some way, for example, a good ear, give good counsel and enjoy talking to people

Didn't like general nursing; receiving encouragement to 'give it a go'

Saw it as a good career to support things like travelling or thought it was a career and wanted a career

Fancied someone who was working in psychiatric mental health nursing

**Thoughts this has prompted**

Ideas about recruitment of nurses to psychiatric mental health nursing. But this isn't really the focus of this research. Could relate to their identity, conflict/doubts/search, as a motivational factor in terms of going into the profession. Does give substance to the idea about 'adding' to the practice of psychiatric mental health nurses; especially in terms of growing up in an environment that challenged the status quo in some way and living as a child that added to their perceptions of what was not ok and what was ok. Participants believed that they had something to offer psychiatric mental health nursing.

Most people talked about their initial interest in a positive way and had good recollections of what they feel attracted them to the job.

**Questions to ponder**

Do participants feel that they still have something to offer psychiatric mental health nursing? If so, what might this be? How does it relate if at all to their identity?

**What are some of the concepts/themes/issues emerging in this node?**

Finding a niche; seeing themselves in psychiatric mental health nursing; finding self; seeking self

*Figure 2: Extract from memo 'initial interest'*

## ***From stories to licensed narratives***

### *Preparing to write the stories; 'the thinking'*

In writing the licensed narratives I wanted to bring the participants to life. I turn to my journal now to track the development of my thinking about how to bring them to life in the licensed narrative. Figure 3 is an excerpt from my memo journal that came about after a walk along the beach, reflecting on an article I had been reading about the nature and presentation of story.

(3/11/03)

I have been reading an article by Sandelowski about finding the findings and it occurs to me that there are multiple story lines. There is the story being told by the person, the researchers story, the story of the theoretical line taken throughout the thesis, the story of the way the research was done (method). Then there is the interpretation of the story, first the person who owns the story has an understanding and interpretation of what the story means and this is influenced by their reflective capacity and ability to position the interpretation in time and place. The researcher has their interpretation of the story both of the participant one and their own one and they cross and overlay each other. This is influenced by the theoretical story which is laid out by the researcher and thus is influenced by how much and what they read and what they choose to include and in some ways what they choose to omit. Finally the story of the research approach outlines the way the story was collected and developed and written and used and adapted to fit the other stories. So where does this leave me? Perhaps this thesis can be chapters of stories?

So, I need to find out what each person thought about their story. What reflective comments they might have and what/if they have any interpretive comments to make.

*Figure 3: Extract from my NVivo journal 'reflecting on an article'*

Coding, journaling, listening to the tapes, reading and re-reading the transcripts and writing in my creative journal are all techniques that helped me to become familiar with the data. However, I was still uncertain about how to write the stories.

After re-reading the article by Sandelowski and Barroso (2002), about researcher interpretation of data and critique of the importance of working on the findings as the main point of research, I did further reading and came across some memorable and wise words that resonated with me when I first read them. I refer to Clandinin and

Connelly (2000) when they suggest a well-crafted story should engage the reader so they can create their own understanding of that text. Admittedly, each licensed narrative has been composed by me and so my influence and emphasis on certain aspects of these are inevitable and unavoidable. The background I have personally and professionally as both a lesbian and psychiatric mental health nurse has guided me in my decisions about what exemplifies each licensed narrative. My construction of these was guided by the quest to answer the research questions, which are imprinted like neon lights in my subconscious: *What is the experience of lesbian nurses who work in psychiatric mental health nursing? How does identifying as lesbian influence the practice of psychiatric mental health nurses?* How each participant was portrayed speaks to their unique experiences embedded in the research inquiry.

I scribbled something down, trying to capture the dynamics and dynamic ways that story is composed. Over the next month I reflected on this scribble and wrote this:

Each story has some experiences  
Each experience is different  
And some the same  
The journey to experience is conveyed  
Sometimes  
Context is contained, specific and constructed  
Each story is not always a story  
Sometimes  
A conversation, a comment, an opinion  
Context is conveyed  
Sometimes  
Each story is a time  
A treasure

This poem helps explain the conundrum I was in, in trying to understand the way(s) a story is formed and what constitutes a story. At the same time while trying to decide what a story actually was, I faced the inevitable dilemma of what to include in each

completed licensed narrative and what to exclude. Another poem gave me the space to creatively deal with this.

I wrote the next poem while collecting shells on our beautiful beach and contemplated the uniqueness of each shell. It seemed a daunting task ahead, to take stories from lesbian psychiatric mental health nurses and create a place for them to stand, knowing that the challenge of revealing all was beyond my comprehension. Yet knowing that I wanted the vibrancy of these women to leap out at the reader, for these women to be who they were and how they wanted to be. For understandings to emerge that would help us as lesbians create, understand and accept our own past and carve a space for others to be part of who we are and how we live in the community today. As the researcher it was my responsibility to hold the shells until we all knew what to tell.

The shape of a shell  
The tracing of its shape  
On to paper  
Portrays little of the image total  
And beauty of each shell  
What to trace  
What to tell

I had to make several important decisions about how to construct these licensed narratives. The individual journeys participants have travelled towards understanding and expressing their lesbian identity have helped to give them a solid foundation from which to express who they are and to position their identity in their practice and their everyday lives. They achieved this ‘at ease with self’ in their own way with different emphases depending on time, context and place. Figure 4 is an extract from my journal in NVivo that captures that time and place.

The thinking, journaling and poetry writing then turned to action as I contemplated using NVivo to help with the story writing. All the text and data was gathered on NVivo, so it seemed worthwhile to access this and progress my thinking.

(18/12/03)

Lying in bed, thinking about how to portray my line of thinking consistent with narrative methodology. How to justify and argue for deconstructing people's stories and choosing pieces out of them. The research questions come to mind, what is the experience, what are the experiences maybe it should read like that, of lesbian nurses who work in psychiatric mental health nursing?

I am taking a key or key identified experiences which I have selected based on my thinking about how they will situate themselves in the theoretical constructs, OR/AND how they best portray the variety of experiences given that I must acknowledge the commonality between issues that my participants had. So, I don't want to tell the same story 15 times, don't want to minimise the experiences, don't want to say everyone is the same. I do want to capture the essence and spirit of each person and work with their story to create a themed story that will illuminate the theoretical construct that I have identified. Base on my listening and re-listening of the tapes and mind mapping the interview, re-interviewing people, getting their feedback, testing out my theoretical ideas and of course it all started with coding.

The other question, how does identifying as lesbian influence the practice of these nurses? Once again, I have to select the best way of conveying the breadth and depth of experience which entails a deconstruction in order to reconstruct. This is a bit weird especially when I started this study with firm ideas about wanting to maintain the integrity of each story, have I compromised this? When I wanted to put each persons' story in word for word, including the um's and ahh's. What has changed? Heaps.

Firstly, the participants commented at length about how their story read. They were concerned that the grammar read well more than anything else. Secondly, I have realised that there are different forms of narrative that focus on a process responsive to content of transcripts. By this I mean that in some narrative even things like language are the focus of interpretation, a deconstruction of the language used is more critical than the story itself. Thirdly, as the researcher I can take responsibility for my decisions in this study as long as I can argue my position and further to this make transparent and track my decision making in the data analysis, interpretation. This is a subjective interpretation of stories, I am there, they are there, and I have to find a place where we are there.

*Figure 4: Extract from my NVivo journal 'lying in bed'*

### *Writing the stories*

As explained previously each participant had a memo document attached to their transcript. Using the memo for each participant I began to write their story. I started

with setting the context of the interview; describing the environment, where we were, what the room was like, anything that had happened before my arrival to meet the participant, if I had got lost on the way, and any mannerisms the person had that might add to the imagery of the story and to the participant as a character. Figure 5 shows how the process began. The numbers 1–8 indicate a link back to Diana’s original transcript where a memo was created in the initial coding stage; a note or reflection on what was being said.



1 Has had about 15 years in psych nursing, done nothing else.

2 Did comprehensive training

3 Mother warned her about lesbians

4 Was heterosexual before started nursing training at 33 years, maybe?

5 Out to colleagues but doesn't introduce self as lesbian

6 Couldn't remember whether or not she came out directly, both clients knew beforehand that she was lesbian, then they talked about it in the process of the relationship

7 This comment was preceded by a lengthy introduction to self-disclosure, authenticity by me.

8 In response to homophobia, experiences of

**2/18/03 08:49:47**

*Creating the character called Diana and telling her story*

I met Diana in her home after several phone calls and reassurance from her about how to find her house. Despite clear directions on how to drive to her place I had still managed to get lost and skirt around the edges of the street which highly amused both of us and set the tone for a very relaxed interview. We both made ourselves comfortable in the lounge. I noticed that Diana had set herself up and prepared well for the interview particularly having cigarettes on a table next to her seat. The tape captured the lighting of cigarettes throughout the interview and the background sucking in of smoke indicated not only pause in thought but that the tape recorder was of very high quality. The snapping of the lighter in the background was also indicative of what tended to be long relaxed spells of talking which Diana seemed to enjoy. Her voice held intrigue, laughter, truth and memory.

I have known Diana for several years mostly through other colleagues or friends referring to her in casual conversation and also by meeting her at the occasional conference or professional meeting. In summary, I knew of her, not a lot about her.

I don't know exactly how old Diana is, somewhere in her forties probably. She arrived in New Zealand at the age of 17. As a child she was fascinated by the human body but didn't immediately think of nursing as a career[]

*Figure 5: Extract from Diana's memo document in NVivo*

After the word 'career' in Diana's memo document I used the node link tool in NVivo to link back to Diana's original transcript and take a passage of text out of the original transcript as illustrated in Figure 6.

**Document 'DIANA', 1 passages, 568 characters.**

**Section 1.2, Paragraph 9, 568 characters.**

Um, and I can always remember as a child I was absolutely fascinated by the human body, I wanted to be a doctor when I was a kid but academically, I mean, I had a pretty sort of um poor upbringing and I wasn't very good at school. And, but I was always fascinated, I mean we used to play games all the time and I was always the doctor or the nurse and that kind of thing and I have always taken care of people. People seem to radiate to me, my friends, I was fascinated by, and if anything happened to anybody when I was a kid I always wanted to know what the go was.

*Figure 6: Memo extract from Diana's original transcript in NVivo*

This process of writing and linking to the transcript continued until the first cut of the story was complete. I then used my creative journal to help with editing and writing the story. Figure 7 is the first page of my creative journal on Diana.

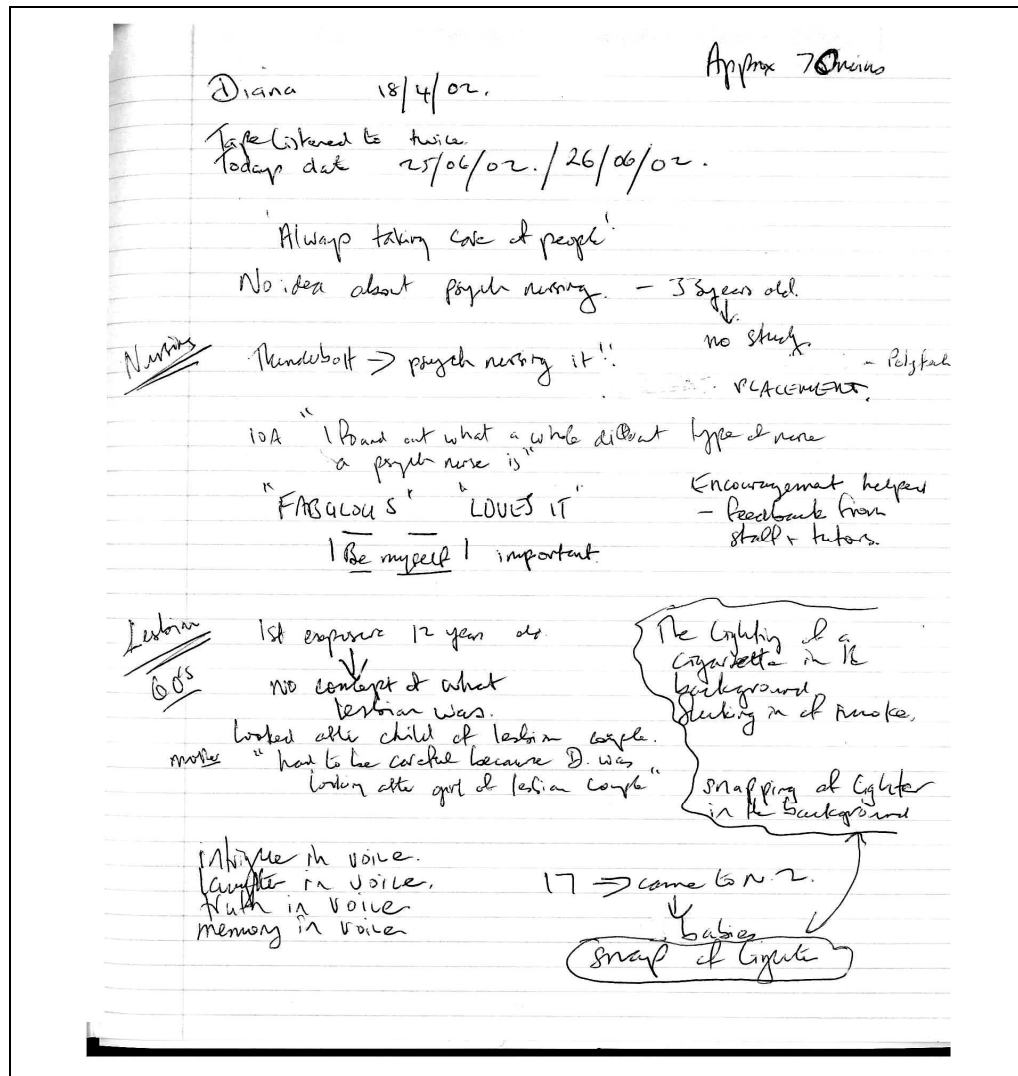


Figure 7: First page of my creative journal on Diana

The final version of Diana's story has taken shape. Figure 8 is an excerpt of the first paragraph from Diana's story, which is also in Chapter Four, Research Findings: Part One.

She tells me that she'd always been fascinated by the human body. That she really wanted to be a doctor, not a nurse. But she didn't have it academically, and besides, she had a poor upbringing and that meant she couldn't be a doctor. I sit listening to her recall her childhood and wonder how different it was for a child growing up in another country. Her mother had warned her about lesbians, told her she had to be careful (Diana never found out what she had to be careful of). As a 12-year-old Diana didn't listen to her mother; it's not much different whatever country you are brought up in.

*Figure 8: First paragraph of Diana's story*

Using Diana as an example of the process of writing the stories it becomes clear that a combination of factors have been used to create the licensed narrative. From the original transcripts, identifying material was removed and corrections were made to the text while the tapes were listened to. These were sent back to participants for comment and letters accompanying the transcripts and stories were also sent (see Appendix J). From here changes were made to the transcripts according to participants' wishes. I kept in touch with participants by writing to them again reminding them to send me any changes to their transcript (see Appendix K). All transcripts were then loaded into NVivo and coded. I then began to write the licensed narratives after much contemplation about how to do this, as described above. The final licensed narratives were then sent to participants for further comment (see Appendix L).

Much of what has just been described in working with the transcripts, with NVivo and writing the licensed narratives has implications for how rigour is achieved in this study. By this I mean that the research process is transparent and believable. I now focus on rigour as I understand it and how rigour has been addressed in this study.

### ***Rigour of this study***

The issue of rigour is one that is inextricably linked to any study, although its interpretation and application relies on the research methodology and the researcher's positioning. I believe research rigour is about making the process of the study transparent; it is about being open and reflective about not only how the study was conducted (and why), but how the information gathered in the research will be

used. For the purpose of this study rigour is concerned with the notions of validity and bias.

Mishler (2000) argues that for social scientists engaged in qualitative interpretive research “the standard approach to validity assessment is largely irrelevant to our concerns and problems” (pp. 119–120) and a new approach to validity is needed that considers the unique features of non-experimental research. Feminist scholars argue that traditional positivist notions of reliability and validity in assessing research rigour are problematic in feminist research because they are reductionist and rely on objectivity rather than individual subjective experience (Cook & Fonow, 1990; Fine, 1992; Hall & Stevens, 1991; Lather, 1991; Maynard & Purvis, 1994; Stanley & Wise, 1983, 1993). I identify with the way Hall and Stevens (1991) have positioned rigour in feminist research. They describe several ways that adequacy in feminist research can be achieved. This is through reflexivity, credibility, rapport, coherence, complexity, consensus, relevance, honesty and mutuality, naming, and relationality. Their descriptions of reflexivity, with emphasis on the examination of the researcher’s “values, assumptions, characteristics, and motivations” (p. 21) are features I have made explicit in my study. I believe the criteria they outlined have been achieved in my study.

Credibility, according to Hall and Stevens (1991), is about the research participants being able to recognise their own stories; something which clearly my participants affirmed. A fundamental premise that I valued with this study was the maintenance of a good relationship with the participants. Communication with participants was a key ingredient to the integrity of not only the emergent research design, but the negotiation of the presentation of their licensed narratives. True to feminist research processes, as previously discussed, I felt it important to keep connected with participants throughout the study. This involved not only conversations within the formal structure of the interviews, but also writing to participants to advise them of how the study was progressing and provide information about completed conference presentations. Most qualitative researchers are aware of the importance of giving feedback to participants and the need to validate participant transcripts (sometimes referred to as member checking). Added to this is the need to discuss with

participants how their transcripts and any material from their interviews will be explored and interpreted. While this was part of the process outlined in the information sheet participants received before agreeing to take part in this study it is nevertheless an evolving dynamic, because research is never static and new information changes thinking and approaches.

Rapport, as described by Hall and Stevens (1991), refers to engagement with participants and this I believe has been achieved in my study through prolonged contact with participants and their willingness to approach other potential participants to take part in this study. The way I have analysed the stories, taking stock of competing perspectives, exploring the different and competing complexities and showing the process of memo and journal entries adds to the criteria of coherence, complexity and consensus. Relevance, as described by Hall and Stevens “whether the questions address women’s concerns” (p. 24), clearly rests with the study being about lesbian experiences. Several participants in my study conveyed surprise at the follow-up phone interview after reading their transcripts that they had divulged such intimate details about their lives. Patsy said, “god did I tell you about that” and Jane queried, “Is this me, is this my life, did I say that?”. Equally, I have understood and identified with their stories as a lesbian, not a heterosexual. They have trusted me even though only some of them really know me. They have understood and expected that because I am a lesbian I will convey their experiences through a lesbian lens.

It was important to me the participants were happy with their stories and the way I had constructed them. This was confirmed from their feedback on copies of the final story. Nell commented, “[i]t has the flavour of what I was trying to say”. Sarah had this to say about her story at the follow-up phone interview, “[i]t’s funny isn’t it, it sounds a bit rubbishy. It’s that stuff about how you talk and how it’s translated”. Diana said, “I like the way it’s a story, it sounds like it’s really me. I think that you’ve done it really well, that’s the way I am. You’ve got the essence”. The ethics of the study have been served (honesty) and mutuality addressed through negotiated understandings about power with the participants. I also hold the belief that participants spoke about their experiences truthfully and with integrity.

While the criteria for adequacy in research, as described above, has been considered, I would now like to specifically discuss validity and bias with respect to my study. Validity in narrative, as with much research terminology, invites different understandings and interpretations.

### *Validity*

In determining how narrative is positioned with the notion of validity, Overcash (2004) notes that, “[n]ot all scholars agree on the notion of validity testing in narrative methods” (p. 17). Sandelowski (1993) observes what happens when stories told by research participants change as the telling of the story brings more experiences and different understandings and suggests “[t]he idea of empirically validating the information in one story against the information in another for consistency is completely alien to the concept of narrative truth and to the temporality, liminality, and meaning-making function of stories” (p. 4). She argues for caution in the use of member checking as a technique for establishing validity in research data, noting the stakeholder claims of both the participant and the researcher as impediments undermining the trustworthiness of research studies. The qualities she describes in staking these claims, such as maintaining personas that portray decent qualities, seem to me to be characteristics of ordinary human beings. Few participants actively seek to appear to be bad people and few researchers’ desire poor responses to their work. Sandelowski urges researchers to acknowledge the complexities of techniques such as member checking and look to our heart for a way forward:

Research is both a creative and a destructive process; we make things up and out of our data, but we often inadvertently kill the thing we want to understand in the process. Similarly, we can preserve or kill the spirit of qualitative work; we can soften our notion of rigor to include the playfulness, soulfulness, imagination, and technique we associate with more artistic endeavours, or we can further harden it by the uncritical application of rules. The choice is ours: rigor or rigor mortis.

(p. 8)

I was heartened reading this as it resonated with my desire to be a little playful and capture the essence of who these participants are, while at the same time conveying their stories and holding the integrity of the research within easy reach. I am not sure that using ‘artistic endeavours’ as an underlying premise necessarily ‘softens’ the notion of rigour; it may change it and present it in a way that frees us from the constraints that have controlled and guided the notions of validity expected and adopted in quantitative research realms as opposed to qualitative studies. Member checking in this study was ensured by sending participants letters updating them on progress and the evolving versions of their stories. These strategies ensured open and ongoing communication and encouraged feedback and comment from participants.

Poirier and Ayres (1997) warn of the dangers of challenging vulnerable participants’ interpretation of their own stories in instances when their narrative seems to falter or contradiction occurs. I did not feel these participants were particularly vulnerable given they were registered nurses and reflection is an expected tool of their practice. Therefore, I was able to seek clarification and negotiate understanding of participants’ experiences, which were reflected in their stories. We discussed shared and different understandings about how to explain their experiences in the context of this study.

### *Bias*

Throughout this study I have been acutely aware of the power dynamics and status of my role as a researcher, an educator and a psychiatric mental health nurse who identifies as lesbian. The potential for my knowledge and experiences in these roles to pre-empt research findings and influence the findings to the detriment of this study is a possibility I have considered. In qualitative research Gillis and Jackson (2002) suggest that research bias refers to “the systematic distortion of research conclusions” (p. 298) and offer the use of an audit trail as a strategy to minimise this.

Through constructing the stories for the participants I have been mindful of the bias and stance adopted and concur with the argument from James and Platzer (1999) that “if bias is seen as holding particular opinions and views of the world, then being clear about our biases and the ways in which we deal with conflicting opinions and



world views is to take a more open and honest approach to the research process” (p. 79). Thus, by being open and reflective about the research process, my positioning in this study, and the research itself I have foreshadowed this bias. Koch and Harrington (1998) are mindful of the tightrope walked between those we claim to represent and our own needs, adding, “the research project not only has the right to assert the interests of those studied but it is unavoidable that our interests are incorporated into the inquiry” (p. 888). I believe research should engage the reader and stimulate and challenge their thinking. Whatever bias is detected by the reader should have also been identified and discussed by the researcher. It then becomes a well-informed reader who can decide to what extent the findings of a study will change their opinion, add to their knowledge or challenge their understandings about, in this case, the experiences of psychiatric mental health nurses who identify as lesbian.

One of the challenges in portraying myself in this study has been to find the balance between giving personal information, which, if ‘overdone’, may be construed as setting out my credentials and hence my authority and power over the research process and findings. Writing me in to the stories of the participants ensures the connection between the participants and my worlds remains closely interlinked. This is unavoidable and, I argue, one of the strengths of this study. I view bias in this study as healthy, integral and entirely appropriate.

## **Summary**

Through history and time people have told and listened to stories. From ancient fairy tales to modern film, narrative has become part of everyday life; we listen to the radio, read books and magazines and surf the internet. It has found favour among researchers as a methodology designed to understand and make sense of people’s experiences. But it is hard to define, categorise and contain. Perhaps this versatility, this freedom, this fanciful play is part of why narrative has evolved and developed to appeal to a wide range of disciplines.

In the next chapter the reader is invited on many levels to engage thoughtfully with the participants’ stories. My reflective comments and metaphorical engagement

throughout the narratives are part of the creative context in which the characters share their stories. While each story and each woman is unique there are, nonetheless, similar threads intersecting across and through the stories. Some experiences are shared; some different. The licensed narratives say something about lesbian identity in New Zealand and about lesbians working in mental health services in New Zealand. They say something about the distinct culture of mental health nursing and of mental health services; about the social and cultural contexts that interplay with being lesbian in mental health nursing and the journey to being who you want to be. These stories capture the essence and uniqueness of their practice and of who they are.

The participants' stories, as licensed narratives, are presented in the next chapter.

## Chapter Four

### Research Findings: Part One

There are two parts to the research findings. Part One contains the participants' licensed narratives. Part Two of the research findings found in Chapter Five describes my thinking about the licensed narratives and how the narratives themes and sub-themes evolved. The two chapters co-exist and contribute to answering the research questions set out previously in this thesis; what is the experience of lesbian nurses who work in psychiatric mental health nursing and how does identifying as lesbian influence the practice of psychiatric mental health nurses?

In this chapter the licensed narratives of the 15 participants are presented in alphabetical order according to their chosen pseudonyms. Each story has been given a title based on what emerged as the essence of their story. These licensed narratives have been written based largely on the interview data gathered at the first interview. Subsequent to these interviews personal and professional circumstances have changed for some of the participants. Any change of circumstance is only mentioned if this change offers a different or new perspective to a participant's licensed narrative (Nell and Pita are two such examples).

Confidentiality was considered when writing these licensed narratives which mean individual characteristics have been made less obvious and identifying information has been altered or omitted. For example, one participant had several cats and also had a distinct accent, lived in a particular suburb, and had a unique nursing role. It is possible to identify this participant if all her characteristics and circumstances are combined and so care has been taken to ensure this has not happened.

The licensed narratives run immediately on from each other so as not to interrupt the flow or lessen the impact of reading a collection of stories. This immersion in the licensed narratives helps the reader to capture the full range of experiences embedded in the individual and collective stories.

The reader will notice there are italics throughout some of these licensed narratives. Italics are used to illustrate a change of emphasis in the participant's voice which I

had noticed when listening to the tapes. I made a note of the occasions when this happened in my reflective journal. The reader will also notice that unlike quotes from the participants in Research Findings Part Two Chapter Five, which have been indented, I have chosen not to indent these in the licensed narratives. The reason for this is so that the text reads more like a story such as one would find in a collection of short stories.

## **The participants**

While the individuality of each participant is important to convey there are none-the-less some shared experiences and common characteristics among the participants that help to define them as a group. For example, Diana, Gloria, Jane, Jean, Jude and Pam were all establishing or had established their lesbian identity before they went nursing. Some of these participants seemed to have a more in-depth analysis of how being lesbian informed their practice in psychiatric mental health nursing. Jude, for example, spoke explicitly about the therapeutic use of self in the nurse-client relationship. Several of the participants (Dorothy, Helen, Jenny, Patsy and Pita) tried general nursing before deciding that the rigid structures were not for them and they shifted to psychiatric mental health nursing. They all felt much more comfortable when they found mental health was more receptive to their evolving lesbian identity.

Participants who married men before coming out as lesbian (Diana, Doris, Helen and Patsy) all knew something wasn't quite right when they married. But they either couldn't pinpoint what this uneasy feeling was or wouldn't acknowledge their lesbian identity. This experience of marriage meant that they often came out later than other participants and had different life experiences behind them. They also had to consciously adjust from a heterosexual identity to a lesbian identity. For example, Helen spoke of her depression when dealing with this adjustment and the stress it put on her first lesbian relationship.

Collectively, the 15 participants have about 250 years of experience working in psychiatric mental health nursing. The years of experience range from 9 to 30. The participants have a phenomenal amount of nursing and lesbian experience among them. Individually they have a wide range of experiences in their nursing and lesbian

lives with some common threads adding to the richness of these experiences. Table 2 (Appendix H) shows a more detailed profile of the participants.

## **The licensed narratives**

The participants' individual licensed narratives tell much more about who they are and how they have lived a part of their lives. The collective impact of all these stories together is compelling. Each time I read them I am reminded that in our journeys towards lesbian identity there may have been times when each of us has felt isolated and lonely; but reading these licensed narratives is a reminder that we will never be alone. I am also heartened by the courage and determination shown by these nurses to be who they are against what must have seemed at times, insurmountable odds.

I begin these licensed narratives with Diana.

### ***Diana: Learning to be lesbian***

She tells me that she'd always been fascinated by the human body. That she really wanted to be a doctor, not a nurse. But she didn't have it academically, and besides, she had a poor upbringing and that meant she couldn't be a doctor. I sit listening to her recall her childhood and wonder how different it was for a child growing up in another country. Her mother had warned her about lesbians, told her she had to be careful (Diana never found out what she had to be careful of). As a 12-year-old, Diana didn't listen to her mother; it's not much different whatever country you are brought up in.

The lighter snaps as she stretches back into her seat. She takes a deep breath, sucking in the smoke, pausing to reflect on the shocking discovery that, "They were just beautiful, they were just so beautiful", these two women who intrigued her because they were a couple. But she was only 12 years old and had no concept of what a lesbian was. She used to baby-sit for them. "The mother of the child was a very ethereal kind of hippie-type woman with long hair and flowy bits and stuff like that. And her partner was butch as, but in a feminine way. She had some sort of office job. She went off to work every morning with her briefcase and she wore long, tailored

suits, sensible, tied lace-up shoes, very, very, short-cropped hair, no make-up. I mean, she looked like a bloke, but she was a woman.” I can tell that Diana feels something for this woman, remembering in such fond detail from such a long time ago. She pauses, sucking in the smoke, recalling that shocking time, knowing now that it was only shocking because it was her first time; her first exposure. There’d been no place for it to go then except into the ocean of childhood games and girly chatter.

The young girl that Diana used to look after occasionally had invited her into the house. She wasn’t supposed to be in there but the young girl was very fond of Diana and wanted to share the delights of play and adventure in her house with her. They walked in. “The partner was home. She was sitting on a mattress on the floor in the living room and she was doing something, my memory is a bit hazy, it was a long time ago.” Diana pauses again and takes another long drag of her fag. “She was doing something like playing the guitar. She was sitting cross-legged on a mattress on the floor and she had men’s underpants on. She had Y-front jockeys on.” Diana roars with laughter at the memory of this and her face comes alive. “She had Y-front jockeys and nothing on top. And her tits were there, they weren’t big but they were there.” She puts her hands out in front of her chest to show me how big the woman’s breasts were. She never went back in that house again and didn’t baby-sit for the young girl again either. Diana, the 12-year-old girl, was terrified. She didn’t give it much more thought and moved on, to marriage, to another country and to children.

The marriage didn’t last. She became single again but had children to bring up. It was hard and she was on a benefit. New Zealand had offered her a lot but when her mother paid for her trip to come home she jumped at the chance. It was to be a life-changing journey. Another snap of the lighter and a deep breath, eyes squinting, recalling the surprise, “I was a married woman.” She had gone with her mother to visit a friend, her mother’s friend, who was about the same age as Diana. “We walked into her house. And here is this woman sitting there, at the end of the kitchen table, and I felt my heart go boing, boing. And I went, oh my god, to myself. I still don’t have the words to describe it. My heart went down to my groin.” Her body is shaking, she’s laughing and smiling at the pleasure this memory bought her.

“Something spun around in there. I mean, I was a married woman. I knew what sex was. I’d had orgasms. But this was something totally different. And I thought, holy shit, this is something else.”

They were inseparable. Diana’s visit home to her mum took on a whole new meaning. One night shortly before she was due to return to New Zealand, Diana took the plunge. “We got shit-faced drunk and I told her, I just said, ‘Do you know how I feel about you?’ and she said, ‘No, how do you feel about me?’ and I was kind of hoping she knew a little.” Her voice betrays this hope. It stretches to the very core of her being, her every fibre aching for the feeling to be mutual. She lights another cigarette. I wait, tense and intrigued. Diana continues, “And I told her I could never have done it unless I was drunk, I’m sure. And she goes ‘Oh dear, oh I’m not like that Diana. I’m not like that. I like boys, I really like you and if I was like that it probably would be with someone like you because we get on so well together.’ But no, she wasn’t having a bar of it.” Diana was heartbroken. Time to move on, exit stage left. This was her first love; she knew what she had to do now.

Back in New Zealand Diana decided it was time to learn how to be a lesbian. She had no qualifications, no knowledge and was unsure about her skill level in the lesbian scene. She had no idea what skills she needed to be a lesbian. She had spent most of her life as a heterosexual woman, married, separated and single; but until now, essentially straight. She began by reaching out to some friends who she knew were lesbian. They looked after her, introduced her to the scene and were quite excited about the prospect of another woman joining the lesbian sisterhood. She met lots of different women who loved women. And she found her first woman partner; a relationship developed which was to last for several years. She felt relaxed and comfortable, and her friends and family were cool about her new-found identity. After all, she was confident and happy.

But something was missing: back to her fascination with the human body. The drive to pursue this interest came from knowing some nurses and her desire to find a career. Now in her 30s, she was bored with living on welfare to support her children and sought new challenges. If she could change her sexual identity from heterosexual to lesbian and cope well with it, she felt she could cope with nursing.

Her voice rises as she remembers her first time working in a psychiatric hospital. She was excited but scared. Being a student nurse in a chronic long-term ward was not something she had looked forward to or felt comfortable about. The ward charge threw her out into the dayroom after Diana had spent most of the morning in the office, too terrified to go out. Her instructions were to try to talk to somebody. She speaks slowly, trying to recapture the moment. "I just sort of wandered around them and got to feel a bit more comfortable." A long pause follows, as she searches for the words. "It just got, well it was like, it felt like something hit me. A thunderbolt hit me and I thought, my god, this is fabulous, I love it." Her voice raises several octaves and she appears almost to scream, "This is what I want to do." She wanted to be a psychiatric nurse. "Forget about blood and guts," laughs Diana, relaxing and reaching for another smoke. Later she describes this moment as a revelation in her life, "a bit like finding God".

She has been a psychiatric nurse now for about 12 years. She still loves it. She is totally comfortable in her nursing and her lesbian identity. It's obvious. She speaks with the wisdom of hindsight and the experience of someone who has led a colourful life. "I am quite good at being myself personally." It hasn't always been this way. She felt differently about herself in that first long-term ward. "I was feeling in the beginning that I would screw it up because I would look at them and they would think that I would think that they were freaks like I was in myself." She stretches out and tells me that part of the reason that she feels so comfortable at work is because of the lesbian legacy that went before her. Other lesbians and gay men had paved the way by working in mental health services and making it possible to be different yet be accepted. "It's not like it's a big deal. We joke about it amongst ourselves, we call ourselves family. We are family. At work everybody knows. There's no ostracising or anything like that." There is a song about being family that has been adopted by the queer community. I wonder if she has danced to it at the lesbian dances she has been to over the years.

The lesbian social scene is small even though Diana lives in a large city. Sometimes lesbian clients would be part of a social scene she was at. This posed a problem for Diana when she first started to work in the community. Nowadays she is much



clearer about the boundaries. Play time and work time need to be separate. She hated being at a party and someone asking her to check up on a script they needed the next day. “For them it was probably a really positive experience having somebody that they trusted, they knew socially. But for me it wasn’t all that great because it was like they knew everything that I did.” Her voice strengthens as if to emphasise the point. “They knew when I was out on the piss because I was out with them lots of times. They knew private stuff about me that other clients wouldn’t necessarily know. They knew when I’d had a fight with my girlfriend and shit like that.” She draws the line now and won’t work with a lesbian client who has known or knows her socially.

On one occasion Diana got into hot water with a client that she had been led to believe was lesbian. Another team member had written in the notes that this client had revealed that she was lesbian. When Diana next interviewed the client and indicated that she was aware that she had come out as a lesbian the woman said little. Diana had wanted to reassure the client that it was okay, that she was lesbian too and was happy to discuss anything if the client so wished. Later that same client wrote a formal letter of complaint, denying that she had come out to the other health worker. Diana was disappointed in this. “I hate making mistakes at work. That’s really not okay and I felt a bit stink about that. I thought we were doing good work and of course that’s it.” Diana throws her hands up in the air. “She never wants to see me again as long as I live. So that was a bit yuck.”

Given this unfortunate experience Diana was able to use this experience to help her to work effectively with lesbian clients. Diana has a great relationship with a client she has known a long time and who also identifies as lesbian. There is an unspoken understanding that both women have. When this client rings the crisis service and Diana answers the phone there is an air of resignation in the client’s voice: “Oh, it’s you Diana.” The client knows that Diana knows her well and, asserts Diana, “She can’t play her little tricks with me”. They get on really well and the boundaries have been well marked out so that any conversation is based on mutual respect and understanding. Diana doesn’t think that the success of this relationship has much at all to do with the fact that she is lesbian and the client knows this. She feels it is

much more to do with them knowing each other. I ponder this; then it occurs to me. They know their limits and boundaries but they also know each other as lesbians.

She stretches her arms out and yawns. She leans forward, her eyes full of concentration and inquiry. She hasn't really given much thought to how her lesbian identity influences her practice. She pauses, contemplates, and finally proffers, "I can't honestly say. I don't think any more so than what my life experience offers. I'm older, I started nursing much older. I had a lot of life experience behind me. It's a part of the whole as far as I'm concerned which permits me to do what I do well. I've got huge [she waves her arms around expansively] experience. Lots of life experience and that's what is valuable. Not necessarily just that lesbianism."

Diana is clear about her identity. Being lesbian is part of who she is and life experience is valuable to her role as a psychiatric nurse. In relationships with clients it is important to know each other but this doesn't mean spilling your guts to them about everything, including your sexual identity. Even though they may know anyway. It is important to get on side with people. The 12-year-old child has come a long way.

### ***Doris: Slow awakenings***

She's definitely not from New Zealand. Her voice carries a familiar English tone though from where exactly is hard to tell, somewhere in England. Doris is poised, cup of tea in hand, and ready to talk. She has a story to tell. It started with her childhood and the influences her upbringing had on her development as a woman and, later, a lesbian.

Doris recalls that she was always interested in helping people. She liked doing first aid and joined the local St John Ambulance at the age of nine. She was always helping her mother, who had asthma, around the home. Doris was a level-headed girl who didn't want to be a problem to her parents and wanted to help look after them. Sexuality was not talked about in her family and Doris remembers that the expectations were that she would get married and have children, there was no viable alternative. "I can remember being about three or four and there was a daughter of a

friend of my dad's, he used to go fishing with him, and she used to come round to the house and I used to kind of have this attraction to her but I didn't know what it was. I used to dream about saving her and rescuing her and having this kind of relationship where we were very much involved. Nothing sexual because I don't think I really knew what that sort of thing was." She describes herself as an anxious child who needed the security of sameness, not difference.

At high school she had a feel for biology rather than the hard sciences like mathematics. Education was not really encouraged at her school and one of her teachers suggested that all that she would be able to manage was a job as a shorthand typist. At about the age of 10 or 12 Doris felt that somehow she wasn't feeling the attraction for males that she was supposed to, "It didn't feel quite right for me". She started to feel an attraction towards prefects at the all-girls' school she attended but she wasn't able to talk about it or recognise it necessarily as lesbian. Doris recalls two of the girls at her school having a thing for each other. "They would pretend that one was the boy and one was the girl. Whereas all my other heterosexual friends, the boys would be coming to the gate at lunchtime, so the boys and the girls were trying to have some kind of interaction. But here were these two, one pretended to be the boy and be very masculine and the other would be the girl and be all girly. We all thought it was a bit weird but I thought, that's interesting. I mean they're kind of proposing something different to me here. I realise now looking back that I think she was definitely lesbian and her way of dealing with that was just doing what she needed to do, which was completely wacky and off-beam. But she didn't seem to get punished for it. So maybe that was helpful learning for me, and we all stayed friends."

Doris lived next to a psychiatric institution, and many of the staff there were her friends, so it was no surprise, given her interest in first aid, that she ended up nursing. She tried to find out more about the feelings she was having for women but came up against a brick wall. "We had very little on television about gay people. We had maybe one or two scandals but I probably ignored them because I didn't want to think about them. Then I started working at 16 years of age. There I was going into this female dominated workforce, not the least bit prepared for what that was going

to do for me, but then falling in love. I mean it was the women, and I was thinking, why am I falling in love with these women, why am I? There were all these men around me but there were all these strong feelings towards the women. Then I began to realise that it was a sexual attraction and so what do you do, you go and read the books. And what do you read in the library, the nursing library? You read about these perverts and deviants and I'm thinking, oh shit, you know. So I didn't even go there and I thought well, okay, it's just a phase." Doris tinkered with males, didn't mind kissing them but didn't feel the need to go any further than the tinkering.

The pressure to conform, albeit benign, saw Doris walking down the aisle marrying a man to whom she had talked about her feelings for women. It wasn't long before she realised she had made a dreadful mistake. "There wasn't any sexual kind of satisfaction, but I thought well, that's sex, you know. People talk, but nobody talked about sex in my peer group. In fact one of my close friends said, 'Oh, you know, it didn't feel right first time.' But anyway I thought, oh well I'll stick with it, it's my duty and that's what I grew up with." She sighs, carrying the heavy burden that some mistakes leave behind them, and continues, "You just stick with it and just be thankful he's not beating you up and he's not an alcoholic. Then of course I realise now that what I couldn't do then was the intimacy. Couldn't do the emotional connection either so we kind of dodged that by whatever way we could deal with it. That was obviously a great struggle for both of us and I think after the first year I could have quite easily have walked out of that marriage and been relieved. Probably after the first few months."

Not wanting to cause a problem and not really knowing what the problem was contributed to her inability to do anything about her marriage. She spent a long time avoiding and not confronting the issues that were making her unhappy. Feeling unsettled, she and her husband travelled abroad and Doris worked in psychiatric institutions, horrified at what she saw in some places. "Seeing some of those gay male clients, that was their only crime or their only kind of reason for being there, if you like, was that they were gay. But they were having these massive doses of hormones to decrease their testosterone, and just the stigma and discrimination that they were experiencing. And having a sense that this isn't quite right you know. And

then seeing girls of my own age, I mean 16 through 17 and 18, teenagers coming in, supposedly mad, but I could identify with a lot of what they were going through.”

Training in family therapy was to be the start of a life-changing journey for Doris. She had been travelling with her husband and working in different countries overseas when she landed a community position. “Two nurses were teaching there at family therapy. That was life-changing in many, many ways because of that systemic view. It reawakened the fact that I’d gone from looking at the world through that medical lens or being forced to look at it that way, but realising that I knew in my heart of hearts that there was another way of working with clients. And it was wonderful to go through that phase of making that transition in my own paradigm in nursing and then learning the skills, some formal therapeutic skills of engaging individuals, couples and families. I had wonderful role modelling from the nurses and other staff that were working there, working as a team of trainees, and seeing the live clinical work. Going in and being the primary therapist. It was a wonderful experience and it shifted me in lots of ways, obviously looking at the congruence of my own relationship and what I couldn’t fulfil in my own relationship, and then being expected to work with other people with couple problems and I realised that somehow, somewhere I’ve got to do something about this.” The realisation that she had to have her own act together in order to work successfully with others was simmering in her subconscious.

Travel and having children had helped to postpone the inevitable, but one day she found an opportunity to explore her feelings further. The culmination of years of denial and uncertainty gave her no doubts about what to do when the time was right. “I had the first kind of lesbian sex and thought bloody hell, this is what’s missing, then tried to deal with it. Tried to deal with him. Do we have open marriage, what do we do? Then in the end I thought this is ridiculous, I’m just going to have to leave, and I left because I’d met somebody who I’d been working with and she was a lesbian nurse. I wanted, I needed, role models, not having had them. I thought, well if I was going to be a lesbian I want to be like that one.” Despite a slow awakening to lesbianism, Doris embraced it whole-heartedly. She left her marriage, careful to

support her children in adjusting to their 'new' mother and negotiating her new lifestyle with friends.

She'd had a roller coaster ride to the realisation that she was lesbian and she needed time to adjust and develop her new identity. "I want to be different, I want to be on the edge, I don't want these nice corporate Hero parades, thank you very much. I want people up there, shocking the world and I want to still shock people by them knowing I'm a lesbian. But I don't want to be treated differently just because I am different. Now I wouldn't have known that 11 years ago. I wouldn't have been able to articulate that 11 years ago, whereas now I have to learn how to be a lesbian." She chuckles, and adds, "It's great". The early days of her new life were both exciting and emancipating. The child who sought security in being like everyone else was now an adult, taking on the challenge of being different and relishing it.

This boldness and excitement is, however, still tempered with the question of self-disclosure to clients, which she negotiates carefully. Doris reflects, "when is self-disclosure appropriate when you're working with a client? If some of the clients I'm working said to me, 'Are you married, are you with a man?' then I might choose to say no. I would say I'm not in a relationship with a man, I'm not with a man, and I'm not married any more. But I wouldn't then say that's because I'm with a woman, a lesbian. But if I felt it was appropriate then I would say yes." Having said this, Doris admits that she hasn't really fully explored self-disclosure in her practice. Her views about her own sexuality are still tainted by her upbringing and negative societal attitudes to homosexuality.

She admits to being quite a shy and fairly reserved person. Even so, Doris is out to her work colleagues but is still negotiating the tricky terrain of self-disclosure with her students. "I don't know how well to do that but I know I'm going to have to find a way to, because I'm also very aware of students coming through who may have issues of identity. I want to be congruent with what I'm teaching. I want them to be able to see that and be a role model because I never have been, so I'd better work out a way of doing that." She also needs to work out how she is going to be who she is within the organisation that both she and her partner now find themselves working in. She admits to needing to "shake off the homophobia" that has pervaded her own

journey and caused her to maintain a certain anonymity when it comes to her partner. She has changed. “What it’s done for me is that it’s given me an enormous amount of sensitivity, more so than I ever had about difference and tolerance.” She is still coming out and learning about outing herself. Doris would like to put herself forward, be available to clients, work more with lesbians and share her self. Then there will be more stories to tell.

### ***Dorothy: Fortune follows the brave***

She is a dog lover so the sound of my 4-month-old puppy yapping periodically in the background doesn’t annoy her. We sit comfortably overlooking the waves, the deep blue sea and the bright shimmering sun.

Dorothy has vivid memories of time spent around psychiatric institutions. Her parents were both nurses and she spent many childhood hours in the company of female psychiatric patients whom she regarded as her friends. Despite these fond memories Dorothy chose to do general nursing instead of psychiatric training. “I was really anti-psychiatry,” she recalls, which pleased her mother, who wanted Dorothy to be a general nurse.

Once registered, Dorothy fled nursing. “I spent a couple of years in the shearing gangs down south and that was very liberating because there were lots of lesbians down there at that stage, all the lesbians were rousing (sweeping up the wool off the floor in the shearing shed), so that was really good timing. But I got involved in one or two problematic situations and finally had to move town.” We both laugh. She doesn’t elaborate on those “problematic situations” and I don’t ask. She had no intention of going back nursing and went with a friend up country to work in a factory but this didn’t last. The first tea break was the opportunity Dorothy had been waiting for and she slipped quietly from the factory escaping the prospect of a boring, mundane job that she “couldn’t stand”. With no money, nursing was her fallback position and she took on a job as afternoon supervisor. Still harbouring anti-psychiatry feelings, she nonetheless became interested in psychiatric nursing when working in Accident and Emergency (A&E) where she had to deal with distressed people who had tried to commit suicide. Curious about this, and wanting to buy some

time while deciding what to do with her life, she decided to give working in mental health a go.

Dorothy was back to being a student again and doing a “lovely little 6-month certificate”, which was designed to upgrade general nurses to work in mental health. She had fallen on her feet and started to change her nursing focus. “I really learnt. The psychiatric nurses there were just fantastic because they were given a lot of responsibility, a lot of control. They were acting and operating autonomously. By crikey it was good, and the clinic was just fantastic. Because we were general nurses we were tolerated *slightly* but we were supernumerary. They were doing some really innovative stuff there. They had an adolescent unit, they had staff nurses taking caseloads and it was really, really good to see what psychiatric nursing could be.” The enthusiasm in Dorothy’s voice reclaims a time long past when nurses were in control of their nursing destiny. She went back to working in a surgical ward after completing her 6 months but she was unhappy. “Something had happened to me of course during that time, in terms of how I was with people.” The psych bug had bitten her and she went to work in a psychiatric unit, which she found both satisfying and challenging.

She then stumbled into a 40-week training programme after pulling out of a 2-year programme, which she found tedious, “Doing biology and colouring in diagrams”. She explains the different dynamic. “I withdrew from the 2-year programme which immediately meant I went from pink epaulets to brown, which meant I was a general nurse and they shoved me down into a real psycho geriatric area, it was terrible.” A chance encounter changed her fortune. “I was walking up the drive to work one day and I was thinking, ‘I can’t stand this, I can’t stand this. I don’t know what to do’. Then the matron drove past and said, ‘What are you doing with brown epaulets on?’.” Dorothy laughs. “I said, ‘I pulled out of the two-year programme because it was just too slow, I couldn’t hack it’. She said, ‘Right, you come and see me tomorrow and you’re in the 40-week programme’. So in a week I was in the 40-week programme, student-based, eight to four.” We both laugh; Dorothy had fallen on her feet again. Fortune does indeed follow the brave.



In her early nursing days she enjoyed the company of other nurses. “We were tough girls. We all smoked and we all drank. Half the time we got round with the policemen and the boys from the Catholic youth movement and the other half of the time we used to get round with the sailors off the ships. So we actually covered quite a lot of ground,” she chuckles. “We were just a good combination, we were eclectic.” She didn’t really know what a lesbian was; a knock on her door one day changed all that. A friend of a friend asked Dorothy if she could put up a woman, who was visiting from London, “And there was this *stunning bloody* woman. Long black cigarette holder, huge black glasses, red hair, real London type, leather boots up to here, short mini skirt up to here,” Dorothy puts her hands between her knee and thigh to show how short the mini skirt was, “and a long woollen tweed coat, just like what London was in the movies. I thought, shit!” she laughs. “This woman said, ‘Hi, I’m so and so.’ I mumbled, ‘Oh hello’ and she said, ‘I hope you can put me up for a couple of days’. And I thought, yeah, there’s a bed, there’s a mattress on the floor there. Anyway we lived like that for 18 months, with her on the floor and me in the bed. And we just had a ball of a time. It was so fantastic.” The 18 months together was strictly on a friendship, good time basis until, as Dorothy recalls, “One night she stood on a needle going from one room into another and I had to take her up to A&E on my motorbike and when we came back we just fell into bed here. It was just fantastic. I mean it was just perfect. However, it was a bit of a problematic relationship because she wasn’t actually lesbian and I wasn’t actually lesbian.” It didn’t last but Dorothy was hooked, once again.

She went out of her way to help clients she came across who she thought might be lesbian, because she realised that the psychiatrist would try to keep them in hospital “just for the hell of it”. “I remember a couple of times I used to take these women, they’d taken a mild overdose, and they were a bit upset, I’d take them out to the sluice room and I’d say, ‘This is what you’ve got to do to get out of here’. And I never came out as a lesbian myself to them.” She continues, in the swing and rhythm of remembering those days. “Now I remember this woman came in one night, a young lesbian woman, she was lesbian I think. She’d slit herself right up there,” Dorothy demonstrates a long swinging motion up her arm, “and her arm was bandaged. Her mates came in to visit her, four big Maori women and said ‘We’re

taking her out.' I was still very compliant and I said, 'You can't do that,'" she screeches and laughs. "And they said 'We're going to do it'. And I said, 'Please don't do it'." Dorothy's voice is quivering as she recalls her fear. "Anyway, the young woman, she was fantastic. She said 'Look, I'll be okay.' And I said, 'Look, I'm certainly not going to stand in your way.' Anyway they took her out. This young woman disappeared off the face of the earth. About 3 weeks later she somehow got hold of my phone number and rang me. She said, 'Thanks, thanks for not kicking up a fuss because that was the best thing you could ever do to me'. And I've never, ever seen her since in the system. And that happened with one other woman as well who wanted to go and I let her go. Risky, risky stuff. But somehow instinctively I knew, they gave me their word and I trusted them and they trusted me. And I don't know how you'd ever put that into a modern day practice." The puppy cries, his plea to be let out like the client's desire to be set free. He whimpers before falling silent, trusting that soon he will get the attention he needs.

Dorothy works as an educator now. Self-disclosure poses interesting challenges. She isn't against it, but, as she explains, "I really have difficulty. I'm not against disclosing but I also don't want to get into a new relationship or a communication in an official setting then all of a sudden say, 'By the way I've got to tell you that I'm a lesbian.' I have great difficulty flagging myself and the difficulty is, is it a political act or am I saying, 'Now that you know that I'm a lesbian ...'". her voice trails off. "I don't know what it is." She sighs, pauses. "Being lesbian is so embodied within me I don't see myself as different in a funny kind of way," she laughs, "because it's who I am". Dorothy continues; she has some more thoughts on how her lesbian identity influences her practice. "What am I trying to say? I'm trying to say that there's..." she takes a deep breath and sighs. "On the one hand, half the time my lesbianism is so internalised I'm actually not aware that my world is different because my thinking is connected with other lesbians in the community so that's my world. The heterosexual world I work in and live in is just there. So I go out of my lesbian world into the heterosexual world because that's where I've got to make a buck. I don't actually go from my heterosexual world into my lesbian world."

Once Dorothy did disclose to her class that she was lesbian. Following this she sought support from management because she wanted to cover herself. Her colleagues know that she is lesbian and sometimes she gets irritated by the fact that any students with gender or identity problems are automatically referred to her. “I don’t have problems with that but it’s a bit like ...” she pauses, “There’s always that crossover between the personal and the political. I don’t want people being referred to me because I’m L, because I’m the resident lesbian. At the same time in my teaching roles there are lesbian students and I think there’s something about me as a lesbian that actually enables us to have a conversation. And they can disclose if they want to.” She doesn’t tend to disclose her lesbian identity openly in her teaching but uses lesbian stories to illustrate points she wants to make and leaves it up to the students to make up their own minds.

Dorothy is ready for the possible heterosexual backlash. “I guess my bottom line as a lesbian, I’ve always said this, and sometimes it’s felt as if it was close and sometimes it’s felt as if it would never happen. But the *bottom* line is that at any time in this world heterosexuals can suddenly make it not okay for me to be lesbian and they can put me up against a wall and shoot me because of who I am. And it’s just a matter of where the tolerance level is in society at the moment. In 5 years’ time it might not be that tolerant. And I could be put against a wall and shot. That’s the bottom line for me being lesbian. I can actually be killed, banished, run out of society, heterosexual society, it just depends on the whim of the heterosexuals really, doesn’t it? When you think about it,” she laughs, “imagine some of our politicians [Dorothy rattles off a few names] getting into parliament and passing legislation. We’d become outlawed tomorrow”. Dorothy is strong, defiant, prepared. One day it may happen. It is time now, however, to free the puppy from his isolation.

### ***Gloria: We’re not all the same***

She took mind-altering drugs in her younger days, which gave her an appreciation of different perceptions of reality. Hence her interest in psychiatric mental health nursing and the people that were affected by mental illness and different realities. A jackhammer, a reality check on the hustle and bustle of city life, is making its way through tired concrete nearby and cars hum by on the motorway as she speaks.

Gloria had started nursing intrigued and attracted to another woman who was a psychiatric nurse. She also felt that she had something to offer, “I could offer good counsel”. So she went for an interview to do her psychiatric nurse training. “They were just enormously accepting and warm and, you know, it was a very friendly interview, it was very easy and I could just be myself. So that kind of confirmed for me that this is a good choice because I can be myself here and I was accepted and there’s something about these people that’s quite cool as well.” That ‘something’ factor was the two women interviewing her, one lesbian and the other bisexual.

Gloria enjoyed her training and the people she worked with. “There were quite a few flamboyant gay boys and there were some dykes who weren’t out and who were probably in their 50s and 60s. Then there were people like me who were out and for me it wasn’t a big deal, it was never a big deal. And there was quite a cross-section of people from different backgrounds. I *liked* the diversity.” A police siren pierces the air. Gloria continues. She developed an interest in family therapy and systemic approaches while doing her training. A continued passion about these ways of working and her training in counselling has sustained her interest in nursing. But now she has a strong management component in her current job and isn’t sure if she will go back to the clinical area.

Gloria’s mother was a dressmaker and this had an influence on how Gloria was dressed as a young girl. “I’ve got lots of photos of me looking very awkward and pained, smiling, you know, wearing something quite beautiful. If I look at it now, I think yeah it would’ve been better for somebody else to wear those wonderful dresses not me,” she laughs. “I couldn’t wait to get out of them and Mum would never insist. I’d then be able to get back into my real skin. The girlfriends that I had, the *female friends*, when I was 9, 10, 11, 12, 13, I certainly had sexual feelings towards them and I was quite confused about it. It wasn’t that it was bad just because it was a new feeling. But because it was a new feeling I didn’t really know what it was about, or who I could talk to about it. I didn’t feel ashamed of it. I just accepted it.” Even though she had this feeling, the word lesbian wasn’t in her vocabulary at that stage.

She recalls, chuckling, having rescue fantasies about an older girl in primary school. By the time she was 14 years old she came out and was able to articulate feelings that she had for other females to her close friends even though the word lesbian didn't resonate with her. "I didn't know and I'd been reading. I went to the library and I got this book about homosexuality. I thought *what is it?* It was, it was almost like it was scientific, and it was all about deviance of course then. I thought no, that's not me, I'm not deviant. So that doesn't fit, that word doesn't fit. I just talked about feelings with my friends. I said, I'm really attracted to this woman and I've got these feelings. My friends were great, I mean, they were all heterosexual, male and female, and just completely accepting and more concerned about how I was troubled by this because I didn't know whether I should talk to the person. It probably wouldn't have been a good idea."

The jackhammer brings us back to the present day and a time in which Gloria feels very comfortable with her sexuality and working in mental health services. "It's never been an issue, people have always known about my sexuality. I've not had to broadcast it, or I've been quite open about who I'm living with when I've had long-term partnerships. And I haven't come across anyone who's openly had a problem with me being lesbian or a dyke, or whatever. If they have, they haven't said anything so I haven't known about it. But it would be their problem. I'm very clear about that, it wouldn't be my problem." She chuckles, pauses, and continues, "I realised quite early on that there are a lot of gay and lesbian, even some transgender people working in psych and I liked that, although I don't think that we've had an influence on making it easier for consumers." To Gloria we are still invisible and will be visible only when policies and processes are in place that take account of non-heterosexual clients; when someone comes in to the service and can be accommodated if they feel safe to ask for a lesbian or gay nurse or therapist.

In her own practice she makes a careful and considered decision about whether to self-disclose. "What's the likely reaction to be? What will the consequences be? Are you ready to deal with whatever the consequences are? But more importantly is the person who I'm self-disclosing to going to cope? So it's usually informed by quickly thinking through those issues like I would for any other self-disclosure. It's got a

little bit more weight to it because it's about sexual identity and because some people can't deal with it, so that's why it's got more weight to it than any other self-disclosure. But I use the same kind of critique I suppose. Is this about my stuff? Yes, it is about my stuff but is it going to be useful and is there another way to do this?" Power dynamics in the relationship between herself and the consumer are something Gloria is very mindful of. Even if a consumer reveals that she is lesbian, Gloria is likely to consider how her own self-disclosure will impact on the relationship and what such a disclosure would have to offer.

Gloria acknowledges the difference it makes to her if she doesn't self-disclose. "Yeah, I'm sure it makes a difference, I'm sure it makes a difference. I think after disclosure there's kind of a little bit of, oh right, so we can have a bit more of an understanding here. There are a whole lot of assumptions; there are some common assumptions. Also there might be some we don't share. Lots of differences, because we're not all the same. So I think, hmm, I think ..." she pauses for a while before continuing, "Well, I guess that when I haven't disclosed it's probably, I've felt like it's not fair, it's not fair to sit on that, not to share that part of myself and that's felt uncomfortable and I was trying to think of the reasons for *not* disclosing". She hesitates and pauses, trying to think why she wouldn't self-disclose. Then it arrives, that memory you thought had gone for good but was still lurking, waiting for the right moment. Then, simply, "There was this incident with a guy and I didn't trust him. I think that's why." And trust is important, both ways. Another siren, an ambulance, closer this time.

Any problems with self-disclosure could be dealt with if, as Gloria puts it, "in the public mental health system people can ask, you can see a lesbian or a gay person. That's out there and it's already brokered so that when you meet with the person it's explicit. You know, this person is a lesbian and this is how it's been set up for me, so you don't have those sorts of dilemmas." In this situation a lesbian therapist would offer something different to a lesbian consumer. "I'd expect that that person would have a better understanding of what I'm talking about than if I saw this person who was a heterosexual. I'd expect that person to have a different sense of humour, to have that sort of queer perspective. They might even be knowledgeable about queer

theory. But then if it was me I'd think, well they might've had some very different experiences to me too and they might be highly political. They might have their own kind of expectations of what lesbian sexuality is and how it should be expressed, how identity should manifest, what you should wear, what you should look like. I don't know, there could be femme/butch roles, all that sort of stuff. That's what I mean about political, and that's largely why I've kept on the periphery because I do not want to be boxed. I don't want to be put in a particular mould. I've felt very strongly about that through my life. So if it was me as a consumer I would have those expectations but then I might have some of those reservations." Not every lesbian who seeks help from mental health services wants or needs a lesbian to work with them. We are not all the same.

### ***Helen: Careful and conservative***

She has prepared the office for our meeting. The fan, strategically positioned on the window ledge, is no match for the heat generated by the searing hot sun.

Helen went nursing when she was 17. However, an early end matched the early start to her career. As she explains, "In the 1970s you had to wear certain shoes and capes and hats and all this sort of rubbish. And you weren't allowed to speak back to the staff nurses and the sister was boss and I didn't like that really. I decided it wasn't really me". She enjoyed the nursing, but the environment, she laughs, just wasn't to her liking. Helen describes herself at that time as "bolshie", but she did leave with integrity and of her own free will.

The pull of overseas adventures sent her travelling, but nursing, with its promise of money, brought her back to New Zealand. She recommenced her training, with the added value of maturity, and was placed in a mental health setting once she registered, much to her horror. "I thought it was the worst *possible* thing that could happen. I thought I could go and be a surgical nurse or something. But in hindsight it's actually quite good because when I look at my original training, I did get quite anxious. To me, medical problems are more out of control than mental health problems. I'm a bit easier with psychiatric stuff." She leans over to open a window.

A gentle breeze flows in, but the air remains warm. Then outside noises intrude and she closes the window.

She recalls her first attraction. “I went to a girls’ school and I fell in love with one of my fellow pupils. As you do,” laughs Helen. “The games mistress was quite cute too,” she chuckles. “They always are. And I certainly had affection for this girl. She was younger than me. I used to do all the things like composing letters and all that sort of stuff. And then I didn’t really put a name to it, didn’t see it as being lesbian. I mean it was in the 1960s so you didn’t, it wasn’t as visible. Well, I didn’t think it was. And then when I left school it sort of just went into the background until I went nursing. I had an inkling that maybe I was more attracted to women but I managed to stamp on that one too. It was probably when I was 18 or 19 but I stamped on it until I was 30.” Stamping on it meant getting married. They had been together for several years before getting married but she had really married him at the end of the relationship. The marriage lasted 18 months. Helen was never really happy with the notion of heterosexuality. But what else was there?

Her first relationship with another woman required her to adjust from being straight to being gay. This was a significant time for her. “I think I ignored it for a while and the relationship that I went into wasn’t a good one, which probably allowed me to ignore it because I had too much else to deal with. And I did have a period where I probably was significantly depressed. I mean, half of it was that relationship but I’m sure that part of it also was that I hadn’t dealt with the shift from straight to gay. I just sort of assumed that it would all come right and that nothing would change and that I’d still be the same person that I was before. But it is a big issue because, I mean, I had to go through telling my friends and I lost a few because of that.” Between us we agree that the lost ones weren’t worth keeping anyway.

Telling the family was difficult as well. Both of Helen’s parents were upset. “The deal was that I would tell Mum that I didn’t have a sexual relationship, because I was living with someone at the time. So I told Mum I didn’t have a sexual relationship and she stopped crying. Now I don’t know what difference that makes to be honest,” she chuckles. “But Mum was also unwell. She had cancer and I think I told her two years before she died. So it was sort of ...” she pauses, regains her focus. “I wanted



her to know because I always had the feeling until I told them that I was being someone that I wasn't to them. So I wanted them to know. But I was quite happy to soften it a bit for her because she didn't need to know the whole thing anyway. I'm wasn't going to go and talk to her about my relationships."

Helen has a good relationship with her father now. But she regrets the impact that her revelation about her sexual identity had on her mother. "It's a pain really, that we have to go through it all. Because it retraumatised me again too, seeing Mum so upset. I thought she knew because she used to say to people, 'Oh no, I don't think Helen will ever get married again,' and I'm thinking, she knows, that's great. She didn't know a thing," chuckles Helen. "I don't know what she thought." Helen pauses again and murmurs, "so it was fairly horrendous". We both sigh deeply. These old hospitals are so heavy and oppressive. The office fan whirrs, circulating the same old tired air.

Helen has moments at work when she is jolted back to reality and the heterosexual world she lives in. "I tend to forget now that people don't know that I'm gay. I work in a very straight hospital setting here; it's not like mental health where being lesbian and gay is acceptable, mostly. In the general hospital they're still into talking about the 22-year-old getting married and they have parties where they all sit around. And I mean that's fine, that's their stuff. I just go along, because I'm so much older than they are. I just think that people know I'm gay. They don't ask me who my husband is or what he does or any of those sorts of things. So I just think to myself, well they know I'm gay. Then someone will say something to me and I'll say, 'Well yes, well I am gay'. And their face sort of changes. And I think wow, no they didn't know that," she chuckles. "So then I'm aware, probably that ward knows now." Helen expects people to know that she is lesbian but she doesn't tell them.

With clients she is circumspect about her sexuality. "Say if I was seeing someone who is self-harming, has cut themselves or taken an overdose, and they happened to be a mental health client maybe with a label of personality disorder. Often they will poke and prod at you. A lot of them have sexuality issues. I don't disclose because often, when I see them, they're in a fragile state anyway and I need to know them a little bit better before I say to them, well I'm gay blah blah. Because, it can be used

against you from time to time. On the other hand I have seen people, clients who have had issues, which are compounded by their sexuality. And if I think it's appropriate then I'll disclose to them that I'm gay and sometimes that can help in them knowing that I understand where they're coming from. Also that I can talk to them more appropriately about referral. If they know that I know what it's about and that I've got an understanding of what it is for them, then they feel more comfortable with the referrals, with who I refer them to, because they know that I'm in there with them, so to speak." If Helen comes across gay women whom she has seen socially she lets them choose whether to work with her.

Helen sums up her thoughts about self-disclosure. "The issue is how much to disclose. I have to weigh up whether disclosing that I'm gay to someone else who's gay, whether it's actually going to enhance the relationship or not. I don't do a lot of counselling as such, I do more brief interactive stuff, but occasionally I see clients as out-patients and part of my therapeutic process is that the client is the person who it's about and not me. And so I have to weigh very carefully how much information I give them. And if I were straight would I tell them about my husband and my kids? I don't know. So yeah, I sort of weigh it up as I weigh anything else up. I've got a client at the moment who is an out-patient, who has been gay and is now straight. She's been probing me a little bit, but I'm reluctant to disclose to her because I'm still not sure what she's actually wanting." Helen remembers being stalked by a female client once so she is even more cautious about what she tells clients and how she portrays herself.

Helen's manager knows that she is lesbian and so do her mental health colleagues. But in the general area where she does a lot of her work Helen feels that homophobia is rife and comments that part of this seems to be because there are a lot more religious people working there. "It was fabulous", working with lots of lesbians and gay men some years ago because, "all of us could be ourselves". The heterosexuals were the minority. Her experiences of homophobia take me by surprise. She has been screamed at by "someone who was psychotic" and punched by a bloke when she was working in the community. Indirect homophobia has come from other staff. "Sometimes it's not about me, but sometimes they'll talk about a patient being gay or

lesbian and it will have negative connotations. I don't know whether I'm a chicken or not. Sometimes I confront it, briefly. Mostly I let it go because it's often in front of a whole heap of people and they're all laughing and saying the same things and it's like, oh get a life. I also have to work with them and to get on the wrong side of them for pointing out something that I don't agree with, be it that or the drugs they're giving or the way they speak to people, isn't worth it in the long run. If I'm sitting around having a conversation with staff and something comes up then I'll normalise people's sexuality for them." For Helen, the smaller groups seem easier to handle.

Is she a better nurse because she is lesbian? "I think I'm more empathic with people because of it. Because I understand what it's like to feel belittled and what it's like to struggle with, not who I am, but presenting who I am, given that a lot of the people that I see are depressed or anxious. I don't feel as though I'm in a minority. I don't feel like I'm a marginalised person. *But* in respect of social mores and normality then I am. And I think I'm always conscious of that. I am able to understand rejection and low self-esteem and depression and all those sorts of things. I think that does help, mm. I'm also a bit, probably a bit more forthright because of it. Like I can't be bothered with being nice to people if I don't want to," she laughs. "I don't think that's right, I'm always nice to my clients you understand," she says, laughing again. "But, I mean I probably stand up for people a bit more because of it as well. Because I know that sometimes the things that you need don't always just come to you. Who you are colours how people perceive you and what happens to you, whether it is in a health setting or social welfare, or whatever. So I guess it does help me."

Helen can't be herself at work but isn't too concerned about this. "I'm careful about what I do in the hospital. My partner works here as well. I would no more hug her or give her a peck on the cheek, or call her dear or whatever other little thing I might call her, in front of staff members, even if they know that we're a couple, than fly to the moon because it's just not worth it really. Sometimes I get mad with the fact that we can't be open with each other in the way that straight people are. But I don't want to get bashed in the street and sometimes when straight couples are all over each other it makes me feel sick anyway," she laughs. "So, I'm sort of conservative I

suppose in some ways, but I don't like being the target of anyone's wrath or mirth or sarcasm or anything like that."

We conclude that the community she works in is small and conservative. Perhaps a blast of cold polar air to clear the homophobia and create a more accepting atmosphere is the answer. Something needs to give in this humid heat.

### ***Jane: Led to lesbianism***

She remembers as a 19-year-old having the best time ever at a party because "the boys were dancing with the boys and the girls were dancing with the girls". We both laugh, recognising and enjoying the naivety and innocence in the early awakenings and unfolding of lesbian identity. With the benefit of wisdom and hindsight, Jane realises that the head girl, who was a very out lesbian, had targeted her at school as a 'potential'. Jane had no idea what a lesbian was or even that she might be one.

While hanging around the Women's Centre, in something akin to a standby state, Jane met a nurse and they had some "nice chats". The attraction seemed mutual, but knowing what to do about it was something entirely foreign to Jane. Eventually, they both got it together. "But it really was something that I didn't know about, hadn't thought about it but the *moment I was there* that's who I was." A smile breaks across her face, revealing the excitement and joy at her discovery. "That's where I was going. Never a moment's doubt, never any discomfort and I felt okay about calling myself a lesbian. It was neat being around those early lesbian feminists, they just made it so ordinary and, you know, possible." Jane was looked after by other lesbians and recalls that an important part of her initiation into the lesbian culture was centred on meeting other dykes at the local pub. She used to drive a delivery truck and run a 'pick-up drop-off dykes' service to and from the pub.

Jane fell into nursing. She had been working in the blood pressure clinic but was having trouble hearing the readings despite trying very hard. Feeling that she "could do better" she went for an interview at the local psychiatric hospital. "They said I was just the kind of person they were looking for, a more mature person," she laughs. "So I started there. I was living with another lesbian at that time and she was a

teacher at a girls' school, and 6 months later she came to the hospital as well because she heard the stories and thought it sounded like a pretty neat place. So that was kind of how I got to be a lesbian nurse, it was just totally being led in the same way that I was led I suppose to lesbianism. Some kind person took me by the hand and pushed me in the door." Jane and I both laugh, knowing that sometimes a little encouragement goes a long way. Jane continues, recalling that she was quite out at work, indicating through her actions, her demeanour and her clothes that she was a lesbian.

She used to ride a motorbike and once a male nurse made some reference to "that throbbing machine between her thighs". Jane is philosophical about her response to him. "Well, it was almost pre-feminism really, at this hospital," she smiles, "and I handled it on the level that he was essentially a kind man acknowledging me in a blokey kind of way. I accepted it as a genuine interaction. He couldn't talk to me about my lesbianism but this was in some way a kind of oblique reference to what he thought might be in that arena. I never, ever got hassled. I never got directly hassled, and never got called names. Being a big strong woman kind of helps that really, people don't take you on quite so easily." She remembers that there were lots of lesbians and gay men working at the hospital as well. "It was just acceptable in the long line of weirdos and misfits that worked there. It was just something about [being] part of the fringe and everybody's behaviour was slightly outside the norm, outside the gates."

Jane has two female clients that she is currently open with about her sexuality. One of these women Jane thinks does have issues with her sexuality and the other woman hasn't, but Jane says, "It's just cool". When deciding whether to self-disclose to clients she is thoughtful. "Mostly I don't because it's not significant. A colleague told me that there's a line on the ground that moves backwards and forwards but you never, ever step over it. And I'm really clear about my boundaries on lots of levels in my work and it's immaterial apart from being integral." Recognising the irony in this, Jane laughs. "It's immaterial in a lot of the work that I do except of course for the purposeful use of self. What it is that makes me is important, but for the client it's not an important thing for them to have to know. And if they're interested and if they

ask me directly, and if I feel that it's safe, I'm really happy to be open. Very rarely have I been asked and had to deny it and that's been for my personal safety and safety of others. I'm really happy for people to know, for my clients to know. There's nothing about me that shadows that for them, I just am who I am, the way I am with everybody. But it's not something that I feel is right out there although there have been a couple of women over the last few years, borderline diagnoses, who I have been clear about it with. I've talked a little bit about myself and about my life and about the children in the relationship I have with my partner and things like that in order to give an opening for a discussion at some point if it seems reasonable, but neither of the two women are women who I've asked directly about their sexuality because with both of them the signals were, don't ask me about that." Traffic light colours come to mind, red for no, green for go.

Jane talks about the women she has worked with who are not explicit about their sexuality and are unclear whether they want to talk about it with her. "It's kind of like a pack of cards with women with personality disorder and lesbians, everything's sort of like shuffled and whichever card comes off the top is a wild card. You never know what's going to come." A good sense of humour is essential in her job. She works closely with a gay male client. "He says, 'It's wonderful having a lesbian nurse, you really know what it's like for me'. Then the next thing he is screaming, 'You fucking lesbian bitch, you think you know it all.' He came in here at Christmas and yelled across a really crowded interview waiting room, 'Merry Christmas lesbian sister'. I shouted back, 'Merry Christmas homosexual brother', which was great." We both laugh. Yes, it's important to have humour and to know when and how to use it.

She won't tolerate anyone giving her a hard time about being lesbian. "I am either in an environment that's comfortable for me, or I'll try and address it. If I can't, then I'm not going to stick around. I'm not going to fight the battle, battle, battle, battle. It's not my battle, it's the other person's battle. They can just sit with their discomfort and I'll go. But it hasn't happened a lot either. There's something about the intention; people read your intentions, and it's not my intention to be given a hard time about being a lesbian. I think with a lot of clients, they're oblivious to the world

and I think a lot of clients see me as kind of fun, have a word, you know, always acknowledge them, look them in the eye and say hello in the street or wherever, lend a helping hand, be warm and interactive. And that's who I am for a lot of people. Perhaps, for the people who know I'm a lesbian and don't talk about it, then I just presume that it's not an issue either. I've never had anybody say they didn't want me to be their case manager." She will go the extra mile for lesbian clients and recalls signing a sick certificate, usually the domain of doctors, for a lesbian who needed some space to sort her work hassles out. Jane feels confident to defend any clinical judgement in these sorts of situations, so far she hasn't been hassled.

As lesbians we have something unique to offer clients. "It's a lack of gain, somehow. It's like when you're at a party and you're having a good time and you have a good conversation with somebody you haven't had a conversation with before. They get to have good conversations with lesbians that don't have a lot of gain around it, that don't have a lot of expectations of anything except for an adult-to-adult conversation about things that matter. I think we're really adept at being personal without digging in an uncomfortable way. We're really adept at showing the fullness of ourselves and maintaining boundaries. And I think a lot of our clients would really like to live to the fullness of themselves but maintaining the boundaries. So there's something about what we do in the world that's appealing to clients who will also have some of those same difficulties with stigma; that stigma thing." As lesbians, Jane feels that we "know what it's like to stand outside". She adds, "And also it kind of puts us outside the possibility of any other kind of relationship. For the women, they're not lesbians so it's not going to be an issue there and for the men, they're not lesbians so there's not going to be an issue there. I think that in this heterosexual society in some bizarre flip-flop kind of way we're safe. There's a safety aspect to it."

Confident about her sexual identity, Jane reflects on how this has come about. "I am so essentially a lesbian. That's the core of my being." She feels that we have lost that "fighting edge" that we needed to have to survive in the 1970s. "Society's changed and we're just like middle-aged women now and there are so many of them that look like us now. Like in the 1980s nobody looked like us. You used to have to go to a special men's shop especially to get those blue overalls." She chuckles. "Nobody

looked like us and we went through that time when people enjoyed saying things like ‘Oh, is it a girl or a boy?’ and it was usually a boy with long hair. The flow-on effect from that is we just look really ordinary, normal, usual. Young lesbians with lots of piercing and stuff, they look like young people and we’re not that leading edge any longer, just boring old farts having fascinating, interesting lives.” We both roar with laughter, boring indeed.

### ***Jean: Not a nice straight girl***

She had a traumatic experience in her early formative years. Jean sits comfortably opposite me not looking at all traumatised, recalling her early adolescence. The benefit of age, experience and new knowledge helped to give her the insights she now shares with me.

Early on Jean knew there was something different about her. “My lesbian lifestyle came before any conscious awareness of lesbian nation; before I had access to any literature, before I really had access to the word lesbian. I remember being about 10, having a crush on the teacher. But at that age being really clear with Mum, my family and aunties and family friends that you call auntie, that when I grew up I was never going to get married and I wasn’t going to have children. And I’ve still got an auntie now who says to me ‘Oh, you’ll change your mind’. Getting a bit late, auntie.” She chuckles, mimicking her auntie. “So always, I just knew that what I saw as the norm around me, without knowing what the alternative was, that I just wasn’t going to have that lifestyle. And I guess it was helped by the fact that my mother’s sister was a dyke, and a diesel dyke, classic diesel dyke.”

Her first relationship with another woman was at the age of 15. Schoolgirl adventures. “That unfortunately had a pretty yucky ending. We both had breakdowns. She ended up having [electro-convulsive therapy]. I ended up losing 2 weeks, having no memory of 2 weeks. But it was the trauma of being so isolated. What we had between us fell apart because there was no support, we couldn’t tell anyone, it was a secret. We’d see each other in secret and that pressure was just too much.” However, she survived and now has a strong sense of identity. She attributes this to her involvement in the gay rights movement and the lesbian feminist



movement. The latter seemed to be a natural progression from early gay rights interests when she got tired of helping the boys who “were only associated with us when it was to their advantage”. Being separatist for a while, she says, has all been part of her journey.

Jean had originally wanted to be a social worker but her lack of formal education qualifications prevented her from pursuing this. Her links with a gay welfare organisation meant links with lesbians. One was a charge nurse at a hospital and she encouraged Jean to go psychiatric nursing and later became her lover. Jean left nursing after sitting her exams because she found that her approach to people with mental illness, very much focused on ideals embedded in recovery concepts, was inconsistent with the care given in the early 1980s. She needed to get out. The long break did her good and she returned with new energy. Jean had noticed that nursing, when she returned after a break from it, was quite different from what she had experienced some years earlier. She was now working with highly skilled nurses and consultants, and working in acute units where she learnt her de-escalation skills from nurses whom she describes as “outstanding”.

At one stage she worked with staff who were a mixture of gay and straight nurses. “There were three guys, one was straight, one was gay, and one was bi. The female nursing staff were exactly half straight and half lesbian. So in terms of it being an appropriate cultural environment for me it was very clearly there. And the other thing you get with such a high percentage of gays and lesbians is that understanding of coming from a *marginalised culture*. The care was a lot more empathic towards the mental health consumers and their marginalised culture. A lot more understanding of the issues, the -isms, of racism, sexism and ageism and all those sorts of things. It was a great place to work.” Her passion for her work comes through in her voice, carrying enthusiasm and renewed hope.

While she is out to her colleagues it is a slightly different story when it comes to being out with clients. “I’ve always thought, in terms of mental health, that there’s certain expectations on us about boundaries and for me my sexuality is one of the boundaries that I have with my clients. If they ask, I’m honest but I never push it and I don’t volunteer it because it has too much potential to get in the way of the

therapeutic relationship.” So how does she manage being Jean in these relationships? She uses neutral terms in communicating with people, like calling them partner instead of husband or wife. She doesn’t make assumptions about people, but leaves the way open for communication. “I think that because my identity as a lesbian is *so* much a part of me I don’t really even need to talk about it. I’m not Jean the lesbian mental health nurse. I’m Jean, that’s me, that’s my identity. If I categorise myself beyond that then my first categorisation is as a woman, then lesbian, then mental health nurse or whatever else comes beyond that. But I guess I’ve worked so long and so hard to have an integrated sense of self that the whole Jean is the package. As I say, sometimes I’ve had clients ask me about it and that’s fine.” She recalls a time when she was asked, “One guy I worked with extensively, he had an unstable bipolar disorder and was epileptic. He also had issues of emotional development, a very needy young man. He was walking back with me one day, we’d been out for a walk, and he says, ‘Can I ask you something’. ‘Yep’, I said, knowing what was coming. He says, ‘Are the rumours about you true?’. ‘Depends what the rumours are’, I said. ‘That you’re gay.’ And I went yeah and said, ‘Yes, so there’s no hope for you sweetie’”. Jean laughs and I join her. This direct question, with no undertone of malice or gain, would serve to strengthen the relationship. “It’s that honesty. I always try to be honest with my clients and if I’m not it’s because at that moment that call is the best. It might involve my sexuality, it might be around anything, but even if I’m putting someone in seclusion I’m always really honest.”

Jean’s boundaries when working with lesbian clients are clear. She has worked with some badly damaged women, most of them having a diagnosis of borderline personality disorder. She won’t work with new ones, but will work with others who know the boundaries. A past experience has helped orchestrate this approach Jean explains “She’d been discharged about a week or two before the lesbian ball one year and she found me there. In the end it got so bad on that night I stood up, leant across the table and shouted, ‘*I will not fuck you, all right!*’. And two nights later, she engineered her admission and I sat down and watched her do this stuff with the doctor. I watched her just reel that medic in and she got admitted into the new ward. I watched her interact and really manipulate. She’s an artist.” It took a long time for Jean to work through the issues with this client because it was compounded by

pressure from staff for Jean to communicate with this client. Jean was unable to engage in pleasantries with the client, who wrongly interpreted this as meaningful interest on Jean's part. To protect herself Jean had to change her home phone number and take her name out of the phone book.

On the other side of the coin Jean recalls a positive time that she had working with a lesbian client. "Things like treating the partner as a *partner*, not her friend. She comes into the meetings; we treat her like a husband or wife. To the point where the woman I'm thinking about, her partner was just blown away by the assumption that the partner would be included in all the decision making because she was her partner", Jean pauses. "And there's just subtleties, the aspects of the culture that you just know, you don't need to have explained to you so you don't go around stomping on people's feet. Working with gay guys and transgender people is the same. The respect that we have for other people with gender and sexual identity issues and the assumptions that we work with them with, give them much more room to be themselves. I also think they feel much safer because you can never tell who you're going to get if you've got a straight nurse and you're gay and what their morality is. And let's face it, certain nurses still get a buzz from imposing their morality on people. So I just think that it's been a relief for them in terms of not needing to explain anything, all the little things. Because someone understands their lifestyle, understands their needs and preferences." She reaches out and takes a sip of water; almost an afterthought, remembering it was there but caught up in the memories, the times, the experiences that were uniquely hers.

She continues, moving on from clients to her colleagues. "Mental health workers have extreme tolerance for difference in general. I've always felt liked and accepted. I'm not as blatant as I used to be. But there's no way that people mistake me for a nice straight girl. And in terms of my politics, my attitudes, my lifestyle, I'm very open about it and it's just accepted as part of me again in this team." As for lesbian and gay staff in my workplace, she is thoughtful. "I think there's a really high awareness of what constitutes discrimination amongst gays and lesbians because we experience so much of it. And therefore there's a lot more effort that goes into what

is the reality for this unique person, this unique time. That sort of care that you see is tailored to the individual regardless.”

Jean feels that her management is very supportive of her. “If I was to lay a complaint that someone had behaved in a prejudiced way and discriminated against me because of my lesbianism it would be taken very seriously. I think that the person who did it would be really freaking out if it got to complaint stage, because one of the things people tend to see more is if they treat their colleagues like that how safe are they with their clients? It does come back to that quite a bit more.” But she would be surprised if this did happen. “I don’t think I’ve ever encountered anything really horrible in mental health about my sexuality. I certainly have out there in the real world. The guys who say, ‘Oh, all you need is a good session with me and you won’t be a dyke any more’. It’s been years since I’ve put up with any of that nonsense. For all its problems I’ve found more acceptance in mental health than I have in the community at large. And I now expect it of course and if I don’t get it I get stroppy.” She laughs and takes another sip of water.

### ***Jenny: Not an issue***

She has a dog. It is in the backyard looking keen and anxious to meet the new visitor. We talk about dogs and share stories of our precious ones. Later she reveals that she had been anxious about the interview but didn’t quite know why or how to handle this.

Jenny started nursing at the age of 17 as an enrolled nurse. It took her 4 years to tire of the rigid hierarchical “yes sir, no sir” environment in the general hospital. Psychiatric nursing called to her and she went. Once she was registered, Jenny worked in a number of mental health settings before setting off overseas. Her quick summary of her nursing career somehow doesn’t do justice to the depth and breadth of experience many years of working in mental health has given her.

The age of 11 or 12 was significant to Jenny’s awakening sexuality. “It was a Catholic girls’ school, so anything sexual was closeted anyway. It wasn’t talked about. Girls were starting to notice boys and stuff and I wasn’t interested. I was more

interested in my best friends. I didn't really think anything of it but later on, I suppose the next year when I went to secondary school, I was sort of fairly aware of my feelings, being at an all girls' Catholic boarding school, but didn't really act. I think probably my first experience was when I was about 17, when I first went nursing." Jenny came out by "falling in love with another woman". At that time Jenny was living in a small country town and she felt isolated, "like the only one in the whole country". This isolation continues with regard to her family. She has never discussed her sexuality with her father. "I've never told him. We've never sat down and discussed it, he doesn't want to. My mother used to joke about it and say if she didn't know better she'd think that I was a lesbian and I did tell her that I was. I used to take girlfriends home and sleep with them and my father thought that was fine as long as it wasn't a man. Absolutely fine, good Catholic girls." As good Catholic girls we both appreciate the irony of this and laugh.

Jenny has little to do with the lesbian or gay community where she lives. She is too busy doing her own thing and finds it "too red-neck, too many rules, and too politically correct". She has clear boundaries between her work and her social life. "Usually at work I don't mention my sexuality; my colleagues are aware of my sexuality, it's not a problem. I don't have a problem with it, I talk openly about my partner. With consumers I don't, it's not an issue. If they ask me, I don't deny it. But as far as I'm concerned, my private life is private and I'm not there to discuss my life." But clients don't usually inquire. Someone once asked her if she "batted for the other side". Her response was that she did, "the winning side". She does seem to have a caseload where lots of clients have sexuality issues and she reckons that they probably pick up on the fact that she is lesbian. "I think they pick up that I'm not really that judgmental, that it's not a big issue and they feel safe, that they can discuss it, and it's not really going to go any further."

Creating clear boundaries with clients has its challenges. "Sometimes I find it quite hard because the boundaries do get blurred, particularly [with] people that I have been working with for longer than 12 months. Because I mean, some of them I spend a lot of time with so I get to know them really well. But sometimes I find that if I'm getting too over-involved I need to back off."

Jenny shares a couple of experiences she has had that she feels have influenced her opinions about self-disclosing. “Once I was working with this woman who was supposedly a registered nurse. I was the charge nurse. She had an alcohol problem. She came to work drunk and I just talked to her and said that I was happy for her to go home sick, to sort herself out and then come back. But she got all gnarly, like she was obviously really drunk. She got really gnarly at me and started to go on about she knew what I did and stuff and it got quite ugly. I just walked out and left her there and got my supervisor to deal with it. And they were really supportive, they were excellent actually.” It crosses my mind how she actually ‘knew’ what Jenny did. Perhaps another one in the closet? A more recent episode had Jenny wondering about the community she lives in. “When we lived out at the beach, one day there were some kids on the sand dunes yelling at us ‘dirty lessies, dirty lessies’. I just thought that that was quite funny because that’s obviously come from their parents who lived three doors down.” Out of the mouths of babes, spewing forth the hatred of those who harbour homophobia.

Mindful of her own experiences, Jenny reckons that “all the hard work has been done” and sexuality is much more fluid these days. On the other hand she feels that being lesbian is still problematic. “My partner has children and we both comment that we hope that her children are straight, that we don’t want them to ...” she pauses and searches for the words. “Sometimes I think that this lifestyle can be hard work sometimes. I think I’m very lucky that I do work in mental health where it’s always been accepted. They’re a bit more open-minded and accept you as a person, not as a label.” But as far as her practice goes, “It’s not an issue. I’m just Jenny. I’m just a psychiatric district nurse, just getting on with it, no different to anyone else. Unless the issue is raised and if it is a safety issue I do need to protect myself sometimes.” It is “hard because it’s dishonest”. But for Jenny it is necessary because of the possible repercussions. Not an issue, but hard just the same.

### ***Jude: I’m a dandy***

She describes herself as a “mature” student of nursing even though she is only 24 years old. Jude had dabbled in a number of things before going nursing, which was not on the agenda of careers initially. She thought nursing was “obscene” because,

“the gals weren’t allowed to be messy and they all had to wear stockings”. We have settled down into the big chairs both cradling our post-breakfast coffees and Jude is recalling the time she worked in Accident and Emergency (A&E) as a receptionist. She takes a long measured sip of her coffee and continues, “One day this woman came into A&E and we had to write down their names and things, and in those days I was being told off severely for asking women if they were Miss, Mrs or Ms. So I was already in conflict with the establishment,” she chuckles. “This lovely young woman came in and her occupation was registered nurse. I was reading the *Greenpeace Chronicles* at the time about all their trips to Mururoa and they had a nurse on board. They always had a nurse on board to look after people and this really interesting woman came in and I just liked the look of her. She looked *contained* and *healthy* and *positive* and her occupation was registered nurse and I was reading this book and I thought, wow.” Seduced by the image of this nurse, Jude did her nursing training, which she “enjoyed hugely”. She took on extra-curricular activities like being the women’s rights officer, which gave her the opportunity to show women’s movies, especially lesbian ones.

She had dabbled with a couple of women during her nursing training before she met her current partner. Once registered, working in mental health was a whole new experience for Jude where she “followed her heart” rather than the dodgy care plans that were around at that time. She recalls an interaction that changed her approach to nursing, a chat with a charge nurse. “I remember saying to her one day, ‘Oh, I can’t get so-and-so to eat, she just won’t eat, she’s doing this or doing that’, and this charge nurse said to me, ‘I think you’re expecting her to be normal, well she’s not, she’s unwell, she has a psychotic illness.’” We both laugh together, knowing the naivety of new nurses. “Something changed for me at that moment in that I needed to know a little more about the specifics of individual illness and presentation. Heart and good intention and willpower [weren’t] enough. So that changed me, I think for the better.” Jude then began to work more therapeutically with clients using psychotherapy as a tool to counsel them, seeing this as an extension of the therapeutic use of self.

Being lesbian didn't "hugely feature" in her nursing and she felt accepted by colleagues. Jude recalls being put on the spot one day by a lesbian who had a few problems with her mental health. She had met this woman socially and spent a pleasant day with her and some friends out walking. At that time the woman had revealed that she had a few problems and Jude had thought that she was a bit eccentric, odd but nothing more. "Well a few weeks later she ended up in the acute ward and was yelling through the ward for a couple of days 'Jude's a lesbian, Jude you're a lesbian', until I actually went and talked to her." Jude pauses, takes another sip of her coffee and raises her voice, "'Jude's a lesbian' was being yelled by this manic woman". We both chuckle, seeing the humour and embarrassment as Jude continues, "And no one was too phased by that. I was kind of mildly uncomfortable, then not. Then I thought, I'll go and talk to her." Jude slips into her calm and comforting voice, "I said, 'Hey yes, it's true what you're saying and it's fine that you know that. But how about not yelling it around the ward. If you've got an issue with it or anything you want to talk to me about, that's fine.' She was fine about that. I don't know what that was about. Some quest for contact or realness or trying to integrate something she found odd." Nowadays, when confronted by clients about her sexuality, she is more circumspect. "As a psychotherapist, if somebody asks me about my sexual orientation then my question is, 'How will that benefit you, therapeutically, what's the benefit to you if I answer that?'."

She was caught out once in group by a very distressed woman who claimed that Jude's mother was responsible for Jude being lesbian and she needed to resolve this. In supervision later Jude posed the question to her supervisor, "How can patients accommodate me being lesbian?" Her supervisor suggested that if there were an archetype that mirrors the lesbian then patients would be able to accommodate it. This intrigued Jude and she has pondered this for some time, finding the answer finally in reading and study, realising that Artemis, one of the Olympian gods, is the archetype. "So that kind of reassured me in a funny kind of way because I thought, well there is a place in the psyche for a lesbian. And of course she's kind of butchy sporty. Well that left me a bit fringe again, because Artemis is butchy sporty in the sort of psyche of the world, I suppose it's often what they think a lesbian is. So it left me a bit fringe again because I'm not a sporty gal, I like being active and healthy but



I'm not out there doing soccer, unlike my sister who's way more of an Artemis than I am, and she's straight. Then I was reading some books one day and there was this picture of some 1930s/1940s lesbians and here was this beautiful film actress in this gorgeous suit looking really gorgeous and it was a quote from her saying something like 'I'm a dandy' and I thought, *yes, I'm a dandy*". Jude reaches for the coffeepot, time for a refill. Her reading, her maturity, and dealing with herself has helped Jude to counter any wobbles that have threatened to crack open the lesbian psyche.

She has chosen to be out to lesbian clients and explains this. "There were times when I thought it didn't seem ethical to leave a lesbian client or patient not knowing that I was available as a lesbian, to be supportive. So there were times when I actually 'outed' myself to lesbian clients for that reason. I think in those situations it was really useful to be known as lesbian. And I think it's really useful to be known as *healthy* with lesbian, having a reasonably sorted personal life in a way too. Not to be some tragic kind of weirdo." Jude was angry and upset at the portrayal of lesbians and homosexuality as having a psychiatric disorder and annoyed at the disparaging comments made by well-known influential writers. Her voice rises and she rattles off names of some of these writers (for example Freud and Klein), accusing them of upsetting many lesbians and not taking responsibility for the damage and deep distress that their comments have caused. More recent influential writers like the gay counsellor Dominic Davies have liberated her thinking, which has helped her attain wholeness in her life and she applies this in working with clients. "If clients ask, I still have to think about how they'll deal with that information in a way that straights don't, but I sure as hell encourage the straights to think about that when they're asked or when they just say it. What do you think a client does, knowing you're married or knowing you're divorced or knowing you're a parent? I think it's really difficult in a mental health job being perceived by others as lesbian. But I think that what it does mean is that I will try and be honest with myself and do my own work, know me, be healthy, maintain health and try and have health in my personal life as much as possible. That's got to be good."

Working with young men has posed different challenges for Jude. "There's a lot of fear, especially among some young psychotic male clients, that they might be gay.

Some of that early developmental confusion around, ‘Am I gay?’ And that would be terrible. Or, ‘Am I attracted to men?’ So I can remember wondering about what to do with those encounters at the time. You’d be thinking, well maybe you are and that terrifies you. Or maybe you’re not but you’re doing some developmental thing about identity, kind of knowing who you are, and sexual attraction and sexual identity is part of that in the recovery from a psychotic episode, which I think is like a huge regression and they have to rebuild themselves again. That would often come up. So the gay man, the gay orientation, enters the realm of the weird and the shadowy and the dark and the frightening. Encountering those moments was often weird because I’d find that you do get a bit contaminated by some of that and I’d think, oh god if they knew that I was a lesbian and they’re in that state, will they run screaming or how do they accommodate this? I think the acutely unwell find it more difficult to accommodate anything that isn’t structured, but I don’t think they’re developed mentally at that acute stage, ready to accommodate the diverse.”

She recalls a challenge from one young man who was unwell at the time. “He’d say things like, ‘Why don’t you grow your hair long, your boyfriend will like it’. Those are moments when you think all sorts of things. You’re dealing with an adolescent psyche even though it’s a grown man and you and I know, and he was hugely sexist, this particular man. So, what do you say, do you say, ‘Actually I haven’t got a boyfriend, let me introduce you to a whole other concept of living’? Or, ‘It’s none of your business’? Or, what do you say? So in the end I said that I choose my haircuts for me, not for anyone else. Not to please anyone else.” Excellent answer, we both laugh.

The coffee has run out. The door opens and we are momentarily interrupted. Jude sums herself up and what being lesbian means to her. “I’m sure that a lot of it’s been my quest for self and okayness and wholeness as a lesbian. Because I didn’t like feeling like a deviant or pathological. I didn’t like that. It really *bugged* me. Whereas some lesbians I know are way surer about that and it doesn’t enter their head to feel too phased. Whereas I wanted to *prove*,” she laughs, “that I was healthy.” Dandy indeed.

### ***Nell: Sanctuary***

She steps off the plane and I know it's her straight away. Nell spots me and we walk towards each other smiling, knowing. We had never met before but somehow the connection between us was already there. It's a short drive to where the interview will take place and we chat on the way about her flight and the weather, keeping our conversation light.

She left school when she was 17. It was the last straw, getting detention for not wearing a hat to town. Nell didn't like authority being rammed down her throat, so being propelled from school was a relief. The money was good at the local hospital where she worked as an aide. Nell soon realised that registered nurses earned more, so she did her training. She speaks fondly of her training days. "Good old hospital-based training, which I think was really a better way of introducing yourself into mental health. I feel quite sorry for some of the new trainees and polytechnic students going through. They are expected to be able to deal with all sorts of people's problems when they probably haven't sorted themselves out sometimes. Yeah, it was good training." Nell speaks slowly, sighing as she recalls the early days. She is tired after a busy time at work and rushed to catch the flight, but adds, "Sometimes we would be third-year students and be in charge of an acute unit if there was no registered staff around. They'd just put you in charge. So you held fairly responsible positions towards the end of your training and you were quite capable of doing it. You knew the patients, knew the place really well and in those days they had supervisors going around the hospital all the time because there were students going through, so it was well supported nursing in those days. You could always call on someone if there was a problem and people were fairly approachable."

Nell suited psychiatric nursing and it suited her. She had always got on with people who were a bit strange, like the lady who was a "bit contrary" and the patient from the nearby psychiatric hospital who used to come and do the next door neighbour's housework. Nell liked to sit and have cups of tea with this patient and chat, she was never afraid of people who were seen as different. Except lesbians.

Nell was terrified of the lesbians at the hospital. “I avoided them like the plague”, she exclaims, not realising then that later, when she came to terms with her own sexuality, many of them would become lifelong friends. But for a long time she didn’t have anything to do with them. She used the years nursing to feel comfortable with herself and to come out. In many ways the hospital was a sanctuary. “It was the sort of place that, because there were so many gay people working there that were open, it was a really safe place. Even though I never used to go to work and talk about my partners or private life much at all. I still kept it to myself until I got to know people really well and then I’d sort of let it out a little bit when you’re having a cup of tea. I felt like you’d have to be nuts to be in a staffroom and be openly homophobic in that place because there were so many people around that were either gay themselves or were very good friends with gay people. And anyway, you were supposed to be non-judgmental in your job for god’s sake,” Nell laughs. “So yeah, it was good like that.”

Despite this it took a long time for Nell to feel comfortable about being lesbian. She’d come across lesbians as a youngster in the softball team but was advised, by the heterosexuals in the team, to keep away from them because they might “smack her over”. Even when she first went nursing a friend that she hung around with accused her of being lesbian, but, laughs Nell, “I was determined to prove her wrong”. Unfortunately this meant that she was subjected to male heterosexual advances and having to put up with “heterosexual shit”. When she finally starting mixing with other gay women she realised that it was okay to be gay.

Nell is a private person. She hasn’t spoken to her colleagues about being gay even though she thinks they may know. She wouldn’t deny it if asked. After much soul searching she deals with her family easily now. “I used to worry my guts out about telling them. Then I thought, no I don’t feel comfortable about it. I feel like they could throw it back at me some time or use it against me. So that’s probably why I didn’t feel comfortable about it. Then as soon as I thought, well I don’t have to tell them, I seemed to get over it and it was okay. That was it.” Matter of fact now about being gay, she says, “I figure if they don’t ask me, they don’t want to know”. She recalls some bad experiences with female clients, but there is a touch of humour in

her recollection of one incident. “I’ve had a woman screaming down the corridor, ‘You fucking lesbian’ after we had to put her in seclusion one time. And I thought she must be talking about me because the other nurse was a guy.” We laugh together, sharing the audacity of the moment. I try to imagine the male nurse as a lesbian and the stunned look on Nell’s face. It wasn’t funny at the time and although she chose to ignore it, Nell was hurt.

These days Nell works with mainly male clients. She gets on well with them and if she is asked about her marital status or anything private she says, “I just look at them and say, ‘Why are you asking me that?’ and they usually know that it’s none of their business”. She has never had a problem with her male clients. “It’s probably strange when I think about it with some of the people that I deal with, because some of them come from fairly hard backgrounds. Yet in the back of my mind sometimes I’ve thought, ‘He’s going to have a go at me about it.’ But it’s never really happened, thankfully. It could be pretty difficult if they took issue with it. Especially if they took issue with it in front of other people. I probably wouldn’t mind so much if it’s just me and face to face, just the two of us. But if you’re interviewing someone with a room full of people, or the police were there, or a student, it wouldn’t be very nice.” Especially difficult for Nell, who works hard at being non-threatening to her clients.

She feels that being lesbian does help with her interactions with clients. “You’re a minority, you’re an underdog, you are vulnerable probably. I guess if you think about it, a prisoner locked up is probably experiencing some feelings of what it’s like to be not liked because of your personality or whatever. And I think maybe that’s why I can relate to them. Because you know what it’s like to be, not *picked on*, but you know what it’s like to be in that position where you’re ...” she pauses, struggling to find the words, then finally, “What you’re doing may not be approved of by other people”. She nods, satisfied.

Then the question we all ponder at some stage, how much should we reveal to others about ourselves. “I don’t know whether it’s the right thing for me anyway, whether I should be saying that I’m a lesbian or not. I don’t know. I just feel that there’s a professionalism that has always been in mental health that you don’t reveal too much

to your clients, especially if they're likely to use it later on. Especially if you're dealing with some people who may be stalkers, or who may decide to have a look at you through the window of your house or something. There's always that element in forensic that you have to be wary of."

Nell has come a long way since her days of working in the large institution. "I was thinking to myself the other day," she muses, "that I was a little bit frightened about going back to my home town. I'd never lived here when I had a partner or been out or anything like that. So, yeah, I was a little bit hesitant about it. That's why I thought, if it turns to crap and I can't stand it and the family are getting on my goat and people are judging me, then I can bugger off. I can always go back to my other job, back to the safety net. But I'm really glad I pushed myself into doing it now because I think it's helped me accept myself and that it's okay for me to be who I am. And I'm not doing any harm to anybody else." Nell pauses, reflects and smiles. "So I think I have moved quite a lot in accepting being a lesbian myself."

I give Nell a lift to a friend's place. Even though she is tired we still manage to chat, to find common ground. Years of practice no doubt.

### ***Pam: By proxy***

She doesn't really have a lot to say about being 'you know'. After all, it's not a "big deal". We're sitting at her work, the sound of doors slamming and cars zooming by providing momentary distractions. She pauses, thoughtful about her life. "It certainly wasn't something I would talk to Mum about, who would still deem it, even these days, as something that *she'd* done." Her voice shifts, lifting, accentuating the deed. Pam continues, "Maybe through giving birth to me, or her parenting or somehow that it was her responsibility that I turned out this way," she chuckles at the silliness of such a thought. "So it's kind of led me to not making a *big deal* about it. I think the whole thing, be it probably 10 per cent cop out, by not turning it into a big deal and by being quite passive about it, and my partner is too, people get to find out by proxy," she laughs, "and it's accepted". Being attracted to women is something that has evolved over time. In her earlier days she admits to struggling with it. "Looking back on those days I was much more protective about only certain people knowing or

trying to keep it a secret, being private about it. I would freak out for short periods but then kind of get over it.” Even today Pam does not talk about it willingly with just anyone. Besides, Pam prefers to listen to other people talk about their lives. That’s why she is a mental health nurse.

A door slams close by; someone shuffles past our door down the corridor. One time, not long after returning to New Zealand from working overseas, she was highly embarrassed when a woman at her gym congratulated her. Through the sweat and toil of gym work a sisterly voice proclaimed, “Great to see that you’ve finally come out Pam.” A look of amazement crosses Pam’s face. She has moved on from that time. “It’s still something that sits completely right with me. It’s not something that I think, oh my god I’m doing the wrong thing here by being in a relationship with a woman. I’m completely comfortable with that. But for me it’s actually more about the person than the gender. So when people have said things to me in the past about being lesbian I’ve often said, ‘*lesbian?*’”, her voice rises slightly, questioning. She adds, “Like it just happens that the person I’ve fallen in love with is a woman. So, oh, that makes me a lesbian? So be it, but ...”, her voice trails off, she shrugs her shoulders. Everyone at her work knows. Pam hasn’t told them. They know “by proxy”. She is accepted for who she is.

It happened in a very small town; a while ago, but nonetheless it happened. Word gets around in a small place, people talk, clients share. “I had one young woman who I went to give a depo [contraceptive injection], and she refused. She refused to let me give it to her because I was a lesbian and she didn’t want me looking at her bum.” Pam laughs, recalling the incident, “I found that really embarrassing.” She didn’t give the injection. She was shocked, but determined not to let it go she rang the client 2 days later to see how she was. Pam felt it was important to follow up this incident. The client had talked to someone else and had said that she felt okay about it now. But Pam never found out what the client was actually concerned about. She is philosophical when I remark that it was a pretty brave thing to do, to follow up the concern of the client, faced with the possibility of another hostile response. “I’m quite passive about things generally. I think being relaxed, this is just how it is, it’s no big deal, makes it easier somehow to work through what the issues are rather than

it being a big horrific lesbian thing, or whatever you want to call it. I tend to take a lot of the emphasis off being different in some way or another when that's just how it is."

Some months later when I catch up with Pam she and her partner are shifting to a small community. She has to rethink how to manage the curiosity of people wanting to know about her and her partner. "I can relate to the idea of living in a cocoon which is quite comfortable for me and that's not necessarily about being in a gay relationship. Other things impact on that, privacy is one. The difficulty with where we are going to live is that it's not us going outside of our cocoon or coming out and saying to somebody that we are in a relationship. It's more someone else reaching in and wanting to find out."

Perhaps they will. If so it will be more than likely by proxy.

***Patsy: This is how it is***

She has the key ready to unlock the door as we walk down the pathway. There is a homely and welcoming feel about the house. Although it's early afternoon, the winter sun struggles to spread its warmth into the room. Patsy flicks the heater on and makes us a drink before settling herself into the couch. She faces me directly and begins chatting, hesitantly at first. It isn't long before she gets into her stride, chattering excitedly, recalling her journey.

Patsy went nursing because she wanted to look after sick people. But it wasn't long before she realised that she hated nursing. "I thought it was really pathetic," she laughs. She had to escape. Desperation drove her to move on from nursing and out of town. But really, she wasn't coping. Her new husband was a little bewildered as to the sudden change of heart. Patsy didn't tell him that she had fallen in love with one of her classmates, a female. It really was time to move on.

Escape seemed to be the theme for Patsy for the next few years. Escaping herself, nursing, and anything that threatened to expose her attraction to women. Even marriage was an escape, trying to prove that she was heterosexual while at the same time trying to please her mother. It was a tough time for Patsy, holding a marriage



together, dancing with danger as she found increasingly that attractions to women were fraught with despair and rejection when she reached out in hope. Always insisting to her husband that there was nothing wrong even when she ran the car off the road once after “losing the plot”, humiliated, having exposed her feelings to a close friend.

After various jobs, Patsy decided to give nursing another shot; she still wanted to look after sick people. Her attraction to mental health nursing was fuelled by her falling for a female nurse working in one of the placements that Patsy went to while still a student. Mental health seemed to be a safe place for her, somewhere she could playfully if not fancifully indulge in the fantasies that she had harboured for so long. “By that stage my marriage was completely a mess because I’d fallen in love with many women over the 2 years [of nursing training].” Finally, the time, place and person were right. “The funny thing was that once I had left my husband and was with my new partner I came out, everywhere.” Patsy laughs, warmly recalling the time. “Like overkill. It was like, well yeah, what’s the big deal. I had my parents who were hideous but it was like I wasn’t actually vulnerable to being humiliated again. It seemed like I was, it sounds kind of melodramatic, but it was kind of like free, actually just being me.” Patsy wasn’t bothered at all by the reactions of other people to her new revelation. She was “absolutely intoxicated” by her new partner.

Working in an in-patient unit was not a place where Patsy felt comfortable to self-disclose to clients. “I don’t think I came out to any of the clients there. I don’t think I would now either. I remember thinking how frightening it was when this colleague of mine was doing something with one of the clients in seclusion and he was screaming at her that she was a dyke and to get her hands off him and all this kind of stuff. And I thought oh, I don’t know if I can handle that,” she chuckles. “I think that would be really yuck.” We both nod together in appreciation and understanding. It is, however, some years later and things have changed a lot for Patsy. She has changed her focus in mental health services and worked in different jobs. With this has come an increasing awareness of the complexities of the relationships that she has with clients and the need to use her experiences as a human being, including being lesbian, to help others in deep distress. Her desire to “look after sick people” to the

best of her ability has lead to thoughtful and considered use of herself as a therapeutic tool in relationships with clients.

Patsy chats on about the various experiences of being lesbian that she has had in her dealings with clients and staff. I listen intently, captivated by her energy, enthusiasm, and forthright, matter-of-fact, 'this is how it is' attitude. You have to be quite discerning when thinking about coming out and weigh up the benefits. Like the young man who became very fond of her. "For him, he had a real immature sense of his own sexuality. It meant for him that he could talk to me about things that he hadn't been able to talk about with anyone. But it also meant that I wasn't potential fodder for him. He wasn't predatory. He was just quite immature. So whenever he had a nice relationship with a girl he'd think that meant that they should have sex and do the whole thing." Or the young male client who was shocked that Patsy was a lesbian, much to her amusement. He had gasped audibly, "What, do you mean you're an actual lesbian?". This disclosure came because Patsy felt that she had to put him straight about lesbians, he was expressing all kinds of stereotypical views about lesbians. The client's disbelief was cemented in the belief that lesbians look like men. Patsy does not look or dress anything like a man.

A male doctor accused Patsy of "looking for a cure" for her lesbianism when he found out that Patsy had self-disclosed to male clients. But Patsy shrugs this attitude aside with the contempt it deserves. She feels that with the air clear in these situations she is able to work more productively and proactively with clients, adding, "I've not had any kind of unpleasant experiences coming out with clients at all, ever. And that's quite a relief really. Well, it used to be quite a relief. It's actually not now. I've come to expect it now." She has also been accused by some colleagues of stretching the boundaries of the nurse-client relationship by self-disclosing her lesbian identity. She challenges this. "I would say, what do I say when clients ask me if I've had a good weekend? Or if I have had a good holiday? Would you not say that you were going on holiday with your husband and your daughter?" Patsy raises her voice, demanding an answer from her inquiring colleague. "So, how do I do that? 'Oh, actually I can't tell you that'," she reflects back to her colleague, gesturing and waving her arms in frustration. "I think that was probably where I thought, oh no I

can't do this. I have to live in the world and these people are people too and I'm a person and so if anyone has a problem with it they'll have to sack me. After I'd told them, I would always say to my client, if they had any difficulty working with me, then ...", she pauses, musing on her stance. "I used to do that and then think, well that was a waste of time because I just knew they wouldn't have a problem. I didn't pick people to come out to that would be safe for me. I picked people to come out because of the relationship and where it was. I wasn't ever worried about anybody telling me to piss off really."

Patsy has thought carefully about her positioning with lesbian clients and explains, "Generally I would decide to disclose to them either because they were lesbian, I mean then I just would straight away, or because the relationship needed to move and it was me that needed to move, not them. It needed to move into a place where, because we have huge expectations that people trust us and that they'll tell us everything that's bothering them, that we'll help them in the world and do all this stuff. And they don't actually have any idea who most of us are, or where we've been, or what we've done. So that was often when I'd make a decision to disclose to somebody that I was a lesbian." One young lesbian client who would get in people's faces because of her struggles with her lesbian identity found that with Patsy as her nurse she no longer had to 'defend' being lesbian.

Another young lesbian, Patsy recalls, "had enormous difficulties with her parents and all of her stuff was about being lesbian. She actually had good coping strategies. She was actually really well mentally. I mean, her mood would get quite low but overall she was young and she came out, full into the scene and it was all really overwhelming for her. All she wanted to do was meet one person that she could fall in love with and be with for the rest of her life and she was bouncing from one woman to another. It was all too much and her parents were horrible to her." This young woman had been in the service for 3 years before Patsy picked her up. She had a diagnosis of borderline personality disorder, which they both dumped immediately because, as Patsy explained, "I don't need it and you sound like you don't want it." Not wanting to blow her trumpet too much, but at the same time acknowledging her influence on the young woman, Patsy recalls, "She hadn't talked to anyone about

*being lesbian* and she'd been in groups. She'd talked about the fact that she was lesbian and how she was out and proud, and how she was fine. But she wasn't. She wasn't okay. She had a really good relationship with one of the nurses that was in the group with her. But as soon as I started talking to her I realised that she'd never talked about this before. Even though she'd had this great relationship with this nurse, and she did, it was a really great relationship, there's something quite different about talking to a nurse who has said to you, I'm a lesbian. So you can actually go blah, blah and blah. It's easy and I'm not going to be mortified at anything and I'm going to have some sense of what it might be like for you". While there is more chance of a deeper level of empathy if a lesbian nurse works with a lesbian client, Patsy is clear that you don't necessarily need to be lesbian to work with lesbian clients.

The air has cooled. Patsy turns the heater up and stretches out, yawning. But she is not done yet. She feels that colleagues still harbour fear about her sexuality even though she has not experienced any aggression towards her. Comments occasionally from friends referring to "those bloody lesbians" are said in jest, but tinged with an edge of distaste, which hurt her. Is she being over-sensitive? "They're actually just challenging themselves or exposing themselves a little bit, but at the end of the day I get a bit sick of it and who gives a toss really. They can sort out their own stuff." If things got heated and she needed their support she wonders if she would get it. "There was that incident in *ER*, that television programme, when Carrie and Lopez [two female characters] kissed. The man at the reception desk had made some remark like, 'You go to hell for that'. I don't know how many people said that same thing to me over the next few days." Patsy laughs, "You can't pull off lesbian humour if you're not a lesbian."

The journey for Patsy is not over. She has chosen to move to a place in mental health services where her role provides an opportunity for her to challenge staff about negative attitudes; where she can frame cultural safety sessions around not only issues with ethnicity but also difference and sexuality. She no longer needs to escape nursing or to escape herself. She is herself, like it or not.

***Pita: Free-flowing***

She is waiting for me, I can tell, but that is to be expected. We have an appointment and it has been easy to find the place. I am early so sit in the car watching, dreaming about my previous life in this city. But that was a long time ago. I was young, drove a Mark III Zephyr, drank lots of beer and smoked. Quite a contrast to the hired car I now sit in. The cigarettes have long since gone, although I still enjoy the odd ale or two.

Pita introduces me to her partner as I enter the kitchen. It's always nice to meet the girlfriend, if you can. It adds another dimension to the person, keeps the other half calm; or maybe me. I don't know Pita at all. She seems polite and caring, a little nervous, but that is to be expected when a stranger comes into your home, asking lots of questions about your personal life; very personal questions.

A luscious smell wafts in from the kitchen, the clatter and clang of cupboards closing, drawers slamming shut, metal against metal. Pita's partner is in the kitchen preparing dinner, a budgie is chirping loudly in the background. I wonder how this is going to sound on tape and how I'm going to concentrate during the interview.

"It is nice to be asked," is the response, when I enquire about how she got involved in nursing. A car roars past, the budgie chirps and a noise from the kitchen momentarily distracts me. It was a pot dropping on the floor. Her partner apologises. I've forgotten her name already, I'm no good with names. Pita's mother was a nurse. I wonder aloud later if this had influenced her decision to go nursing. She hasn't really given it much thought but agrees that it could have.

She didn't realise that she would have to do some psychiatric nursing as part of her training. It seems her tutors thought that she had what it takes and encouraged her to pursue working in mental health. She didn't really believe them at that time and went general nursing for a while until she realised that her skills really lay in talking with people. She found that she enjoyed working in mental health. She "fitted in", and liked living in the nurses' home.

Her family and her parents are important to her. Her father believed that the family were 'late developers'. He didn't really care about her being who she was, as long as she didn't 'take a criminal path'. She recalls telling her family about her new identity. "Once I realised, then I wanted to tell my brothers and sisters and they were all really cool. I knew they would be because they're quite adaptable. I'm lucky in retrospect. I told my mother and I thought she would never want to see me again and that would be that. And she obviously had a chat with dad. He wasn't too worried basically." Pita laughs, "So that's cool".

Pita admits that she likes to "fit in". She went out with boys but once she became more confident in herself, which seemed to coincide with working as a registered nurse in mental health, she started to look around at her options. Her friends accepted who she was, which also made it easier for her to live her life as she wanted to.

She screws her nose up and hesitates, thinking about her self-esteem. One job she had wasn't very supportive of her, people with particular religious beliefs had issues with her lesbian sexuality and she felt the scorn of their disapproval. Even those people in senior positions didn't accept her for who she was. It's so different now and she talks about it more openly with her colleagues. "I'm lucky to work with one or two gay guys and they make a bit of a joke of it. We are very professional but we have a few laughs occasionally. I enjoy that side of my work; working with gay people is very good. You can talk about your partners and their problems, not problems really, but different views." Her voice is confident, she knows what she is talking about here and wants to share. "Obviously it would get boring after a while, it's just good to be able to talk about anything with my work colleagues and I think in turn it helps me to manage in psychiatry." It helps too that the manager is gay friendly. "So I think having that starting from the top is that we are halfway there, we've got that support from the top, so I'm pleased about that." The budgie is squeaking with pleasure too, maybe it agrees with Pita.

She cares about how her clients' relatives see her. What they might think is important and she doesn't want them to take issue with her. She agrees that it is hard to shut out one part of who you are when you are working with clients and families. "I think it's quite free-flowing being a lesbian and being a community mental health nurse, being

involved with families and individuals. Sometimes there's no need for that side of things to pop up. Like, I've been doing my job now for 4 years and it's just like, 'Hi, I'm Pita' and it's Pita rather than a lesbian. I'm compartmentalising things here, but sometimes it's not so obvious, or it doesn't need to be obvious. But it's just the time and place and I think sometimes it may be crucial." More crucial, she says, especially if the other person is like her. But then she may not be the best person to work with the client. Just because they are the same doesn't mean that they are instantly compatible. Pita is open-minded when working with her clients. She thinks this comes from her own experiences and acceptance of people. She is free-flowing.

The smells from the kitchen have taken over the room. I would have loved to have stayed for dinner and they both invite me. A stranger, how nice, how friendly. I have another appointment. We smile. I thank them both and disappear into the night.

Some months later Pita tells me that she and her partner have broken up, but things are amicable. She "attempted to have a look at the heterosexual side of things and it's not really me and I've gone back to being lesbian again". I ask her why she had done that. "With the absence of 20 years I just wanted to see if I wasn't missing out on anything, but no, I wasn't."

We both laugh, relieved. She still has the budgie.

### ***Sally: Blowing rapport***

She sits there, composed and in control. "We had a really good rapport, but again I was closeted and would just never ...", she pauses, thinking aloud. "I'm going off on a tangent but a lot of clients don't even ask. A lot of clients are just so egocentric, quite frankly, and they don't want to know." She raises her hand and quickly, deftly lets it fall, hitting the table, slapping it purposefully. Oblivious, she continues. "She knew I had a child. Mostly we talked about her life and her wellness. I don't know what happened, but she started to get unwell towards the end of last year and just before she went into hospital she said to me on the phone, she'd been making snide remarks for a while about girls and I'd been ignoring them, then she said to me 'Oh, but you like girls, don't you?'" Slap, the noise echoes in the room as Sally's hand

bangs the table, defiantly. “I had this kind of flitting thing where I thought, well stuff it, there’s this kind of line where, okay, they don’t ask and I don’t tell. I just don’t tell. But she’s blatantly saying to me ‘Are you a lesbian?’ And I’m not going to say no. So I said, ‘Well yes, yes I do, but I don’t see what that’s got to do with what this conversation is about’”. The client wouldn’t have anything to do with Sally again, despite Sally’s best efforts to contact this client. “When I attempted to ring her back she just abused me. Then she went into hospital about a week later so she wasn’t well. Then I saw her about three times and she was disgusting, she was just disgusting.”

Her hand slaps the table, releasing the tension and hurt. I really feel for Sally; for every lesbian nurse who has been subjected to the rage and recrimination often associated with same-sex disclosure to the unforgiving. I ask Sally if it was possible that this client was disappointed in her for not sharing this information about her earlier in their relationship. She nods her head in agreement. “Yeah, probably, probably. I wonder about her sexuality as well. I do wonder about her sexuality and I think she questions her sexuality a lot, so that when she was unwell she was really angry with maybe my freedom and with me lying to her, never having told her before.” Her voice begins to quiver. “It was just foul. I went home and cried, she was so foul,” Sally’s voice rises to emphasis how foul this woman had been. “I’m no longer her key worker, I just can’t even forgive her. I think about it and I keep taking that to supervision because, you see I’ve got tears in my eye at the thought of it.” At this moment I feel little sympathy for this client; yet I try to understand, as did Sally, why this client would react in such a way. Could the fact she was getting unwell be an excuse? To bring someone like Sally to the brink of tears does not seem to me an easy thing to do.

We had talked earlier of Sally’s staunch upbringing, her nursing training where Sally described herself as a “naughty girl”, a tag given to her because of her involvement in the union and her constant challenges to those in authority about the way things were done. She didn’t see why she would be a better nurse if she stood up when a doctor or a sister walked into the room. She didn’t see why student nurses had to



wear uniforms, and with the assistance of the union she soon had students wearing ordinary street clothing at work.

It had never occurred to Sally that she was anything but heterosexual, she recalls, again slapping her hand on the table. “I had no idea, no idea. I remember when I was about 13, one of my sister’s best friends was a woman who was a lesbian and I was terrified of her. I thought that to be a lesbian you had to hate all men, have short hair, never wear make-up and never shave your legs and under your arms. Not,” she laughs, slapping her hand on the table, “that I do ever shave my legs or under my arms. So, I thought, how could I possibly be anything like that. So anything that kind of flitted into my mind very fleetingly was, well, I can’t be one of them anyway.” Things started to shift and her awareness of lesbians changed from fear to admiration. “I actually think it was going nursing, because we had three lesbian tutors when I first started psychiatric nursing. We had three lesbian tutors and they blew me away and I just thought they were the most wonderful things on earth. I just thought they were such *strong* [her voice emphasises the ‘strong’] women and fantastic, and I think there was this gradual dawning then.”

Sally came out in the 1980s after friendships with women, lesbian dances and “wonderful mind-blowing sex” with a woman. It was exhilarating. Her voice rises in excitement, cherishing the feeling. “Totally liberating, like completely liberating, you just want to scream it from the rooftops, *I’m a lesbian*’. And I remember feeling, in the kind of circle, that sort of lesbian circle that I was mixing in, a sense of, why didn’t I do it before? I was still a baby dyke even though I was 27. I had no problem coming out to friends and family, but in your practice it’s a completely different thing, isn’t it?” The tensions in this are evident. It is hard to be so close to clients, to be part of their lives and have them be part of yours, without sharing. And part of Sally’s despair and anger at how her client had reacted was merely a confirmation that others, if given the same information, might also react. Once bitten, twice shy, as they say. “I don’t care if the people that I work with or the people that I meet don’t like me because I’m a lesbian. I don’t have to have them in my life. But then, you have to have your clients in your life, you’ve got to keep seeing them and have things to do with them.”

Sally does not want to fail professionally and if clients refuse to work with her because she is lesbian, she would see this as failure. Being mostly closeted with clients is her solution. She likes her job too much, the passion shows in the rising excitement in her voice. “I really like it, it varies. It’s a caseload that varies from people who have been in the system for 20 years to those who have just come in. That’s a huge variety and my whole goal is to get people out of the system. That’s my whole goal and I’m not up front with them about that, but my goal is to be made redundant.” She smiles and her face lights up. “I love it.”

If Sally thinks the client will benefit from knowing that she is lesbian she will tell them. She even had a successful disclosure once. But it was a close call. Tiring of the assumption that because she has a child she must be heterosexual, Sally told a client. She had grown tired of the pretence and realised that she was sharing more and more with this client over what Sally calls “cup-of-tea therapy”. “The poor woman just completely freaked out, totally. Totally freaked out. It was typical of me, I just blurted it out,” her hand falls, connecting with the table and making that characteristic slapping noise. “The poor woman was just totally spinning. When I went to see her the next week, she was stammering about the terrible week she had just had. She had an anxiety disorder anyway and she’d had panic attacks all week. For her, she’d had nothing to do with lesbians and I was normal and she didn’t know why I had told her, what was the reason I had told her.” Things turned out for the better in the end and Sally remains the key worker for this “poor woman”.

Sally’s life experiences lead her to reflect that, “Because I’m lesbian I’m more open to differences. When I think about the ignorance that I had before I had any inkling of lesbianism, I probably wasn’t as open in those days to differences”. She pauses, struggling to find the right words. “What am I trying to say without saying differences? I mean I’m just so much more open to possibilities that could be happening in people’s lives. So if homosexual people come into the service, gay or lesbian, then I don’t have a problem. That’s a huge advantage because I think that there is still a running difficulty for some clinicians around homosexuality even though they don’t mention it. It’s sort of like outside their scope of what they know.” Sally thinks that she has even more of an advantage if people are questioning their

sexuality, especially with sexuality being so fluid in these modern times when labels will not necessarily be lifelong ones. But the old nagging problem returns, it is never far from her thoughts. To disclose or not to disclose, and does her silence do more harm than good?

Sally farewells me at the top of the stairs, still talking, exclaiming, remembering, and sharing. We will talk again.

### ***Sarah: Not a good lesbian***

She had no idea what she wanted to do when she left school. The bank job held her interest fleetingly but it was the “intense relationship” with a close friend that eventually saw her go nursing. The close friend was, of course, female and had also started her nursing training. It is a cold winter afternoon and we sit in Sarah’s study, hugging the warmth of the heater. Listening to her nursing story I quickly realise that this is a woman with whom you want to work, who encourages you to think for yourself and who is deeply and widely respected in nursing. It was a good decision that she made all those years ago to go nursing, but an even more crucial one exploring and finally realising what it meant for her to have intense relationships with women.

Sarah knew there was something different about her long before her first lesbian relationship. But like so much uncertainty that stirs deeply, she was able to shrug it off and replace it with an easier certainty. “Well, I didn’t know I was a lesbian until I was about 27, although there was something different about me and I always felt different. Intense relationships with women had been a pattern throughout my life. And I think that’s why I developed really strong role models in nursing, because they were all women. There were a couple of blokes in there as well but mostly they were women. But I never really wondered about it,” her voice is tinged with regret, “and I should’ve. In hindsight I should’ve because I was never really attracted to men and the few flirtations I had with men when it came to sex,” she laughs, “they’d end up disastrous”. Her first relationship with a woman was a disaster as well.

It happened while she was overseas and as I listen to her tell me about it I realise that this was tabloid material. This incident, if the media had got hold of it and distorted it in a way only sensational reporting can, would have sold newspapers in its day. It was traumatic for Sarah, messy and bewildering. Sarah was sent home, “with my tail between my legs”. She was ashamed and horrified at what had happened, determined to put it all behind her. She vowed that she wasn’t a lesbian, she didn’t want other people to think she was a lesbian either. It had been a terrible mistake. She needed to get married and have children. She grew her hair long so that she wouldn’t be recognised. But she pined for her new love and paid for her to come to New Zealand. Disaster reared its ugly head again as cultural differences injected fear and misunderstanding into an already tense relationship. Heartbroken, Sarah ended the affair and sent her lover packing out of New Zealand and back to her own country.

Finding it difficult to cope, Sarah plunged herself into work mode. “For a long time I didn’t tell anybody about what had happened, so I lived with all this stuff a long time. It just about drove me mad and I think I actually took out life insurance with the intent of actually ending it all a bit further up the track but knew that I needed to have a little bit of money to be buried or whatever. It was sort of stupid, I remember.” She pauses, blows her nose and continues, “I don’t think I ever really had the intent to do that but I just felt really traumatised and really unhappy and just couldn’t really figure out who I was and what I was about.” She pauses, turns the heater down and checks my comfort level. I am fine, not too hot, not too cold; totally absorbed in her story, her pain, her self-imposed isolation all those years ago; amazed at her resolve to bring her lover over from a third-world country to live with her in New Zealand against a backdrop of fear and rejection. Sarah lived in fear of being exposed. “I was the most homophobic person on earth at the time. Honestly I was. I thought lesbians were women with short hair and were half men, that kind of thing. But underneath I had this thought that that’s not how it is because I’m just me, I haven’t changed and I’m a good person and there was that sort of thing trying to fight through as well. And there was this sort of, this is who I am, and I just need to reach a point where I can accept this.” Eventually she allowed herself to start thinking about her attraction to women. She met a woman, fell in love and 3 weeks

later they were living together. It felt the right thing to do at the time and that feeling has not left Sarah.

Sarah and her new partner kept their relationship fairly quiet, careful to avoid the gossipmongers at work. It was a tricky situation because they worked closely together and any knowing nods between them could easily set tongues wagging. Mindful of this, they decided to work in separate areas. However, it wasn't long before word got around and they were both 'outed'. Several months down the track families were told, tears and rejection followed and only recently, after many years together, has Sarah begun to feel accepted by her partner's family. Over the years she has gradually become more comfortable with herself, and more relaxed about coming out. "But I think it depends on who they are, how well I know them and how well they know me. It's no secret, I don't ever keep it a secret nowadays. But still there's always something that might hold me back. I still have that fear of rejection and that fear of being looked at slightly differently. It's small but it is still there and I'd be dishonest to say that it wasn't." I appreciate her honesty, her revelation about herself and nod in recognition of this. She continues, "I do find myself holding my mouth shut a lot. I find myself in various gatherings and sometimes I feel like I'm trapped in a service and an organisation that doesn't support the very important principles that underpin me and who I am in my practice." As a manager Sarah is loyal to the organisation and has learnt to pick her battles. She needs to look after herself.

"I'm not very political," she smiles at my reaction; I look slightly dumbfounded. "It's not that I'm not political, I don't know what it is. I still sometimes wonder if there's a little bit of homophobia that sits with me, but it's about fitting in. It's about life being really busy at the moment. I'm just not political. I feel really confident and assertive in my own right but I still think sometimes I'm not a good lesbian. I should be helping part of the dykes' collective group here and helping out with things that go on and supporting within that group. I don't know if it's guilt, but I just feel that sometimes I can become quite isolated in a heterosexual world because of that. A lot of my friends are heterosexual and I often have to ask myself, am I still running from it, am I still not completely comfortable with it? I think I am. I think that gets better

and better as I sort of grow wiser and wiser and older and older. But I just love catching up with a group of lesbians or a group of gay men. It's just so different and it's just so me, and it just fits so well. It never fits quite that well at any gathering of heterosexuals." We both nod in agreement and understanding.

Sarah has never disclosed to a client that she is lesbian. This is partly because much of her nursing has been spent in management roles and partly because of an incident she recalls happened some years ago when she was working overseas in an acute intensive ward. "A guy was brought in with the police and a social worker. He came in and sat down and I was in charge on that shift and had to go and assess him. I went and assessed this man and I couldn't get a word in edgewise because he was quite manic, he was really elevated. He was abusive, calling me a fucking lesbian, telling me to get out of his sight and shouting, 'Look at what you're wearing', and going on." The comment about her clothing was particularly hurtful to Sarah because she had spent so much time before coming to work choosing what she was going to wear, making sure it didn't look too butch. She continues, "It was all directed at me. The two staff that were there were laughing along with this, not overtly but it was there. It was the most disempowering position to be in. Of course I was just so caught up in what I should be doing with this assessment, the policy, procedure, risk assessment and so on, that I thought I just couldn't walk away from this. I'm responsible for the safety of this man and the safety of these staff and I need to somehow work through this. In the end I did. I just walked away and said, 'Look, you're not going to talk to me, talk to this person'. And it was sorted out that way. But that was disclosure being done for me." Silence pierces the air; she takes a deep breath as she considers what she offers to the therapeutic relationship. "Just sort of being in touch with what would be going on with this person. Getting alongside people because of who I am and my life experience and the fact that I am a lesbian, albeit not stated ever in that moment."

Sarah; a person of outer and inner self.

## Summary

In some ways Sarah's story, with reference to her being "a person of outer and inner self", embodies the experiences of many of the other participants especially in relation to living the self-disclosure decision experience. Even for those participants who chose to self-disclose there were caveats around this. No participant self-disclosed her lesbian identity to a client or family member indiscriminately. It was always 'context considered' and mostly thoughtfully planned. It was seldom an automatic response to a given situation, so, while self-disclosure offered freedom on the one hand, and a chance to combine the "outer and inner self", there was acknowledgement that this was not always possible or desirable. If authenticity of self is viewed as being congruent with the "outer and inner self" what impact did this have on the therapeutic relationship, which is such an important tool in the kit of the psychiatric mental health nurse?

In Chapter Four, Research Findings: Part Two, I explain how the narrative themes identified in Chapter Five have evolved and how they address the issues around being authentic in practice. While the focus of this thesis is on how their identity as lesbians influences their practice as nurses in mental health it is important to remember that before they can be therapeutic in their practice, psychiatric mental health nurse have to know who they are. They have to realise the importance of the use of self in the therapeutic relationship. Therefore their personal lives, development of their identity, and their life experiences to becoming and being lesbian, are at the forefront of addressing the research questions about nursing practice. Unlike general nursing, where the tools are often mechanical, in psychiatric mental health nursing the primary tool is the nurse. In the next chapter I begin with an exploration of the narrative theme examining personal identity followed by the narrative theme in relation to professional identity.

The interpretation of the licensed narratives continues in the next chapter and the reader is invited to consider the contribution that the experiences of the participants in this study make to psychiatric mental health nursing practice.

## **Chapter Five**

### **Research Findings: Part Two**

This research describes the experiences of lesbian nurses who work in psychiatric mental health nursing and explores how their lesbian identity influences their practice. Narrative inquiry is a framework suited to understanding participants' experiences and is the methodology adopted for this study. Feminist research processes underpin the way that this study is conducted with particular emphasis on establishing a collaborative research relationship between me, as the researcher, and the research participants. The experiences of the 15 participants which are set out in the previous chapter were presented in the form of licensed narratives. This term, licensed narrative, expresses the trust developed between me and the participants during the research process and the understandings about becoming and being lesbian that we negotiated in creating their unique and individual stories.

In this chapter, I theorise about the participants' experiences in the context of the research focus, that is, what have their experiences working in psychiatric mental health nursing been; and how does their lesbian identity influence their practice? Theorising, as conveyed here and as I understand it, involves exposing my thinking about how the themes and sub-themes came about and how these themes engage with the research questions which are:

- What is the experience of lesbian nurses who work in psychiatric mental health nursing?
- How does identifying as lesbian influence the practice of psychiatric mental health nurses?

A combination of data from the original interview transcripts, the participant's licensed narratives (as constructed by me in Chapter Four, Research Findings Part One) and the follow-up phone calls to participants are used in the theorising and analysis process. So, how did the themes come about and how do they engage with the research questions?



## **Theme development**

Identifying themes and sub-themes required reading and re-reading all the data. In Chapter Three I describe how the data was analysed and how the licensed narratives were created with the assistance of the software package NVivo. The creation of the licensed narratives and the themes and sub-themes are closely related. Specifically, the coding process adopted when reading the original transcripts and noting my reflections on this process helped to organise my thinking about what broad themes would resonate with the collective experiences. Working with the transcripts, creating the licensed narratives and re-listening to the follow-up phone calls to participants enabled me to feel confident in creating themes and sub-themes. These themes reveal the subtleties in the participants' experiences that sit between, alongside and within individual stories. I have used segments from the participants' licensed narratives (Chapter Four, Research Findings: Part One) and quotations from the original transcripts to illustrate how the themes relate to the participants' experiences.

I had several ideas about the participants' stories I thought were important to explore. These ideas were triggered from participants' stories about how they realised they were lesbian; the dilemmas they faced in whether to or how to disclose their lesbian identity in their nursing practice; and finding and negotiating a place for themselves with their personal, professional and political identity. These dilemmas created a tapestry of tension about the decision to self-disclose. Uncertainty about disclosure, fear of rejection, isolation, and constantly shifting and mediating between the lesbian worlds and the heterosexual worlds meant that the tension created by constant weaving between worlds was ever-present. From these ideas, these experiences, themes and sub-themes have emerged to help describe and understand the collective voice of participants in relation to how their lesbian identity influences their practice.

### ***Narrative themes and sub-themes***

The decision about what to call the themes and sub themes has been an evolving process. At times it seemed like a circular process trying to get a feel for what overall theme might best represent or describe experiences that participants had shared with

me. Experiences seemed to overlay themes and finding the ‘fit’ for different experiences meant making a decision about the best ‘fit’.

There seemed to be a strong link between the identity of many of the participants as professional nurses and their personal identity. This link took me back to the political activity of the early seventies and at the same time resonated with a period when many of the participants were young adults. At that time there were a number of catch-phrases bandied about in private discussions between lesbians, at various meetings, protest marches and gatherings. One that I particularly recall, that still has some relevance today is the catch-phrase ‘the personal is political’. With this in mind and reading the participants’ stories and their experiences I have identified two narrative themes and three narrative sub-themes from the data. The two narrative themes are *personal identity disclosure* and *lesbian identity disclosure in the professional setting*. These two narrative themes with their reference to the personal and the professional sit alongside the ideological claim that it is difficult to separate your life as a lesbian from what you do in your professional life as a nurse. As with the catch-phrase ‘the personal is political’ both professional and personal identity non-disclosure/disclosure in nursing practice is also political. The politics arise from making a stand against what is deemed to be the ‘norm,’ in this case heterosexuality.

The importance of the link between the personal and the professional lives and identities of the nurses is crucial in the specialist area of psychiatric mental health nursing. Underpinning the notion of identity are different dilemmas that these nurses encountered both in their personal and professional lives about the disclosure of their lesbian identity. These dilemmas have lead to the creation of three sub-themes adding another layer of complexity in response to the research questions about the experience of lesbian nurses and how their lesbian identity influences their nursing practice.

The sub-themes help to explain and describe the context and environment that the personal and professional identity of the participants has shaped and been shaped by. These sub-themes are *making choices, tackling tensions and mediating boundaries*. Both narrative themes feature participants in their professional and personal identity

having to make choices about disclosing their lesbian identity and stories told about reaching this decision are integral to the research questions about identity and the influence this has on their nursing practice. Alongside decisions about disclosing is the ways in which participants handled the different reactions, both professionally and personally, to their decision about disclosure. Finally, the way participants negotiated/mediated the boundaries between relationships with clients, colleagues and others is a feature of many stories from participants. In Table 1 the overall framework for articulating the narrative themes and sub-themes is set out.

*Table 1:* Narrative themes and sub-themes

<b>Narrative Themes</b>	<b>Narrative Sub-themes</b>
Personal Identity Disclosure	Making Choices
Lesbian Identity Disclosure in the Professional Setting	Tackling Tensions
	Mediating Boundaries

The interface between *personal identity disclosure* and *lesbian identity disclosure in the professional setting* is integral and inseparable; both of these narrative themes co-occur. However, as argued in the previous chapter, because of the importance placed on the use of self in the therapeutic relationship (and thereby knowing self) the narrative theme *personal identity disclosure* is discussed in detail first.

### ***Personal identity disclosure***

The first narrative theme *personal identity disclosure* focuses on the coming out process and becoming lesbian which contribute to the way these nurses practice and how they experience working in mental health. For some participants (Dorothy, Gloria, Jane, Jean and Jenny) the coming out process and becoming lesbian occurred during the 1970s. The remaining participants (Diana, Doris, Helen, Jude, Nell, Pam, Patsy, Pita, Sally and Sarah) were working towards their lesbian identity in the 1980s, with one or two of them having their first relationship in the very early 1990s.

Four of the participants (Diana, Doris, Helen and Patsy) had all married before eventually coming out as lesbian.

While the narrative theme *personal identity disclosure* could be regarded as a backdrop to the research questions, it never-the-less has an important and enduring role in how these nurses engage in the therapeutic relationship. The journey to becoming lesbian on a personal level provides the setting for the professional identity of these lesbian psychiatric mental health nurses. No matter when they realised they were lesbian the participants were making choices about their lifestyle, tackling the tensions associated with this decision and mediating the boundaries at a very personal and often private level.

Participants' lesbian identity have been influenced by several different factors, including others' attitudes to homosexuality and lesbianism, both when the participant was growing up and when they disclosed to family. Some participants were able to make the connection between feeling different and their sexuality while they were quite young (in their early 20s or younger). For example Jean had her first lesbian relationship as a schoolgirl and said that "my lesbian lifestyle came before any conscious awareness of lesbian nation". As a young school girl, Jenny felt different because "girls were starting to notice boys and stuff and I wasn't interested" and had her first lesbian experience when she was about seventeen. Other participants were well into their 30s before these feelings about being different in some way translated to sexual identity differences. Sarah knew "there was something different about me and I always felt different" but didn't become lesbian until she was about 27 years old. What is evident now, in listening to their stories and talking with them, is that they have different ideas and opinions about how this difference now influences their lives.

Other people's attitudes had an impact on how participants formed their ideas and controlled their emotions while trying to express their thoughts and feelings in environments not always open to expressions of difference and indecision. *Personal identity disclosure* is presented using three narrative sub-themes to explore the issues.

### *Making choices*

For participants in this study *making choices* embodies the beginning process of lesbian identity. It started early for participants like Jane and Jean who had an idea when they were quite young that in some way they were 'different', and later for others like Diana and Sally who lived out their lives unaware there were alternatives to heterosexuality. The process of *making choices* is characterised by participants awakening to the fact they were in some way different, described by some women as not feeling they were able to "fit in" with their peers, uneasiness about the roles ascribed to them by society, and uncertainty about what to do about this uneasiness. It is also characterised by the decision about whether or not to tell family members and friends about their lesbian identity.

Two participants, Diana and Sally, did not consider the possibility of being lesbian, and firmly located themselves as heterosexual (even though they knew lesbians existed) until they felt sexually attracted to or had a sexual experience with another woman. For Diana it came as a complete surprise and caught her unawares:

Something spun around in there. I mean, I was a married woman. I knew what sex was. I'd had orgasms. But this was something totally different. And I thought, holy shit, this is something else.

For Diana this experience signalled the desire to make a choice about her identity. Sally was adamant she was heterosexual and made her choice based on stereotypical ideas of lesbians having short hair and being man haters. This attitude ensured that she remained in heterosexual encounters till she was in her late 20s. On a slightly different note, Dorothy and Nell had not really given it much thought to being lesbian until they met another woman, but they did not necessarily consider themselves heterosexual either. Dorothy literally 'fell' into lesbianism when a friend needed help, but even then she still did not recognise or claim the lesbian identity persona:

One night she stood on a needle going from one room into another and I had to take her up to [the accident and emergency department] on my motorbike and when we came back we just fell into bed here. It

was just fantastic. I mean it was just perfect. However, it was a bit of a problematic relationship because she wasn't actually lesbian and I wasn't actually lesbian.

Others spoke about their decision not to tell their families. Jenny has not discussed it with her father. Nell has not discussed her sexuality with her family either:

I think they just take me for what I am any way so it doesn't really concern them too much. I'm just a chicken. I just can't bring myself round to talk openly about it with them. I feel a little bit weird about it I suppose. It's like they don't talk to me about their relationship with their wives so why should I talk to them about my relationship. Or maybe I just sort of see it as part of my life but not all of my life.

Participants spoke less about making the choice to tell friends than family. There were risks involved in telling friends and participants who revealed their lesbian identity to friends recalled mixed reactions. Helen lost these friends altogether, while others found their friends very accepting of their self-disclosure as lesbians. While the loss of friends was regrettable, the upside was that participants gained new friends in the lesbian communities they then moved into.

Some participants had positive stories to tell about reactions from their own families. Diana's response from her sisters' reactions illustrates this:

I just rang them up and told them. I said, "I'm a lesbian". And they said, "You're what?". I said, "I'm a lesbian. Do you want to come and meet my girlfriend?". "Yes please", they said. So they came over, for the inspection. My brother didn't give a shit. Men, they don't care. I wasn't very close to him anyway. I didn't really have any big trauma with my family, or my friends really. For me, I think it was because I had confidence in myself and I was obviously much happier than I had been for a long time. And that's what my family said, what my sister said. "We don't care as long as you're happy."

Being so ‘obviously happy’ about their new revelation and being keen to speak directly to family about such an important disclosure seems to have helped participants to feel more confident and self-assured about the expression of their lesbian identity. As some participants found, having the support of family was important. Sarah’s comment typifies the easy transition that some family members were able to make:

My family were absolutely fine. I’m sure that they went through whatever they had to go through in accepting it and there was a few tears shed and that kind of thing of how I was sort of lost or you know died this sort of death and had come back as something else. It was all quite amusing at the time. But they’ve been great really, in terms of support.

Sally came out with a ‘hiss and a roar’ to her family and did not elaborate on any problems with the reaction of family members; nor did Pita or Jean. Jude, Pam and Jane did not talk much about their families’; it did not seem to be a major issue.

Participants, like Nell and Helen, from smaller towns and provincial areas, generally felt they were more exposed to the vagaries of gossip and more likely to be taunted and ridiculed if they revealed their lesbian identity. Jenny, who lives in a smaller community, summed it up:

If I was in Auckland I’d be happy to walk down the street and hold my partner’s hand but I wouldn’t do it here because it’s not really safe to do it. So you are always on the back foot.

Incidents where participants felt at risk and uncomfortable, triggered by external events, usually resulted in them internalising these emotions and feeling bad about being openly lesbian. Nell, Helen, Sally and Sarah also recalled incidents that influenced their attitude and behaviour both in public and at work and Jenny conceded that her whole attitude towards clients, and relationships she has with them about her lesbian identity, has stemmed from bad experiences.

### *Tackling tensions*

The dilemmas and associated tensions about disclosing their lesbian identity participants faced at a personal level arose from early experiences to do with family and society in general. Some participants were exposed at an early age to negative reactions about lesbians and homosexuality. Their stories suggest that the development of their lesbian identity was hindered by several factors. Negotiating these negative messages at an early age may have influenced the choices made by participants and their ability to contemplate a lifestyle that was outside of the so called normative ranges of acceptability. Diana reflected on early childhood experiences that illustrate the clandestine nature of any discussion about lesbians. Diana recalls being a 12-year-old receiving cautionary guidance from her mother about coming into contact with lesbians:

I had no concept of what a lesbian was but my mother and her friends would say stuff about them being lesbian and would make, I mean I didn't really listen to what my mother had to say, I wasn't taking much notice. But I think from the gist of it my mother wanted me to be careful because they were lesbians and I was looking after this child of the lesbian couple.

It is not clear what Diana's mother's actual concerns were, but Diana's mother and her friends gossiped and speculated about the women. Parental guidance and the tensions within that play a major part of the early development of children's thinking and Diana, like other participants, was likely to have been influenced by the attitudes of the adults around her.

For some participants becoming lesbian was influenced by tensions of public attitudes and societal views of that time. Even today Helen was cautious about fickle public attitudes:

I always remember a friend of mine who had been married for, ooh I don't know, nigh on 30 years and left her husband for a woman who had been a friend of mine for a long time, saying to me, "Oh no", she said, "Society's actually accepting lesbian women much more now



and it's actually quite good". And I said to her, "Have you listened to talk-back lately?" I said, "It's actually no different than it ever was". There's always, in my mind, going to be a level of society that does accept difference. But the level, the degree, the percentage that doesn't I'm sure is far greater. I actually don't think that ever changes.

Despite some participants not specifically referring to societal attitudes as something that influenced them, some did mention incidents where these did create a tension in terms of their behaviour and self-acceptance as lesbians. It is difficult to see how it couldn't. Being guarded about expressing affection with your partner or lover in public places or at work, listening to members of the public and religious groups decry lesbianism and homosexuality as 'immoral' and 'unnatural', and being discriminated against on the basis of sexuality are just some of the ways that participants struggled with societal tension associated with their acceptance of their lesbian identity.

Other participants were aware of this discrimination and ready to counter it. Dorothy, despite the fact her lesbian world has become her whole world, is still mindful of the impinging heterosexual world on her life:

I suppose for me that is the anger, "If you come too close to me I'll do you" and that's real street like, I'll tolerate this but you cross that line and that's where I'm strong being a lesbian. I will move around in your world and you can move around in mine but there are limits.

Dorothy is all too aware of the potential that right-wing politics has to erode the gains made towards equal rights and recognition of same-sex lifestyles since the 1980s. This potential threat requires constant monitoring. Nell also recognised that her tolerance for this potential backlash is limited:

Being in the minority, we get on with our lives, what choice do we have, lie down and say okay we'll go heterosexual. We do build up defences that we don't realise we've built up but we have to in order to survive. You do have your own line that you go to and no more.

Being aware of the possibility of losing their freedom, however that was perceived, meant a heightened awareness for some participants about what behaviours and attitudes they were prepared to accept and what they were not prepared to accept.

### *Mediating boundaries*

Participants had different experiences when becoming aware of their lesbian identity and the dilemmas in trying to walk in both the heterosexual and lesbian worlds. In mediating the boundaries between heterosexuality and lesbian identity a 'failed first relationship' with another woman was in Sarah's case a hindrance to confirmation of her lesbian identity:

I think I persuaded myself that it was just this brief period of my life and that it was going to happen and I'd get over it and move on. Because I couldn't be a lesbian, I couldn't come out to all these people. I'd be ashamed and horrified and I think for a long time people thought that I probably was a lesbian. Probably my whole family knew before I knew and some of my friends and people at work probably knew that I was a lesbian 10 years before I knew. So it was kind of like well I can't go home and have this be proved true. So I thought I'd go home and get married and settle down with a bloke and of course there was, I had this long-term relationship, which really when I look back was a platonic relationship with a man. Wonderful relationship and I think I used that as my sort of alibi really. So, I didn't really know anything about what a lesbian was.

This early intense and demanding experience of her first lesbian encounter sent Sarah scampering back to the normality of heterosexuality and the accepted societal boundaries this offered.

Some participants spoke of their involvement with various all-women sports teams and how this had influenced their beliefs about lesbians. Nell was cautioned by the heterosexuals in the softball team that she played in as a youngster to keep away from the lesbians in case they "smacked her over", but despite this she recalls those times with fondness:

We all got on really well but it was pretty clear who were the women that liked going out with men and who were the women that just liked going out with the other women. It was very noticeable when I'd go away for tournaments and there'd be other teams from around the country and you'd go to the socials towards the end of the tournament and the women would be dancing with each other.

This was Nell's first real awareness that lesbians existed, but it did not necessarily trigger any thoughts for her about her own sexuality. She observed women who were lesbian mediating the boundaries and finding a space to be lesbian in a predominantly heterosexual world.

Other participants in revealing their sexual identity had mixed reactions from family members. Dorothy could not recall ever telling her mother, but felt her sister's reaction was telling:

She's known me with my partners. I think my sister had a bit of difficulty with it. She demeans it sometimes.

For Helen, telling her family drew a response that other participants could also relate to:

Telling family was difficult. I told my sister straight away, I've only got one sister. She was good, she was very supportive, and she always has been. But Mum and Dad, I didn't tell until, ooh gosh it must've only been about 12 years ago now. So it was sort of 8 years after the event. And, my mother cried for 3 days (as they do). And my father said some quite hurtful things but you know we got past that. That was a reaction and he was just upset because Mum was so upset.

Some participants expressed uneasiness about being heterosexual. Doris, Helen, Patsy and Sarah knew something was not quite right, but for varying reasons they were unable to explore this uneasiness and three of them in this group married before meeting another woman and having a sexual relationship with her. For some, the uneasiness that had pervaded their pre-marriage lives had resulted in encounters with

other females, but these had been brushed aside for the pursuit of heterosexual marriage.

Sarah knew that she was different in some way long before her first lesbian relationship and spoke about the intense relationships that she had with women before she had her first sexual relationship with a woman. Patsy knew she too was different, but felt compelled to try marriage first. Diana also married and had children before she fell in love with another woman. They conformed externally to the societal boundaries associated with the 'norm' of heterosexuality. However, internally they were sub-consciously mediating the boundaries outside of heterosexuality but not being sure about being lesbian.

These instances of becoming lesbian are very significant in terms of being able to be with clients who may be questioning and exploring sexual identity issues. They are also significant in preparing these nurses to accommodate diversity and difference in their contact with clients.

### ***Lesbian identity disclosure in the professional setting***

The second narrative theme *lesbian identity disclosure in the professional setting* focuses on the issues around the self- disclosure of lesbian identity in the nursing practice of the participants. Featured prominently in this disclosure is the notion of acceptance of their lesbian identity within their professional practice and the impact this had on the therapeutic relationship.

Working in mental health services was often associated with positive identity development where there were many other non-heterosexual people working and colleagues were mostly supportive. There was still a cautionary approach from many participants who were mindful of keeping themselves safe from possible retribution in the workplace. All participants are aware that their work colleagues know they are lesbian. They either told them themselves or someone else told them. Participants who had worked in other nursing health services felt there was more discrimination against them and less acceptance of lesbian nurses. For some, like Helen and Jenny, their discomfort in working in these services prompted a shift from the general side

of nursing to a career as a psychiatric mental health nurse. There was a high level of confidence among participants that work colleagues had little or no difficulty coping with the fact they were lesbian, as this observation from Gloria suggests:

It's never been an issue, people have always known about my sexuality. I've not had to broadcast it, or I've been quite open about who I'm living with when I've had long-term partnerships. And I haven't come across anyone who's openly had a problem with me being lesbian or a dyke, or whatever. If they have, they haven't said anything so I haven't known about it. But it would be their problem. I'm very clear about that, it wouldn't be my problem.

Participants expected that working in mental health services equated with a high level of acceptance of anything that was 'different' from the so-called 'norm'. Jean's comment typifies this:

Mental health workers have extreme tolerance for difference in general. I've always felt liked and accepted. I'm not as blatant as I used to be. But there's no way that people mistake me for a nice straight girl. And in terms of my politics, my attitudes, my lifestyle, I'm very open about it and it's just accepted as part of me again in this team.

Even though participants felt accepted, Patsy wondered about the tensions of homophobia and how accepting colleagues really were as this observation suggests:

There was that incident in *ER*, that television programme, when Carrie and Lopez [two female characters] kissed. The man at the reception desk had made some remark like, "You go to hell for that". I don't know how many people said that same thing to me over the next few days.

Participants like Jean and Pita felt that management were very supportive of them as lesbians. Meantime Sarah, herself with management responsibilities, offered a different view:

I do find myself holding my mouth shut a lot. I find myself in various gatherings and sometimes I feel like I'm trapped in a service and an organisation that doesn't support the very important principles that underpin me and who I am in my practice.

Sarah does not want to be seen as different, overstep the mark or draw unnecessary attention to herself so she keeps quiet when at times she would like to speak out. She is silenced by her perceptions of others' reactions to her sexuality. Working in management in mental health services for Sarah necessitated her being silent about being lesbian.

### *Making choices*

In trying to decide about whether or not to self disclose some participants felt uneasy about the fact they had not or did not disclose their lesbian identity to clients.

So, making the decision to self-disclose was tempered with thoughtful consideration and at times much consternation. Safety is paramount in the decision about whether or not to self disclose. Although Doris had had little contact with lesbian clients she would often find herself challenging her own thinking about whether or not to self-disclose by asking herself questions like; what is it, what does it look like, what is therapeutic about it, how do we do it? She, like other participants, expressed disappointment in herself in some situations:

There are times when I think that I didn't tell that person so am I letting myself down. What am I trying to hide and I feel a little bit angry with myself because I hadn't disclosed. Then I think that the reason I didn't do it was because of this and that which is not about not being true to your self. It's protecting yourself which is probably just as important.

In this situation, like some of the participants, their own safety was fundamental in making the choice to remain silent about their lesbian identity. Sally described a persistent nagging thought that always seemed to be in the back of her mind about her preference not to self-disclose her lesbian identity to clients:

It's about the assumptions that people make in terms of who I am. I have that kind of nagging me. Then I have another thing that says the vast majority of these people don't really want to know that much about me anyway. They are distressed and are wanting some assistance with their distress. They don't really want to know about me. It's all about them. So it's academic, that nagging feeling because what difference would it make? It's not going to assist them in any way.

In this instance the safety of the therapeutic relationship underpins making a choice about self-disclosure. Another participant, Dorothy had tried to help younger lesbians when they were admitted to the in-patient setting, but had never disclosed her lesbian identity to them. Even so, she was still able to make a connection therapeutically although she chose to conceal her lesbian identity. She described helping female clients (who she thought might be lesbian) by taking them aside and giving them instructions on how to get themselves out of hospital.

Jean, while being very comfortable with who she is, had another view about revealing her lesbian identity to clients:

I'm very circumspect about how I push my sexuality with my clients and with my team for no other reason than I won't push my cause, that's not what I'm there for.

Her choice was very considered; while being clear about not wanting to self-disclose her lesbian identity she none-the-less keeps the door open to possible situations where it may be appropriate and necessary.

### *Tackling tensions*

Ethical integrity in negotiating the how, when, if and why of lesbian self-disclosure is a feature of the tensions for participants' in their decision making. Patsy chose to self-disclose her lesbian identity to a male client one time because of the stereotypical views the client was expressing about lesbians. Sally had a long and sustaining relationship with the client and blurted out her lesbian identity to her

because she was sick and tired of the pretence and the assumption that Sally was heterosexual. Gloria spoke of needing to establish trust before she would self-disclose. Participants remain true to their own identity, yet are concerned about revealing their lesbian identity to clients and the impact this might have. They make judgements and predictions about the client: their personality; past experiences; presenting problem; mood; background and stress threshold.

Jude's experiences' working with young males who thought they might be gay typifies the kind of thoughtfulness that participants engaged in when thinking about revealing their lesbian identity in the therapeutic relationship. She thinks that those who were acutely unwell were not ready to accommodate her being lesbian and her concern was for the client and their reaction. In tackling the tensions between disclosing to a client participants' assess the context and the environment beforehand. They do this not only for their benefit but for the client's benefit. This level of engagement with themselves is both demanding and rewarding.

Gloria expressed thoughts and feelings similar to those of several other participants about what influenced her decision about self-disclosure in relationships with clients. She outlined some of the tensions she has experienced:

It's that sort of ethical decision making and using your intuition and relying on the feedback from the other person, reading their body language or eye contact and making those often quick decisions always asking what the purpose of it is, is it really going to benefit this person here. Is it going to contribute in a really positive way to the conversation. You could disclose to someone and they could be absolutely horrified. They could recoil, they could really feel affronted, they could feel threatened, they could feel unsafe and then you've really lost them. They could also call on you about being inappropriate. That could happen. It's a possibility, you never know.

The fear of getting it wrong and causing pain and suffering to the client meant that care was needed in reading the cues, assessing the environment and taking care not to compromise the relationship between the client and the nurse.



Pam described having a nasty experience with a client who refused to let her give her an injection because she was a lesbian:

To me it was a focal point because it's the only singular event that's happened in my nursing career in regards to that and it was also influenced by working in a very small town, a very small rural area where boundaries and personal information just got around anyway, as it does. I was seeing half of the main street. It was actually a great influence on the things that people discuss. Small places are much more likely to be curious about people's lives and personal situation. That's why it made an impact in a way too, because I've always had this thing about people finding out by proxy or not necessarily saying to someone that I'm in a relationship with a woman because it's never really been appropriate to do that. It's part of me rather than something that I make a big deal about. It certainly made me more aware that part of this by proxy stuff is wanting to normalise the situation too and when I was challenged in that way it was interesting.

This tension, created by the interface between the professional and the personal lives, became an issue that Pam had to deal with. She reflected on this incident and rang the client a few days later, showing genuine concern in wanting to understand where the client was coming from. Although the client had resolved whatever it was she was feeling, Pam was unable to establish what the actual concern was the client had.

### *Mediating boundaries*

Participants were very cautious about when and where they self-disclosed their lesbian identity. When participants did reveal their lesbian identity in the therapeutic relationship they usually did so because of the benefits they felt this would add to the relationship with the client. They were thoughtful about how they mediated the boundaries around the use of this self-disclosure. Like most participants, Jude was clear that the boundaries around self-disclosure to clients were something that she considered carefully:

As a psychotherapist, if somebody asks me about my sexual orientation then my question is “How will that benefit you, therapeutically, what’s the benefit to you if I answer that?”.

Patsy had a slightly different take on how she used her lesbian identity with clients:

My level of authenticity is necessary because for really badly injured people to be in a relationship with somebody, they need to know that the person actually does care about them. It’s not just about doing. It’s all that stuff that you can’t write in a care plan I guess.

For Patsy her level of involvement and establishing boundaries with her clients meant at times that the best call was to self-disclose her lesbian identity.

Several participants spoke about the boundaries that they put on working with clients who identified as lesbian. The negotiation of these boundaries was often based on previous experiences that the participants had had with lesbian clients. Views about this varied from participants not wishing to work at all with lesbian clients, to feeling okay about working with them to expressing caution about working with them. Diana was clear that these days she will not work with clients who know they are lesbian and whom she knows socially. She has learnt her lesson about professional boundaries when working with lesbian clients but recalls that she was not always that clear:

I’m more experienced. It was quite a few years ago, when I first started here and I was just learning how to be a community mental health nurse. I think it made me feel good that they wanted me, you know. They fired all the other nurses and said “No we just want Diana, we don’t want anyone else”.

In contrast to this, Helen had a slightly different approach in mediating boundaries with lesbian clients whom she knows socially:

Sometimes I see gay women that I’ve actually known socially and that’s interesting. And I give them the choice of seeing me or not. But

I would do that for straight people as well because sometimes if I know people, or even if I've met them once in the community, at a friend's place or whatever, they might not want to tell me their life story, perhaps because they know that I know people that they know. So I give them the choice and often that's fine and it actually allows me to talk at a deeper level I suppose. Yes, it does.

Jean too has had bad experiences working with lesbian clients and now will not take on those who are new to the mental health system. She spoke particularly about her caseload who were mostly lesbian clients diagnosed with borderline personality disorder. Jenny also had similar experiences and expressed her reservations:

A lot of the consumers I work with have personality disorders and have been sexually abused and so my sexuality is not really an issue.

While concerned that this information might be used against her in some way, if she was working with lesbian clients and it came up, Jenny would disclose her lesbian identity.

Helen was also cautious with lesbian clients who had a diagnosis of personality disorder. She remained mindful that information about her own sexuality could be used against her. Jane chose to talk about her life and her sexuality with two female clients who had this diagnosis so as to create an opening for discussion when she felt it would be helpful. Nell moved to another mental health service area and found herself reconsidering her position on self-disclosing when she came across a lesbian client:

It did go through my mind on a couple of occasions when we were talking about things whether I should disclose or not. If she asked me I would tell her, I would have felt comfortable about it because of the person she is. I get a feeling that it's probably happening anyway without saying anything, just from my obvious understanding of the different situation she is in, she probably would have clicked I would say.

Several participants, like Diana, spoke about how working with lesbian and gay male nurses helped them to express themselves as lesbians, relax, enjoy their lesbian identity and accept who they are:

It's not like it's a big deal. We joke about it amongst ourselves, we call ourselves family. We are family. At work everybody knows. There's no ostracising or anything like that.

They were mediating the boundaries with much more flexibility and freedom knowing that these colleagues identified with them on both a professional and a much more personal level.

In mediating boundaries participants still felt confident that the process left them open to therapeutic encounters. Gloria speculated on what qualities she expected from a lesbian nurse working with a lesbian client. These included having an understanding about what the client was talking about, a certain sense of humour, knowledge about being queer, and views about lesbian identity. She noted too that she might also have some reservations about being nursed by a lesbian nurse because of the different views held by lesbians that may be contrary to her own beliefs and life experiences. This illustrates the complexity of knowing how to mediate between the lesbian and heterosexual worlds and between lesbians.

Some participants found it difficult to articulate how being lesbian helped them in their nursing practice or what they offered as lesbians to psychiatric mental health nursing, because it was so embedded in who and how they are as lesbians and nurses. Others, like Jean, were more certain about what being lesbian offered:

I think there's a really high awareness of what constitutes discrimination amongst gays and lesbians because we experience so much of it. And therefore there's a lot more effort that goes into what is the reality for this unique person, this unique time. That sort of care that you see is tailored to the individual regardless.

Several participants were able to articulate that being lesbian meant they had a much better understanding of what it meant to be 'different'. They were able to work with

people in mental distress using their own understandings and experiences of being different to help establish a therapeutic relationship. Jude was clear that lesbians offered something unique:

As far as I'm concerned being lesbian benefits culture in that we're actually inviting people to experience diversity in terms of gender and sexual presentation and lifestyle. We're inviting people out of restricted gender polarising that means women can only be feminine and men can only be masculine. So I think we do a big service to women.

## **Summary**

There are many similarities in events in the lives of these participants. Often there were times during the interviews when one of the stories I had heard from a participant had a hauntingly familiar ring to it. For instance, several participants spoke of their youth and early days nursing as being a time of rebelling against authority. Nell remembered her rebellion at school and eventually left when she got into trouble for not wearing a hat to town. Jenny and Helen rebelled against the authority imposed on them in the rigid structure of general nursing and Helen recalled being "bolshie" at that time. Sally was heavily involved in the union in her early nursing days and was tagged a "naughty girl" because this involvement meant she challenged authority constantly. Behaviour on their part often resulted in consequences like leaving a job because of not liking being told what to do or not conforming to expectations of families or friends. Paradoxically, some stories spoke of conforming, despite knowing and feeling different, because of these same expectations. Marriage for participants like Doris and Patsy was a common consequence of the quest for normality.

The experiences in their nursing practice of being lesbian, and issues around self-disclosure, offer insights into how these practising lesbians manage their own professional identity and level of engagement in the therapeutic relationship. The importance of feeling comfortable with lesbian identity within the psychiatric mental health nursing setting is significant. The nurse uses herself to engage therapeutically

with people who are in mental distress. The ability to relate to others and to engage in these therapeutic relationships is critical to the practice of the psychiatric mental health nurse. To do this successfully, the nurse must know who they are. This helps the lesbian nurse to prepare for the challenging task of knowing the person in mental distress who seeks help.

Participants were not paralysed by having to adjust to a whole different way of life or by the reactions of others to their self-disclosure. At times they were upset or surprised but they worked through the issues and situations that confronted them. They reached a level of self-acceptance making them comfortable with being who they are. The influence of family, society and others varied, but once again it was something they worked through and resolved. They made choices about when and when not to disclose to family and friends. They also made choices about how and when to disclose their lesbian identity to the clients and the colleagues they worked with. Making choices about self-disclosure when working with clients often created tensions because of the perceived need to be honest and authentic in their relationships with clients. This very intimate level of self-disclosure has the potential to engage or dis-engage the client. Trying to be honest and authentic with the client is one of the challenges addressed by the participants.

In the final chapter of this thesis (Chapter Six) I discuss the findings that have been presented in the previous two chapters. The experiences of the lesbian nurses in this study are unique to each individual. However, at the same time literature and research on lesbians' self-disclosure in their personal lives and in their nursing suggest many of the participants' experiences and issues are similar and familiar to lesbians. Moreover, the issues and experiences for the participants in this study are also context specific and the New Zealand psychiatric mental health nursing setting adds to the uniqueness of the experiences. The uniqueness is explored through the socio-political environment that is New Zealand. At the time when these participants were becoming and being lesbian, a medical discourse dominated views and homosexuality was still seen as a mental disorder.

## **Chapter Six**

### **Discussion and Conclusion**

I stated at the outset of this thesis, that I believed lesbian psychiatric mental health nurses offer something unique to their nursing because of their journey of becoming and being lesbian. I hold to this belief and add that they offer something to their practice that is unique because of the deep connection that this journey has given them to be who they are: lesbian, in a predominantly heterosexual society and practising in a marginalised area of nursing.

In this chapter I discuss the findings presented in Chapters Four and Five, and how they fit with current knowledge. Through the discussion of the findings the uniqueness of the practice of these nurses that I believe exists is revealed. Importantly, I am not claiming that nurses who are non-lesbian don't have something unique to offer in their practice. I said at the beginning of this thesis that I agreed with Barker and Kerr (2001) that our personal experiences are what makes us unique. What this study shows, through the participants' licensed narratives and my theorising about these in chapter Five, is how their uniqueness is revealed in the New Zealand and psychiatric mental health nursing context.

Following the discussion on the findings I have added 'methodological reflections' as a way of sharing my thoughts about the research processes and bringing the research to its conclusion. This is followed by identification of the key findings for the practice of psychiatric mental health nursing and other significant aspects that emerged from the research. Implications and research possibilities in light of the findings are identified and I conclude this thesis with the ultimate question; has this study answered the research questions?

There are two key findings explored in this chapter. The first is how the experiences in their personal lives have influenced how the participants 'know themselves' and therefore guide how they 'use self' in their therapeutic nursing. Alongside their personal development as lesbians sits their professional development in the mental health setting. In this setting their lesbianism was largely accepted and the presence

of other lesbian and gay male nurses helped them to gain confidence in their lesbian and nursing identities. The second key finding identifies and explores the tensions between being a lesbian psychiatric mental health nurse and self-disclosure in the therapeutic relationship. In particular, the notion of being authentic as a lesbian and authentic in the therapeutic relationship is teased out. What is clear from the findings is that the personal and professional identities of the lesbian psychiatric mental health nurse cannot be separated and both contribute to negotiating the participants' position as lesbians and nurses in the therapeutic relationship.

### **Becoming and being lesbian: personally and professionally**

In this section I argue that the findings from chapters Four and Five illustrate that the personal and professional identities of the participants contribute to how they negotiate their positioning in the therapeutic relationship. The platform for participants developing their personal and professional identities is framed in two ways. First, the socio-political climate in New Zealand influenced their personal experiences of becoming and being lesbian. Second, the mental health environment where the participants learnt to become psychiatric mental health nurses helped to shape their lesbian professional identity.

In the participants personal development of becoming lesbian they spoke of many 'significant' events in their lives, but the target for my contextual time-frame is the realisation that they themselves articulated their lesbian identity. Participants spoke about their early lesbian experiences mainly from their life in a New Zealand context although some participants had travelled overseas at what seemed to be poignant moments, for example, the cementing of a lesbian relationship or seeking to explore their own identity away from family and friends.

#### ***Personal lesbian identity development***

The experiences shared by the participants' in the development of their lesbian identity are unique to each woman. Their experiences were shaped by time, socio-political environment, self-knowledge, experience, and opportunity. During the 1970s and 1980s in New Zealand, when many of the participants were starting to



develop their personal lesbian identity, political activity was beginning to shift public opinion about homosexuality. This political activity is important because up until then the opportunities participants had for exploring their lesbian identity were shaped by an environment where lesbianism was largely invisible and homosexuality was until 1973, understood mainly from a medical discourse. One participant recalled the powerful and pervading medical discourse of the early 1970s where gay men were treated with hormones in psychiatric hospitals for their homosexuality. Another spoke of her first lesbian experience ending in her partner having ECT, and yet another participant remembered times when female patients who were thought to be lesbian were contained in hospital longer than she felt was necessary.

As the 1970s progressed New Zealand was bombarded with new ideas about feminism and gay liberation from overseas particularly from countries like the US, UK and Australia. Little has been written about what life was like in early New Zealand for lesbians and gay men, and even less written about those who transgressed the bounds of these categories, like transgender and transsexual people. In the only substantive written description of pre-1970 lesbian life in New Zealand (before the influences and impact of feminism and gay liberation), Laurie (2003) offers a snapshot of what life was like for women who dared to be different arguing that “before 1970 most women could make lesbianism the organising principle of their lives only through the strategies of discretion and silence” (p. i). Even though I didn’t ask participants their age it is possible to work out their approximate ages from the stories they related about being lesbian, and from my personal knowledge of some of the participants.

While most of my participants had post-1970s experiences in relation to the development of their lesbian identity, the aftermath of the ideals and ethics of the pre-1970s time-frame were still evident and therefore influential in their lesbian identity development. At these times, according to Laurie (2003):

Despite apparent censorship, many classical, religious, legal, medical and functional discourses on lesbianism informed New Zealand opinion, as regulation of this material was one thing, but enforcement another, and most English language material was available. These

discourses functioned as cautionary tales, warning women of the consequences of disclosure, while at the same time alerting them to lesbian possibilities. Though lesbian sexual acts were not criminalised in New Zealand, lesbianism was contained, regulated and controlled through a variety of mechanisms including the fear of forced medical treatment, social exclusion and disgrace, as well as the loss of employment, housing and family relationships.

(p. i)

Several participants expressed sentiments that suggest they were adversely affected by attitudes from other people towards lesbianism. Some participants were warned to keep away from lesbians, lost friends when they ‘came out’ as lesbian or were verbally abused for being lesbian. Homophobia and heterosexism contributed to participants’ uncertainty about becoming lesbian. Paradoxically, exposure to homophobia and heterosexism has also given participants an understanding of how stigma and discrimination influences the every day lives of people who experience it, such as people who are in mental distress and seek help in mental health settings.

The imperatives that control and orchestrate how society should behave towards homosexuality remain powerful predictors of the socio-political climate. Foucault (1978), reminds us that “canonical, Christian and civil law” (p.37) controlled sexuality and sexual practices up until the eighteenth century. Although he was referring mainly to matrimonial relations, these laws helped to determine and sanction what was legal and what was illegal, and what sexual behaviour was approved of and what was not. Lesbian researchers Stevens and Hall (1991), argue that “lesbian women have lived for centuries under heavy moral, legal, and medical penalties that have forced most to lead hidden, unobtrusive, isolated lives” (p. 235). Little seems to have changed today and attitudes towards homosexuality and lesbianism are still largely negative. Today it is much more difficult to be open about discriminatory attitudes and practices, because human rights are monitored and supported by anti-discrimination laws.

In New Zealand much of the debate and discourse around homosexuality continues to be orchestrated by religious, legal and political imperatives. However, while New

Zealand may bask in the knowledge that they have made progress in addressing people's attitudes, and reforms are in place taking account of the lifestyle choices of lesbians, there are still many examples where lesbians and gay men are forced to hide their sexual identity. For example, headlines such as *Gays assaulted because of their sexuality* (Bell, 2004) are a reminder that full acceptance of non-heterosexual people in New Zealand remains a goal for the future. The same newspaper also reported preliminary findings from the Lavender Islands survey, the most extensive survey of gays and lesbians ever carried out in New Zealand, that "18.2 per cent of the men who responded and 9.2 per cent of the women had been physically assaulted because of their sexuality" (p.5). The same survey also found that "three-quarters of the men and two-thirds of the women had been verbally assaulted for the same reason" (p.5). These findings "came as no surprise to Human Rights Commissioner chief mediator Mervin Singham, who said it was well known to the Commission that Kiwis, whose sexuality was not 'mainstream,' were the target of assault" (p. 5).

Further evidence of public perceptions of homosexuality were highlighted in a telephone poll that was conducted (2 December, 2004) through the New Zealand television news programme *Close-Up*. The question was asked "should gay relationships be legally recognised?" (Wood, 2004). Of the 17463 responses 4,316 responded yes and 13,147 said no. While there are limitations to telephone polls, such as people voting more than once, the time frame for the poll was only 30 minutes, thus limiting the number of times one person might cast a vote. Notwithstanding this, the results do suggest that equal rights have some way to go before full acceptance of equality for lesbians and gay men is a reality in New Zealand. Further, being lesbian in political campaign seems to still carry stigma and discrimination. In recent local body election campaigning one candidate denied being lesbian (but is campaigning on Christian values), and the other (who is openly lesbian) claimed that her lesbian identity has "absolutely nothing to do" with her campaigning and refused to comment further (Gurunathan, 2007, p.5).

Religious views about homosexuality remain negative. A religious gathering addressed by the daughter of the late Dr Martin Luther King, the Reverend Bernice King, reported her saying that her father 'did not take a bullet for same-sex

marriage." (Chapple, 2004, p.A4). Most Church groups remain unsupportive of gay and lesbian people in leadership roles and the Catholic Church "would not knowingly ordain a practicing homosexual" (Press, 2004, p.A5). There remains a pervasive political, religious and social anti-homosexual sentiment in New Zealand.

So, how did the pervading socio-political discourse at the time the participants were becoming and being lesbian influence their lesbian identity and nursing practice today? The findings from this study point to the participants' exposure to homophobia and heterosexism at the time they were becoming and being lesbian. Not only was society anti-homosexual and lesbians discouraged to live openly as lesbian, thereby rendering them invisible, but most participants also experienced the negative consequences arising from stigma and discrimination associated with homophobia and heterosexism. Participants did not talk about themselves as victims or express sentiments that might suggest they felt oppressed because of their lesbian identity. Some felt compelled to acquiesce to the dominant views and expectations of heterosexual society by getting married or having relationships with men and at that time in their lives they were oppressed because of these prevailing attitudes. Feeling uncomfortable revealing lesbian sexual identity is a form of oppression and serves to put people on the margins.

Whatever the presentation or experience of oppression, the participants in this study have learned to deal with it. They are sensitive to the political whims and social stigma associated with being lesbian. This awareness, sensitivity and readiness for reaction make them unique and make their practice unique.

Through their journey to becoming and being lesbian, participants have learnt a lot about themselves. Knowing and accepting self on a personal level is a prerequisite to establishing a therapeutic relationship (Fontaine, 1995; Fontaine & Fletcher, 1995; Kneisl, 1996; Moore & Hartman, 1988; Stuart & Sundeen, 1987). While knowing and accepting self is well argued, there is less information about how the 'knowing who we are' translates to the notion of 'using who we are' as a tool. The 'who am I' and the 'how do I do what I do because of who I am' is less well articulated especially with regard to the sexual identity of the nurse.

The nurses responsibility in understanding themselves is an important component of nursing and recognised in literature on cultural safety in New Zealand (Nursing Council of New Zealand, 1996, 2002; Ramsden, 1990, 1992, 2002; Spence, 2003). However, much of the early discourse about cultural safety in New Zealand has been dominated by attention to how to nurse Maori and people from other ethnic groups. Mental health services have also identified Maori as a cultural group needing specific attention to the health outcomes for Maori (Mental Health Commission, 2001b) In the last ten years the definition of cultural safety has broadened to include the nurse being aware of how age, ethnicity, gender, and disability impact on health outcomes. The professional standards for psychiatric mental health nurses recognise sexual preference under the umbrella of cultural safety towards the client (Te Ao Maramatanga New Zealand College of Mental Health Nurses, 2004) However, there is still no focus on sexual identity of the nurse and how this impacts on cultural safety. This study offers new insights into how lesbian nurses use the 'who I am' to 'do what I do'.

In becoming and being lesbian it was important for participants to protect against or at least minimise and prepare for, the possibility of unexpected negative challenge from others about their identity as lesbian. One of the consequences of the need to protect themselves was participants monitored and modified their behaviour to meet the expectations of that particular therapeutic encounter. They also sought to minimise any harm to themselves and so assessed the risk of this by observing the behaviour of the client and the surroundings the client was in. Findings from Morris (1997), noted that women who identify as lesbian do a risk assessment of the environment before deciding whether to self-disclose. As lesbian psychiatric mental health nurses the participants had a lot at stake if they misread the cues from the client and the environment. The participants maintained a constant vigilance in not only their own but other people's behaviour, meaning the participants were well prepared for interactions with a wide range of people, something essential in psychiatric mental health nursing practice. Participants have attuned their surveillance and assessment skills so the choices and decisions they made about how 'to be' in that environment were the right ones. Because participants have a secure

lesbian identity and psychological well being they understand and accept the necessity to reveal or conceal their lesbian identity according to the context.

Participants understood the distress of clients because of their own experiences and distress in their journey to becoming and being lesbian. Peplau (1952) identified the need for nurses to strive for common understandings with patients. The experiences the participants bring through becoming and being lesbian prepares her to be open to negotiating common ground. Gallop (1997) describes the process of understanding the world the person in mental distress occupies (being empathetic) as important to engaging with that person. People in mental distress have asked for psychiatric mental health nurses and other health care providers to “provide emotional support and validation of their situations” (Shattell, Starr, & Thomas, 2007, p.282). Once again, lesbian nurses in this study, through their own experience and therefore more in-depth understanding, can validate the situation that many clients experience with respect to feeling marginalised in society because of their mental illness.

This study has shown the socio-political context of the 1970s and 1980s was important to the development of the participants’ lesbian identity and remain important today because homophobia and heterosexism remain underlying tensions in people’s attitude and behaviour towards lesbians.

As I said at the beginning of this thesis context is an important part of understanding the practice of these lesbian psychiatric mental health nurses. The next sub-section addresses the mental health nursing context and how the mental health setting accommodated the participants’ lesbian identity.

### ***Professional identity development***

Psychiatric mental health nursing in New Zealand has been regarded as a ‘fringe’ area of health and those who work in this area are ‘marginalised’. As a lesbian in their work environment, participants were clear that mental health services were generally very supportive of them being lesbian. This support mostly took the form of accepting the lesbian identity of the participants and treating them, on the surface at least, as no different to heterosexual nurses. Unlike the findings in the study

undertaken by Thurston (1993), participants in this study expected to be accepted by co-workers and did not expect to encounter homophobic attitudes. They have adapted to their lesbian identity in the fringe area of psychiatric mental health nursing where acceptance of difference is mandatory, but where heterosexuality is still the norm. In developing a lesbian identity Sophie (1987) argues that, “[h]abituation is the process whereby lesbianism becomes ordinary rather than unusual” (p. 63). I believe the lesbian nurses in this study are so adept at being lesbian they convey this as something that appears ordinary, yet somehow understates the journey to this ‘ordinariness’.

The findings from this study also differ from what Giddings and Smith (2001) who argued, “nurses who are lesbian often believe they have little choice but to remain closeted, and in so doing, put at risk their health, relationships and their ability to practice authentically with their colleagues and patients” (p.19). A recent study involving interviews with 21 homosexual nursing staff found that women were less likely to be open about their sexuality than men. Participants in the same study all spoke of their constant fear of being excluded because of their sexual identity (Rondahl, Innala, & Carlsson, 2007). None of the participants in this study were closeted at work, but most were mindful of how ‘out’ they were with colleagues. So, why was it that mental health services seemed so accepting of the participants being lesbian? Diversity is more accepted in mental health nursing. Nurses who work in mental health services are not easily shocked and what was once considered ‘unusual’ is nowadays more accepted, including homosexuality. It is safer to self-disclose being a lesbian or gay man and stigma associated with discrimination against minority groups are recognised as impediments to good mental health (Mental Health Commission, 2007). Mental health services cannot promote diversity and acceptance for their client group, and then discriminate against their own staff, in this case lesbian nurses.

Role models of lesbian and gay male nurses helped some participants’ confidence in becoming and being lesbian. Unlike general nursing where participants were uncomfortable being lesbian and reported not feeling like they fitted in. Positive role models are important guides when trying to establish who you are and how you ‘fit’

into any professional group. Some participants spoke of uplifting times when working with gay and lesbian colleagues. They did not have to pretend to be someone else and they could talk comfortably and freely about how they spent their days off with their partner who happened to be a woman. This acceptance was a huge relief because lesbian and gay colleagues came from a place of understanding that located them firmly alongside the people they were looking after. For participants in this study, contact with other lesbian nurses in the workplace was important for them working in nursing. This view is supported by Hansen (1992) who notes the value of good relations with co-workers. One consequence of feeling supported and acknowledged as lesbians is that self-disclosure becomes much less traumatic when working with other lesbian and gay nurses. The study's findings support Zurlinden, (1997) who found that kinship, familiarity and a deeper level of understanding have been identified as important to lesbian and gay nurses.

Feeling accepted and supported in their practice is significant for the participants in this study. They had experience in appreciating the value of understanding and acceptance. This meant that they were able to convey to consumers who were in mental distress that they understood why it is important not to be shunned and to remain open to engaging in a unique connection with that consumer. Participants used life experiences to recognise and understand the vulnerability and rejection that people in mental distress so often feel. These understandings help the lesbian nurse make a meaningful connection with this person, thereby helping to establish the beginnings of a therapeutic relationship. This is of fundamental importance in the therapeutic encounter and what the practice of psychiatric mental health nursing is about.

### **Authenticity of the lesbian nurse in the therapeutic relationship**

Authenticity in the therapeutic relationship is described in the literature as being real or honest with another (Kneisl, 1996) and "being genuinely and naturally yourself" (Fontaine, 1995, p.84). While noting the importance and value of honesty Kneisl adds that honesty "is not always the best policy, especially if it is brutal or if the



client is not capable of dealing with it” (p.121). Adopting this policy is relevant when the information might be harmful to the mental state of the client and is more likely to be about the clients’ unique circumstances or treatment they are undergoing. It does not necessarily take account of revealing information that might protect the client from the nurse. Tracking the decision making of the lesbian nurse in revealing/concealing personal information especially about sexual identity is not clearly articulated in the literature.

When preparing to engage in a therapeutic relationship all nurses must assess the client and the environment. For the lesbian nurse part of this assessment also necessitates trying to get a feel for how the client might react to the fact that the nurse is a lesbian. The issue of appropriate self-disclosure and its relevance to being “real or honest” with the client is critical to the success of the therapeutic relationship in psychiatric mental health nursing. Identifying as a lesbian psychiatric mental health nurse challenges the nurse to be authentic and genuine while assessing whether or not the client can handle her ‘honesty’ and whatever choice she makes how can she remain genuine? So, what of the notion of being authentic/genuine if the nurse decides not to self-disclose her lesbian identity in therapeutic relationship? I begin the discussion about authenticity of the lesbian nurse in the therapeutic relationship by examining how lesbian self-disclosure in nursing is positioned.

### *Lesbian nurse self disclosure*

Previous studies about lesbian nurses had mixed findings about the self-disclosure of lesbian identity in nursing (Deevey, 1993; Hansen, 1992; Thurston, 1993). Thurston’s participants reported having a more positive view of them-selves when they self-disclosed their lesbian identity but the nurses working in mental health settings were less likely to self-disclose. She speculates that one of the reasons for this is to do with the nurses’ role being to listen rather than talk about them-selves. In contrast to the way Thurston viewed this non-disclosure, participants in this study who chose not to self-disclose being lesbian carefully considered what the relationship with the client would be like if they did disclose their lesbian identity.

As part of their decision making about whether to disclose their lesbian identity, some of the participants were influenced by whether they had experienced adverse reactions from clients or other people in the past. In some cases the fewer bad experiences participants had been exposed to, the more open they were to self-disclosing in their work environment. At other times even though nurses had not been exposed to horrible experiences from clients, self-disclosure to clients was not always appropriate.

When meeting with different clients the nurse's identity as a lesbian may be in the foreground or the background of interactions with clients. The nurse waits, anticipating a response, looking for the cues to guide the therapeutic connection with the client. The lesbian identity of the nurse comes to the foreground when it feels welcomed and lingers in the background when uncertainty prevails. The nurse does not automatically share her lesbian identity; the fact that she is lesbian may pass unnoticed by the client. But the lesbian identity of the nurse remains with her no matter what.

The findings from this study have shown that most of the participants thought carefully about why a client might need to be informed about their lesbian identity and how their self-disclosure might contribute towards a more healthy therapeutic relationship. Despite the dominant heterosexual discourse, or because of it, the participants in this study feel comfortable with their identity and at ease with others around them. Participants' journey to understanding, knowledge and acceptance of self has prepared these nurses to be ready for the different and challenging encounters that are a part of psychiatric mental health nursing. Their growth as women and nurses for most of the participants has involved experiencing the depression, isolation and rejection that often accompanies becoming lesbian and self-disclosure (Anderson & Mavis, 1996; Kahn, 1991; Levine, 1997; Sophie, 1987; Thompson, 1996; Wilton, 1995). The participants were able to demonstrate empathy through her experiences of becoming and being lesbian. Being marginalised has exposed the participants to feelings of hurt and shame but instead of being victimised by these feelings the nurses have used the experiences to deepen the empathy they have in their professional lives towards the mental health client. They identify and

are able to understand what it feels like to be marginalised and so engage with clients in a way that reveals their empathy.

In the next two sub-sections I discuss the lesbian nurse in the therapeutic relationship in terms of lesbian authenticity and therapeutic authenticity. Lesbian authenticity and therapeutic authenticity are both embedded in the therapeutic relationship.

### *Lesbian authenticity*

Lesbian authenticity captures the subtleties and complexities in the decision that participants made about their lesbian identity and their disclosure to clients. Therapeutic authenticity explores the boundaries the participants negotiate revealing and using their lesbian identity as a therapeutic intervention and seeks to explain how lesbian identity contributes to the therapeutic relationship. These two concepts are not mutually exclusive. They overlap and at times guide each other; they co-occur.

The lesbian nurse engages in much ‘soul searching’ about the clients’ expectations and understandings that will be changed or challenged with self-disclosure. Through their life experiences and journey to becoming and being lesbian, the participants in this study know themselves. Knowing self is a key ingredient in psychiatric mental health nursing because you have to know yourself before you can use yourself as a therapeutic tool (Barker & Kerr, 2001). The decision about whether to self-disclose their lesbian identity to clients in the therapeutic relationship necessitates becoming in tune and aware of their own personality and how their personality might influence the therapeutic relationship. Psychiatric mental health nursing scholar, Annie Altschul (1997), reported on the important features she felt a psychiatric nurse should have, and observed that psychiatric nurses are “different from those who want to be general nurses” (p. 1). They are “mature people” with “an affinity for the underdog” (p. 3). In reference to personality characteristics she said:

My experience tells me that psychiatric nurses are people who are fascinated by other people’s behaviour, their thoughts, [and] their peculiarities. They are people who are non-judgemental and not easily shocked. They have a fair amount of self-confidence and do not need

the gratitude of patients or the admiration of fellow workers. Above all, they are people who have considerable inner resources. Though many are extrovert and enjoy company and social life, others are more content in one-to-one communication. All can be relaxed in silence and inactivity.

(p. 4)

The reference to people with “considerable inner resources” is significant. People who have had to challenge their ability to survive under considerable duress show great inner resources. People who have challenged their lives in different ways or have changed their lives- adapting to a new life, draw on their inner resources to survive. While many groups and individuals can claim to have achieved much in the face of adversity those people, like lesbians, who belong to minority groups and live on the fringe and survive well are different. The lesbian-identified psychiatric mental health nurses in this study are such people.

In the follow-up phone calls for this study I spoke with several participants about being authentic in their therapeutic relationships with clients. One of my pre-study assumptions was that to work authentically and therapeutically with someone in mental distress the nurse needs to self-disclose her lesbian identity. Otherwise, how could she be truly authentic? The tensions in this, as a basis for proceeding effectively in the therapeutic relationship, were discussed with participants and my thoughts about this began to shift.

The relationship between authenticity and non-self-disclosure of lesbian identity and being dishonest is not straightforward. Being authentic or genuine in the therapeutic relationship is important to establish trust, rapport and an open honest relationship. If a client presumes the nurse is heterosexual the nurse who identifies as lesbian may feel obliged to correct this presumption, thereby reclaiming the authentic space and her honesty. However, if that same nurse decides not to correct that presumption the client has made, she can still claim to be authentic.

By deciding not to disclose the nurse is being authentic to herself and the client. She is being true to herself for that time and that place, having considered the context and

environment. Authenticity is therefore reflected through knowing herself and thereby establishing a platform from which to get to know others.

### *Therapeutic authenticity*

There are different levels of authenticity in the therapeutic relationship both on the part of the nurse and the part of the client. These levels depend on many factors, including context and time. However, it is the nurse's responsibility through interpersonal processes to facilitate the therapeutic encounter and engage the client in a one-to-one helping relationship. The nurse must know how to be with her 'self' and how others will be with her, when and how to engage with people, when to use her life experience to guide and support the interaction, and when to acknowledge less experience. The nurse must recognise the signals warning her that to reveal her lesbian identity would be counterproductive to the therapeutic relationship.

Mental health nursing promotes the therapeutic relationship as being at the very heart of its practice. Participants in my study have careers that rely on engaging authentically with clients. They were also very clear about how they negotiated self-disclosure with clients. Some chose not to under most circumstances, others assessed the need for self-disclosure almost on a case-by-case, day-by-day basis. These negotiations are complex and individual. But they raised questions about the authenticity of those interactions, not because they were inauthentic but because they were about being true to themselves and practising in a safe and appropriate way to protect the client and themselves.

Paradoxically, whether or not nurses self-disclose their lesbian identity, the authenticity expected in the therapeutic relationship is still achieved. The double-edged nature of the self-disclosure has been thoroughly thought through by these nurses. The notion of reveal/conceal in relation to self-disclosure and authenticity contributes to self and therapeutic authenticity. The security in knowing self and when to reveal/conceal is part of what the participants offer psychiatric mental health nursing.

### *Negotiating self-disclosure and being authentic with a lesbian client*

The difficulties and complexities of being a lesbian psychiatric mental health nurse and working with lesbian clients are experiences that many of the participants had in common. Most participants spoke about the need to keep clear boundaries with lesbian clients'. For example, if they knew any lesbian client socially some participants would not work with that client.

Others, if they thought the therapeutic relationship would benefit from their self-disclosure would decide to reveal this to the client. The nurse's self-disclosure was not necessarily a 'given' even if the client was known to the nurse. However, it was more likely if the nurse knew the client. In establishing a therapeutic alliance the lesbian nurse seeks to get alongside the lesbian client.

So, did the level of authenticity of the nurse or the client change if the client was a lesbian? What influenced the authenticity of the nurse? Perhaps there are lessons to be learnt from lesbians who have reported working in private practice with lesbian clients. Two lesbian psychoanalysts Magee and Miller (1997) found that "neither analyst disclosure nor non-disclosure determines what is therapeutic"(p.215). They argue that whatever fits and works for both persons engaged in the therapeutic process is important. Pearlman (1996) argues that:

There are many advantages when a lesbian client works with a lesbian therapist. For the lesbian client, these advantages include shared experiences and understandings, and the opportunity to identify with and idealize another lesbian as a role model. For myself as a lesbian therapist, it gives me the opportunity to offer my respect for the clients' integrity and authenticity, to affirm their relationships and relationship struggles, and to accept their idealization of me as a role model. It allows me both privilege and joy to enter so many personal worlds, to be part of lessening pain, and increasing authentic self-acceptance and pride, as well as to learn once again that change within therapy lodges over time and in the repeated experience of feeling

deeply heard, cared about, and respected by a loved or idealized therapist.

(p.80)

The participants in this study spoke about the contact they had mainly with lesbian clients who were diagnosed with borderline personality disorder. Some of the features of this medical diagnosis include impulsive and unpredictable behaviour, unstable but intense interpersonal relationships, manipulation in relationships, attention seeking behaviour, mood swings (including rage), sexual provocation and demanding behaviour (Campbell & Poole, 1996). The participants were more likely to experience disadvantages from their contact with lesbian clients particularly those who were diagnosed with borderline personality disorder. So, while other lesbian therapists practising outside of mental health services have the opportunity to work with lesbian clients who may be less challenging, participants in this study were often practising with more acutely unwell lesbian clients.

The lesbian psychiatric mental health nurse, if she successfully discloses to a lesbian client is establishing her credentials with the lesbian client. She is acknowledging that they are both lesbian and that she understands some things differently and more deeply than a non-lesbian nurse might. The benefits and risks for both the lesbian therapist and the lesbian client with mutual successful self-disclosure have been highlighted in the literature (Hanson & Weeks, 1998; Pearlman, 1996; Sophie, 1987). These benefits include the recognition of common bonds such as shared values, experiences and politics. In the literature potential problems such as transference and counter-transference are also acknowledged which may result in the therapist setting limits and negotiating boundaries much earlier than with a non-lesbian client.

Participants when working with lesbian clients tread carefully the territory between therapeutic support and therapeutic 'sacking' (when the therapeutic relationship breaks down and the client refuses to see the nurse). Sometimes participants knew intuitively that a woman might be struggling with her lesbian identity. They would only intuitively know this because of their own personal experiences of becoming and being lesbian. So the cues they were reading and their experiences meant they did not 'presume heterosexuality' and were open to possibilities and ready to take the

opportunity to discuss these with the client. Sometimes, although the client is lesbian, she may have other issues that are causing her mental distress.

When participants used their lesbian identity successfully to help bridge the gap in a therapeutic relationship the lesbian client felt better understood, felt safer and trusted this nurse. Under these circumstances therapeutic support is more likely to have been established. Alternatively, if participants in using their lesbian identity to bridge the therapeutic gap chose the wrong moment for whatever reason then the lesbian client in those situations felt misunderstood, unsafe and distrusted this nurse. Further, the lesbian nurse who misreads how and when to use her lesbian identity as a therapeutic tool will think twice about her own lesbian self-disclosure with lesbian clients in the future; or with any other client.

Some participants tried to be friendly with lesbian clients often in social situations. In small lesbian communities it is inevitable that lesbian nurses will meet lesbian clients. For the lesbian psychiatric mental health nurse being both therapeutic and friendly with the lesbian client in the therapeutic relationship requires careful negotiation. In her examination of therapeutic friendship Geanellos (2002a) identifies behaviours that align with nurse–client friendship as close involvement and alignment with another person; attachment and mutual affection that binds the two people together; and reciprocity, which suggests a shared exchange and give and take. She adds that “these behaviours suggest that a deep, affective rapport and exchange take place” and that “the therapeutic outcomes of nurse–client friendship include belonging, familiarity, acceptance, protection, comfort, support and safety” (p. 242). Geanellos did not mention friendship between the lesbian nurse and lesbian client but given the pervasiveness of heterosexuality in society, it seems likely that a ‘presumption of heterosexuality’ of the nurse and the client underpins her study. So, how might the lesbian nurse and lesbian client engage in friendship?

This study showed that few participants identified ‘friendship’ as a goal of the therapeutic encounter with lesbian clients. For the most part participants had mixed experiences of disclosing their lesbian identity to lesbian clients. For participants whose social contact with lesbian clients backfired often creating tensions, setting and maintaining clear boundaries with those clients (particularly those diagnosed



with borderline personality disorder), seems to be a strategy that was adopted and worked well for most participants.

For the lesbian identified nurse working outside of mental health services, the literature revealed many possibilities in the lesbian nurse–client alliance, which when carefully negotiated, offer extraordinary experiences and opportunities for both women. To make the most of these possibilities the lesbian psychiatric mental health nurse needs to understand the reasons why the lesbian client might benefit from her self-disclosure and recognise the cues that precipitate successful self-disclosure. The timing of the lesbian nurse’s self-disclosure also needs careful consideration as does assessment of the context and environment where the self-disclosure takes place. The lesbian nurse must also know herself, her lesbian self and the values she brings to her nursing practice.

This concludes the discussion sub-sections. The most significant shift in my thinking since commencing this thesis is from believing that the lesbian nurse should self-disclose her lesbian identity in the therapeutic relationship in order to be authentic. Given the findings I now believe that the lesbian psychiatric mental health nurse through knowing herself and her practice is authentic, whether she self-discloses or not.

The next sub-section provides an opportunity for reflecting on the research processes and the research methodology.

## **Methodological reflections**

What follows are my thoughts about issues that arose during the research that were unexpected and how I dealt with them. In a sense these reflections are a way of preparing for closure of the study.

### *Recruitment*

All of participants in this study were working outside of the hospital-based mental health (in-patient) units. While many participants were able to talk about past experiences in various in-patient units, none of them was currently working there.

This was not planned on my part. I have considered possible explanations for this. One is that all of the participants are experienced and seasoned nurses who, having worked in the in-patient setting, have chosen to move on to areas where there are more opportunities for autonomous practice. Acute in-patient settings usually have high acuity and more rigid structures than community or educational settings. Further, being lesbian in environments where there is an increased chance of unpredictable behaviour by clients, such as an acute in-patient setting, could be a source of undue stress for lesbian nurses (and stories from nurses in this study support this idea). Having control over their self-disclosure seems to be important and there is less likelihood of the lesbian nurse being in control of this in acute in-patient settings. A further possible reason for the lack of recruitment of in-patient nurses is that an 'apprenticeship' in nursing usually entails working in an in-patient setting. Participants in this study have all done their 'apprenticeship' and moved out of the in-patient unit. It is possible that if more in-patient nurses had been recruited they also would have been younger and contributed another perspective to the research focus.

### *Keeping confidentiality*

Confidentiality is challenging to maintain especially in a small country like New Zealand and a specialty nursing service like mental health. People tend to know each other or know of people because of the small professional circles they move in. As a result of this throughout the course of this research I found myself mixing socially and professionally with a number of the participants. They would ask me how the study was progressing and I had to take care not to acknowledge their participation in front of other people. I recall one time when several of the participants were at the conference I presented some interim findings from this study. Later that night we happened to all sit at the same table at dinner. I had to avoid acknowledging individuals as participants because this may have lead to individuals' story being recognised by others. This situation became almost farcical because I overheard most of the participants at the table having conversations periodically through the night about being interviewed by me and chatting about this. So, although I wanted to

acknowledge their involvement within the social environment I had to keep my 'researcher persona' and respect the agreement we had.

Keeping the confidentiality of the participants was difficult for me at times, especially when I imagined that many of them would like to get to know each other because of their shared interests and experiences. The best I can do in connecting the group is the writing of their stories as licensed narratives. Reading their collective licensed narratives is one way they can connect with each other.

### *Using narrative inquiry*

In considering why narrative is not a popular research methodology with lesbian researchers in psychiatric mental health nursing there are several possible explanations. Narrative inquiry suits smaller rather than larger sample sizes, and to date research about lesbians has sought to canvass as many opinions as possible. Also, narrative is underpinned by experience and 'meaning making', which are not always highly valued in terms of legitimate new knowledge and attracting research funding with its focus on outcomes and dollars. Therefore, to a certain degree, the combination of narrative inquiry, psychiatric mental health nursing and lesbian research is more likely to be found in academic institutions that have Women's Studies or Nursing Departments. Students and academics have more opportunity here to explore depth and complexity with groups like lesbians who sit on the margins.

### *Using NVivo*

The qualitative software NVivo has been useful particularly for storing and managing the data. Initially, the process of coding gave me the opportunity to familiarise myself with the data quickly and efficiently. It has been easy to retrieve information, to work back through the transcripts checking information when I needed to. The process of creating the licensed narratives using NVivo was a little like putting a jig saw puzzle together with text rather than pictures. Other qualitative software packages have similar tools, but with its wide range of possibilities NVivo has much to offer.

One of the advantages of using this type of software was that I was able to lay out the actual process undertaken in the thinking and creation of the licensed narratives. Not only does transparency of process add to the credibility of the research it also offers opportunity for other researchers to scrutinise the material and consider how the process undertaken in this research might be useful for adapting their own studies especially when using narrative.

### *Interpreting the licensed narratives*

One of the most demanding challenges in writing this thesis has been how to interpret the participants' experiences as told by them in their stories and create licensed narratives. Each story has its own complexities and I wanted to portray these complexities in unique and individual licensed narratives. I was mindful of context is being symbolic and deeply personal to each participant. Collectively the stories convey these unique contexts and participants have contributed to the deeper understanding of how becoming and being lesbian influences their nursing practice.

Talking with participants has been a privilege. I feel honoured and humbled that they shared their stories with me and revealed so much of themselves in the interviews. They have recalled both painful and pleasant experiences in their stories about becoming and being a lesbian and working in psychiatric mental health nursing. In the process of exploring their experiences, and in conversations with the participants, they gave me 'carte blanche' to work with their stories. I likened this to them giving me a licence to write about them. They trusted that this licence would not be used by any non-licensed holder or abused in any way. There were no caveats on the licence. Each participant after reading their licensed narrative felt happy with the way they were portrayed in it. The term 'licensed narrative' arises from my expression of the relationship between me and the nurses telling their stories.

The co-creation of the licensed narratives adds weight to the argument and positioning explained in Chapters One and Two about lesbians doing research on lesbians. It would have been highly unlikely that a heterosexual researcher would have been able to gain the same level of rapport, understanding, and trust as was evident between myself and the participants. Negotiating the meaning behind

experiences and walking alongside participants has created a space for shared understandings to emerge about being lesbian in psychiatric mental health nursing to emerge.

## Significant findings

What are the key findings to emerge from this thesis? How might these key findings contribute to understandings about the therapeutic relationship in psychiatric mental health nursing particularly in relation to being a lesbian nurse? There are two findings that make a major contribution.

The first key finding is articulating the relationship between how the ‘who’ participants are as lesbian psychiatric mental health nurses contributes to the ‘how’ they practice. In the beginning of this thesis I noted the intensity of the debate around articulating the ‘what’ and ‘why’ and ‘how’ of psychiatric mental health nursing practice. My hope was that this thesis would contribute to understandings about how the ‘who’ we are makes a difference to the person in mental distress. I believe that this has been revealed through participant’s descriptions of becoming and being lesbian in the socio-political and mental health nursing contexts that are New Zealand.

The second key finding is the notion of being authentic in practice. I began this study with the idea that lesbian nurses working in mental health needed to self-disclose their lesbian identity in order to remain honest and genuine in their interactions with people in mental distress. The key narrative themes identified in Chapter Five capture the significance and complexities of this self-disclosure. Specifically, the interface between *personal identity disclosure* and *lesbian identity disclosure in the professional setting* clearly demonstrates that the lesbian nurse cannot separate her personal experiences in becoming and being lesbian from her professional identity as a nurse. The three narrative sub-themes, *making choices*, *tackling tensions and mediating boundaries* are features of the decision making process throughout the personal and professional lives and identities of the participants.

Findings from this research suggest that the nurse remains authentic whether she self-discloses her lesbian identity or not. The negotiation of self-disclosure of their lesbian identity as expressed by the participants adds a new layer to the ongoing questions about 'how' psychiatric mental health nurses actually think about and make choices about what is appropriate self disclosure. The complexities of this decision are so embedded in context and time that revealing them through the licensed narratives has helped to make more transparent the depth and process of thinking required to work therapeutically and authentically with clients.

As well as the key findings, was there anything else significant that emerged? The adaptation of the participants' stories, the opportunity to create unique stories for these unique nurses, was provided by having the freedom to work creatively with a methodology that allows for innovation: narrative inquiry underpinned by a feminist research process. 'Licensed narratives' have arisen through the understandings between me and the participants (who gave me the freedom to use the transcripts to co-create their stories) and the adaptation of narrative inquiry. The NVivo software helped me to manage the data and organise the transcripts in the preparation of the stories. I am not aware of any similar adaptations or interpretations of narrative and NVivo. In Chapter Three, I went to some lengths to explain the process for engaging with the participants to ensure they were satisfied with the way they had been portrayed in their licensed narratives. From this explanation it is clear they were satisfied; this satisfaction is confirmation of the integrity of the research process and thereby the licensed narratives.

Another aspect to emerge was the way participants seemed to 'downplay' their lesbian identity as being significant in their nursing practice. I'm uncertain as to why this is. Part of the explanation could be that being lesbian is so integral to them that being asked to focus on their lesbian identity and their nursing practice which they had never had to articulate before, took them by surprise. Even though they had been sent information about the study and knew they were going to be talking about being lesbian and their nursing, many still struggled with being asked to explain how their lesbian identity influences their practice. What some of them were able to articulate was the way they understood and engaged with clients through their own life

experiences and exposure to homophobia and heterosexism. What they offered was good counsel, knowing what it is like to feel rejected because of stigma and associated discrimination, and shared understandings.

A further aspect to emerge was the core features of the licensed narratives. By this I mean the collective similarities that seemed to run through many of the participants' lives which came through in various ways in their stories. For example, many spoke of feeling 'uneasy' in their childhood or young adult lives but not being sure what this was about. Others felt very sure or had an opportunity to act on this 'uneasiness' and responded at an early age to their feelings. Feeling 'different' came through in many stories, being a rebel, taking leadership roles and putting themselves out there also featured throughout many participants' lives. It was important not to clump these core features together and make 'collective claims' about the participants' personal and professional lives. The aim was to capture the collective uniqueness of the participants.

## **Implications and research possibilities**

So what are some of the implications and applications of findings for lesbian psychiatric mental health nurses in practice? First, as I stated at the outset, no study has investigated the practice of lesbian psychiatric mental health nurses nationally or internationally. Nor has much attention been given to how the nurse's sexual identity influences her practice, particularly in the therapeutic relationship. This study therefore offers a beginning point to be built on and developed. There needs to be more narrative research about how lesbian identity influences their practice as nurses working in mental health settings in order to understand more about how their identity shapes their practice and practice shapes their identity. Because this is the first study of its kind, there was no evidence in the literature that addressed the impact that lesbian identity has on the therapeutic relationship in psychiatric mental health nursing. It is important to articulate the 'self' particularly with respect to sexual identity in the therapeutic engagement with the person in mental distress and this study shows that being who we are makes a difference to how we practice. Nurses who identify as heterosexual might like to examine how their sexual identity

influences their practice and therefore the relationships they have with clients. Lesbian authenticity and therapeutic authenticity are features of the therapeutic engagement and revealing the complexity of this engagement is part of the contribution this study makes to psychiatric mental health nursing.

Second, this study has been focussed on lesbian nurses who work in mental health. All of the participants worked in the community. But what of those lesbian nurses who work in in-patient units, in much more controlled areas of mental health nursing where clients are more often acutely distressed? What shape would the therapeutic relationship take given that it is more likely that the lesbian nurse would be 'outed' unexpectedly and having some control over this seems to help lesbian nurses in their practice? The participants in this study have described their experiences 'doing their time' in acute in-patient units. These were often highly distressing times for them particularly facing homophobia from acutely unwell patients. They had few strategies for dealing with this. To counter this we need to share our stories with other nurses and also with mental health consumers about the contribution that lesbian psychiatric mental health nurses' make to nursing practice in the mental health setting. This topic lends itself to a collaborative research study involving both lesbian psychiatric mental health nurses and lesbian mental health consumers.

Third, what are the issues for lesbian clients who have worked with lesbian psychiatric mental health nurses? Has their therapeutic engagement with the nurse been better because of the nurse being lesbian? What expectations might the lesbian client have knowing that the nurse identifies as lesbian and how did the nurse reveal/conceal her identity? If these issues are explored it can lead to more understanding about how lesbian clients might benefit from working with lesbian nurses or in fact why they might prefer heterosexual nurses. An argument could be made for lesbian clients to have access to lesbian nurses as a preferential choice.

Fourth, how do heterosexual nurses working in mental health view their lesbian colleagues? Because this is the first study of its kind, there is no evidence in the literature that addresses this relationship. This question requires further investigation.



Fifth, further investigation is needed into homophobic attitudes by heterosexual nurses working in mental health. Although participants felt accepted by their heterosexual nursing colleagues, they expressed concerns about underlying homophobia. Also, while work colleagues appeared accepting of the lesbian nurse this study revealed examples of homophobic attitudes to lesbian and gay male patients.

Finally, how might nurse educators especially at an undergraduate level teach about the therapeutic use of self, being authentic, and appropriate self disclosure given the findings in this thesis? One of the positive spin-offs of these findings is the material in this thesis which offers a way of educating heterosexual nursing students about the intricacies of the therapeutic relationship. Lesbian nursing students may identify with the findings and the participants stories and feel more confident in their lesbian identity. Using material in this thesis offers further opportunities for educators to illustrate how heterosexist and homophobic attitudes impact on the lives of lesbians, both as nurses and consumers of mental health services.

## **Final comments**

This research has given me the opportunity to explore and reflect on the experiences of 15 lesbian psychiatric mental health nurses who identify as lesbian and theorise about how their lesbian identity influences their practice.

As this study reflects the lesbian identity of the participants sits alongside other identities which are important in their day-to-day lives. Participants spoke of their identity as a lesbian, a woman, a nurse, a mother, a friend, an aunt and a partner. All of the participant's identities are embedded into who they are. At times one identity had more presence while other identities simmered in the background. But all of them are always there. Participants negotiate and mediate the boundaries and presence of their identities according to time, context, and the environment.

For participants in this study, their personal and professional lives are intertwined. Further, their experiences in their personal and professional lives contribute to how they negotiate their position in the therapeutic relationship. Participants stories about

becoming and being lesbian in New Zealand and in the mental health setting revealed how they came to 'know themselves' in order to 'use self' in therapeutic practice. In stories about their professional practice the participants spoke about the tensions and challenges of negotiating a place between being authentic as a lesbian and being authentic with the person in mental distress.

At times I have felt the participants' stories were familiar and similar to each other; at other times unfamiliar and not at all that similar. It has been challenging to capture the uniqueness of each participant. But it was important to do so. We lesbians are not all the same, although we may have some shared beliefs and experiences.

As a society we tend to more fearful, and at times dismissive of what and who we do not understand. Heterosexuals who know non-heterosexual people and who have opened their minds to accept the uniqueness of all of us have had the opportunity to learn about understanding and acceptance not only of who they are but also of who others are.

I hope other nurses will find something of use in this thesis; that they will ponder its possibilities and read further. I am sure other lesbian nurses reading this will find something that resonates with their own experience. Knowing more about how other lesbian nurses have discovered and developed their lesbian identity and about how other lesbian nurses work in their practice may help to prepare you for what lies ahead, wherever you live, whatever your personal circumstances and whatever your choices. Knowing you are not alone, that many others have walked alongside you and shared your experiences, and that many others will follow makes the pathway somehow easier to walk.

In concluding this thesis I revisit the research questions which I began with:

- What is the experience of lesbian nurses who work in psychiatric mental health nursing?
- How does identifying as lesbian influence the practice of psychiatric mental health nurses?

I ask now have the research questions been answered in this study? My intention was to bring to the foreground the experiences that lesbian psychiatric mental health nurses have in their nursing practice. For these 15 participants their uniqueness has been revealed through the licensed narratives and revealing my thinking about these narratives in Chapter Five Research Findings Part Two. This study illustrates the complexities embedded in the reveal/conceal personal and professional identities of the lesbian nurse in the therapeutic relationship in psychiatric mental health nursing. The daily practice of the lesbian psychiatric mental health nurse holds many challenges in the choices, tensions and boundaries she negotiates to work therapeutically with clients. Further, this research adds knowledge and understanding to the relationship between who you are (the personal) and how you practice (the professional) as a nurse. This relationship is difficult to articulate, poorly researched but critical to psychiatric mental health nursing practice.

The four month old puppy I mentioned in Dorothy's interview is now five and a half years old. It seems an age ago when I began this thesis by getting ethics approval and doing the interviews. Much has shifted in my life and the lives of many of the participants who I see occasionally socially and around the mental health nursing traps. Several participants have changed jobs or moved to different cities and at least two have moved overseas. With each day for all lesbians come new experiences and different challenges. For lesbian psychiatric mental health nurses in this study, being and knowing who they are help to create a unique practice. Their identity as lesbians is part of who they are and their journey to becoming and being lesbian defined and shaped their practice.

I hope I have done justice to a part of the lives of these lesbians, these nurses, these women. The stories participants shared are such a gift to me and to anyone reading this. I trust that reading about a part of their lives and their nursing practice you are gracious in your acceptance of this gift and learn something about yourself from what it offers.

**Appendix A**  
**Ethics Approval Letter**

VICTORIA UNIVERSITY OF WELLINGTON  
*Te Whare Wananga o te Upoko o te Ika a Maui*



**MEMORANDUM**

**TO:** Chris Walsh  
Nursing and Midwifery

**FROM:** Graeme Kennedy  
Convener, Human Ethics Committee

**cc:** Student Administrator  
Nursing and Midwifery

**DATE:** 14 December 2001

**SUBJECT: APPLICATION FOR ETHICAL APPROVAL: EXPERIENCES OF LESBIAN  
PSYCHIATRIC MENTAL HEALTH NURSES**

Thank you for making the amendments requested by the Standing Committee of the Human Ethics Committee.

Your application, as revised, has now been approved. Approval is given for the period 13 September 2001 to 28 February 2004.

With best wishes for your research.

A handwritten signature in blue ink, reading "G. Kennedy".

Graeme Kennedy  
Convener, Human Ethics Committee

## **Appendix B**

### **Starter Questions for the Interviews**

**Title of thesis: Experiences of lesbian psychiatric mental health nurses: A narrative inquiry.**

Starter questions for thesis

The interviews will be conducted using an unstructured approach with reflective questioning used to assist the person to reflect on and share their experiences. This approach invites the telling of personal stories and so specific questions are difficult to pre determine. However, some broad possibilities are outlined below with the knowledge that questions will be asked dependant on the reflections and stories from participants.

I will start with an introduction and lead in about the study, clarify any queries or issues, explain where my interest lies.

#### **Question one**

Lets start by hearing from you about why you are interested in being interviewed for this study?

#### **Question two** (depends on the response to question one)

In what ways do you identify as lesbian? Have you always identified as lesbian? Do you have a story that you would like to share that might help to explain who you are?

#### **Question three** (depends on the response to question two)

How does being lesbian influence your life? Do you have a story about a key moment or time that illustrates how being lesbian influences your life?

#### **Question four** (depends on the response to question three)

How does being lesbian influence your work? Do you have a story that that might explain how being lesbian impacts on your work?

## Appendix C

### Participant Information Sheet

VICTORIA UNIVERSITY OF WELLINGTON  
*Te Whare Wananga o te Upoko o te Ika a Maui*



### Participant Information Sheet

**Title of study:** Experiences of lesbian psychiatric mental health nurses: A narrative inquiry.

- **Who am I?**

This information sheet is by way of introducing my doctoral studies and myself. My name is Chris Walsh and I identify as lesbian. I work at the Graduate School of Nursing and Midwifery at Victoria University in Wellington where my area of expertise is psychiatric mental health nursing. My interest in the above mentioned study stems from many years of working in mental health services with lesbian nurses and sensing that we offered something different to the people and places where we work but not being clear as to what this was and how this made a difference to the way we practised. To date there is very little information in New Zealand or overseas about the experiences of psychiatric mental health nurses who identify as lesbian work in mental health nursing.

- **What is this study about?**

Specifically the overall aim of this study is to explore the experience(s) of lesbian nurses working in psychiatric mental health nursing. The study will explore issues related to the questions:

What is the experience of lesbian nurses working in psychiatric mental health nursing?

How does identifying as lesbian, influence the practice of psychiatric mental health nurses?

- **Who is being invited to participate?**

It is proposed that eight to twelve nurses who self identify as lesbian and are registered comprehensive or psychiatric mental health nurses, will be the participant group for this study. You will live in New Zealand and have had a minimum of two years experience in psychiatric mental health nursing i.e. clinical, educational or management.

- **What is the time commitment envisaged?**

You will be invited to take part in two to three individual interviews (60–90 minutes). An unstructured interview approach using reflective questioning will be used to assist you to reflect on and share your experiences. This approach gives you an opportunity to share your experiences through telling your own stories as well as encouraging you to think about and reflect on the meaning of those stories for your practice. You will be sent a copy of your transcript to read and given the opportunity to comment and give feedback. At this time any information that you wish to withdraw will be removed from your transcript. A draft of the initial findings will be sent to you for comment and these will form part of the analysis.

- **How can you withdraw from this study?**

Should you feel the need to withdraw from this study at any time you may do so without question. Just let me know. Any data that has been collected from you can also be withdrawn at any time up until the analysis stage.

- **How will your identity be protected?**

To protect your identity and confidentiality you can choose a pseudonym, which will be used throughout the study. Any information that could lead to your identity being known or disclosed will be removed at time of transcription. The person transcribing the tapes will sign a confidentiality form agreeing that they will protect your confidentiality by not divulging any information about you or about the study.

- **How might participating in this study harm you and what will be done in case this happens?**

It is possible that while reflecting on past experiences you may become distressed during or after interviews. If this happens during an interview you will be offered the

opportunity to stop the interview and decide whether or not you wish to proceed. Debriefing with myself after each interview will be offered as part of the process undertaken to ensure that you feel satisfied with your participation. It is anticipated that you will have a supportive network of friends whom you could call upon to debrief with.

You will also be offered the opportunity to have up to three counselling sessions with a person of your choice which will be paid for by me. Once again just let me know if you require this.

- **What will happen to the information you give to me?**

Information collected from you will form the basis of my PhD and will be put into a doctoral thesis. I will keep all written material (interview notes, etc) in a locked file and access will be restricted to me. All electronic information will be kept in a password-protected file and once again I will be the only person who has access to this. Any information you provide will be kept confidential to me, my two supervisors Lynne Giddings and Margi Martin and the person who transcribes the tape recordings of our interviews. All interview notes and similar materials will be destroyed five years after the conclusion of the study.

As part of the requirements for PhD studies a copy of the thesis will be deposited at the Victoria University library. I envisage that there will be opportunities to publish this work, in its entirety or parts of, in relevant academic or professional journals and also present it at conference.

***Contact details for further information***

My contact details are:

Email: Christine.Walsh@vuw.ac.nz or girlies@paradise.net.nz

Mb: 021300073 or Hm: 06 367 3930

My supervisors are Lynne Giddings and Margi Martin.

Lynne can be contacted at Auckland University of Technology

Email: lynne.giddings@aut.ac.nz

Phone: 04 917 9999 ext 7013



Margi can be contacted at Victoria University in Wellington

Email: [margaret.martin@vuw.ac.nz](mailto:margaret.martin@vuw.ac.nz)

Phone: 04 463 6140

This study has the approval of the Human Ethics Committee at Victoria University Wellington.

Thank you for reading this. If you are not interested I hope you won't mind passing this onto someone who you think may be interested.

Cheers

**Chris Walsh**

(August 2001)

## Appendix D

### Consent Form

VICTORIA UNIVERSITY OF WELLINGTON  
*Te Whare Wananga o te Upoko o te Ika a Maui*



### Consent Form

**Title of study:** Experiences of lesbian psychiatric mental health nurses: A narrative inquiry.

**Participants Name:** \_\_\_\_\_

- I have read and been given the participation sheet dated August 2001 for the above mentioned study and have understood an explanation of this study being undertaken by Chris Walsh for her doctoral studies.
- I have had an opportunity to ask questions and have them answered to my satisfaction.
- I understand that I may withdraw myself (or any information I have provided) from this study (up until data analysis) without having to give reasons or without penalty of any sort.
- I understand that any information I provide will be kept confidential to the researcher, her supervisors Lynne Giddings and Margi Martin and the person who transcribes the tape recordings of our interviews.
- The published results will not use my name and any identifying material will be removed at the time of transcription.
- I understand that all the material gathered from me will be destroyed five years after the completion of the study.
- I understand that I will have an opportunity to comment and give feedback on my interview transcript and that a draft of the initial findings will be sent to me for comment and these will form part of the analysis.

- I understand that the information that I provide will be used for the purposes described in the participant information sheet and will not be released to others without my written consent.

***I agree to take part in this study***

Signed \_\_\_\_\_ Date: \_\_\_\_\_

## Appendix E

# Non-disclosure Agreement for Person Transcribing the Tapes

VICTORIA UNIVERSITY OF WELLINGTON

*Te Whare Wananga o te Upoko o te Ika a Maui*



**Name of person transcribing the tapes:**\_\_\_\_\_

**Title of study:** Experiences of lesbian psychiatric mental health nurses: A narrative inquiry.

I understand that any information that I am privy to as a result of transcribing the tapes for the above mentioned study will be kept confidential. I undertake not to divulge any information about this study or its participants to anyone.

**Signature of person transcribing tapes:**\_\_\_\_\_

**Date:**\_\_\_\_\_

Appendix F  
Creative Journal: Jane

Jane interviewed on 7/03/02, <sup>approx (hr)</sup>  
today's date: 10/06/02.  
listened to tape 4 times (one several weeks ago) <sup>exchange</sup>  
Thoughtful - reflective - meaningful. A Conversation  
engaging with + engaged to lesbian sexuality  
Memory - Warmth. enjoyment. being 'it  
like others',  
excitement/joy of youthful 'coming-out'  
tentative exploration. comfortable  
↓  
INNOCENCE. OF UNFOLDING SEXUALITY  
↓  
Then the 'moment' - the clicking of  
ORDINARYNESS. everything  
Social safety. LEAD TO LESBIANISM.  
Striving → seeking a place.  
emphasis on some works. sense of humor,  
straight - talking.  
Learning to be lesbian from younger days  
comfortable w/ sexuality now.  
↓  
Clear about self + boundaries,  
'signals'

## Appendix G

### Creative Journal: Sally

approx 75 mins

Sally interviewed on 17/04/02.

today's date 12/06/02.

Listened to tape 3 times

exchange  
A Conversation

Engaging - emphasis on words + flow make an interesting story.

Background slapping on table - all thru tape!!

Rebel, stood up to things 'naughty' -  
nice naughty.

Constantly questioning Bin Hamed.  
That institution culture → unions.  
old school.

Took on authority.

As a student

Time of change in nursing + new staff nurse.

Fast/slow in voice  
gentle in voice  
excitement in voice.  
ponder in voice.  
struggle in voice  
must in voice  
matter-of-fact in voice  
seriousness in voice.  
Question in voice.  
ease in voice.  
emphasis in voice  
puzzlement in voice  
tone in voice  
tears in voice  
Hurt in voice

Magic in voice.  
humour in voice  
Passion in voice  
laughter in voice.  
enjoy in voice  
thoughtful in voice  
receptive in voice.  
energy in voice.  
drama in voice  
Pause in voice  
integrity in voice.  
tenderness in voice  
emotion in voice.  
life in voice.  
angel in voice  
amusement in voice  
knowledge in voice  
comfortableness in voice  
self in voice.  
emphasis in voice.

Feeling of the story(s)

## Appendix H

### Profile of Participants

*Table 2: Profile of participants*

Participant	Children	Relationship	Interview length in minutes	Known to me	Urban or rural	Been married	New Zealand born	Nurse training	Work area	Years in mental health
Diana	Yes	Yes	70	Yes	Urban	Yes	No	Rcomp	Community	12
Doris	Yes	Yes	90	Yes	Urban	Yes	No	Gen/psych	Education	25
Dorothy	No	No	60	Yes	Urban	No	Yes	Gen/psych	Education	30
Gloria	No	Yes	70	Yes	Urban	No	Yes	Psychiatric	Management	20
Helen	No	Yes	45	Yes	Rural	Yes	Yes	Rcomp	Community	13
Jane	Yes	Yes	60	Yes	Urban	No	Yes	Psychiatric	Community	15
Jean	No	No	65	Yes	Urban	No	Yes	Psychiatric	Community	9
Jenny	No	Yes	35	No	Rural	No	Yes	Psychiatric	Community	18
Jude	No	Yes	80	Yes	Urban	No	Yes	Rcomp	Own practice	10
Nell	No	Yes	60	No	Rural	No	Yes	Psychiatric	Community	18
Pam	No	Yes	50	No	Urban	No	Yes	Psychiatric	Community	20
Patsy	No	Yes	90	Yes	Urban	Yes	Yes	Rcomp	Education	10
Pita	No	Yes	45	No	Urban	No	Yes	Rcomp	Community	15
Sally	Yes	No	75	Yes	Urban	No	Yes	Psychiatric	Community	15
Sarah	No	Yes	65	Yes	Urban	No	Yes	Gen/psych	Management	20

Note: Rcomp = registered comprehensive; Gen/psych = registered general and psychiatric.

## Appendix I

### Tree and Children Nodes

*Table 3: Coding used in NVivo*

<b>Tree node</b>	<b>Children</b>
Background	Initial interest Training First experience Feelings about job Attraction to job Nursing experiences Family
<b>Tree node</b>	<b>Children</b>
Lesbian	First memories First real awareness Knowledge of them First time knowing The scene described Support Transition Relationships Coming out Others responses Describes self Visibility Coping strategies Being different
<b>Tree node</b>	<b>Children</b>
Heterosexual	Experiences Environment Marriage
<b>Tree node</b>	<b>Children</b>
Feminist	Views
<b>Tree node</b>	<b>Children</b>
Issues	Lesbian clients Identity to practice
<b>Tree node</b>	<b>Children</b>
Psychiatric nursing	Working with clients Therapeutic relationship Offers what



## Appendix J

### First Letter to Participants

25th June 2002

Hi

Well, at last here is the typed version of our interview, which seems to be ages ago!! I have been through your transcript and changed names that could compromise confidentiality. Please let me know if there is anything you want taken out or changed. I have enclosed 2 copies of the transcript, one for you to keep and one for you to send back to me with any changes. If you could do this by the end of July 2002 I would appreciate it. I am contemplating how to present your character and how to bring you to life in the thesis without compromising confidentiality and this is something I would like to discuss with you again. There is such life; joy, energy, wisdom, emotion and laughter in the transcripts that I don't really want to lose this.

I have finished my study leave for this 6 months and will be recommencing leave again in December. My plan still is to take all the transcripts to Sydney in October and spend a week with Pat Beazley who is a whizz on qualitative data packages. So, I will put the data on Nvivo and explore possibilities with this software. I'm not sure at this stage how things will be presented in the final thesis and will have a better idea of this when we meet again early next year. I had this fleeting idea that a focus group at *Waitaquery* (known as Waitarere in the map book) beach where I live would be one way of discussing the data further. It would be such a buzz to get everyone together and relax in the tranquil surroundings of the West Coast! Otherwise it's back to see all of you for another interview at some stage to discuss and share thoughts.

I have put an abstract in for the Health in Difference conference (October 31<sup>st</sup>-November 2<sup>nd</sup> 2002) which is being held in Sydney as part of the Gay games. The working title of the paper is 'Practising lesbians: Psychiatric mental health nurses bordering the boundaries between self-disclosure and nursing practice'. It is based on the interviews so far and will present some interim reflections, which I will share

with you before then if the paper gets accepted and after if it doesn't! As usual I haven't got these reflections sorted yet!! Partly because I have only half the tapes back from the transcriber so far and partly because it's all still swimming around in my head. But the 7 tapes so far have proved to be all very different yet similar. Self-disclosure comes in many forms, being lesbian is integral to practice but manifests in many ways, boundaries are important to negotiate (tricky to define at times), colleagues are pretty cool about our lesbianism, we are pretty cool about it (no big deal), lesbian consumers are not always cool to work with and so it goes on.....and some of us have mellowed out heaps!! I will be concentrating on literature around identity and practice, the therapeutic relationship, self and reading along these lines in the next 6 months, between work (no doubt poised to get HEAPS done). It has been so peaceful and spacious to have this time at home and a real privilege to listen to the tapes, share your lives and be lesbian.

Finally, I have attached a copy of the lesbian competencies that will go on the Mental Health Commission web-site soon, I am assured. Thanks to those who gave feedback, there are only a few minor changes as you will see.

Meantime take care, contact me if you have any wild thoughts about your transcripts or the study (or just jot them down till we next meet).

Actually any wild thoughts would do.

Cheers Chris

## **Appendix K**

### **Second Letter to Participants**

12<sup>th</sup> October 2002

Hi everyone

Here is another update on my progress with the old PhD studies and more importantly information about your transcripts. All fifteen of you will have had a copy of your transcript back now. I have heard back from just over half of you so far with comments on the transcripts (if you want changes please let me know by next week). Mostly they are to do with the horrors of um's and ah's and repeated sentences which of course we all sound like, but reading it is another thing entirely. At this stage I am leaving all those pauses, um's, ah's and repeats in the transcripts because those um's etc help to capture the essence of each persons interview and I don't really want it to read like a novel with perfect sentences and structure. I have taken out some dialogue as requested by one or two of you.

My abstract (see below) was accepted for the Health in Difference conference which I am pretty excited about because this will be the first time that the audience will have some idea about what I am talking about when it comes to understanding about being lesbian. Now all I have to do is prepare something for the conference, I have re read the abstract and think it sounds pretty good, I'd go to that paper myself. At this stage I won't actually write a paper for the proceedings but will do some overheads and talk to those. I have selected four areas to discuss/reflect/ask questions emerging from the analysis. These are acceptance, authenticity, rapport and safety. Will develop these further next week before I leave on Friday!

I am meeting with Lynne, my supervisor, in mid December to review my visit to Sydney where if you remember I am doing some intensive data analysis just before the conference. Even though a gathering at Waitaquery was flagged it looks like this will turn out to be one of my pipe dreams but hey, you are welcome to come stay anyway for some rest and relaxation. Instead I will contact you to discuss possible questions I have and hear what you have been reflecting on since the interview. This

is likely to be early in the year, late Jan/early Feb so hopefully you will be available at that time. Meantime don't hesitate to contact me if you want to, and this is really scary, Merry Christmas.

Cheers Chris

**Title: Practising lesbians: Psychiatric mental health nurses bordering the boundaries between self-disclosure and nursing practice.**

In 1973 one of the most significant achievements for lesbians and gay men was realised with the removal of homosexuality as a diagnostically recognised mental disorder. This achievement has encouraged some lesbian health professionals to critically examine their sexuality in the context of their practice. The degree of openness about sexual orientation amongst lesbian health professionals varies and is dependent on an individual and personalised process. Authentic and meaningful relationships with consumers and others are fundamental concepts in mental health care and sexual identity forms part of the context in which lesbian nurses practice.

Lesbian consumer experiences of health care suggest that mental health services can be difficult places for lesbian consumers to be in. However there has been little research on what it is like for lesbian psychiatric mental health nurses working in mental health services and how being lesbian influences the care they provide.

This paper is part of a current doctoral study and reports on the interim reflections gained through interviews with fifteen lesbian psychiatric mental health nurses in New Zealand. The experiences of these nurses are considered through the methodology of narrative inquiry, which provides a broad framework for understanding experience, stories lived and told.

While most nurses in this study are out to their colleagues few discussed their sexual identity with consumers and described varying experiences of delivering health care to lesbian consumers. The decision whether or not to self disclose is a complex and at times contradictory one but is one of the most critical decisions lesbian nurses negotiate in their practice. The impact of this decision forms the basis for discussion

in this paper and conclusions about the contribution that these nurses make to mental health nursing practice and health care will be addressed.

## Appendix L

### Third Letter to Participants

February 2004

Hi

This letter is an update of my progress with my PhD. I have enclosed your story, written in a kind of short story style. I would appreciate any feedback from you about how I have adapted your transcripts.

As you may recall, in our phone interview last year, I mentioned that I needed to consider how to present the stories for the thesis given the word limit restrictions and my desire to present you as a unique woman, lesbian, person. With this in mind I started to read fictionalised NZ short stories and came up with the idea of presenting your story as what I have called a 'licensed narrative'. The licence aspect comes from the fact that I have taken some liberties with describing the context and environment in order to create a story that embodies the character, you. This has been very interesting and challenging. I have tried to minimise identifying characteristics such as your specific job, city, family details and of course physical attributes. An overall profile of all 15 participants will be given at some stage in the thesis and details such as training background, work area and so on will be included. Interestingly no one works in the in-patient area and most of you are aged mid thirties onwards (this age status is a guess because I didn't specifically ask this).

My construction of your story has been influenced by my impression of the *essence* of who you were/are and how this was reflected in your transcript and notes that I took when listening to the taped interview. The research questions have also been considered in relation to your story. These are, what is the experience of lesbian nurses who work in psychiatric mental health nursing and how does identifying as lesbian influence the practice of these nurses? Finally, the theoretical constructs that have surfaced have also influenced what has been included and what has been omitted. These theoretical constructs so far have been identified as queer theory,

feminism(s), the therapeutic relationship, other(ing) & difference, marginalisation/fringe, gender and identity.

I will use the phone follow up interview information in the discussion section and possibly a few more quotes from your transcript when developing the theoretical constructs. My next step is to frame the theoretical lens(es) with your story. This may include two or three of the theoretical constructs. When I have drafted this I will get back to you once again for your feedback. My e mail is [girlies@paradise.net.nz](mailto:girlies@paradise.net.nz) and phone 06 367 3930.

Thank you once again for your support and patience. I am hoping to submit the thesis in 2004, all going well.

All the best

Cheers

Chris

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