Practised Ways of Being:
Theorising Lesbians, Agency and Health

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Transcript notations

[pause] Non-verbal cue or words added by the author to make the context clear

[laughter] Interviewer’s interjections

… Indicates words deleted or omitted

¶ Indicates paragraph number from web page

– Marks self-interruption or change of direction in sentence

SD Introduces interviewer’s question or speech in indented quotations

The American Psychological Association (APA) Fifth Edition style has been used throughout this document for referencing and layout.
Abstract

The contemporary field ‘lesbian health’ was shaped by a range of social and political changes in the last third of the twentieth century, as well as by discourses originating in the historical regulation of lesbianism. In discourse, lesbians have been produced as invisible, passive victims of heterosexist and potentially homophobic health-care providers. This project sought to understand how lesbians produce and manage their own health, and their interactions with doctors and other health-care providers. The research questions asked how discourses about lesbianism and the construction of the lesbian health field influence the ways in which lesbians construct and manage their own health, and how lesbians position themselves as they negotiate clinical spaces. Using semi-structured interviews, 19 women, aged between 22 and 64 years, who identified as lesbian, gay, same-sex-attracted and queer were interviewed. Interview data were analysed using discourse and content analysis.

When they engaged with the health-care system, some participants produced their lesbianism as a social matter of no relevance to health; while for others their lesbianism was central to their health. An analysis of power relations revealed the complexity of ways the participants used agency to speak or remain silent about their sexual orientation. This was motivated by complex embodied understandings about the potential for emotional, physical or ontological harm involved in coming out in clinical spaces. Some chose to remain silent all, or some of the time, others to assertively identify themselves as lesbian. This depended on a range of contemporaneous factors including safety concerns, past experience and personal judgement. Whether to come out or not in the medical encounter was not necessarily a conscious decision, but was shaped by the individual’s embodied ‘sense for the game’. While the health-care system had frequently provided less than optimum care, these women were not passive, but used agency to decide whether or not their sexual orientation was relevant to the medical encounter.
Statement of Authorship

Except where reference is made in the text of this thesis, this thesis contains no material published elsewhere or extracted in whole or in part from a thesis submitted for the award of any other degree or diploma.

No other person’s work has been used without due acknowledgement in the main text of the thesis.

This thesis has not been submitted for the award of any degree or diploma in any other tertiary institution.

All research procedures reported in the thesis were approved by the Human research Ethics Committee at La Trobe University.

Signed:

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Date:

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1. Introduction

This project has become something very different from the one originally envisaged, and to say it has been a personal as well as an intellectual journey would be an understatement. I set out to describe what I knew about lesbian health, and my thinking underwent many shifts and re-conceptualisations as the work progressed. In order to theorise the notion of ‘lesbian health’, I have interrogated the concept of ‘lesbian invisibility’, which has frequently been reported to be responsible for lesbians having less than optimum physical and mental health.

This thesis opens with an introduction that articulates my motivation for undertaking the project and traces how the project (and my thinking) changed as it progressed. Following the introduction there is a genealogy of lesbian invisibility which traces the origins of discourses about lesbians and invisibility, and a Chapter that reviews literature about lesbian health. This is followed by Chapters that detail the methodology and theoretical frameworks used in the project, after which the participants’ stories are introduced. At the end of the thesis, the appendices include copies of recruitment documents, questions and themes used in the interviews, and detailed bio-sketches of the participants.

In this introductory Chapter I provide an overview of the discourses of invisibility and outline some of the factors that motivated me to undertake this study. I briefly discuss the development of the lesbian health movement and lesbian health activism, and then focus on the shifts in my thinking that occurred as the project unfolded. As indicated above, later in the document theoretical frameworks are discussed in more depth.

Motivation: Some Personal Reflections

In many ways my own life story has some significance for the way in which this project was conceived. My initial training was in nursing and my work experience has covered health education, community development and health promotion, with a focus on women’s health and wellbeing. I was a ’70s feminist; my politics were influenced by my involvement in consciousness-raising groups and by the works of a range of feminist authors, for example, Simone de Beauvoir’s The Second Sex, Betty Friedan’s The Feminine Mystique, Germaine Greer’s The Female Eunuch, and Anne Oakley’s Sex, Gender and Society. Without doubt my feminism has influenced my work, and before I started post-graduate studies, I adhered to a political framework in which power was
inherently oppressive, with patriarchal forces dominating women and marginalised people.

In the early 1980s I took a women’s studies course (one of the first in Melbourne) and for the first time I encountered theoretical frameworks about feminism. I learned about four main branches of feminism: liberal (which sought political and economic equality with men within capitalism), radical (men and capitalism were the main sources of oppression of women), socialist (which critiqued capitalism, Marxism and radical feminism), and Marxist (which sought to develop Marxist theory in order to understand the oppression of women) (Gimenez, 1998). While the aims of these feminisms sit on a continuum from changing ‘the system’ from within to overthrowing ‘the system’, they all view women as oppressed by men and/or patriarchy, and all require some kind of systemic reform or revolutionary change to achieve women’s liberation.

After three children and the end of a long marriage, in 1986, I fell in love with a woman and started to identify as a lesbian. I did not feel I had found my ‘true’ self, but viewed the change as a choice freely made. Because I did not think this choice had changed who I was as a woman, I saw no reason to come out to the family doctor I had seen for many years. As far as I was concerned, my choice of partner did not change my health-care needs. In the late 1990s, I started work in a regional women’s health service as a lesbian health worker. While I was experienced in women’s health, I had no particular knowledge of lesbian health. In this new position I was exposed to a body of literature that argued that lesbians had some specific health issues that were different from those experienced by heterosexual women. I also encountered a field of activism that positioned lesbians as invisible in the health system, and attributed this to heterosexism and homophobia. It has been argued that the health of lesbians is negatively affected by the automatic assumption of heterosexuality on the part of health-care providers, and by women’s fears that disclosure will lead to discrimination. These two factors are said to lead to lesbians being invisible in the health-care system (Daley, 1998; B. Roberts, 2001).

In a Canadian publication about lesbian health, one lesbian described her dilemma about whether or not to come out by saying that if she did not challenge the presumptions of heterosexuality, she risked receiving inappropriate care, but that she feared antagonism or

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1 Homophobia is defined in the Shorter Oxford Dictionary as ‘hatred and fear of homosexuals and homosexuality, usually associated with hostility and sometimes with violence’. Heterosexism is defined in the Shorter Oxford Dictionary as ‘discrimination or prejudice by heterosexuals against or towards homosexuals. These concepts are elaborated throughout the thesis (see for example pp. 62, 72, 77, 114).
medical mistreatment (Hudspith, 1999). Because of statements like this, some activists have argued that all lesbians have been rendered invisible in practice, research and policy and are consequently bypassed in mainstream health services (R. Brown, 2000). The remedy proposed for this has been to increase lesbian visibility (McNair, 2000a).

My professional practice as a lesbian health worker was shaped by this discourse. Later, as an experienced practitioner but a naïve researcher, I considered the possibility of undertaking post-graduate studies. I assumed that my knowledge about, and work experience in lesbian health would position me well to document what I knew, and earn my degree. I applied, was accepted, and commenced reviewing the literature about lesbian health to frame research questions and plan my project. Early in my first year of study I was invited to participate in an annual event at my University, the Post-Graduate Student Festival, in which students present their work in progress to an audience of other students and academic staff. I confidently presented my work, and received some interesting feedback from the audience, to the effect that ‘it sounds like you know a lot about your subject, but what is the unknown that you seek to explore?’

At the time, the question mystified me. I had accepted activist discourse about lesbians fairly uncritically, however, by chance I noticed some letters to the lesbian press in Melbourne, that contested the calls for increased visibility. One writer argued that the matter of sexual orientation was essentially private, saying: “We all have the right to live our lives in a way which is satisfying and fulfilling to ourselves and the issue of sexual orientation should not be an area for public invasion” (Szikla, 1996, p. 1). This was a time during which gay and lesbian health issues were being publicly debated in Victoria. A writer in another publication called for attitudes to change towards lesbians in the broader community before moving towards increased visibility in health. In a scathing critique of government and activist initiatives, she argued that: “Lesbian invisibility in the health-care system may add stress to our lives and lead to less than satisfactory health-care, but it may also be useful protection against lesbophobia [sic]. If broader community attitudes do not change before lesbians achieve visibility, we will render ourselves vulnerable to continuing discrimination and disempowerment” (Clarke, 2001, p. 28).

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2 A Gay and Lesbian Ministerial Advisory Committee was constituted in 1999 to advise the Victorian Minister for Health. A series of discussion papers were commissioned, which covered issues of relevance to lesbians, such as lesbian health, mental health, drugs and alcohol, cultural issues, bisexuality and ageing. The discussion papers, were published together by the Victorian Government, under the title What’s the difference? GLBTI health concerns research paper in 2002 (for details see http://www.health.vic.gov.au/macglh/). This brought lesbian health issues into the public arena.
These letters to the lesbian press exposed me to challenges to the dominant discourse that I had not been aware of before. Another challenge occurred when I was commissioned to facilitate a focus group, designed to inform the development of government health policy for lesbians. The group was structured around questions, posed by the Department of Human Services, about the lesbian participants’ experiences with the health system. In the group, discussions focused on disclosure and whether responsibility for coming out lay solely with the lesbian, or whether doctors should provide opportunities for lesbian patients to feel safe and comfortable enough to disclose their sexual orientation during consultations. The overwhelming opinion expressed in the group was that the choice to be out lies with the lesbian, and that doctors should not raise the subject of sexual orientation. They argued that coming out should be a woman’s choice and that she must be ready to deal with any consequences of her choice to disclose or remain silent. This conflicted with activists’ promotion of good lesbian health practice, which argued that doctors should provide opportunities for lesbians to come out by asking questions about relationships and sexual behaviour. These women also asserted that unless there was a specific health-related reason for disclosing to a doctor, they did not see it as necessary to come out.

As a result of these events, I started to understand that the discourse I had taken for granted about lesbian invisibility was not supported by some lesbians. Indeed, there existed contradictory and competing discourses about lesbian health, that positioned lesbian health activists (many of whom are lesbians and health-care providers themselves) and some lesbians differently. The dominant discourse called for increased visibility, while some lesbians asserted their right to privacy and argued that invisibility could provide protection against discrimination and abuse. This conflict can also be seen in some of the empirical literature, in which there are conflicting accounts about lesbians’ experiences with the health system; some glowing, others damning. For example, in a report of a survey with lesbians in Melbourne, one participant discussed her experience at the Royal Women’s Hospital, saying: “I was present at the birth of my daughter as the non-biological mother. In this context we were treated respectfully as a couple” (R. Brown, 2000, p. 3). The same report also noted that a woman said: “I have never felt so invisible”. In her file under support was written ‘friends’ when there was actually a co-parent, but she didn’t feel she could say anything because she was at the ‘mercy’ of the nurses (p. 4). These contradictions are often not discussed in lesbian health literature, where the focus has generally been on negative experiences and health outcomes.
Lesbian Health Activism

Lesbian health emerged as a field of activism as a result of a number of social and political changes that occurred more broadly in health policy and practice in the last half of the twentieth century. Arguably one of the most influential of these developments occurred was the 1948 World Health Organisation (WHO) definition of health as a state of complete physical, mental and social wellbeing, not merely the absence of disease or infirmity, and one of the fundamental rights of every human being (World Health Organisation, 1948). This statement, which has become the basis for a model of health that recognises the impact of social conditions on the health of individuals and communities, has influenced the ways in which health has been conceptualised and services delivered ever since. While the 1948 statement has been reconsidered, it has not since been changed or amended. It was reaffirmed by WHO at the Declaration of Alma-Ata in 1978, and has been supplemented over the years with additional statements about health promotion. This construction of health as encompassing physical, mental and social wellbeing, and as being about more than the absence of disease, has not only influenced mainstream approaches to health, but has played an important role in carving out territory for previously unrecognised, or marginalised, groups such as indigenous people, people of colour and those with disabilities, to struggle for justice.

The women’s health movement grew out of the women’s liberation movement in the 1970s in the USA. One of the most influential publications in this movement was the Boston Women’s Health Collective’s *Our Bodies Ourselves*, which was published in 1971. Until that time women’s health had largely been seen as synonymous with men’s health, except in the area of reproduction, and one of the early struggles of the women’s health movement was to demonstrate the differences between men’s and women’s health needs, so that women could be better served by health services (Dyson & Giffney, 2001). In its early days, the women’s health movement aimed to empower women with knowledge about their bodies, health and sexuality. This feminist critique of the health-care system called for a woman-centred view of health. In self-help and consciousness-raising groups women explored their own health issues and bodies. Collectively women demonstrated and lobbied for social problems such as sexual violence to be seen as both health and social issues for women. All these issues had not previously been seen as health issues for women (Berkeley, 1999).

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3 See, for example, the WHO’s Ottawa Charter for health promotion (1986) and Jakarta Declaration (1997).
In Australia women also organised around these issues, but the women’s health movement did not formally emerge until the late 1970s. In the 1980s, in response to political pressure from women, the Australian Government funded women’s health services in every state to provide both direct services and health education, using the social model of health. While many lesbians were active in the women’s health movement from its early days, health issues for lesbians were not on the agenda, and with few exceptions, the women’s health movement was silent on the existence of lesbians. Women’s health activists who were lesbian recognised this, and lobbied to be included, however, many heterosexual women feared being branded as lesbian, and to some extent, lesbian health diverged from the women’s health movement into a field of activism in its own right. Wilton (2002) posited that:

Not only did lesbian health activists cut their teeth on [women’s health] issues, they also had to fight within feminism, against the heterosexual majority who thought lesbian issues unimportant or who believed that to include lesbians would bring feminism into disrepute (p. 255).

Lesbian health activism does not constitute a highly organised social pressure group. It is, rather, a collection of loosely knit individuals and groups who struggle for change in the light of perceived injustice. Although lesbians had been politicised, and had argued for equity and rights since the 1960s, as a social movement lesbian health activism appears to have coincided with the emergence of HIV/AIDS activism by gay men in the 1980s. It has never been entirely clear which connections best serve the lesbian health movement, gay rights or feminism. Sedgwick (1993) noted that the course of these movements have been “radically, often violently shaped by differential historical forces, notably homophobia and sexism” (p. 59). Another factor that influenced the course of lesbian (and gay) health activism, was that, although the social model of health recognised the social, and addressed a range of human rights issues as health issues, it was not until 2000 that the WHO formally acknowledged sexual rights. It has been suggested that this recognition occurred as a result of the combined influences of the HIV/AIDS epidemic, the gay and lesbian rights movement, and the second wave of the women’s movement (Tiefer, 2002).

Historically the development of lesbian health activism appears to have followed a different trajectory from that of gay men. Wilton (2002) argued that gay men’s and lesbian health activism have both been influenced by inequitable access to political and
professional power, socio-economic inequalities, shifting norms and the influence of sexism. The lack of access to political power experienced by lesbians, which may stem from gender inequity, has led to vastly different outcomes for gay men and lesbians in the health arena. Lesbian health research has tended to remain located in practice or policy areas, whereas gay men’s health, driven (and dominated) by the imperative of the HIV epidemic since the mid-1980s, has benefited from the dual focus of policy and practice (in the field) and theory (in the academy) (Wilton, 2002).

In the field of health practice, the main aim of both lesbian and gay activism has been to draw attention to health-care needs and service improvement, and to work towards the elimination of heterosexism and homophobia. In the academy health can be studied as a contested concept, medicine as a discourse, and issues to do with sexuality can be integrated into the debates about subjectivity, identity, medical power, the social construction of gender and the medicalisation of gender and sexuality (Wilton, 2002). It is here that gay and lesbian health diverge, and Wilton argued that the whole notion of lesbian health “remains a taken-for-granted concept in most publicised work on the subject” (p. 256). Furthermore, Wilton argued, the pragmatic and policy-driven areas of research about lesbian health must be informed by theoretical work on sexuality.

The production of theory is not limited to the academy. Individuals within a movement can and do produce their own theory, largely outside academic circles (Bevington & Dixon, 2005). This has been referred to by McLaughlin (1996) as “vernacular theory”, which he described as an aspect of critical theory that arises from understanding the experience of marginalised people or groups who “lack cultural power and who speak a critical language grounded in local concerns” (p. 6). This, according to McLaughlin, arises out of intensely local issues that lead to fundamental theoretical questions. He asserted that people in a movement are capable of untrained deconstruction of the ‘official’ version of reality based on their own, or their group’s experiences, and this can pose serious questions about the social structure. To contribute theory to activism, social movement theory argues that validation, elaboration, and refinement of concepts are important to provide useful knowledge for those seeking social change (Bevington et al., 2005). When applying this approach to the field of lesbian health, it is apparent that there is an official ‘theory’ about lesbian health, and a version that arises from those (lesbian) individuals on the ground, who are the subject and object of activism. The latter can also be seen as what Foucault (1980) called “subjugated knowledges” (p. 81). As I demonstrate later in this thesis, those who promulgate the official theory (or in
Foucauldian terms, globalising discourses), often speak with an authority that overlooks or denies those subjugated knowledges of ordinary people (McLaughlin, 1996). Reflecting on the competing discourses about lesbian health discussed above, the voices of those who contest the dominant discourse about increasing lesbian visibility as a way of improving lesbian health constitutes a subjugated discourse, and a vernacular theory.

**Lesbian health: deficit or asset?**

The predominant focus of lesbian health activists on ill-health and a medical model of health and discrimination has been theorised by gay men’s health activists as a deficit-based approach to health (Rofes, 2006). This posits that accepting an inaccurate and phobic portrait of gay men as sick and damaged by homophobia promotes a position that gay men are inherently unhealthy. Rofes suggests that this can be countered by an asset-based approach, that would recognise and build on community strengths, resources, skills and values, to demonstrate gay men’s commitment to survive and thrive, even under the most formidable circumstances. He argues that gay men are “individually and collectively healthy, reasonable, life-affirming and successful in creating fulfilling and meaningful lives” (¶ 55). Furthermore, he argues, the current paradigms that produce gay men as essentially unhealthy misrepresent the group.

This idea of the health and wellbeing of individuals who have been discriminated against and marginalised by the mainstream being produced as being in deficit has also been theorised in other fields, such as drug education and restorative justice, as an ‘individual deficit model’ (see, for example, Treloar & Holt, 2006; Jackson & Henderson, 2006). In this model, the shortcomings of the individual are produced as barriers to access, deficit problems of the individual (Jackson & Henderson, 2006). Through this lens, it is possible to see how activists have applied a deficit approach to lesbian health where the focus has been on lesbian invisibility and its health implications, rather than on the strengths and assets of lesbianism and the lesbian community.

**Shifts in my thinking**

As I read and reflected on the dominant and subjugated discourses about lesbian invisibility, and the question posed to me at the Student Festival, I realised that here was the unknown I sought to understand. I started to rethink the dominant discourses about lesbian invisibility, and as I did this, I shifted from wanting to describe what I had known, to wanting to better understand lesbians’ lived experience of both visibility and invisibility in health-care settings. I realised that while ‘lesbian’ and ‘health’ had each
been extensively theorised in other fields, ‘lesbian health’, in its own right, had not. As I started to recognise the contradictory discourses concerning lesbians and health, I reconsidered the political paradigm I had been working within for many years. In this section I outline some of the ways in which my thinking, and ultimately the direction of this project, changed as a result. In Chapter Five, which discusses the theoretical frameworks used in this thesis, I discuss the work of Foucault in greater detail, but at this point I compare Foucauldian notions of power with those of Marxist feminism, to illustrate the shifts that occurred in my thinking during the course of this project.

Although the term ‘power’ is in common usage and generally applied in a variety of contexts, in social and political theory it is a contested concept. There are essentially two ways of conceptualising power, as power-over and power-to. Models of power that underpin Marxist and liberal theories of feminism are characterised by three main features: that power is possessed, that it flows from above to below from a centralised source, and that it is primarily repressive (Sawicki, 1991, pp. 20–21). This is sometimes called juridical power, a term that refers to legal or administrative forms of power, such as the power of the state, or the law. French philosopher Michel Foucault argued that the ‘juridical’ theory of power at the base of Marxism constituted a force that was only useful “under feudalism, in the maintenance of the monarchy, and as a justification for parliamentary democracy” (Foucault, 1980, p. 103). Within juridical models of power, it is argued, those who possess power oppress those who do not have it. In critical theory, meta-narratives, or grand, encompassing accounts can provide a framework that creates a kind of universal order for an individual or group’s experience. Meta-narratives are generally characterised by some kind of transcendent and universal truth (Stephens & McCallum, 1998).

Within the juridical meta-narrative, the only option for the oppressed is to overthrow the oppressor. McNay (1992) argued that this is limiting and provides only limited options for change. Within the Marxist framework, feminist strategies for change range from revolutionary to evolutionary, but regardless of the strategy, power is seen as a possession, to be won and redistributed. Foucault rejected the notion of power as something negative, that can be possessed (or seized):

> We must cease once and for all to describe the effects of power in negative terms; it ‘excludes’, it ‘represses’, it ‘censors’, it ‘abstracts’, it ‘masks’, it ‘conceals’. In
fact, power produces, it produces reality; it produces domains of objects and rituals of truth (Foucault, 1977, p. 194).

This is not to say power cannot be used to oppress, but for Foucault power was of more interest as a mechanism that operated between subjects in their mutual relations. He described power thus:

Power . . . is exercised from innumerable points in the interplay of non-egalitarian and mobile relations . . . Power comes from below; that is, there is no binary and all-encompassing opposition between rulers and ruled at the root of power relations (Foucault, 1978, p. 94).

In Foucault’s theory power is not possessed, and is neither positive nor negative, but it simply exists and circulates in social networks (Foucault, 1980). This conflicts with the hierarchical notions of power and oppression, upon which many liberal and Marxist theories of feminism are based.

I approached my initial readings about post-structuralism with some scepticism. Nonetheless, as a result of my reading and reflections, I started to experience a shift in my thinking, away from liberal and Marxist feminist frameworks. I had ascribed to the meta-narrative of women as an oppressed minority in need of liberation for many years, and had read angry feminist critiques of post-modernism. For example, Oakley (2005) called post-modernism an ‘urgent threat’ to gender. In the early days of this project, I would have seen suggestions that there might be other ways of thinking about power, gender and sexuality as being anti-feminist. However, at the same time I had also become increasingly aware that there was some instability in this thinking. Radical feminists rejected post-modern ideas and argued that such ideas had hastened a fragmentation of bodies, minds and souls (Klein, 1999). Women of colour had challenged the ‘truths’ of mainstream feminism as being for white middle-class women, and young women also challenged the long-held ‘truths’ of older feminists. For example, in the USA, women of colour argued that mainstream feminism was dominated by white, middle-class women, and acted as a system of domination to oppress and silence individuals from marginalised groups (hooks [sic], 1994). Young women’s resistance against second-wave feminism can be seen in The Riot Girl movement of the early 1990s. Largely located within the punk music scene, The Riot Girl movement’s manifesto argued that the untamed nature of girlhood disappears upon adolescence, with the cultural expectation that young women will take up traditionally passive, feminine roles. Twenty-five years after second-wave
feminism’s struggle to change the role of women, The Riot Girl movement rejected the contemporary notion of womanhood prevalent within the dominant culture, preferring instead to remain as girls (Long, 2000).

These ideas caused something of a rupture in how I viewed feminism. I continued to read, discuss and reflect on how post-structuralist feminism could be applied to contemporary feminist objectives. Foucault’s works have been embraced by some feminists, approached with caution by some, and completely rejected by others. According to McNay (1992), this may be because gender analysis was not a feature of his work. The main issue that feminists who object to Foucault have with his work appears to be in relation to his notion of the ‘docile body’ (Foucault, 1977). McNay (1992) has argued that this is because of:

… the difficulty of assimilating a primarily philosophical form of critique into feminist theory which is rooted in the demands of an emancipatory politics. For the emphasis that Foucault places on the effects of power upon the body results in a reduction of social agents to passive bodies and does not explain how individuals may act in an autonomous fashion. This … conflicts with a fundamental aim of the feminist project: to rediscover and re-evaluate the experiences of women (p. 3).

This critique of Foucault’s construction of the body as passive was based on his early work, however, in his later work he developed a theory he called care of the self, that accounts for individual agency (McNay, 1992). This issue of agency will be addressed in more detail in Chapter Five.

Butler (1990) argued that the notion that the oppression of women has a singular form (patriarchy) is simplistic. Post-modern and post-structuralist feminist theorists have found Foucault’s analysis of power to be a useful tool for gaining a deeper understanding about the position of women in society. For example, theorists such as Scott (1993) and Sedgwick (1993) have used feminist theory to further develop Foucault’s (1978) analysis of the intersections between gender and sexuality from a feminist perspective. They (among others) have argued that sexuality, like gender, is a socially constructed category that varies over time and between cultures. This is not to say that there is no corporeal reality. Olssen (1999) has argued that:

Although Foucault maintains the constructionist nature of discursive systems, [is] based on … the performative function of language, this should not be seen as
amounting to a naive form of linguistic idealism whereby it is claimed that nothing exists outside of discourse, or that *everything* about ourselves is constructed by discourse. Foucault's philosophical nominalism ensures that his constructionist claims vary depending on the object of his analytical focus … These facts give his constructionism a ‘dynamic’ quality (p. 32).

In this project I have adopted Foucault’s notion of power as a mechanism which is exercised rather than possessed, productive as well as repressive and tends to rise from the bottom up. I have opted not to reject feminism, but seek to approach feminism from a post-structuralist perspective. In saying this I mean my feminism is a political position that frames my life and influences my thinking. I have elected not to use a feminist post-structural theoretical approach (which will be discussed in detail in Chapter Four), but acknowledge here my own feminism, how it has changed during the project, and how it continues to influence my thinking. My shifting understanding about power and feminism have without doubt influenced my work in this project.

**Insider or Outsider?**

Because working on this project has been partially based on my own experience as well as being a doctoral project, early in the process it was suggested that I might position myself as a participant, and write about my own experiences. Some feminist researchers have included themselves as participants in their own research, based on recognition of qualities and experiences they share with their participants (Kirkman, 1999). The application of feminist theory to research methods has led to an increased acceptance of the personal as a starting-point for feminist research, and addresses the position of the researcher who belongs to the same community or shares similar experiences with those being researched as an ‘insider’. It is argued that being an insider to an experience positions the researcher in ways that make it possible for her to understand what others in a similar position have to say, in ways that no person from outside the group can. This has been called a new ‘epistemology of insiderness’ that sees life and work as intertwined (Reinharz & Davidman, 1992). This position has been described as an advantage for a lesbian when working with other lesbians:

Who designs, conducts and controls the research raises issues of ownership. There is often a need for lesbians to conduct research with lesbians because from the very outset of identifying the problem, the insiders (lesbians) have more knowledge and sensitivity to the issues than outsiders (non-lesbians). In collecting
data it may also be an advantage to be lesbian because informants may disclose more to you, feeling that you understand and respect their whole lifestyle and they can trust you to use the research in their interests (Waite, 1996, p. 173).

Waite asserts here that lesbian participants are more likely to open up to lesbian researchers, but it is also possible that because lesbian communities are usually small, the researcher may be confronted by ethical issues. For example, participants may hold back because they fear being judged, or a breach of confidentiality (Horsley, 2003). The issue of power relations underpins the inclusion of the researcher as a participant, and feminist theorists have posited that the researcher should strive to recognise her position of power over the participant, and equalise it in some way (Kirkman, 1999).

I argue that the assumption of homogeneity and the possibility of equalising power relations in a research project is naïve, and the insider/outsider binary sets up a false dichotomy that is problematic. Because I elected to use a Foucauldian notion of power as something that circulates, I elected not to write myself in as a participant, but to assume reflexivity in relation to my own position and that of the participants. In a post-structuralist paradigm, power relations can be recognised and acknowledged with the aim of understanding or addressing inequities. However, power is an unpredictable, dynamic quality, and rather than being concerned about equalising power, in this project the objective was to be aware both of the ways in which power operated within the interview situation, and of what the participants told me about their experience with power within clinical encounters.

Having considered my own theoretical and personal position in relation to this project, I realised that the challenge facing me was how to hear the participants outside the liberal/Marxist feminist paradigm, that had dominated my thinking for so long. While my theoretical readings were influential, it was the women I interviewed who cemented the conceptual shift I made, away from viewing power as primarily oppressive, to seeing it as productive. Rather than being passive or feeling oppressed, these women used a range of strategies that demonstrated agency within clinical spaces in a variety of ways. The production of lesbians as invisible victims, that was apparent in much of the lesbian health literature I had read⁴, and to which I shall return in Chapter Three, was challenged in a number of ways by the women I interviewed. In relation to visibility, some confronted their health-care providers with their sexual orientation and demanded fair

treatment and acceptance, others used a more understated approach to disclosure, and still others did not disclose at all. Many described coming out situationally, deciding on each occasion according to their needs and the circumstances of the consultation. However, without exception, rather than being a passive victim in interactions with health-care providers, each woman used agency around visibility, to protect herself from the possibility of prejudice, discrimination or harm. Not that any of these strategies guaranteed a positive outcome. Foucault’s conceptualisation of power as operating within systems and between individuals made more sense of, and was more applicable to, the ways in which the women talked about negotiating the health system, than those models in which power was produced as simply oppressive. In re-thinking my feminist philosophy, I was not tempted to deny the existence of inequalities based on gender or sexuality, and was motivated by a desire to better explain the complexities I was encountering.

I reflected on the contradictions between the dominant lesbian health discourse and the voices of those who contested these discourses about invisibility, as well as on the ease with which I had uncritically accepted (and done my fair share of promoting) the dominant discourse. It was through this reflexive process that I started to understand the importance of the question posed to me at the post-graduate student festival. I no longer sought to simply describe what I knew, but to understand how in/visibility played out for lesbians who were ‘consumers’, and what influenced their relations with health-care providers. This project is not about investigating the health of lesbians, but their experiences in clinical spaces. It represents an attempt to theorise ‘lesbian health’ as a concept, by analysing the ways in which the technologies of power operate in clinical spaces for lesbians. While extensive theorising of women, sexuality and gender has occurred in the past few decades (see, for example, the work of Judith Butler, Eve Kosofsky Sedgwick, Anna Marie Jagose, and Tamsin Wilton, among others), there have been few attempts to theorise lesbian health.

**Problematising Identity Politics**

In the lesbian health literature, increased visibility is promoted (both actively and by inference) on the basis that lesbians will receive better care and have better health outcomes if they disclose their sexual orientation to the medical practitioner (R. Brown, 2000; Clark, Landers, Linde & Sperber, 2001; Daley, 1998; Henderson, Reid, Hickson, McLean, Cross & Weatherburn, 2002; Robb, 1996; Robertson, 1992). Health-care workers are encouraged to create an environment conducive to lesbians disclosing, and
for individual lesbians to take responsibility for making themselves more visible. It is taken for granted throughout this literature that disclosure represents a positive step. This is exemplified in the following quote from the US-based, gay and lesbian magazine, *The Advocate*:

> More and more lesbians are coming out to their doctors, and that’s helping them get better health-care, a new study reveals, but they’ve still got a long way to go … The percentage of lesbian patients willing to discuss their sexuality with their doctors is up from 63% in 1987 to 80% in the current study. ‘This is vital because [the inability to be out] is one of the reasons that’s always given for why people don’t get preventative care’ … But lesbians are still lagging far behind the general female populace in getting physical examinations (Allen, 2004, ¶ 1–2).

The assumption that coming out will actually ensure preventative care for lesbians (or that not coming out will deny preventative care) involves a notion that doctors will know about lesbian health issues, and that they will provide better care if they know that a patient is a lesbian.

Lesbian health activism is based on identity politics; the idea that social identity is grounded in a shared core self, which assumes that a clear dividing line exists between us and ‘the other’ (Weedon, 1999). Weedon asserted that identity was important for resistance by the oppressed, and this position is apparent in calls by activists for increased visibility for lesbians in health-care services. The aim of lesbian health activism is to improve the experiences of lesbians in health-care services, and ensure better health outcomes for lesbians. To achieve this aim, a minority-rights discourse has been structured, however, identity politics can also have conservative effects, because they tend to become naturalised as self-evident descriptive categories (Jagose, 1996).

In lesbian health discourse, homogeneity among lesbians is assumed, but as Butler (1997) asked, who or what is it that is ‘out’ when a lesbian reveals herself, and what is concealed? Furthermore, Butler asked, what can the lesbian who comes out be said to share, and who decides this? Embedded in the assumption that lesbians are a homogeneous group is the notion that all women who have sex with, or are attracted to women, identify as lesbian and that all lesbians share similar health risks.

Heteronormativity refers to the ways in which social institutions and policies reinforce the belief that normal gender behaviour is either masculine or feminine, and that sexual
relations can only occur between a male and a female (Warner, 1991). This concept reveals the expectations, demands and constraints produced when heterosexuality is constituted as the norm. In health discourse, the term ‘lesbian’ is produced in opposition to ‘heterosexual woman’ or ‘gay man’, thus playing into heteronormative binaries. Thinking about the lesbian in relation to health is somewhat problematic. Lesbianism can be produced as a social issue, in that it relates to sexual relations between women, or it can be medicalised, as it tends to be in lesbian health discourse, with its focus on potential illness and disease. In the latter formulation of the lesbian, the term ‘lesbian’ is in itself problematic. Notwithstanding the strength of lesbian identity as a political tool, non-heterosexual sexuality in women can take many more forms than that of being a simple binary opposite to heterosexuality, and many women who are not exclusively heterosexual refuse to apply the term lesbian to themselves. Much of the early research with lesbians focused only on those women who identified as lesbian (see, for example, Stevens, 1992). There have been moves in the past decade to recognise that sexuality can consist of any part of behaviour, identity or attraction (Laumann, Gagnon, Michael & Michaels, 1994). The concept of behaviour has been extended further by Kippax (2005), who introduced the concept of sexual practice. Kippax suggested that the term ‘sexual behaviour’ is somewhat limited in its diversity, whereas the term ‘sexual practices’ conveys a more complex meaning that is rooted in social conditions and the discourses that construct them. Sexual practice is about the ways in which people relate to each other and shift according to time and culture. Using these broader concepts of sexuality, it can be seen that there are some women who have sex with other women, who claim lesbian identity, while there are others who share the same attraction and/or behaviour who do not. Using the term lesbian to encompass all women who are not exclusively heterosexual, excludes women who do not identify as lesbian, but engage in sexual relations with other women. What lesbians (and all women) need in terms of health-care and prevention goes much further than the disclosure (or withholding) of information about sexual orientation. While lesbians may experience a number of different health outcomes from heterosexual women (which appear to be more likely to be related to social than physical factors), the actual preventative care that they require is unlikely to differ. For example, all women need to be screened for cervical and breast cancer, and other preventative screening is usually based on the individual’s history. It is family history, behaviour and life-style that are more relevant to health-care than sexual identity. Furthermore, the assumption that all women who are attracted to women, or engage in homoerotic acts with other women identify themselves as lesbian is a simplistic
understanding of the category lesbian, which limits it to those who embrace lesbian identity.

There are many ways in which homoerotic attraction and practices play out. These are not stable, and have shifted over time, according to the prevailing social and cultural norms. In contemporary culture some women embrace the identity ‘lesbian’ and are strongly connected to the lesbian community, while others avoid the use of the word but are still linked with the lesbian community. Others engage in same-sex relationships, or sexual acts but refuse to embrace any form of sexual identity, and still others sit somewhere between these two extremes. Having criticised a tendency in the literature to conflate lesbian identity with same-sex attraction and behaviour between women, in writing about the experience of women who have sex with other women this can create a problem, as there is no encompassing terminology that comfortably describes this category. Therefore, throughout this document, I use the terms ‘lesbian’ and ‘lesbianism’, regardless of whether or not the time being discussed precedes the common usage of the term. I use the terms ‘lesbian sexuality’ to describe women who have sex with other women, and ‘lesbian identity’ when referring to that specifically. In doing this, I acknowledge that the language is problematic, as I have argued above.

**Problematising Invisibility**

One of the aims of this project has been to problematise the notion of invisibility concerning lesbians and health, and to understand how this plays out for lesbians in clinical spaces. This requires an interrogation of the whole notion of lesbian invisibility. In health discourse, lesbians are produced as invisible, and this notion is seldom questioned. Invisibility is constituted as oppressive, with implications for the health of lesbians, both individually and collectively. The charge of lesbian invisibility extends beyond lesbian health discourse, and to interrogate the notion of invisibility, I turn to the works of authors from disciplines such as literature, history and queer studies, where the concept of lesbian invisibility has been the subject of extensive scholarship.

Instead of accepting invisibility as a given for lesbians, theorists from fields other than health have interrogated this phenomenon more fully. For example, Jagose (2002) posed the question:

> Why it is so difficult to see the lesbian – perhaps it is because she has been ‘ghosted’ or made to seem invisible – by culture itself? It would be putting it
mildly to say that the lesbian represents a threat to patriarchal protocol: Western civilization has for centuries been haunted by a fear of ‘women without men’ – of women indifferent or resistant to male desire (pp. 4–5).

In this passage, Jagose suggests that lesbians have been ‘disappeared’ because they pose a threat to normative notions of (hetero)sexuality and gender roles. In a similar vein, Castle (1993) argued that Western civilisation has for centuries been haunted by a fear of women who are indifferent or resistant to male desire, and that by constituting them as invisible the threat that lesbianism poses to the natural order of things can be effectively neutralised. This view of the lesbian as challenging the dominant (hetero)paradigm takes a far more active view of the role of the lesbian in culture than that promulgated by lesbian health literature, which will be explicated in detail in Chapter Three. To understand the ways in which invisibility is produced and plays out for lesbians in relation to health, it is necessary to consider the ways in which they are produced as “a reversal of the cultural conventions that naturalize heterosexuality as visible” (Jagose, 2002, p. 2). Jagose argued that in culture, the lesbian is:

Less an absence than a presence that cannot be seen, the lesbian marks the limits of sexuality’s cultural visibility … a strategy of representation in the maintenance of the ideological bulwark of gendered and sexual hierarchy (2002, p. 3).

Jagose (2002) suggested that lesbianism has been less the subject of prohibition, than a denial of its very possibility. Because lesbians are seen as challenging the dominant heterosexual paradigm, culture has, by a kind of sleight-of-hand, made it possible to both disappear the lesbian and vilify her at the same time. This phenomenon was identified in the early days of the lesbian feminist movement:

Lesbian is a word, the label, the condition that holds women in line. When a woman hears this word tossed her way, she knows she is stepping out of line. She knows that she has crossed the terrible boundary of her sex role. She recoils, she protests, she reshapes her actions to gain approval. Lesbian is a label invented by the Man to throw at any woman who dares to be his equal, who dares to challenge his prerogatives (Radicalesbians, 1997, original 1970, p. 153).

It is perhaps as a result of society’s vilification of, and incredulity about the possibility of lesbianism, that many lesbians embraced identity politics. However, as discussed earlier,
identity categories do not capture the totality of women who are attracted to, or are sexually active, with other women:

For as powerful as the claims of identity are, they are neither universally appropriate to the past nor conducive to epistemological claims that extend beyond pointing, ‘Look there! Look, there’s another one!’ (Traub, 1999, p. 392).

Here Traub drew attention to an essential problem with lesbian identity politics, which neither fully accommodates those whose practices or affections can be broadly described as lesbian (in the past or the present), nor makes all lesbians instantly recognisable. In the 1980s and 1990s, identity politics resulted in ‘visibility politics’, which involved a process known as ‘outing’, where under certain conditions the identity of an already high-profile homosexual person was made public, usually without her or his consent (Roof, 1996):

Terminal visibility, as a metaphor of public knowledge, is thus produced by inviting or forcing a joinder between appearances and pre-existing ‘private’ or closeted knowledge about quality and quantity (p. 147).

The logic behind outing was that increased visibility would remedy homophobic oppression. The logic of the argument for increased visibility was that it would provide role models, overcome internalised homophobia, and reveal the sheer numbers of gay and lesbian people (Roof, 1996). Sedgwick (1993) cited a US magazine article that exemplified the argument for coming out leading to acceptance:

If every gay person came out to his or her family, a hundred million Americans would be brought onto our side. Employers and straight friends could mean a hundred million more (p. 48).

Scott (1993) argued that rather than bringing the fact of difference into the field of view, which is the intention of visibility politics, “it is more important to explore how difference is established, how it operates, how and in what way it constitutes subjects who see and act in their world” (pp. 399–400). Similarly, Roof (1996) has argued that visibility can become an end in itself:

… visibility politics tries to strong arm opinion by changing the image of an identity within the same logic that produced that identity, instead of trying to
identify and alter the processes by which identities are produced and situated and by which visibility/invisibility itself becomes the problem (p. 148).

In attempting to understand lesbian invisibility, issues of both gender and sexuality come into play. Roof (1996) posited that sexuality is constructed within a hierarchical order of man/woman/gay man/lesbian. In relation to gender, the lesbian is produced as a figure who occupies

... the definitional center [sic] of neither femininity nor homosexuality, the two categories whose additive logic is presumed to describe her most fully (Traub, 1999, p. 3).

Roof (1996) suggested that invisibility may be likened to a misleading knowledge and visibility to truth. This appears to describe the logic behind calls for increased visibility for lesbians in health-care services. Yet sexual orientation is only one part of the complexity that constitutes identity, which is socially constructed, and historically specific. Being lesbian in the twenty-first century is different from what it was fifty years ago, or fifty years before that. It is a mistake to assume that acknowledgement of sexual identity, or recognition of sexual orientation by a doctor or other health-care worker will reveal the truth about the needs, practices or desires of the person presenting to them. That there are dissenting views in the lesbian community about increased visibility in health care, demonstrates that the simplistic binary approach to in/visibility advocated by activists is being met with resistance. Some lesbians prefer to conceal, or avoid the matter of sexual orientation with doctors, and in health services. Sedgwick (1990) argued that being in the closet (concealed) is a performance initiated “by the speech act of a silence – not a particular silence, but a silence that accrues particularity by fits and starts, in relation to the discourse that surrounds and differentially constitutes it” (p. 3). The dilemma for the lesbian is, that having once remained silent about her sexual orientation or practices, coming out becomes increasingly difficult. Health-care workers commonly assume heterosexuality, and not correcting these assumptions and remaining silent about sexual orientation leads to a silence that accrues. As a result, coming out becomes increasingly difficult, and sexual orientation can become a secret that impacts on all future interactions.

Lesbian invisibility results from the in/action of the two parties to the medical encounter, the doctor (or other health-care provider) and the lesbian. Thus, invisibility results from the doctor/service provider’s unwillingness to see beyond the dominant heterosexual
norm, and from the lesbian refusing to identify herself. Lesbian health discourse acknowledges these two operations, but puts the onus on the individual lesbian to come out, in order to increase the visibility of all lesbians. In this construction, the actions of the individual who does not come out are equated with invisibility and passivity, while the actions of those who do come out are equated with visibility and agency. In this project I argue that where it does exist, invisibility is not born of passivity, but of agency, and that the onus for ensuring that lesbians are recognised, acknowledged, and receive appropriate services lies with those who administer, manage and deliver health-care, and refuse to acknowledge any kind of sexuality beyond heterosexuality.

Foucault’s work on ‘confession’ is relevant when seeking to understand the concept of, and calls for, increased lesbian visibility. He hypothesised that in the modern era the Christian tradition of confession has been extended into everyday life and identified this as a modern ‘ritual of discourse’ (1982, p. 61). According to Foucault (1978) the effects of confession have spread far and wide and can be found now in:

… justice, medicine, education, family relationships and love relations, in the most ordinary affairs of everyday life, and in the most solemn rites; one confesses one’s crimes, one’s sins, one’s thoughts and desires, ones illnesses and troubles; one goes about telling, with the greatest precision, whatever is most difficult to tell (p. 59).

Power relations can be seen to exist where confession occurs. The discourses that operate to create sexual subjects from the outside as an effect of power/knowledge also use techniques such as confession, so that inner knowledge and truth can be claimed (Olssen, 1999). Foucault (1978) described coming out as a form of public confession. Some have taken his work on confession to infer that not being out conceals a truth that awaits revelation, and coming out is then associated with visibility, while not coming out is associated with invisibility. According to Wendy Brown:

… confessional discourse … not only regulates the confessor in the name of freeing her, as Foucault described that logic, but extends beyond the confessing individual to constitute a regulatory truth about the identity group: confessed truths are assembled and deployed as ‘knowledge’ about the group (1998, p. 320).

There are many ways of doing and being lesbian, and disclosure about sexual orientation in the consulting-room, or elsewhere, does not reveal any essential truth about either the individual who comes out, or the group to which she might be assumed to belong. The
binary production of lesbians as either visible or invisible is simplistic and in no way represents the many facets of lesbian sexuality, or the many other aspects of each individual’s identity.

**Research Goals and Questions**

The field ‘lesbian health’ has been shaped by a plethora of discourses concerning lesbianism, as well as by biomedicine\(^5\), the social model of health, the women’s health movement, HIV and gay men’s health, and the 1970s liberation and identity movements. In this field, lesbian health has been constructed as a deficit. Rather than focus on wellbeing and a broader social view of health, the lesbian health field has to some extent been constructed around discourses that have their origins in historical regulation and control of lesbianism. Given the dominance of the deficit discourses, and the normalising effect of discourses about lesbian invisibility and lesbian identity in relation to health, the challenge for this project was to find a way of hearing the diversity of women’s voices. By this I mean, not only those who speak with authority from their professional or activist position, but also those who challenge the dominant discourse. The goal of this project is to understand how lesbians produce and manage their own health, and their interactions with doctors and other health-care providers. To do this, it has been necessary to go beyond the deficit constructions of lesbian health that dominate lesbian health discourse, and to explore the following research questions:

- In what ways do discourses about lesbianism and the construction of the lesbian health field influence the ways in which lesbians construct and manage their own health?
- In what ways do lesbians position themselves as they negotiate clinical spaces?

**Project Overview**

I provide here a brief summary of each Chapter to come; a broad overview to assist the reader to understand the direction taken. In this **Introduction** I have described some of the factors that led to and shaped this project. The work I originally envisaged for this project is very different from the work that actually transpired. It has been a personal and intellectual journey, and is more reflexive and rigorous as a result. I have problematised the concepts of lesbian identity and of lesbian invisibility (which are frequently cited as

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\(^5\) Biomedicine is the term applied to western medicine, because it is pre-eminently focused on the body (Gaines & Floyd-Wright, 2003). According to Foucault (1973), biomedicine constructs the body it treats, largely through discourse.
the root cause of lesbian health problems). Early in the project it became apparent that the ‘accepted’ history of the lesbian required interrogation, to clear the field in order to better understand the concepts of lesbian health and lesbian invisibility.

In **Chapter Two** I use a Foucauldian genealogical approach in order to trace the shifting network of relations between power, knowledge and the body. This provides insight into the connections between historical constructions of female sexual deviance and the contemporary lesbian subject. The contemporary category ‘lesbian’ has been shaped by a complex web of discourses that have operated to regulate and control lesbians throughout history. To understand the present it is necessary first to know the limits imposed by past discourses and knowledges and how these impact on the present. In the past few decades, the identity category ‘lesbian’ has been extensively narrated, and theories about lesbianism have been imported into the lesbian health field uncritically. Using a Foucauldian genealogical approach, I outline some of the ways in which homoerotic love between women has been produced as both non-existent and deviant throughout history. I discuss some of the ways in which lesbianism has been regulated and controlled over time by religion and the law, and later by science and medicine, and how this repressive use of power has produced varying forms of resistance. I also examine how the category ‘lesbian’ emerged in the early twentieth century as an identity, and the impact of popular culture on contemporary constructions of lesbianism. I argue that homoerotic sexuality in women is far more complex than any identity category. The genealogy of lesbian invisibility was positioned before the lesbian health literature review, because it allowed me to think the clinical encounter differently.

In **Chapter Three** I discuss the ways in which lesbian health has emerged as a discipline, how it has been largely constructed by practitioners and activists, and how this influences discourses about lesbian health. I also delineate how activist objectives differ from those of the academy and the ways in which theorising lesbian health could benefit the field. I discuss the ways in which lesbians are produced in health discourse as invisible, and the differences that emerge from essentialist and social constructionist discourses in relation to lesbian health. To do this, I critically review the literature concerning lesbians and health, and identify the ways in which early deficit discourses constructed lesbians as mentally ill, limited women’s health to reproductive and sexual health and can be seen to impact on contemporary lesbian health literature.
While Chapters Two and Three contain most of the literature reviewed in this project, In later chapters I also review literature of relevance to the issues being addressed therein. In Chapter Seven I discuss literature about the structure of, and changes in, the field of ‘health’. In Chapter Eight, I also review literature that describes developments in the field in which lesbians have conceived and given birth over the past twenty years.

In Chapter Four I describe the methodology used to ensure depth of understanding about the ways in which in/visibility plays out for lesbians in health-care settings. I do this by discussing research strategies and ethical considerations and go on to describe the methods used to recruit and interview participants, and analyse interview data. I close the Chapter by providing a series of ‘capsule biographies’ to inform the reader about the women who gave their time and told their stories as participants in this project for subsequent Chapters. More detailed profiles are also included in Appendix Three.

Chapter Five details the theoretical frameworks used to interpret and understand the participants’ stories. I discuss in more detail Foucauldian concepts of power as a subtle entity, not possessed, but enacted by individuals within fields of power, and the notion that where there is power there is resistance. I also introduce the work of Bourdieu on agency, habitus, dispositions, and symbolic and cultural capital, and discuss the ways in which these concepts can be useful in understanding how individuals position themselves within clinical spaces. Hegemony as a shared understanding of societal ‘rules’, and the influence of discursive formations on subjectivity and resistance will also be discussed.

In Chapter Six I start to introduce the project participants’ perceptions of their own difference, and how this shaped their willingness and ability to be out, or conceal their sexuality. I consider the concept of sexuality, its origins and the ways in which the term is used to discuss contemporary constructions of human sexual life. I also address the ways in which sexual subjectivity develops, is embodied by the individual and influences a sense of difference in relation to the field. The participants narrate how, in inadvertent or unintentional ways, their early exposure to stereotypes, assumptions and representations of lesbians transgressing gender norms contributed to shaping them as sexual subjects. Their stories also cover such experiences as exclusion and bullying, particularly at school, and ‘just knowing’ that difference, even if it was not visible to others, was unacceptable. I then discuss how these formative experiences can be seen to play out in clinical encounters as part of a shared understanding about heteronormative rules: of what it is
acceptable and not acceptable to speak about, and some of the ways in which the women have resisted perceived power in medical encounters.

In **Chapter Seven** I present data on the ways in which participants used agency in the space of the consulting-room. Just as the category ‘lesbian’ has been extensively narrated, so has health. These two areas have been combined in lesbian health literature uncritically. Having critically examined the factors that have influenced the emergence of the contemporary lesbian in Chapter Two, in this Chapter I focus on the emergence of contemporary medicine. I detail some of the factors that have contributed to shaping contemporary clinical spaces and go on to briefly describe the major shifts that have occurred in the practice of medicine in the past two hundred years. Drawing on Foucault’s theories about power circulating, post-structuralist notions about the discursivity of both speaking and silence, and on Bourdieu’s theories about habitus and dispositions, I analyse some of the participants’ perceptions of in/visibility, and examples of speaking, silence, coming out and passing as forms of resistance against the perceived power of doctors within clinical spaces. I demonstrate that rather than being passive (or invisible) victims, the women in this project used agency in a variety of ways.

A more recent development in lesbian health can be seen in the specific field constituted by lesbians who have conceived, become pregnant and given birth within their lesbian relationships. While some lesbians have probably always had babies, the technology that allows them to conceive without the direct involvement of a man is relatively recent. Conception, pregnancy and birth experiences were not initially conceptualised as part of this project, but because the interviews were semi-structured, a number of stories emerged concerning these life experiences over a twenty-year period. In **Chapter Eight** I look further at the ways in which the women who told their stories about these experiences used agency in this very specific context. I go on to examine their responses to the clinical gaze in these clinical spaces. I also describe the ways in which changes in the field in this time frame have affected the space with some, at times, unexpected outcomes for lesbians.

In **Chapter Nine** I discuss participants’ accounts of experiences in the space of the general practitioner’s consulting-room. This is the space where the most frequent contact between doctor and patient is likely to occur, and in which a number of the women in this project had expectations of, or the desire for a relationship with their doctor. In this Chapter I explore the different constructions of women’s health and lesbian health,
suggested by the participants. The women had ideas about what would make the clinical relationship effective from their perspective, and I discuss the skills and qualities that they saw desirable in a doctor.

In Chapter Ten, the conclusion, I summarise the findings of the project, and identify the implications of these findings for lesbians, health-care workers and lesbian health activists.

The nineteen women who participated in this project are all represented in the stories to come, but as may be expected, some of the interviews resulted in deeper, richer data than others. This is reflected to some extent in the ways in which I have chosen to present some of the women’s narratives in more detail, or more frequently than others.
2. A Genealogy of Lesbians and In/visibility

In contemporary health discourse, the lesbian is produced as both invisible and subject to potential harm because of heterosexism and homophobia. The solution that has been suggested is for lesbians to become more visible by coming out, and for health-care practitioners to be better educated about the needs of lesbians. The assumption underlying this pressure for increased lesbian visibility is that it will lead to better services, and achieve better health outcomes for lesbians. In this Chapter, I draw attention to how this discourse can be seen to derive from the broader coming-out discourse that suggests that visibility will eliminate homophobia and silence prejudice by accruing sheer numbers of supporters. To do this, and to gain an appreciation of how the discourses and domains of knowledge that associate invisibility with poor services and ill-health have arisen, I follow Foucault’s method of historical analysis which (following Nietzsche) he called genealogy (Foucault, 1984a). In his genealogical work, Foucault speaks about discursive and institutional practices, not what people thought or did in the past (Halperin, 1998), and this Chapter will follow that style of genealogy.

In political discourse a lesbian is said to be ‘in the closet’, or ‘out’. In/out can be seen to be tropes for invisibility and visibility, also for private/public. In lived experience, being in/visible is far more complex. Sedgwick (1993) encapsulated some of the complexity faced by people about being in/visible, in her statement that:

… there are remarkably few of even the most openly gay people who are not in the closet with someone personally, economically or institutionally important to them (p. 46).

To become visible, coming out is required. Invisibility requires secrecy or silence. But coming out does not once and for all make sexual orientation visible:

… the subjective practice in which the oppositions of private/public, inside/outside, subject/object are established … the phenomenon of the ‘open secret’ does not, as one might think, bring about the collapse of those binarisms and their ideological effects … (Miller, 1988, p. 207).

Because issues of secrecy and disclosure are so central to lesbian health discourse, as well as to the lived experience of many lesbians, I have elected to start this thesis by providing a brief overview of some possible origins of these discourses. I use a genealogical
approach, to identify some historical discourses and domains of knowledge that have contributed to the contemporary production of the lesbian, and of lesbian health. I examine the ways in which, over time, regulation and control practised by religion, the law, science and medicine have not only policed, but have also produced the very categories they have aimed to suppress. I also discuss the essentialist/constructionist debates that emerged about lesbianism during the nineteenth and twentieth centuries, and the emergence of the concept of lesbian as an identity, as opposed to a form of erotic practice or desire.

**Why genealogy?**

Genealogy is a form of critical history that investigates the complex and shifting network of relations between power, knowledge and the body, and how they produce historically specific forms of subjectivity (Foucault, 1978). It interrogates origins, without resorting to the idea of essential beginnings, and seeks to understand the ways in which power operates to produce effects. Knowledge and power are related, and how they interact must be considered in a genealogical project. According to Foucault, power:

… is constructed and functions on the basis of particular powers, myriad issues, myriad effects of power. It is this complex domain that must be studied (Foucault, 1980, p. 188).

Thus, Foucauldian genealogy critiques power/knowledge relations, and seeks to understand the ways in which discourses and domains of knowledge are produced. It involves an analysis of the historical limits that are placed on individuals; Foucault referred to this as an ‘ontology of the present’ (Foucault, 1984b, p. 96). Furthermore, he argued, an ontology of the present is a project: “… in which the critique of what we are is at the same time the historical analysis of the limits that are imposed on us and an experiment with the possibility of going beyond them” (Foucault, 1984c, p. 50). In relation to this, Halperin (2002) suggested that: “A genealogical approach begins with an analysis of blind spots in current understanding, or with a problematization of what passes as ‘given’ in contemporary thought” (p. 13). If invisibility is a blind spot and a given in contemporary thought about lesbians and health, taken for granted in discourse, then a genealogical approach can reveal the ways in which power has operated over time to produce contemporary ‘truths’ about lesbians and health, in this case ‘truths’ about in/visibility, openness, secrecy, subjectivity and identity.
Sedgwick (1993) argued that although over time there have been different ways of categorising sexual behaviours, the old ways of defining sexual categories do not disappear or become obsolete, but continue to emerge within, and shape later definitions. According to Sedgwick, the continuing essentialist/constructionist debates about homosexuality are not helpful, and there is no coherent, definitional field that classifies homosexuality. Rather it consists of related, yet contradictory and conflictual forces (Halperin, 2002). Sedgwick (1993) opted to describe the space in which homosexuality is defined as a “performative space of contradiction” (p. 48). According to Sedgwick, rather than stress “the alterity of disappeared or now-supposed-alien understandings of same-sex relations” (p.48), it is more appropriate to pay attention to the residual force of historical understandings about homosexuality, that are “unexpectedly plural, varied and contradictory” (p. 48) in the here and now (Sedgwick, 1993).

While same-sex desire and sexual acts are not new, the creation of lesbians as a class of people as it is understood today, only emerged in the nineteenth century, as a result of more general shifts in the regulation of sexual practices in the whole population. While there is ample evidence that prior to the nineteenth century same-sex relations between women existed, there does not appear to be any record of the existence of this coinciding with lesbian identity as it is known and understood today. The history of sexuality, then, is a history of erotic subjectivity, not simply sexual categories, classifications or representations (Halperin, 2002).

**The Invisible Lesbian?**

Discourses about lesbian invisibility are not limited to health. For example, B. Harris (1978) stated that between 613 BC and 1876 AD there was a lesbian silence of twenty-four centuries. Traub (1999) cited the following passage from the Gay and Lesbian Literary Heritage (1995) as an example of the invisibility of lesbians in history:

> Female homosexual issues do not appear explicitly in medieval English literature … For lesbians attempting to understand why they have been silenced for much of the English tradition, it is with the silence of medieval English texts that they should begin. … Lesbianism is almost invisible in the [Renaissance] period (Traub, 1999, p. 363).

This discourse suggests that because prior to the nineteenth century, lesbians as a class of people did not appear in historical documents, they were rendered invisible. The
argument does not suggest that lesbians did not exist prior to that time, but that as a result of homophobia their existence has been erased.

Discourses about the historical invisibility of lesbians have been by no means unanimous, and a number of contemporary scholars have excavated a genealogy of female homoerotic desire and behaviour going back to antiquity. As with any historical investigation concerning human sexuality there are many gaps, but a number of historical, ecclesiastical and legal documents show that lesbianism has always been discernible to, even produced conceptually by, those concerned with regulating sexual behaviours (Traub, 1999). The existence of same-sex desire and the regulation of lesbianism is amply evident from early Greek and Roman times through to modernity. References to this have been found in such diverse locations as classical Greek love spells, renaissance stage plays and ancient medical treatises. It has been posited that the scholarship that is being undertaken to reveal the previously ignored history of homoerotic love between women, is transforming contemporary understandings of lesbianism. Nevertheless, those who have promoted the lesbian silence, or hidden-from-history discourses, may also be correct to some extent. The stories of women who practised same-sex love have rarely been found in historical accounts, and the historical references that are available appear to relate mainly to regulation and control of female homoeroticism (Traub, 1999).

Brooten (1996) argued that the binary homo/heterosexual production of sexuality is a contemporary phenomenon, and that early Christian writers used a matrix to classify erotic orientations. This included whether a person played an active or passive role in sexual relations, the gender, age, or the nationality of partners, and whether s/he was a slave or free. This is supported by Halperin (2002) who argued that:

> The most salient erotic distinction made by the ancients rested not on a physical typology of anatomical sexes (male vs. female) or even on gender differences (man vs. woman) but on the social articulation of power (superordinate vs. subordinate social identity). The result was a social/conceptual/erotic grid that aligned masculinity, activity, penetration and dominance along one axis, and femininity, passivity, being penetrated, and submission along another. These two

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6 See, for example, Valerie Traub’s 1999 article, ‘The Rewards of Lesbian History’, in which she reviews seven books published since the mid-1990s that trace literary and historical mentions of homoerotic relations between women since antiquity. She notes that the proliferation of scholarship that makes lesbianism an object of inquiry all engage with methodological issues crucial to historicising lesbianism.
axes corresponded to, but could function independently of, gender differences (p. 56).

It appears that people in the ancient Mediterranean did have a concept of erotic orientation between women, but it was not necessarily viewed positively. Second-century Christian writer, Clement of Alexandria, discussed the problem of women who act like men and marry other women. Clement described this as “an ‘unspeakable practice’ a result of a luxury that confounds nature’s clearly gendered order” (Brooten, 1996, p. 322).

A language did exist to describe sexual love between women, although not in the contemporary sense of lesbian identity. Brooten argued that classical authors refrained from using ‘lesbian’, because for them, the verbs lesbianzein, and lesbizen (to behave like the inhabitants of the isle of Lesbos) generally meant to perform fellatio, which better fitted masculine sexual practice. Halperin (2002), argued that the term lesbian became associated with the poet Sappho, because she and the other women from Lesbos were reputed to practice tribadism. Regardless of whether they practiced fellatio or tribadism, they appear to have enjoyed sexual abandon, and the word lesbian is associated with these women. Brooten (1996) further discussed the terminology for female homoeroticism, and argued that it:

… is differently distributed throughout history than that for male homoeroticism. Writers continually use the term tribas ... from the Roman period until well into the twentieth century ... The Greek word lesbia occurs in a medieval marginal note on Clement of Alexandria’s comment on women marrying other women, making ‘lesbian’ ... older than any of the terms currently used for persons in same-sex relationships (Brooten, 1996, p. 22).

Thus, it is apparent that while some authors have argued that same-sex relations between women have been rendered invisible and written out of history, and few direct accounts have been found from women who practised same-sex relations, others have found ample evidence of their existence. Given that in ancient times it was generally men who were scholars, and it is their writing that has survived, it is not surprising that the evidence is limited. Brooten (1996) argued that records suggest that the ancient scholars may not have recognised any difference between male and female sexual desire or practice, but that because of the sexual hierarchy of the time, transgressing gender norms in any way was considered deviant.
It is of note that two thousand years after the writings of the ancient Mediterranean scholars cited by Brooten (above), claims are still being made that the differences between female and male sexuality are not understood. For example, feminist philosopher Luce Irigaray posited that female subjectivity and sexuality have always been defined as a deficiency or atrophy in the phallic order. She argued that this has resulted in a failure to understand female sexuality as diffuse and plural, rather than as a mirror image of male sexuality, with its primary focus on one (phallic) erogenous zone (Irigaray, 1991). Kitzinger & Wilkinson (1995) have also asserted that the fluidity of women’s sexuality has seldom been explicitly theorised. Despite an ongoing lack of ‘understanding’ about female homoeroticism, its practice appears to have continued throughout history. Most of the ancient ‘evidence’ concerning this can be found in church and state records that document attempts to regulate and control sex between women.

**Technologies of Regulation and Control**

In this section I demonstrate how, over time, homoerotic love between women has been regulated and controlled, through both punishment of the material body and discursive measures. Religion, the law, science and medicine and, more recently, popular culture are technologies of power that have acted to regulate lesbianism.

**Religion and the Law**

Prohibitions against same-sex relations between women predate Christianity, and Roman and Byzantine texts can be found that produced female homoeroticism as deviant (Brooten, 1996). These prohibitions were taken up vigorously by the early Christian church, and subsequently by the law, and both have variously produced homoerotic desire and behaviour as a sin and a crime, for both men and women (J. Brown, 1986). Many historical references to lesbians appear as a result of attempts to regulate such behaviour, initially in ecclesiastical and later in legal documents.

Early Christian sources strongly condemned sexual practices between women, and defined female homoeroticism as “monstrous, unnatural, diseased and more” (Brooten, 1996, p. 191). From early in its history the church defined same-sex relations as physical acts to be deterred. The Biblical text most often used to justify religious objections against female homoerotic acts, is Paul’s epistle in Romans 1:26 in which he warns against ‘vile affections’ between women: ‘for even their women did change the natural use into that which is against nature’. The application of this Biblical exhortation through church doctrine influenced the laws of European (and other Christianised) countries for centuries.
For example, in the thirteenth century laws were passed prohibiting sex between women in France and Spain, and similar Italian laws in the sixteenth century (J. Brown, 1986). In each of these countries the maximum punishment allowed for those who were found guilty of same-sex sexual relationships was to be burned at the stake. Sixteenth-century legislators in Geneva described sex between women as “the detestable crime of unnatural fornication” and deemed it a crime that could not be named (Ussher, 1997, p. 134).

In this period, laws pertaining to homosexuality were gendered; men who were charged with sodomy had their crimes broadcast in public, while women were considered to have weaker natures and be more susceptible to suggestion, therefore the crime of sexual relations between women was left unmentioned (J. Brown, 1986). Presumably this was because on hearing about such things, ‘weak’ women would be compelled to investigate it for themselves. For Brown: ‘The contradictory notions that Western Europeans had about women’s sexuality made it impossible to discuss lesbian sexuality openly, if at all. Silence bred confusion and confusion bred fear’ (J. Brown, 1986, p. 20).

Foucault (1978) addressed the role of silence and confusion surrounding sexual relations, albeit in relation to men, when he posited that “silence and secrecy are a shelter for power”:

The extreme discretion of the texts dealing with sodomy – that utterly confused category – and the nearly universal reticence in talking about it made possible a two fold operation: on the one hand there was extreme severity (of punishment) … and on the other hand a tolerance that must have been widespread (as evidenced by the infrequency of judicial sentences) (p. 101).

Here Foucault highlighted the paradoxical nature of attitudes towards homosexuality, and this can also be applied to lesbians. For women the ‘punishment’ alluded to by Foucault involved rejection and exclusion rather than more physical forms of violence (although there was provision for these), and tolerance was likely to have been born of incredulity. Sodomy, that ‘utterly confused category’ referred to by Foucault (1978) may be another reason why some authors have found the lesbian so difficult to locate in historical accounts of same-sex relations. The sin and crime of sodomy was easily connected to same-sex relations between men. By the seventeenth century, Italian priest Sinistrari d’Ameno in *De sodomia* (item 39) had clearly defined sodomy as anal intercourse between two men, or a man and a woman (J. Brown, 1986). For the men of the Church it was more difficult to define what two women might do together. A vast array of
terminology did exist to describe sexual acts between women, but these appear to have remained limited to legal (and later medical) discourses and do not appear to have entered the common vernacular to any extent. Legal and medical discourse included terms such as:

… mutual masturbation, pollution, fornication, sodomy, buggery, mutual corruption, coitus, copulation, mutual vice, the defilement or impurity of women by one another. And those who did these terrible things, if called anything at all, were called fricatrices, that is women who rubbed each other, or tribades, the Greek equivalent for the same action (J. Brown, 1986, p. 17).

As the application of the term sodomy to women was problematic, one seventeenth-century cleric attempted to define “sodomy between women” by taking a ‘universalising approach’ and described it as: “… carnal intercourse in the wrong vessel. This includes heterosexual anal intercourse and coitus between women” (J. Brown, 1986, p. 18).

Because female sexuality was produced as passive, law-makers could not conceive that coitus between women could occur without the involvement of a phallus. This may have led to the belief that same-sex relations between women only occurred because at least one of the women was excessively masculine, with an enlarged clitoris. In some cases a large clitoris was enough to be considered a sign of guilt of engaging in ‘female sodomy’ and punished by death (J. Brown, 1986). However, apart from attempts to equate same-sex sexual acts between women and men such as the one mentioned above, in general sodomy was not a term applied to women, and law-makers were unable to name the crime that might be constituted by such acts between women. Perhaps more than the silence and confusion suggested by J. Brown (1986), it was disbelief that played a role shaping discourse concerning lesbians and the law, in which lesbians appear to have enjoyed less regulation in legal systems based on British justice than their male counterparts. The belief that sex between women was not possible is usually attributed (possibly apocryphally) to Queen Victoria’s refusal to believe it to be possible. Ussher (1997) has asserted that it was not Queen Victoria’s incredulity that was responsible for this, but the fears of the gentlemen of the British Parliament. A nineteenth-century parliamentary debate on the matter elected to not discuss proposed legislation concerning the recognition of the crime of indecency between women in the 1885 Criminal Amendment Act. Parliament appears to have preferred an absence of legislation rather than openly acknowledging the existence of lesbianism. In the aforementioned debate lesbianism was
referred to as a “beastly subject that the House should not be polluted with” (Ussher, 1997 p. 135).

Even before the British Parliament’s refusal to recognise the crime of indecency between women, a legal case from Scotland demonstrates the existence of legal incredulity about the possibility of same-sex relations between women. In Edinburgh in 1811, two female schoolteachers were accused by a student of having had a sexual relationship with each other. The teachers denied the accusation and sued their accusers for libel. The defendants in the case had to produce evidence that sexual relations between women were even possible. Because their accuser did not mention the use of any penetrating object (sex between women was only deemed possible if one penetrated the other), and this had not been proven, the teachers won their libel case (Brooten, 1996). Brooten pointed out that, regardless of the outcome, the case was won because sexual contact between two British women was inconceivable. Several of the members of the House of Lords, who ultimately decided the case on appeal, claimed that such lascivious behaviour might occur in other countries like India (the home of the accuser), but was not possible in Britain. Like earlier discourses about active/passive sex roles, incredulity about homoerotic sex between women had a long history before this libel case. The available classical and Christian writings about same-sex relations between women demonstrate that both of these discourses had been in existence in various forms for centuries.

Not only has women’s sexuality been poorly understood, it has been surrounded by contradictions, as exemplified by the dichotomously opposed figures of the virgin and the whore. Perhaps as a result the differences between male and female sexuality, contradictory constructions of female sexuality in general, and lesbian sexuality in particular – as both deficit and deviant – have succeeded in surrounding lesbian erotic activity with silence and confusion. It has been argued that this silence and confusion led to an “impenetrable barrier that has lasted for nearly two thousand years” (J. Brown, 1986, p. 62). This barrier has not concealed the existence of female homoeroticism, rather, it has surrounded it with myth, rumour and mystery. Confusion and disbelief, combined with ever-changing, multiple constructions of the lesbian as subject and object, have contributed to the production of lesbians as deviant and ‘the Other’7 and the domains of knowledge and discourses that accompany these productions continue to pathologise lesbianism to the present day. Thus it is apparent that lesbian sexuality has a

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7 Psychoanalytic theory posits the self as always defined against the ‘other’ – that which is not ‘us’. The ‘other’ “represents danger or risk to the individual and anything that cannot be ordered or categorized leads to feelings of uncertainty and angst” (Lupton, 1995).
long history of being disregarded and disbelieved, while at the same time being policed and regulated. Regardless of attempts to regulate and control lesbianism, and the pervasive disbelief in its possibility, attempts to suppress it have not succeeded.

**The State, Science and Medicine**

The ancient discourses described above, that constituted lesbianism as a deviant performance of gender, can also be seen to have influenced ancient medical discourses. Spiritual and surgical interventions to prevent or cure lesbianism are not new. Roman and Byzantine medical texts have been found, that diagnosed women who practised homoerotic sex as suffering from a disease of the soul, or in need of mind control. Others have been found that diagnosed an enlarged clitoris as disposing women to behave like men, and prescribed clitidorectomy as a cure (Brooten, 1996).

Until the nineteenth century, the regulation of sexuality remained primarily the domain of the church and the law. Around this time, a more general shift in the locus of juridical power moved regulation of the population (including the regulation of sexual practices) away from these institutions, towards the newly emerging sciences. Medicine, and the developing allied sciences of psychology and sexology, undertook a taxonomy of human sexual behaviour to describe and quantify it in every detail. This cataloguing of sexuality resulted in a shift away from sexual relations being seen only as something people do (behaviour), to something they are (identity); thus the object of desire started to define the individual’s sexual identity (Ussher, 1997). Foucault located this shift as occurring in the eighteenth century, as a result of a shift in power as the State started to take on the individuating power of the church. Instead of leading people to salvation in heaven, as the church had, the State focused on ‘salvation’ in this world. According to Foucault: “In this context the word ‘salvation’ takes on different meanings: health, wellbeing (that is sufficient wealth, standard of living), security, protection against accidents” (1982, p. 784).

In this shift, power that had for centuries been held by the church was now diffused and located across a number of institutions, including the family, medicine, the sciences, and education. These institutions carried out surveillance of the whole social body on behalf of the State, including surveillance of the sexual behaviour of the entire population. This was so that the State would be able to know:

… what was happening with its citizens’ sex, and the use they made of it, but also that each individual be capable of controlling the use he made of it. Between the
State and the individual, sex became an issue, and a public issue no less; a whole web of discourses, special knowledges, analyses and injunctions settled upon it (Foucault, 1978, p. 26).

Thus sex moved into the public arena and was transformed into a multiplicity of discourses with diverse machinery operating in a number of discursive formations including religion, pedagogy, medicine, and the law.

While sexual behaviour is as old as human kind, the concept ‘sexuality’ itself is relatively recent. Heath (1982) identified the word as first appearing in 1800, specifically in relation to sex as a reproductive function, in both plants and animals. According to Heath, the term ‘sexuality’ was first used in 1889 to refer to the human capacity for the possession of sexual powers, or the capability of sexual feelings. In the latter context, a physician initially used the term in reference to the surgical removal of a woman’s ovaries, after which it started to appear regularly within medical discourse. Since the introduction of the term sexuality, its meaning has become increasingly complex and fluid. Heath has drawn attention to the ways in which sexuality has been fabricated, or constructed through sets of representations including “images, discourses, ways of picturing and describing” (p. 3).

The development of contemporary classifications to identify sexual behaviours occurred as part of the institutionalised taxonomic discourses of medicine, psychology, the law and literature (Sedgwick, 1990). The use of the term ‘homosexual’ was introduced in the last third of the nineteenth century and predates the use of the term ‘heterosexual’. Kinsman (1987) argued that: “While same gender erotic pleasures have always existed, they have been organised very differently ... homosexuality and lesbianism in the contemporary sense of distinct identities and cultures are recent creations. Heterosexuality ... is also a recent creation” (p. 15).

Sexology as a science was not distinct from medicine and psychology until 1920 (Heath, 1982), however, evidence of medical experts proffering advice about sexuality has been found to pre-date the emergence of the science of sexology in the West by almost a century:

... before the emergence of sexology as a specific professional discourse dedicated to studying sexual variation, there were other discourses of sexual advice, sexual health, and sexual pathology which began to construct and represent lesbian identity. A concept of sexuality in general as pathological, and
As medicine and sexology started to describe homosexuality in clinical terms, and develop ‘new’ theories about its origin or cause, it moved away from the realms of sin, as it had been categorised under the rule of the church, towards being seen as a disease. Carl Von Westphal, a German physician in the mid-1800s, described lesbianism as an example of ‘contrary sexual impulse’ in women. His contemporaries, Charcôt and Kraft-Ebbing, claimed that homosexuality was congenital, involving inborn predispositions to perversion (Stevens & Hall, 1991). Later, British sexologist Havelock Ellis (1915) used the term ‘inverts’ to describe homosexuals, because he believed their sexual contact to be an inversion of normal sexual behaviour. Havelock Ellis and Richard von Kraft-Ebbing both claimed that a lesbian could be identified by her mannish demeanour. In psychiatric discourse, lesbians have variously been constituted as masculine, anti-social, aggressive, predatory, self-destructive and developmentally delayed (Thompson, 1998). It is of note that these contemporary productions of the lesbian as dominant and masculine are not markedly different from those of ancient Roman and Greek writings about lesbians. Lesbianism is produced as a kind of gender transgression. Until the last third of the twentieth century, medicine and the ‘psy sciences’ continued to experiment with a variety of ‘treatments’ to cure or deter sex between women, which included electric shock therapy, aversion therapy, and medical or surgical treatments such as hormonal injections, surgical removal of the hypothalamus, frontal lobectomy and clitidorectomy (Haldeman, 1991; Silverstein, 1991). While treatments for homosexuality may have advanced over two thousand years, the focus of curing or deterring same-sex relations between women have not changed vastly, although this is now a minority rather than a dominant practice.

In psychology and psychiatry, lesbianism continued to be identified as a disease until relatively recently. Homosexuality was still defined as a mental disorder (a ‘sexual deviation’) by the American Psychiatric Association’s standard reference book, Diagnostic and Statistical Manual of Mental Disorders (2nd Edition), published in 1968. In 1973 the American Psychiatric Association voted to remove homosexuality from its official diagnostic categories of mental illness. When the third edition of this book was

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8 Rose used this term to describe the range of sciences that lay claim to “heterogeneous knowledges, forms of authority and practical techniques that constitute psychological expertise”. He asserts that these sciences, largely invented since the mid-nineteenth century, embody “a particular way in which human beings have tried to understand themselves – to make themselves the subjects, objects, targets of a truthful knowledge” (1999 p. vii).
published in 1980 it said “homosexuality itself is not considered a mental disorder” (p. 282), although some practitioners in the psy sciences have continued to treat homosexuality as a disease (Wilton, 2000). It was not until the early 1990s that the World Health Organisation removed homosexuality from the *International Classification of Diseases* (King, 2003).

**Essentialist and constructionist debates**

As homosexuality fell within the purview of science and medicine, theories emerged about why some people deviate from the accepted norm in sexual behaviour. This led to two opposing theories about the development of gay and lesbian identity, which dominated scientific literature in the last half of the twentieth century. These theories can be broadly described as the social constructionist and essentialist positions.

Constructionism posits that differences are constructed, not innate (Fuss, 1989). Applied to sexuality, constructionism argues that people are not born gay, but are influenced by social conditions. Essentialism is commonly understood as “a belief in the real, true essence of things” (Fuss, 1989, p. xi), and those who promulgate this position argue that homosexuality is due to an essential biological difference. The essentialist position led science to search for the cause of homosexuality. Essentialists argue that sexual orientation is not a choice, but a difference that cannot be changed, and should therefore be tolerated by mainstream society. In the past two decades considerable resources have gone into attempts to prove that homosexuality is the result of an essential biological difference. In the 1990s a number of studies attempted to find a genetic cause (although many of these focused only on gay men). For example, twin studies found a greater correlation of homosexuality among identical than fraternal twins, implying that there may be a genetic cause (LeVay & Hamer, 1994). Another study found differences in brain physiology; the hypothalamus in gay men was found to be different from that in heterosexual men (Silverstein, 1991), and yet another that sought to find a genetic link, reported that fruit flies became homosexual when transplanted with a single gene (Hall & Love, 2003; LeVay et al., 1994; Nuffield Council on Bioethics, 2003). During the 1990s many newspaper and magazine articles argued that the origins of homosexuality were genetic.⁹ For example, a study with women theorised that homosexual orientation could be predicted by comparing the length of the index finger to the ring finger in baby girls. It

was claimed that the difference is smaller in male humans than in females, and smaller in lesbians than in heterosexual women (presumably because lesbians are more masculine) (Hall et al., 2003). This study suggested that this may be due to exposure of the foetus to increased androgens in-utero. The findings of this study were disputed by another study, which concluded that early androgen exposure plays a role in only some cases of female homosexuality, and that the sexual orientation of ‘femme’ lesbians is unlikely to have been influenced by early androgens (W. M. Brown, Finn, Cooke & Breedlove, 2002). These last two studies again link lesbianism with masculinity. The essentialist position argues that sexual orientation is fixed or waiting to emerge, a position which is supported by psychological theories, such as that of Erikson, which posits there is a true core self and a clear dividing line between ‘us’ and ‘the other’ (Weedon, 1999).

Many lesbians support the essentialist position, and believe themselves to be intrinsically different from heterosexual women. hooks (1994) argued that essentialism (in relation to both sexuality and race) underpins the politics of identity. She argued that essentialism is crucial to the struggle of marginalised groups for recognition and justice. However, she argued that while essentialism is a way of asserting presence for those who are marginalised, it is not a cultural practice that is solely constructed by them, but is part of the “controlling apparatus in structures of domination” (hooks, 1994, p. 81). In other words the production of those who deviate from heterosexual (and other) norms, as ‘the other’, constitutes a technology of control that polices difference. hooks draws attention here to the productive nature of power. Essentialism, as well as being the basis for political action and a platform on which some lesbian activists argue for civil rights to change an iniquitous system, also provides a way to socialise collectively.

According to Fuss (1989), producing essentialist and constructionist theories in opposition to each other conceals that essentialism is actually essential to the constructionist debate. While the social constructionist position acknowledges the importance of discourse, the essentialist position, with its focus on psychological and/or biological explanations, also relies on discourse to promote its meaning. She argued that, with regard to homosexuality, rather than seeking a cause, or arguing its origins, it may be more productive to consider whether sexuality is an ontologically stable object. Post-structuralist theory posits that rather than being something that is fixed and stable, sexuality is fragmentary, partial and shifting (Fuss, 1991), and a genealogical approach reveals that over time this is indeed the case. Understanding the relation between sexual categories in ancient and modern societies reveals that there are both continuities and
discontinuities (Halperin, 2002). As noted in Chapter One, Sedgwick (1993) argued that rather than the contemporary concept of homosexuality being a coherent definitional field, it is a “space of overlapping, contradictory, and conflictual definitional forces” (p. 45), and this applies equally to lesbians. Regardless of whether homosexuality is defined in essentialist or constructionist terms, it is clear that at any given time, attempts to explain or define it have occurred in a “performative space of contradiction” (Sedgwick, 1993, p. 48).

**Popular Culture**

For centuries religion, the law and science dominated the material and discursive regulation of homosexuality, and most of the records that are available come through ecclesiastical, medical and other learned texts (Halperin, 2002). From the eighteenth century, the media increasingly became accessible to the populace. Works of fiction such as romantic novels and poetry started to be popular, and carried the potential to communicate about matters that had previously been the domain of a select few. It is likely that popular culture has always had the potential to shape behaviour and beliefs through discourse, however, few records exist to attest to its operations prior to the late seventeenth and eighteenth century. Since then, popular culture has increasingly provided records of same-sex relations between women. These are available through personal correspondence, journals and diaries, which were not written for publication (Vicinius, 2004), and later through novels.

In this period, friendship between women appears to have been idealised. According to Vicinius (2004), this is exemplified in Rousseau’s novel *Julie, ou la nouvelle Héloïse* (1761), in which female friendship is epitomised as ‘pure feeling’. Sensuous friendship between women was seen in society as a preparation for marriage, after which a woman’s affection for female friends was expected to be transferred to her husband. It appears that the cultural and social gender segregation of the time may have made it possible for some women to develop close, intimate, same-sex friendships. Inside their intimate world, women could share confidences, joys, sorrows, and the experiences of marriage, birth and death, that were their main rituals (Smith-Rosenberg, 1975). Vicinius (2004) argued that in the second half of the eighteenth century these intimate friendships were divided into two types, sensual romantic friendship and sexual sapphism. She claimed that the latter is confirmed by pornography from that time. In one case she cites, a man is depicted watching women as they make love to each other. Leaving aside the matter of pornography, Smith-Rosenberg (1975) asserted that ordinary relationships between
women were often physical as well as emotional, which is evidenced in correspondence and diaries which provide a window into the lives of the women whose writings have survived. Some wrote of physical contact – hugging, kissing, and holding – and spoke freely of their passion for each other, and it is evident that intimate relations did continue between women after marriage. However, regardless of the tolerance for affectionate friendships, in ‘respectable’ circles the consequences of speaking openly or acting on homoerotic physical desire could be perilous. According to Vicinius (2004), to ensure their own safety: “Women wrote in code, warned each other to conceal or burn letters, and used metaphors or allusion. Far better, most women felt, to remain quiet or to speak only to trustworthy allies” (p. xix).

At the same time that society generally ignored women’s intimate friendships, assuming them to be sensual rather than sexual, there are examples of women who openly challenged cultural norms for gender and sexuality. Anne Lister (1791–1840), a well-off land owner in Yorkshire, was a self-avowed lover of women, and was known as ‘gentleman Jack’ by her neighbours. Lister’s published writing openly expressed same-sex desire, declaring that she loved only the ‘fair sex’. Unlike Lister, the women who have come to be known as the ladies of Llangollen – Lady Eleanor Butler and Sarah Ponsonby – were an upper-class Welsh couple well known in British society at around the same time as Lister. Butler and Ponsonby, who often wore men’s clothing, worked at representing their relationship as chaste, but newspaper archives from the time show that society was not entirely convinced by them (Mavor, 1971).

By the early twentieth century, romantic novels portraying loving relationships between women had proliferated, however, these relationships were not explicitly sexual. Faderman (1978) argued that sexuality was absent in these novels because explicit sexuality was not depicted in most novels of the day. It was not until 1928 that the first specifically lesbian novel, *The Well of Loneliness*, was published, in which the protagonist is a sad, lonely, ‘mannish’ woman. *The Well* was banned in England and the author, Radclyffe Hall, was tried for obscenity in the USA. While *The Well* may have been the first specifically lesbian novel, Inness (1997) argued that it was not the first time

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10 Eleanor and Sarah eloped together rather than be married to men by their families, and lived together in Wales until Eleanor’s death. The sexual nature of their relationship was (and is) unclear. They were held up as ‘exemplars of chastity’ by some, while others questioned their gender. In 1790 an account of the friendship, entitled ‘Extraordinary Female Affection,’ appeared in a local Welsh paper. The article described Butler’s ‘tall and masculine’ appearance, her ‘air of a sportsman,’ and how she appeared ‘in all respects as a young man if we except the petticoats which she still retains,’ contrasting these attributes with Ponsonby’s ‘polite and effeminate, fair and beautiful’ demeanour (Mavor, 1971).
same-sex desire and masculinity had appeared, and that the figure of the mannish lesbian was already well established when the book was published. Weeks (1981) argued that in *The Well*, Hall, “more than anyone else during this period gave lesbianism a name and an image” (p. 117). Halperin (2002) drew attention to the importance of identification:

…it picks out resemblances, connections, echo effects. Identification is a form of cognition. And the ability to set aside historical differences in order to focus on historical continuities … (p. 15)

Identification with images like those portrayed in *The Well* were dominant among lesbian subcultures until the event of gay liberation and second-wave feminism in the 1970s. Until then, lesbianism remained underground and was either ignored by mainstream society or portrayed as deviant and depraved. Until relatively recently, lesbians were represented in popular culture as a threat to the decency of other women and girls, for whom failure to accept passive, traditional (hetero)sexual roles meant failure to gain male approval, and the chance to marry well (Weedon, 1999). Thus lesbianism was constituted as at once transgressing norms for gender and sexuality, while at the same time being impossible. Nonetheless, the power of discourses transmitted through popular culture lay not only in its capacity to render lesbianism unacceptable, but also in its capacity to provide women who identified with the images of deviance with tangible evidence that they were not alone. In popular culture, two divergent images of homoerotic love between women sat alongside each other:

… ‘the chaste female friend and the masculinized tribade’ …. function as two dominant means by which erotic bonds between women were rendered intelligible. In discourses both past and present, the tribade (and her counterpart, the cross-dressed woman) has been, for good or ill, a figure of cultural fascination (Traub, 1996, p. 23).

As the psycho sciences and popular culture produced the sexual category ‘the lesbian’, and as women started to connect their own desires with these images, lesbian identity as it is understood today emerged. As the twentieth century drew to an end, more positive representations of lesbians started to emerge in television, film and literature. Television shows such as *Ellen, The L Word*, and *Buffy the Vampire Slayer* (with openly lesbian characters) and movies such as *The Hunger* (1983), *Fried Green Tomatoes* (1991), *Go Fish* (1994) and *The Hours* (2002), and a plethora of lesbian literary fiction emerged and portrayed a more diverse and positive view of lesbianism. In this view, lesbians were
represented as normal, and lesbianism as an acceptable expression of sexuality. This does not mean that the older, negative discourses disappeared; as suggested by Sedgwick (1993) they have continued to emerge within, and shape later definitions of lesbianism.

**Lesbian Identity**

As discussed above, there is a large body of work predicated on the assumption that lesbianism is an essence, a fundamental way of being determined early in life (Kitzinger & Wilkinson, 1995). Essentialist models of lesbian (and gay) identity are increasingly the norm. These models reflect and perpetuate popular theories about homosexuality, however, they also fail to address the experiences of many women. It is not uncommon for a woman to have married and had heterosexual relationships, and to later fall in love with another woman. These women have been described as ‘protean’11 (Bart, 1993).

According to Kitzinger and Wilkinson (1995), most research about sexual identity focuses on young people and is based on the (essentialist) assumption that this is when sexual identity is formed, or emerges. They argue that there has been little research to understand the longitudinal ‘stability’ of women’s sexual orientation over the adult life-span.

In the last third of the twentieth century, scholarship on the concept of identity proliferated, and different disciplines developed theories about the origins and meaning of identity. Psychology (clinical and academic), sociology and other social sciences, as well as literary and cultural theory have all contributed to developing theories on identity formation. Esterberg (1997) has posited that

\[\ldots\text{at least ten different meanings [of identity, have been] used by scholars,}\]
\[\text{ranging from the sense of oneself as continuous, existing throughout time, to a}\]
\[\text{sense of oneself as belonging to a group or having shared group membership.}\]
\[\text{Some see identities as something essential, tangible, and real, inherent in the self;}\]
\[\text{yet others see identities as shifting, constructed, a matter of creating meaning from}\]
\[\text{social categories and coming to attach labels to oneself. The body of academic and}\]
\[\text{popular literature on identity is so large that it nearly defies categorization.}\]
\[\text{Perhaps no term has been used so much in recent years or become so popular –}\]
\[\text{both in academic and in lay worlds – as identity (Esterberg, 1997, p. 14).}\]

11 Protean refers to displaying diversity or variety, thus, the protean woman demonstrated sexual fluidity.
This quote draws attention to the way in which debates about the origins of identity are often constructed as being produced by either nature or nurture, which reduces what is essentially a complex process to a simple binary.

As previously noted, psychologists such as Erikson defined identity as the development of individual personality involving a stable core sense of self, within the context of the social milieu. Here notions of stability and interiority are central. However, for sociologists: “… identities are not something deep down inside the individual but are located in the interaction between the individual and society. Identities, thus, are always in process” (Esterberg, 1997, p. 14 – 15). Ussher (1997) represented this debate as material/discursive, arguing that the two are always placed in opposition to each other, which is counterproductive. She argued that:

Material and discursive elements are always intertwined in the negotiation of being ‘lesbian’ or ‘gay’. To examine one level of analysis without the other will always give us an incomplete picture; to incorporate both emphasises the point that there are no easy or simple answers in this sphere (p. 132).

In their study of the discursive strategies used by lesbians who transition from heterosexual to lesbian sexual orientation, Kitzinger & Wilkinson (1995) appear to be in accordance with Ussher’s assertion (above) concerning the importance of both material and discursive elements in sexual identity. They argued that:

… the essentialist-social constructionist debate is not resolvable with reference to empirical fact … Data cannot settle questions of epistemology. … Only through … critical engagements [between those who maintain either essentialist or social-constructionist accounts of identity development] and through developments within both theoretical frameworks, can a vital and comprehensive psychology of lesbianism be developed (pp. 102-3) (italics original).

Sexual identity is only one of many constructions of identity, and while records demonstrate that same-sex relations between women have existed since antiquity, lesbian identity is generally located as emerging in the early twentieth century. Psychological and sociological theories about identity, taken in conjunction with the proliferation of discourses about homosexuality in the twentieth century, highlight the potential for discourse to produce what it seeks to regulate. Thus, representations of lesbians as mannish in popular culture provided images with which some women could identify, influencing the construction of lesbian identity. By the mid-twentieth century, a thriving
underground of meeting places existed for lesbians. Nestle (1987) described the underground lesbian bars of New York City in the 1950s as a world of “lesbian want, adventure, and bonding” (p. 38). She described the general attitude towards lesbians at this time as: “… a world that gave messages such as hate yourself because you are a freak, hate yourself because you use your tongue, hate yourself because you look butch and femme, hate yourself because you are sexual” (p. 38). Nestle described the environment in the bars as “a sexually powerful butch/femme community” (p. 37), and related how the women entered this space with “rage, with need and with strength” (p. 37). Even though the bars, which were run by mainstream business for profit, provided nights for lesbians, they would only allow one woman into the toilet at a time to prevent ‘deviant’ sexual acts from taking place (the door was guarded and toilet paper doled out). The ‘bathroom line’ became a space in which women joked, flirted, and developed a ‘line act’. Nestle (1987) wrote: “We lived on that line; restricted and judged, we took deep breaths and played” (p. 39). She went on to describe how the women resisted their oppression in joyful and creative ways.

Between Nestle’s description of the clandestine territory occupied by lesbians in the 1950s, and the 1970s, another discursive break occurred for lesbians. With the emergence of the second wave of the women’s movement, lesbian feminists were no longer prepared only to resist domination in the covert ways of their predecessors. They asserted that lesbianism was not simply a matter of sex, but a political issue, and ‘the personal is political’ became the catch-cry of the 1970s. Butch/femme roles, which had been celebrated in the 1950s, became regarded by many in the 1970s as an enactment of homophobic oppression and not a reflection of the reality of lesbian lives. According to Faderman (1992):

For many women who came to lesbianism through feminism, butch/femme looked like nothing so much as a repetition of that which they left heterosexuality to avoid. Those roles seemed to place a limit on their free growth and expansion, which to them was the most exciting part of feminism. They refused to believe that butch or femme roles came naturally to any women and explained their prevalence in some lesbian communities as resulting from socialization: lesbian had been well brainwashed by the parent culture so that they acquiesced into making their subculture a carbon copy of heterosexuality (p. 95).

The discursive break constituted by the second wave of the women’s movement, and the developments in lesbian culture since, demonstrate the extent to which lesbians occupy a
performative space of contradiction, as suggested by Sedgwick (1993). For many contemporary lesbians in the early twenty-first century, the notion of lesbian identity is naturalised to the point where those who claim it do not question its ontological centrality. Late in the twentieth century, queer theory challenged the whole notion of identity: “Queer theory draws attention to the exclusive and boundary-constructing nature of ‘identification’ and encourages examination of how the normalization … is implicated in attempts to construct lesbian and gay identities” (Esterberg, 1997, p. 16).

“Lesbian desire is everywhere, even as it may be nowhere” claimed Vicinius (1996, p. 433), in a discussion about what it is that constitutes a lesbian. She suggested that a way of considering lesbian identity and desire might be within models of fragmented subjectivity.

… We cannot assume any coherent or unified collective lesbian experience when we recognise the diversity of definitions and experiences of lesbians (Stacey, unpublished conference paper, quoted in Vicinius, 1996, p. 433).

**Discussion**

In this Chapter I have outlined some of the ways in which lesbians have been produced as deviant, how they have been regulated and controlled by religion, the law, science and medicine, and how these efforts have contributed to producing, and even normalising the contemporary identity category, lesbian. To understand the present it is necessary first to know the limits imposed by past discourses and knowledges. By tracing the shifting network of relations between power, knowledge and the body, it is possible to gain insight into some of the connections between historical constructions of female homosexual deviance and the contemporary lesbian subject. Genealogy offers a way of understanding the origins of established theories and a method of analysing these in terms of power effects (Sawicki, 1991).

In health discourse lesbians are produced (and often produce themselves) as invisible. Understanding the ways in which lesbians have been defined, categorised and classified over time can provide a framework within which to view this phenomenon. The current understanding of lesbian identity, while generally taken for granted in the health field as being biologically determined, can be seen to have been constructed as a result of intersecting historical, cultural and social factors at this particular moment in history. Being or doing ‘lesbian’ is not the same now as it was in the past, and is an evolving
social position. There have been multiple expressions of lesbian identity in the twentieth and twenty-first centuries, that have range from the early productions of the mannish or femme lesbian; to butch and leather dykes and lipstick lesbians and lesbian chic; from hiding and passing to lesbian separatists to more recent lesbians who constitute themselves as model citizen/parents in de novo families\(^{12}\) who are no different from their heterosexual neighbours except in their choice of partner. All of these constructions are lived materially, but produced discursively. In relation to the shifting nature of discourse, Sedgwick (1993) argued that older discourses and definitions do not disappear or become obsolete, but continue to re-emerge and shape later discourses. The positions available to the lesbian are ever-changing, and many of the earlier productions of lesbian identity are apparent in contemporary constructions. Despite the adherence to expressing identity by many lesbians, not all lesbians adopt expressions of lesbian identity of any kind.

In this Chapter I have used Foucauldian genealogy to develop an understanding of the ways in which deficit discourses about lesbians have shaped the contemporary production of lesbian identity. Using this approach, it is possible to understand the limits of what passes as given in contemporary discourse, and how these discourses have operated over time to produce contemporary ‘truths’ about lesbians and health. This investigation of the genealogy of discourses about lesbianism made it possible to for me to review lesbian health literature through a different lens. In the next Chapter, I discuss the emergence of lesbian health as a discipline, review the literature about lesbian in/visibility and health, and go on to review the literature concerning lesbian physical and mental health.

\(^{12}\) The phenomenon that leads to the creation of lesbian families (that is, where a child or children are conceived, born and raised within a lesbian relationship), has been termed ‘de novo’, to denote that these families are ‘new from the start’ (McNair, R. Brown, Perlesz, Lindsay, Pitts & DeVaus, 2005) and this terminology will be used wherever this kind of family is discussed.
3. Lesbian Health: A Review of the Literature

Background: the Emergence of Lesbian Health as a Discipline

The purpose of this review of lesbian health literature is to explicate the ways in which the group broadly characterised as lesbian is represented in the health literature, and to describe the main health issues that have been identified from previous research. The intention of this Chapter is to provide a critical framework for understanding the field of practice and activism called lesbian health.

Much of the recent research and literature concerning lesbians and health has been produced by activists, who are also often practitioners working in biomedicine or allied health areas. The goals of lesbian health activism are to work towards the elimination of homophobia and heterosexism, and to demonstrate the health needs of, and improve the health-care services available to lesbians (Wilton, 2002). These goals are appropriately different from those of academic social science inquiry, in which sexuality can be studied as a contested concept, medicine as a discourse, and issues to do with sexuality can be “integrated into debates about subjectivity, and identity, medical power, the social construction of gender and the medicalisation of gender and sexuality” (Wilton, 2002, p. 254). In academic terms, this makes much of the existing research into the health of lesbians problematic, as it is largely produced from within the field and published in:

- Practice journals, reports directed at policy-makers, papers or poster presentations at conferences and study days for nurses and other health-care professionals.
- Education and information are also targeted at lesbian … community members, in the pink press or health-care handbooks (Wilton, 2002 p. 253).

An assumption of homogeneity emerges from activist accounts of lesbian health. Lesbians are at the margins in terms of health research, however, as a group, lesbians are not homogeneous, and there is also diversity within the lesbian ‘community’ (Dyson, 2001).

Some studies of lesbians have focussed on diversity among lesbians, or on specific groups, for example lesbians of colour (cf. Eder, 1995; Demo, 1996; Ristock, 2002; Gordon, 2006). While a few studies have focused on diversity, the dominant assumption embedded in much lesbian health research remains one of the lesbian being white, middle class and able-bodied. Intersectionality refers to the relationships among multiple
dimensions and modalities of social relations and subject formations (McCall, 2005). This concept reveals how markers of difference are not independent of each another, but interrelate, based on each individual’s different kinds of diversity. Intersectionality thus holds that knowing, for example, that a woman lives in a sexist society is insufficient information to account for her experience, and it is also necessary to consider her race, age, class, sexual orientation, dis/ability, class, etc.

Because of this diversity, there is nothing coherent or unified about lesbian experience, which has implications for the field ‘lesbian health’. Truth claims produce discourses that determine, produce and limit what can be seen, heard, thought, known and done (Ristock, 2002). From this perspective, lesbian health activists have produced a ‘grand narrative’ about lesbian health, that produces lesbians as relatively homogeneous, invisible victims, regardless of the diversity of lesbians as a group, or their experience. According to Wilton (2002), the “hegemony of medicine as a paradigm, a world view and a social institution enables its practitioners to speak with great authority” (p. 260). Perhaps because of this authority, the body of work concerning lesbian health carries considerable weight, and invisibility has become a taken-for-granted ‘truth’ in the field.

Until the 1970s, within the health system lesbians were mostly seen as patients in need of treatment, because of their deviant sexual proclivities. Around that time, largely as a result of the feminist and gay rights movements, major shifts occurred in the ways that homosexuality was perceived. Because of these social changes a concomitant shift occurred within the field of health, whereby lesbianism was no longer only produced as an illness, and lesbians were increasingly constituted as experiencing disadvantage due to their status as a marginalised group.

As a discursive formation, biomedicine is a structure that contains clear (but not explicit) rules and regulations that are to some extent shaped by contemporary views, although older discourses are also apparent. While shifts may occur in these rules and regulations at particular points, they are never complete (Olssen, 1999). While lesbianism per se is no longer officially viewed as an illness, much of the literature concerning lesbian health is framed within a biomedical model. This approach may serve the activist aim of demonstrating health needs, but it also promotes a deficit view, in which lesbians are produced as essentially unhealthy.
Lesbian In/visibility and Health

In lesbian health literature, lesbian invisibility is said to be due to heterosexism and homophobia (see, for example, R. Brown, 2000; Daley, 1998; Denenberg, 1992; Eliason, & Randall, 1991; Hudspith, 1999; McNair, 2000a; Plumb, 1997; S.J. Roberts & Sorenson, 1995; Stevens & Hall, 2000). Heterosexism is based on the assumption that everyone is heterosexual, which, it is claimed, results in health-care workers ignoring the specific health-care needs of lesbians (Hudspith, 1999). Homophobia, which has been defined as the irrational fear and hatred of homosexual people (Meyers & Lavender, 1997), is said to result in lesbians hiding their sexual orientation or practices from their health-care workers. It has been argued that lesbians will receive better care and have improved health outcomes if the process is reversed, and lesbians become more visible (Gulbin, 2001). It has also been suggested that increased visibility will occur if health-care workers ask more questions to encourage disclosure of lesbian identity, and if lesbians disclose their sexual orientation to their health-care providers. McNair (2000a) also identified invisibility as a barrier to honest and open relationships between doctor and patient. She argued that failure to disclose sexual orientation denies doctors the opportunity to demonstrate that they are non-judgmental and accepting, although there is clearly no guarantee that this will happen. McNair (2002) argued that responsibility for lesbian invisibility does not lie entirely with the consumer’s reluctance to disclose, but equally with the failure of practitioners to provide an environment in which disclosure is safe or beneficial.

In the USA, research into health-care workers’ attitudes towards lesbians (and gay men) has repeatedly found homophobic attitudes among doctors, nurses, social workers and other health-care workers (Eliason, Donelan & Randall, 1992; Klamen, Grossman, & Kopacz, 1999; Murphy, 1992; Randall, 1989). Although these studies are from the USA, they are widely cited in Australian literature to show that health-care workers are homophobic. One survey of gay, lesbian, bisexual, transgender and intersex (GLBTI) people in Australia noted that few respondents reported negative experiences with health-care providers, and that the vast majority reported their experiences to be neutral. The authors posited that the high number of reports of neutral responses may have been because the health-care provider had not been told about the sexual orientation of the client (Pitts, Smith, Mitchell & Patel, 2006). In this publication, these data are not broken down by gender, however, on further inquiry, I ascertained that there is little difference in the results between the gay men and women (H. Mulcare, personal communication...
December 5th., 2006). There does not appear to have been any rigorous research in Australia to date to investigate the extent to which homophobic attitudes exist among health-care workers. There are a number of largely anecdotal accounts in the ‘grey’ literature\(^\text{13}\) concerning lesbians’ fears about homophobia. These appear to be based largely on hearsay rather than personal experience, although heterosexist assumptions are reportedly commonplace in contacts with health-care professionals (Boardman, 2001; R. Brown, 2000; Murray, 1997).

A number of sources have reported that either personal experience, or hearing about others’ experiences of heterosexism and homophobia, can lead some lesbians to avoid or delay health care (Barbara, Quandt, & Anderson, 2001; Dean, Meyer, Robinson, Sell, Silenzio et al., 2000; Saphira & Glover, 2000; van Dam, Koh, & Dibble, 2001). Discourses about lesbian invisibility and poor treatment are generated by word-of-mouth and through the gay media. It has been charged that concealing sexual orientation in health-care interactions may lead to inappropriate or inaccurate diagnosis or treatment (Deevey, 1993). Cases have been identified in which diagnosis has been obscured or delayed by physicians’ assumptions about heterosexuality (Patel, DeLong, Voigl & Medina, 2000). Deevey (1993) also suggested that disclosure of sexual identity in health-care settings may itself constitute a health risk, because of the stress caused by having to repeatedly come out. It has been argued that although most lesbians would like to confide in their physician, few do because they fear negative reactions, and that communication between lesbian patients and health-care providers must be improved to better address lesbian specific health-care needs (Lehmann, Lehmann & Kelly, 1998).

A major problem that has been identified with lesbian health research in the past, is that many studies have recruited only self-identified lesbians. Other problems that have been identified are the use of non-probability samples (making it difficult to generalise results), and recruitment of convenience samples from sources such as lesbian bars, music festivals, or gay and lesbian organisations (Sell & Petrulio, 1996). Solarez (1999) criticised the use of non-probability samples and argued that in US research, most samples of lesbians have been predominantly white, middle-class, well-educated, and between 25 and 40 years old. Greene (1994) argued that these methodological problems obscure health issues for minority groups within the lesbian population. Lesbians are as

\(^{13}\) According to the most widespread and generally recognized definition, grey literature is all that material which is not available through the conventional, commercial distribution channels (Alberani, Peitrangeli & Mazza, 1990). This allows us to consider documents produced in professional practice that are sometimes excluded from scholarly literatures, i.e. peer reviewed journals and books.
diverse as the general population of women, and they are represented in all racial and ethnic groups, all socioeconomic strata, and all ages (Solarez, 1999). There is no single type of family, community, culture, or demographic category characteristic of lesbians, which makes researching lesbians as a discrete group problematic.

The discrepancies and inconsistencies described above in how to identify lesbians, who to study, and the proportion of the population they represent, pose a number of challenges. These include whether to privilege identity over behaviour; whether to include bisexual or not exclusively heterosexual women and how to reach the not inconsiderable proportion of the women who constitute the ‘hidden’ part of this population. The actual extent of this hidden population is unknown, and the phenomenon is complex. Some lesbians may be hidden because they do not identify as such. For example, a major survey of sexual experience in Australia reported that while 0.8% of Australian women identified as homosexual, 6.9% reported their sexual experience to be not exclusively heterosexual (Smith, Rissel, Richters, Grulich & deVisser, 2003). There is, however, another dimension to this hidden population; anecdotally it is understood that there are women who identify as lesbian living in suburban or rural settings, who pass as heterosexual to protect their children, or because they feel unsafe to reveal their sexual identity for fear of recrimination from neighbours, family or strangers. Women who identify as lesbian and pass, and those who do not identify as lesbian but engage in relationships with other women, are part of the ‘hidden’ population of lesbians.

A further challenge is whether lesbians should be separated from women in general or included as a sub-group in all women’s health research. To address these challenges, it is necessary to understand health issues for lesbians in more detail. Much of the research into lesbian health in the past two decades appears to have been influenced by two main discourses, which have origins in earlier discourses about women’s health and homosexuality. In the first, women’s health is constituted as synonymous with reproductive matters, in the second homosexual people are constituted as mentally ill. These discourses are reflected in the literature; much of the lesbian health research appears to have focused on reproductive, sexual, emotional and mental health (Bernhard, 2001). For example, the report from the US Committee on Lesbian Health Research Priorities described existing research on lesbian health under headings of mental health, cancers (breast and cervical), sexually transmitted diseases (particularly HIV/AIDS), and substance use (including alcohol, tobacco and illegal drugs) (Solarez, 1999). Each of these areas is narrowly linked to reproductive or mental health.
While institutional homophobia clearly has implications for health and access to services, societal and institutional attitudes towards homosexuality differ across borders, and according to Wilton (2002), the fundamental question is not how much homophobia there is, but “why is the health-care profession failing to meet the needs of lesbian and gay service users?” (p. 260). Here I address the literature pertaining to lesbian health under the two broad headings of reproductive and sexual health, and mental health. I then briefly discuss more recent shifts in lesbian health literature.

**Sexual and reproductive health**

A deficit view of lesbian health is apparent in the research literature concerning breast cancer, cervical cancer and sexually transmitted infections (STIs), which has resulted in lesbian sexual health being defined largely in terms of infection or disease. While these are important health issues for all women and prevention and treatment are no different for lesbians, there has been no attention paid to issues such as sexual fulfilment or the attainment and maintenance of positive self-esteem for lesbians (Farquar, Bailey & Whittaker, 2001). Sexual health can be understood simply in biomedical terms, or more holistically as encompassing physical, psychological and social aspects of sexuality. For lesbians it has been argued that this should include “the enjoyment of sexual activity of one’s choice without suffering or causing physical or mental harm” (Farquar et al., 2001, p. 6).

In a review of lesbian health literature, Bernhard (2001), found that in addition to STIs and HIV, the most prevalent lesbian health topics discussed were screening for breast and cervical cancers. In relation to STIs, some researchers have suggested that there may be a risk of transmission associated with some lesbian sexual practices, such as sharing sex toys and oral/vaginal sex (Fethers, Marks, Mindel & Estcourt, 2000), however, there is scant literature about sexual practices between women. This means that theorising about risk of transmission remains guess-work. Some studies have reported that lesbians, particularly those who have never had sexual contact with men, have a low incidence of STIs (Moran, 1996). However, the majority of lesbians have had heterosexual relations at some time, and some continue to have relations with men whilst identifying as lesbian. While there have been few large-scale surveys with lesbians to establish the extent to which lesbians have had sexual relations with men, in a recent Australian survey of more than 1,900 women, who responded to an internet-based survey of lesbian, gay, bisexual and transgender people, 82.4% of those who identified as lesbian or bisexual reported that they had at some time had sexual relations with men (Pitts, Dyson, Rosenthal & Garland,
forthcoming). Another Australian survey that included 643 same-sex attracted young women, reported that many young women who are lesbian or same-sex-attracted pursued relationships with men, as a way of avoiding or hiding their sexual feelings. This may also be a strategy to ‘prove’ themselves heterosexual and thereby avoid homophobic bullying (Hillier, Turner, & Mitchell, 2005).

There has been a persistent myth among both doctors and lesbians, that lesbians do not need Pap tests (Ferris, Batish, Wright, Cushing & Scott, 1996). The origins of this may be two-fold, because of the link between heterosexual sex and cervical cancer, and the assumption that lesbians never have heterosexual sex. The human papillomavirus (HPV) is strongly associated with cervical cancer, and its transmission is most likely to occur through penetrative heterosexual sex. The time between infection with the virus and the onset of cervical cancer vary, sometimes taking years (Pitts & Clarke, 2002). Studies with lesbians in the USA, the UK, and New Zealand have all reported that lesbians have lower screening rates for cervical cancer (Kunkel & Skokan, 1998). It has been suggested that this may result in lesbians presenting for treatment of infections or pre-cancerous cell changes of the cervix later than their heterosexual peers (Marazzo, Koutsky, Stine, Kuypers, Grubert, Galloway et al., 1998). In addition to sexual contact, HPV is transmitted through skin-to-skin contact, and has been demonstrated to occur as a result of a range of sex practices, including sharing sex toys, which makes transmission possible even in the absence of heterosexual intercourse (Bailey, Kavanagh, Owen, McLean & Skinner, 2000).

Other STIs are also spread through heterosexual sex, so having had sex with men can put lesbians at risk of acquiring, and transmitting a range of STIs (Farquar et al., 2001). A number of authors have also reported that lesbians are less likely than heterosexual women to seek routine gynaecological care (Peterson & Bricker-Jenkins, 1996; Trippet & Bain, 1993). A study in a fertility clinic in the UK reported that the lesbians had a higher incidence of polycystic ovary syndrome (PCOS) than heterosexual women. PCOS can lead to sterility, and has therefore caused some concern, but the authors of the study that published these findings caution that PCOS only occurs in women with increased levels of androgens, and these findings cannot therefore be generalised to all lesbians (Agrawal, Sharma, Bekir, Conway, Balen et al., 2004). In the USA, lesbian health activists have been concerned with HIV as a lesbian health issue for some time (Goldstein, 1995; Kaufman, Ford, Pranger & Sankar-Mistry, 1997), even though sexual transmission between lesbians remains low and few lesbians have contracted HIV through woman-to-
woman sexual practices (Kwakwa & Ghobrial, 2003; Farquar et al., 2001). In Australia, Fethers et al. (2000) found that women who self-reported having sex with other women in Sydney had a higher prevalence of behaviours that increased the possibility of transmitting bacterial vaginosis, hepatitis C, and HIV, when compared with controls. These findings were supported by another survey of women in contact with the gay community in Sydney, who were found to be at risk of contracting HIV from both injecting drug use and (hetero)sexual activity, often with gay men (Richters, Bebbington, Prestage, Ellard, & Cassar, 2001). HIV is transmitted via body fluids, and infection occurs as a result of a range of behaviours, including heterosexual sex, injecting drug use and alternative insemination with HIV positive semen (Kaufman et al., 1997). Despite there being evidence of increased risk-taking behaviours, and of a range of STI infection, there was no evidence of HIV infection among women who have sex with women in Fethers’ study.

When considering the studies cited above, however, it is important to note that risks for transmitting or contracting STIs or blood-borne viruses (BBVs) are not an issue of sexual identity or orientation, but of sexual and other practices, such as injecting drug use. As such, they are not specifically lesbian health issues. Nonetheless, withholding screening based on sexual identity, on the assumption that lesbians are at lower risk, is a lesbian health issue. The findings reported above point to the importance of lesbians having regular sexual health checks and Pap tests, regardless of whether or not they have ever had sex with men.

In the past decade there have been claims in the gay media and ‘grey’ literature that lesbians are prone to breast cancer. These appear to have originated in the USA, when a National Cancer Institute (NCI) researcher analysed some lesbian health research data, applied what the NCI considered risk factors for breast cancer, and in a presentation at a health conference concluded that lesbians may be 2–3 times more likely to get breast cancer than non-lesbians (Plumb, 1997). The Associated Press reported that lesbians had a one in three chance of developing breast cancer, and the ‘lesbian breast cancer epidemic’, which echoed around the world, was born. Risk factors that have been identified for breast cancer include uninterrupted menstrual cycling, nulliparity, breast-feeding delayed until after the age of 30 and high levels of alcohol consumption (Council on Scientific Affairs & American Medical Association, 1996; Hudspith, 1999). Like the problems associated with screening for cervical cancer and STIs, the projected risks for lesbians having breast cancer were based on an assumption that lesbians do not have sex.
with men, and have therefore not had children or breast-fed babies. As indicated earlier, many lesbians have children from prior heterosexual relationships (Fish & S. Wilkinson, 2000). Furthermore, increasing numbers of lesbians are having babies within lesbian relationships without the direct involvement of a man, with the assistance of alternative reproductive technologies (ART). No studies to date have actually demonstrated that lesbians have a higher rate of breast cancer than heterosexual women, and a study that compared the family history and risk or protective factors between heterosexual and lesbian women found little difference between the two groups (B. Roberts, 1999). Another issue that has been raised when projecting increased risk for breast cancer is obesity, and studies in the USA have reported that there is a higher incidence of obesity among lesbians (S. J. Roberts, 2001). In Australia, the Private Lives survey confirms these reports: 49.2% of respondents self-reported that their weight fell into the overweight (25.6%) or obese (23.6%) categories (Pitts et al., 2006).

While it appears that there are few if any differences between heterosexual women and lesbians in terms of breast cancer, there may be differences in their participation in preventative practices, such as breast self-examination (BSE) and mammograms. Analysis of data from the UK Lesbians and Healthcare Survey found that lesbians were less likely to practise BSE (Fish & S. Wilkinson, 2003), and supports earlier findings about lesbians and BSE from the USA (Trippet & Bain, 1993). No data is available about lesbians’ breast examination practices in Australia. It is difficult to compare the available data on breast health, because recommended practices and frequencies differ between countries. In the USA, mammograms are recommended every one to two years, in the UK every three years after the age of fifty, unless for some reason it is indicated more frequently. In Australia, mammograms are recommended every two years from the age of fifty, and provided free to all women thereafter, unless recommended more frequently by a doctor. The Institute of Medicine in the USA found that while younger lesbians had fewer mammograms, there was no difference between heterosexual and lesbian women’s participation rates after the age of fifty (when the risk of developing breast cancer increases) (Diamant, Wold, Spritzer & Gelberg, 2000). Conversely, in New Zealand, lesbians over the age of fifty were found to have mammograms more frequently than heterosexual women (Saphira et al., 2000).

**Mental health**

There is a considerable body of literature on the mental health of lesbians, with a strong theme of isolation and lack of support, leading to depression, anxiety and alienation. In
one US survey of over 500 lesbians, depression and conflict over coming out were identified as serious mental health issues. In this study, lesbians reported seeking professional assistance for depression and relationship problems because of a lack of family support to help them to deal with grief and loss (Trippet, 1994). Hughes, Haas & Polinger (1997) reported significant rates of depression and suicidal behaviours from a comparative study with 284 lesbians and 134 heterosexual women in Chicago, Sorenson (1997) reported from a survey of 1,633 lesbians in Boston that rates of alcohol use appear higher in lesbians, and that the secrecy of hiding sexual orientation leads to stress and suicidal feelings. In the USA, the National Lesbian Health Care Survey (1984–1985) found that over half the sample had had thoughts about suicide at some time, 18% had attempted suicide, and about three quarters had received counselling, for reasons of sadness and depression (Bradford, Ryan & Rothblum., 1994). A survey of lesbian, gay and bisexual mental health service users in the UK reported that heterosexism and homophobia among service-providers can lead to individuals internalising negative feelings about their sexuality that may have an impact on their mental health. The report of this project suggested that internalised homophobia can hamper emotional growth and development, lead to feelings of shame and self-hatred and result in alienation and isolation, which can lead to depression and may result in self-harming behaviours, and alcohol and drug abuse (McFarlane, 1998; Hillier et al., 2005). In Australia the longitudinal study of women’s health also found higher rates of self-reported depression, anxiety and self-harm among a younger cohort of women (aged eighteen to twenty-two years) who self-identified as lesbian, bisexual or not exclusively heterosexual, when compared with a similar group of heterosexual women (deVisser, Hillier, Horsley, Kavanagh, Pitts, Tonge et al., 2003). These young women were more likely to have experienced a range of abuse, and to experience higher levels of stress. Because the survey is a cross-sectional study, the authors cautioned that a causal link cannot be established between these factors and sexual orientation. In another large-scale survey of Australian self-identified lesbian, bisexual and women who have sex with women (n=1900), 44% reported having at least one of two criteria for a major depressive episode, and half of all respondents had seen a counsellor or psychiatrist in the past five years, for issues such as depression, anxiety, or relationship and family problems (Pitts et al., 2006).

Some studies have asserted that lesbians may not necessarily benefit from seeking counselling or therapy, because counsellors from a range of disciplines have been found to be heterosexist and homophobic (Berkman & Zinberg, 1997; Dean et al., 2000;
Golding, 1997; Trippet, 1994). In one UK study, many lesbians reported seeing therapists for support, only to have their sexual orientation be seen as the problem, rather than the matter with which they were actually presenting (Golding, 1997). In this study, mental health services were reported to be homophobic, and commonly occurring themes for lesbians who used mental health services included anxiety, lack of privacy, and fear of discrimination and/or physical violence. Another issue was that staff saw them in purely sexual terms (Golding, 1997). Greene (1994) argued that lesbians experience stressors, including potential isolation, anger and frustration, and that these emotions underlie many of the emotional and mental health issues they experience.

Lesbians have also been found in a number of studies to have higher rates of alcohol, tobacco and drug consumption, compared with heterosexual women. It has been suggested that due to the stresses of living with homophobia and heterosexism, they have low self-esteem, and their drug use may be a form of self-medication (Haas, 1994). In Australian studies, same-sex-attracted young women have been found to be significantly more likely than their heterosexual peers to have injected drugs or smoked marijuana (Hillier et al., 2005). A survey of the gay and lesbian community in the Australian state of Victoria found alcohol consumption and smoking rates to be higher among younger lesbians aged twenty to twenty-nine years. Overall, consumption rates were found to be considerably higher that those found in the general community (Murnane, Smith, Crompton, Snow & Munro, 2000). These findings were supported by the WHA study which found higher alcohol and tobacco consumption and greater likelihood of illicit drug use among lesbians in a cohort of women aged 18–23 (Hillier, deVisser, Kavanagh & McNair, 2004). In another Australian survey of 1,000 women aged between sixteen and ninety-two years, who identified as gay, lesbian or bisexual, 35.6% reported they had smoked tobacco and 14.5% had used marijuana more than five times in the previous month. These rates are somewhat higher than the Australia population (Pitts et al., 2006).

These findings are also born out in international studies. For example, in a number of US studies, lesbians and bisexual women under fifty have been found to be more likely to smoke and drink heavily than heterosexual women (Bradford et al., 1994; Diamant et al., 2000; Gruskin, Hart, Gordon & Ackerson, 2001). UK lesbians have also been reported to be at serious risk from excessive alcohol consumption. In a survey of young lesbians aged seventeen to twenty, 85% used alcohol and 50% of these had experienced serious problems as a result, for example, passing out, getting arrested for being drunk and disorderly, being hospitalised for drink problems or attempting suicide whilst under the
influence of alcohol (Bridget & Lucille, 1995). In a New Zealand survey, 30% of lesbians reported that they smoked tobacco, and despite a relatively low consumption of alcohol, 48.1% of respondents expressed the view that alcohol was used excessively in the lesbian community. Of these survey respondents 32.6% had used cannabis at least once in the past year; and 4.5% had used recreational drugs other than cannabis in the past year (Welch, Howden-Chapman & Collings, 1998).

Discussion

While the focus of much of the lesbian health literature to date has been on mental and sexual/reproductive health, recently there has been a shift to a wider view. For example, with increasing concerns about obesity in the general population, surveillance has turned to lesbians. Studies have reported that when compared with heterosexual women, lesbians have different attitudes about beauty and their own bodies. Lesbians have been found to emphasise physical fitness and reject excessive thinness (Bergeron & Senn, 1998; Cohan & Tannenbaum, 2001). Nonetheless, these authors argued that little is known about the risk factors for lesbians compared with heterosexual women, for example, whether there are protective factors in lesbians’ higher level of physical activity. Yancey, Cochrane, Corliss and Mays (2003) reported from a study with US lesbians, that the expectation suggested by studies about lesbians’ attitudes to physical fitness – that increased body mass index may be due to increased muscle, which weighs more than fat – was not borne out in their study. These authors reported that obesity among lesbians was generally comparable to that among American heterosexual women.

There are considerable social, cultural and legal differences between countries like the USA and Australia. Until recently, a lack of available Australian evidence has led to assumptions being made about the health of lesbians, based mainly on American studies. These assumptions have shaped lesbian health discourse and dominated practice in Australia. The lack of Australian evidence is now being addressed by a number of large scale, rigorous local studies, which give a clearer picture about lesbian health in Australia (see, for example, Pitts et al., 2006; Hillier et al., 2005). To attain a more holistic view of the health status of lesbians, a range of health issues that contribute not only to mental and physical health, but broader social issues, such as access and equity, need to be investigated in accordance with the WHO social determinants of health. To do this, well-designed, large-scale, population-based comparative studies are needed, as well as qualitative studies to gain an in-depth understanding about the health of women who identify as lesbian, or whose sexual practice is not exclusively heterosexual.
In this Chapter I have discussed the emergence of lesbian health as a discipline and a field of inquiry. This is a field that has been subject to rapid change. From a field dominated by biomedicine in the middle of the twentieth century, in the 1980s lesbian health emerged as an activist field. For the next twenty years scholarship was predominantly produced by practitioners and activists, however, in the past decade this has started to change. More recent scholarship has taken a wider view of lesbian health, and more studies, both qualitative and quantitative, are emerging that provide a wider view and better understanding of the health of lesbians. Regardless of these changes, the biomedical model of health still dominates lesbian health discourse. In this study, I have sought to take a wider view of lesbian health by investigating not only the health issues that are the focus of most lesbian health literature, but also the wider field in which lesbians come to understand their sexual attraction or behaviour as different from the discursively produced norm, and how this impacts on constructions of health and well being, and interactions with the health care system. Given the long history of lesbianism being produced as deviant, and lesbian health in deficit, this project therefore seeks to explore the following research questions:

- In what ways do discourses about lesbianism and the construction of the lesbian health field influence the ways in which lesbians construct and manage their own health?
- In what ways do lesbians position themselves as they negotiate clinical spaces?
4. Methodology and Methods

As noted in Chapter One, the sexual identity category ‘lesbian’ has been extensively theorised in disciplines other than health, such as queer theory and literary studies. In Chapter Three, I described the ways in which the field of lesbian health has been constructed from within using a biomedical model of health. Within this model, lesbian health has been produced as a deficit; because of homophobia and heterosexism, the lesbian is said to have been rendered invisible in health-care settings. Lesbian invisibility is said to have led to lack of participation in screening programs, as well as to anxiety, stress and a range of consequent poor health outcomes. The solution that has been proposed within the field is for lesbians to become more visible in health-care services, which, it is argued, will lead to culturally appropriate health-care and services. Although this discourse has been contested by some lesbians, dissenting views are not reflected in the available lesbian health literature, in which no attempt has been made to explicate the meaning or experience of invisibility, and invisibility is constituted as always having negative consequences. While this discourse may have a degree of validity, there are other ways to position lesbians in the health field. The goal of this project is to go beyond the deficit constructions of lesbian health that dominate the field in order to understand how lesbians construct and manage their own health. A qualitative approach has been selected to do this, because it allows the complexity of the processes involved to be elaborated and better understood.

All research methods are underpinned by a philosophical framework, or methodology. The methodology reflects the theory behind the methods used in research, the fundamental assumptions and characteristics inherent in the approach. It is about a general orientation to life, a view of knowledge that is associated with the research methods (Koch, 1995). Qualitative methodology draws upon and utilises a range of approaches and techniques in order to gain important insights and knowledge without necessarily privileging one method over another (Nelson, Treichler, & Grossberg, 1992).

Phenomenology offers a framework for the study of experience from the perspective of the individual. It is concerned with discovering and understanding the meaning of individual lived experience, and is driven by a desire to understand and explain the phenomenon under study (Lester, 1999). There are two principal schools of thought on phenomenology: Husserl’s (1962) transcendental phenomenology, and Heidegger’s
(1962) hermeneutic phenomenology. These grew out of descriptive psychology, which paid attention to both mental and intellectual processes and attempted to eliminate all assumptions about causation and the wider significance of mental processes (Koch, 1995). However, Husserl and Heidegger diverged on one important point, Husserl’s phenomenology was based on Cartesian duality. He argued that human consciousness actively constructs objects of experience, and his project was to “investigate the structures of consciousness that make it possible to apprehend an empirical world” (Denzin et al., 2000, p. 488). He proposed a methodology whereby the elimination of all preconceived notions about the phenomenon to be studied were to be ‘bracketed’. This bracketing neither confirmed or denied the reality of the outer world, but set it aside in “an act of phenomenological reduction” (Koch, 1995, p. 829). This applied as much to the scientist as research participants, because it “defends the validity or objectivity of interpretation against the self-interest of the researcher” (Koch, 1995 p. 829). Heidegger, on the other hand, considered phenomenological reduction to be impossible (Winpenny & Gass, 2000), as he posited that individuals come to any given situation with their own story, or ‘pre-understanding’ of a situation, which cannot be bracketed or set aside. According to Heidegger (1962), this is because individuals are too much beings in the world to be able to? disconnect from their own experience.

Hermeneutics is the science of interpretation, it is concerned with analysis of the meaning of a text (Harvey & Myers, 1995). There are different forms of hermeneutics, all concerned with the textual treatment of social settings, but not all concern themselves with reflective critique of the meaning of interpretations derived from textual analyses. Pure hermeneutics is interested in interpreting texts at face value. Critical hermeneutics takes a broader view of texts, and the interpreter recognises that the act of interpreting texts is never closed, as there is always another possible interpretation (Harvey & Myers, 1995).

There are also different forms of phenomenology. As I argued above, Husserl’s formulation of phenomenology suggests ‘bracketing’ lived experience in attempt to reduce the individual to an essential self, while Heidegger argued that we are too much beings in the world to bracket lived experience. Following Husserl and Heidegger, French philosophers further developed phenomenology. Merleau-Ponty (1962) developed an existentialist form of phenomenology that deals with the existence of people in a pre-given world. He was not interested in the abstract, but in an ‘historical’ person who engages with and lives in the social world. For Merleau-Ponty, people live in a social
world and it is in this world that they learn about themselves, which supersedes the notion of ‘consciousness’ (Sadala & Adorno, 2001). In this way, Merleau-Ponty’s construction of phenomenology is more closely aligned with that of Heidegger.

Phenomenological theories of embodiment have been concerned to distinguish between the various (essentialist) physiological and biological causalities that structure bodily existence, and the meaning that embodied experience assumes in the context of lived experience (Butler, 1986). Butler argued that Merleau-Ponty took issue with essentialist accounts of bodily experience, and claimed that the body is an ‘historical idea’ rather than a ‘natural species’ (Butler, 1986 p. 520). She goes on to argue that from this perspective, the body can be understood as being in an active process of embodying certain historical and cultural possibilities, and that this complicated process is one which any phenomenological theory of embodiment needs to describe.

Agger (1991) argued that post-structuralism rejects the project of a universal social science, and posits instead that particular modes of knowledge are defined by the multiplicity of people’s subject positions. In this, Agger argued that post-structuralism is highly reminiscent of social phenomenology, which emphasises the irreducibility of experience. He further argued that post-structuralism and social phenomenology, as branches of knowledge, each emerged from the same sources – the philosophies of Nietzsche and Heidegger. Furthermore, these philosophies influenced the work of significant post-structuralists like Foucault and Derrida (Agger, 1991).

My project is concerned with historicising the social construction of lesbianism, in order to understand the construction of discourses about lesbianism. I seek to understand how these discourses are embodied by contemporary lesbians, how this affects their interaction with the health care system, and how they negotiate their own health and health care in clinical space. For this project, hermeneutic phenomenology offered a methodological framework for understanding the complexity of lesbian experiences in clinical spaces, as it acknowledges the prior experience of participants in relation to the phenomenon of lesbian in/visibility being studied.

In Chapter One I discussed my positioning in relation to the group, and I was clear that it would be difficult for me as a researcher in this project to bracket my personal and professional knowledge and experience. It has been suggested that lesbians are best placed to carry out research with other lesbians, because lesbian research subjects may feel vulnerable with an ‘outsider’ (because of the fear of being judged) and therefore not
be as open as they might be with a lesbian researcher (Waite, 1996). A way that has been suggested of conceptualising the positioning of the insider–researcher is as being ‘embedded’ in the community she is researching, which, it has been argued, is not without risk: “In the hands of relatively privileged researchers studying the experience of those who have been marginalised … the potential to silence subjects is of particular concern. It is easy … to slip into … a “compulsive extroversion of interiority” (Denzin et al., 2000, p. 109 quoting Clough, 1992 p. 63). In this statement, Clough draws attention to the possibility of over-identifying with, or even becoming hyper-critical of those being researched, to the detriment of the project. The extroversion of interiority can be read as the possibility of imposing personal values and beliefs, for example, that there are ‘right’ and ‘wrong’ ways to be lesbian. It is possible to silence subjects in many ways. As an embedded lesbian researcher, there was a risk that I might privilege of one way of being lesbian over another, by implying that there is one ‘true’ way of being lesbian. This presented the possibility that those participants who considered that they did not fit, or even refused the category ‘lesbian’, might feel unable to tell their stories, because they feared being judged, or their difference could de-legitimise them. The methodological problem this generated was addressed through the use of reflexivity.

For the embedded researcher, reflexivity is essential. This is a process by which the researcher can critically reflect on herself and how she is positioned in relation to her research participants, as well as on herself as an instrument of research. According to Kincheloe (2005), reflexivity reveals invisible ‘artefacts’ of power and culture, and it is important for the researcher to acknowledge the influence of these on her own scholarship. The issue of power is central for any researcher. Foucault (1980) argued that fields of knowledge take their forms as a result of the power relations of discursive practices. In recognising these issues of power and how knowledge is constructed, it is important for the researcher not only to acknowledge the influence of prior modes of knowledge production on her scholarship, but also her position in relation to those she is studying.

Critical engagement with the self is an ongoing process, a dialogic that focuses on the researcher and the people she plans to research, as well as the context, materials, data, and the historical process of knowledge production. According to Hodge and Kress (1988), in social semiotics, the theorist Voloshinov posited that rather than assuming coherence in society, conflict and contradiction are the norm. For Voloshinov, language was dialogic, a

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14 I would like to acknowledge the input of Professor Gary Dowsett on reflexivity.
site for competing voices and interests. This is in opposition to monologic, in which
difference is actively suppressed by rules that preclude opposition. Dialogic codes signify
the existence of opposition, resistance and negotiation within a group (Hodge & Kress,
1988). Recognising the dialogic nature of the field was a first step towards reflexivity,
and by continuing to use a reflexive approach allowed the task of describing and
understanding the complexity of the phenomenon under study to be approached with
greater rigour.

Immersion in the data is another feature of high-quality research, and it has been argued
that this requires: “… a faithful account of people’s own words. In order to do this,
researchers need to immerse themselves deeply enough to be able to establish the
principal aspects of the event being studied” (Fortner & Christians, 1981, p. 366).

Following Denzin and Lincoln (2000), there are four phases in which reflexivity is
important: in the design phase, in the relations between existing knowledge and the
phenomenon under study, in the selection of methods and methodology, and in the
analysis and interpretation of data. Phenomenology calls for the researcher to be deeply
immersed in the data, critically describing what emerges about the phenomenon.
Grounded theory has been described as not so much a specific method or technique, as a
style of doing qualitative analysis (Strauss, 1987). In using grounded theory there is a
constant interplay between data collection and analysis, which is useful for developing
contextualised, process-oriented descriptions and explanations of the phenomenon being
studied (Orlikowski, 1993). This is a reflexive practice. The aim is to discover patterns
and processes to aid in understanding how social interactions shape the experience of
individuals (Cutcliffe, 2000). According to Glaser and Strauss (1967), the task of theory
in social research is to provide a perspective on behaviour and enable it to be predicted
and explained. The central feature of grounded theory is ongoing comparative analysis of
data, which is collected and analysed simultaneously. Because lesbian health has been
under-theorised (Wilton, 2002), the spirit of grounded theory was seen as a way for the
data to drive the emergence of theory by allowing for the specifics of the lesbian
experience of health-care to emerge, separate from prior articulations of lesbian in other
disciplines. Grounded theory was also seen as appropriate because it provided possibility
of acknowledging the researcher’s prior knowledge. In grounded theory, it is incumbent
upon the researcher to bring this knowledge into the open and discuss how it has
influenced the development of the theory, and the interplay between the data and the
researcher’s knowledge, values and beliefs. This then provides opportunities for the researcher to creatively explore and articulate theoretical links (Cutcliffe, 2000).

While some authors argue against combining different research strategies, such as phenomenology and grounded theory, others argue that they can successfully be used together. A grounded theory analytic approach takes a line by line analysis and constantly compares the data searching for themes or categories. This usually entails further research into the meaning of the developing categories by further sampling from appropriate participants or other data sources. A phenomenological approach identifies themes which derive from the participants’ stories in order to answer questions such as, what was it like for you? (White, 1998). Cutcliffe (2000) argued that combining the related strategies of phenomenology and grounded theory can produce a more thorough, multi-dimensional understanding of the phenomenon being studied.

Justification for the modification of grounded theory with other techniques can also be found in the concept of bricolage. Lévi-Strauss (1966) introduced the bricolage when he argued that a knowledge producer never carries on a simple dialogue with the world. Instead, he posited, a knowledge producer interacts in a relationship between nature and culture that is definable in terms of the particular time, culture and materials available.

The relationship between individuals and their contexts is a central dynamic to be investigated. A key ontological and epistemological concern … [is the] connection that shapes the identities of human beings and the nature of the complex social fabric (Kincheloe, 2001, p. 334).

The diversity of elements within this general connection was addressed by Denzin and Lincoln (2000) who introduced a multi-dimensional account of bricolage:

- **Methodological**: uses many data-gathering strategies, including interviewing techniques, genealogy, discursive analysis, textual analysis, and phenomenological analysis.

- **Theoretical**: uses a wide variety of knowledge and social theoretical positions including constructivism, feminism, critical theory, post-structuralism, cultural studies, and queer theory to situate and determine the purposes, meanings and uses of research.

- **Interpretative**: strategies which emerge from a detailed awareness of the field of hermeneutics. This draws on the researcher’s awareness of her own location on
the web of intersecting axes of personal history, race, socioeconomic class, gender, sexual orientation, ethnicity, religion, geographical location and numerous other dynamics. This helps to clarify the multidimensionality of the interpretive process.

- **Political**: all research processes are manifestations of power. The information that is collected and the knowledge that is produced by the researcher are studied to discern the technologies of power that have shaped them. Attempts are made to discern and document the ontological and epistemological effects of ideological, hegemonic, discursive, disciplinary, and regulatory power. Normative foundations are explored and questions of political economy, racism, sexism and homophobia are of critical concern.

- **Narrative**: all research is shaped by the stories researchers tell about their topics. These stories are not innocently constructed.

According to Denzin and Lincoln (2000), the bricolage approach provides the opportunity for the researcher to move between different perspectives, working between and within competing and overlapping paradigms. They acknowledge that perspectives are different from paradigms, which are more difficult to mingle or synthesise. However, they also argue that the *bricoleur* should be familiar with, and understand, different interpretive paradigms, such as feminism, Marxism, cultural studies and queer theory. This can result in a set of fluid, interconnected representations and images, that pose the challenge of constructing a sequence that can connect the parts of the stories into a whole. Furthermore, both grounded theory and hermeneutic phenomenology recognise the subjective involvement of the researcher, which is present regardless of the method. Employing this methodological perspective in the analysis of the data made it possible to look beyond the narrowly defined phenomena of lesbian invisibility and health deficit, and to draw on wider perspectives, in order to theorise lesbian health more fully.

**Methods**

**Interview Design**

To gain a meaningful understanding of the experiences of lesbians in the health system, in-depth, semi-structured interviews were used. In designing the initial interview schedule, a number of themes were developed based on the literature review, the researcher’s personal knowledge of the area and her experience as both a worker and a
lesbian user of the health system. Associated with each theme were a number of probe questions, which covered the following:

**Growing up, experiences of health and the health system:** questions sought to elicit information about growing up, family structure, childhood health and experiences with doctors and other health-care providers, family experiences and attitudes towards health.

**Sexuality:** first recognition of sexual orientation, coming-out experiences, identity.

**Stigma, discrimination and prejudice:** recognition that same-sex-attraction might not be ‘normal’, experience of discrimination, feelings of being at risk or in danger of violence or rejection.

**Coming out, being lesbian:** relationship status, degrees of ‘outness’, ways of coming out and what influences this, extent of lesbian visibility, awareness of public/high-profile lesbians.

**Lesbian community and activism:** involvement in social networks, family structure, political activism.

**Information about women’s/lesbian health:** sources of information, what they know about lesbian health.

**Mapping constructions of health:** perceptions about what constitutes a healthy woman and a healthy lesbian, issues affecting personal health, knowledge of lesbian health issues.

**Experiences with the health system:** relationships with health-care providers, experiences in clinical spaces (including with support staff, ancillary staff and doctors), experiences with partner/children in clinical spaces as part of a lesbian family, participation in preventative screening, experiences with counsellors, what they have heard from others about their experiences with health-care providers.

**Disclosure, coming out, in/visibility with health-care providers:** experiences of passing, concealing or being out with health-care providers, conditions conducive to disclosure, ways of coming out/disclosing, ways of concealing/passing with health-care providers, relevance of sexuality to health-care consultations.

**Lesbian health and activism:** awareness of lesbian health activism, whether this has influenced behaviour.
Two pilot interviews were conducted to ensure the themes and questions were relevant, and some minor changes were made in the interview schedule as a result. Full details of interview themes and probe questions are provided in Appendix Two. The themes and exploratory questions covered a range of issues, concepts and categories and created a starting point for opening up the issues under investigation. They also provided a way of grouping the data during the early stages of analysis. Because the interviews were semi-structured, the interview schedule was only a guide, and if participants raised issues or took the interview in a different direction, that was followed.

**Ethical Considerations**

Ethical approval was obtained for this project from the La Trobe University Human Ethics Committee. Some lesbians have been reported to be sceptical about being recruited as research participants for a variety of reasons, which may include fear (or actual experiences) of persecution, discrimination and misrepresentation. This had to be taken into account when considering recruitment, and steps were taken to ensure that volunteers were able to feel safe, secure about their privacy and confidentiality, and able to feel comfortable with, and trust the researcher not to exploit or misrepresent them. The ethical implications of this were addressed in several ways.

Prior to the commencement of interviews participants were provided with an informed consent statement that detailed in plain language their rights, and procedures for withdrawal and complaints. They were given time to absorb the contents and ask questions, and once they were satisfied they provided signed consent to participate, retaining the right to withdraw at any time prior to the end of the project.

Because of the potential during interviews for participants to recall distressing incidents or feelings, after the interview each interviewee was provided with a *Directory of Lesbian Health Services* published by Women’s Health in the South East. This left them with information about how to access counselling, support and health services specifically designed for lesbians, should they feel the need to approach someone to deal with issues raised during the interview. The directory also provided information about what to look for in a counsellor and client’s rights and responsibilities in the counselling setting.

After the interview, participants were offered the opportunity to read the transcript and provide comment and feedback if they so desired. Six of the nineteen participants took up this offer and were sent transcripts, but none offered any suggestions for changes or
edited their transcript in any way. As lesbians make up a relatively small proportion of the general community, there is a risk of individuals being recognised in written descriptions of their experiences, and in participant profiles, so privacy was a significant concern. All names, places and other descriptive details have been changed, and some detail has been left intentionally vague where it might be able to be recognised, to protect the privacy of those who participated in the project.

Recruitment and Sampling

The target group for the project was defined as lesbians who are users of the health system. Diversity was sought within that group on the basis of age, education level and geographic spread, to ensure broad representation of the group under study. Recruitment was geographically limited to the state of Victoria, Australia. The project aimed to gain a deeper understanding of the ways in which lesbians constructed and managed their own health, and their interactions with health services. Purposive recruitment is a technique of qualitative research. Patton (1990) described purposive sampling as selecting research participants because of some characteristic. He suggests it can be used to seek maximum variation in a sample. This is supported by Maykut and Morehouse (1994) who described purposive sampling thus:

In qualitative research, participants … are carefully selected for inclusion, based on the possibility that each participant (or setting) will expand the variability of the sample. Purposive sampling increases the likelihood that variability common in any social phenomenon will be represented in the data, in contrast to random sampling which tries to achieve variation through the use of random selection and large sample size … Thus, in an emergent research design the composition of the sample itself evolves over the course of the study. (p. 45)

Purposive recruitment was used in this project, with the aim of including difference. Recruitment proved more difficult than was initially expected. The original recruitment flyer was designed and widely distributed through women’s health services (see Appendix One). Key contacts in the field of lesbian health were asked to display and distribute them to women who might be interested in participating. These flyers invited ‘lesbians’ to contact a ‘lesbian-friendly researcher’ about their experiences in the health system. More direct recruitment was not possible because of the requirements of ethics processes in Australia.
Responses to this round of recruitment were all from tertiary-educated women who had some professional link with the health system. Bradford, Honnold and Ryan (1997) reported that, in survey work with women, there was greater willingness to disclose sexual orientation among younger, highly educated and higher income women. This may explain the limited response to the initial recruitment flyer in this project. The preponderance of well-educated, city-dwelling lesbians who responded also highlighted a weakness in the initial recruitment strategy. The flyers appeared to have remained among lesbian workers and their networks, rather than being distributed to a broader group of women who take part in the lesbian social support groups run by these services. This may have been because the workers have both a personal and professional interest in the issues being raised.

Because of these difficulties, and because purposive sampling for difference was planned, the recruitment strategy had to be reviewed with a view to reaching a wider group. Subsequent flyers were distributed inviting gay, queer, same-sex-attracted women or lesbians to be interviewed by a lesbian researcher (see Appendix One). Bradford et al. (1997) also reported that the sexual orientation of the interviewer made a difference to participants’ willingness to disclose in her study. By calling on women who identified themselves in different ways and identifying the researcher as a lesbian, the circle of recruitment was widened. The recruitment strategy was also extended to include direct contact with all lesbian social groups listed in public documents such as the gay press and gay and lesbian directories. Advertisements were placed in the gay and lesbian media using similar language to the flyer and, where e-mail addresses were available, for example, from public and community notices in the gay press, e-mails containing the flyer were sent to social and sporting groups. Flyers were handed out at a public lesbian health forum and the assistance of key workers in lesbian health was again enlisted to distribute the revised flyers to women who might be willing to be interviewed. The second round of recruitment netted a broader sample, including women from different geographical locations, ages and educational background.

**Data Analysis**

Interviews were audio-recorded and transcribed professionally. I then followed a process in which I carefully compared the written text and recorded word line by line. This

15 For example, weekly free gay newspapers such as BNews, MSO and the Victorian lesbian magazine Lesbiana.

16 For example, the ALSO Foundation directory of services and Women’s Health in the South East Lesbian Directory
allowed me to immerse myself in the data and identify emergent themes. With each new transcript, data were coded into categories and, as new transcripts were coded, these themes were connected. Chenitz and Swanson (1986) posited that this process constitutes an ongoing internal dialogue within the researcher. In the early stages she asks questions of the data that stem from her knowledge of the area being studied, and as the interviews progress she asks different questions of the data, such as: what is going on here? What does it mean? What is happening? When? Who is doing it? How is it being done? What is happening as a result? Later, as more dense categories emerge, the questioning continues, but micro/macro level comparisons can also be made between interview transcripts (Chenitz & Swanson, 1986).

The data analysis was grounded in a critical notion of hermeneutics that focused on the cultural, social, political and historical nature of the phenomenon under study. Hermeneutics maintains that meaning cannot be separated from social context and that interpretation is a complex process influenced by social forces. Critical hermeneutics is concerned with the ways in which power operates to shape meaning, and in the theory and practice of interpretation. It focuses on the cultural, social, political and historical nature of research. In this understanding of data analysis there is a distinction between describing a phenomenon and understanding it; rigour demands that the object of inquiry is located in relation to the many contexts in which it is embedded (Kinzeloe, 2005). Furthermore, the relationship between the researcher and the researched is valued, meaning is linked with human experience, and data analysis is not divorced from the human context in which meaning is produced. By engaging in critical hermeneutics, the issue of how technologies of power operate at a micro and macro level in the lives of individuals is not lost (Kinzeloe, 2005).

Following Ussher (1997) who argued that material and discursive elements are always intertwined in the negotiation of being lesbian (or gay), and that to examine one level of analysis without the other will always provide an incomplete picture, multi level analysis of the interview data was undertaken. Discourse analysis was used to examine underlying assumptions in the language participants used to talk about their experiences of in/visibility in clinical spaces. In addition, attention was paid to the participant’s accounts about their material experiences, and the interplay of both discursive and material experiences. This process opened up new insights into areas not previously considered, for example, while it was not a focus of the project, a number of participants’ stories about their experiences of conception, pregnancy and birth emerged. These are described
in detail in Chapter Eight. By not disregarding material experience, subjugated voices can be heard. Viewing material experience through a critical, deconstructive lens, such as that provided by the theoretical work of Foucault and Bourdieu (see Chapter Five), also enabled deficit discourses to be identified and their effects to be better understood.

Thus the process of analysis involved at least three in depth readings of the data – thematic, discursive and material. This included looking at silences and deflections, as well as the spoken word. Analysis revealed difficulties in bringing forward the complexities and counter discourses concerning lesbian health. Discourse analysis is important for the study of the experience of people who are marginalised within dominant discourses (Ristock, 2002), and the thematic, material-discursive approach, pays attention to language, subjective experience and the material realities of the lesbian subject.

**Participant Profiles**

Eighteen interviews were carried out with nineteen women ranging in age from twenty-two to sixty-four years (one was a group interview with a couple). Eleven participants were from inner city and suburban areas, five from outer suburban areas and five from rural areas. Four of the women had post-graduate qualifications, nine were tertiary educated and six had high-school education. In a recent Australian study, 26.4% of GLBTI Australians had education to high school level, 53.6% had a diploma or university degree, and 19.4% had post-graduate qualifications (Pitts et al., 2006). These data were not broken down by gender in the report, however in personal communication I have established that there was little difference when the data were broken down by gender (Mulcare, December 5th., 2006. In the present study, participants educated to high-school level were slightly over-represented (31.5%), as were those with post graduate qualifications (21%). Participants with a diploma or university degree were slightly under-represented (47.5%), however in education the sample was broadly representative of the GLBTI population in Australia. Seven of the participants were currently not in a relationship and twelve were partnered. Six of the participants had no children; one was a step-parent in a relationship with a woman who had children from a former heterosexual relationship; seven had children from previous heterosexual relationships (all aged in their teens or older); three were non-birth parents, and two were birth parents in de novo families. Limited diversity was achieved in racial mix. All of the participants were Anglo-Australian, except for Melanie, whose mother was Asian, and Mandy and Georgia, who were Aboriginal Australians. All of the participants have been assigned pseudonyms, and their details have been altered to protect anonymity, although details of where they live,
occupation and such have been only slightly changed to maintain the integrity of their stories.

To assist in differentiating the participants discussed in the Chapters that follow, I have prepared a series of capsule biographies (Dowsett, 1996).

**Melanie** was in her late thirties when I interviewed her, she lived in the inner city, had post-graduate qualifications in a psychology and had her own private practice. Her mother was Asian and her father Anglo-Australian. She lived with her female partner and two step-children. She was married to a man when she was younger, and when I interviewed her she identified as queer or bisexual. She has had some peripheral involvement in women’s health activism.

**Gillian** was in her early fifties, had a doctorate and worked in a tertiary institute in Melbourne in a biomedical faculty. She was born in England and grew up in Australia, was married to a man for many years, but when I interviewed her she identified as gay. She lived in the country with her female partner; both women were childless.

**Rebecca** was also in her early fifties with qualifications in a psychology. She worked in a health promotion agency and had a long-time involvement in women’s health activism. She had identified as a lesbian since the 1970s and had two adult children from heterosexual relationships. When I interviewed her she lived in the inner city with her female partner.

**Lesley** was in her late forties, identified as a lesbian and is the non-biological parent of a nine-year-old son who lives with her former partner, his birth-mother. When I interviewed her Lesley worked in a social welfare agency and lived in the inner city with her current partner.

**Sandy** was in her early fifties, with post-graduate qualifications when I interviewed her. She had recently taken leave from teaching to explore other work options. She was single, and although she had tried in the past to become pregnant, she had no children. She had some heterosexual relationships as a young woman, but had identified as a lesbian since she was a university student.

**Monica** was in her early forties, with a daughter from a previous heterosexual marriage. She has post-graduate qualifications and worked as a union activist. She lived with her
female partner and her daughter in the inner city. When I interviewed her she identified as a dyke.

**Sally** was in her late fifties, with post-graduate qualifications. When I interviewed her she was working in a health-related field. She had two adult children from a heterosexual marriage and had identified as a lesbian since her marriage ended twenty years ago. She was currently single and lived in the inner city.

**Deb** was thirty-nine when I interviewed her. She was working on a doctorate and employed part-time. She grew up in a country town, and experienced physical and sexual abuse throughout her childhood. She had one daughter from a heterosexual marriage, but had identified herself as a lesbian or dyke for many years. Her daughter was twelve, and was about to move in with Deb and her female partner. They had recently moved to a country centre to live and commuted to the city for work.

**Adele** was in her mid-sixties, identified as a lesbian and lived with her female partner in the inner city. She had two adult children from a heterosexual marriage and a number of grandchildren. She was a retired teacher.

**Jenny** was in her early thirties and although she had had a few heterosexual relationships in her teens and early twenties, when I interviewed her she identified as a lesbian. She has qualifications in a psychology and worked as a counsellor in a welfare agency. She was single and lived in the inner city.

**Shona** was in her mid-thirties and the non-biological parent of a one-year-old child with her female partner. She worked as a lecturer at a university, lived in the inner-city and identified as a lesbian.

**Imogen**, a university graduate, was in her early twenties when I interviewed her. She had always identified as a lesbian. The daughter of accepting parents, she had been a gay youth rights activist for a number of years. She had worked in both the Government and private sectors, was single and lived in the inner city.

**Anna** was in her mid-forties when I interviewed her. She had left before completing high school, and was currently unemployed and on benefits. She lived in a country town, identified as a lesbian, had one daughter from a heterosexual relationship and was currently single.
Kelly was in her early thirties and a university student. She lived with her female partner in the inner city and identified as a lesbian. Kelly came from a family who had been welfare dependent most of her life and she was for many years bulimic.

Candace was in her late twenties and had a two-year-old son conceived by self-insemination from donor sperm. She had identified as a lesbian since her early teens. When I interviewed her she lived with her son in the Melbourne suburbs and was on a supporting parent’s benefit.

Colleen was in her mid-sixties and lived alone in the outer Melbourne suburbs. When pressed she identified herself as lesbian or gay, although she usually avoids any kind of identification. Until the death of her mother a few years earlier, she had lived with and cared for her, and did not come out until after her mother’s death, although she has had close friendships with women all her life. She has never had a heterosexual relationship.

Mandy was thirty-four when I interviewed her. She had finished high school, and was currently unemployed. She lived with her partner Georgia in the country and identified as gay. Mandy and Georgia elected to be interviewed together. At the time of interview she was pregnant by IVF.

Georgia was in her mid-forties; she and Mandy lived together. Georgia had identified as gay since her school days. She finished high school, and was employed as an administrator, but was on stress leave from work when I interviewed her.

Mary was forty. She has a long history of mental illness and was under treatment with a private psychologist and a general practitioner when I interviewed her. She had recently come out as gay. Mary had two daughters from a heterosexual marriage, who lived with their father and stayed with her on weekends and during holidays. Mary remained friends with her husband and was in her first lesbian relationship. She lived in an outer Melbourne suburb.

These are the women who volunteered their time to this project. Their stories emerge in the Chapters that follow, and more detailed profiles can be found in Appendix Three. In the next Chapter, I discuss the theoretical framework used in this project.
5. Technologies of Power

In this Chapter I discuss Foucauldian constructions of power as a subtle entity, not possessed but enacted by individuals. I also introduce the work of Bourdieu on habitus, dispositions and capital, and discuss the ways in which these concepts can be useful in understanding the ways in which lesbians react and position themselves in the medical encounter. Health and the medical encounter are social and bodily experiences, albeit constructed discursively. Analysis of the nature of these interactions, as suggested in Chapter Two, calls for theoretical paradigms that account for both the material and discursive operations involved. McNay (1999) argued that while Foucault's work influenced both theory about reflexive identity and feminist work on gender, he did not adequately theorise the materiality of the body. According to McNay, Bourdieu provided a dynamic theory of embodiment that enabled a differentiated analysis of social context. By drawing on both of these theorists, a more thorough analysis of power, embodiment and the field is possible.

Foucault on Power

Foucault proposed a number of ways in which power might be conceived and characterised. Rather than seeing power as a simple hierarchical concept, he constituted it as a force that could be either a positive or negative, repressive or productive, and his work on power developed over a number of years. In his early work, he examined the effect of power on bodies, which resulted in his ‘docile body’ theory. In this theory, the docile subject had no capacity for resistance, and was subject to the power of the State. Foucault saw subjectification as a dual process, that operated via external regulation, as well as internally, as a process through which individuals make themselves subjects (Foucault, 1973). For Foucault, juridical (or State/legal) power had limited functions, and played four roles. It was a mechanism that was effective under feudalism, an instrument of monarchies, it reinforced the power of royalty and justified parliamentary democracy (Foucault, 1980).

Foucault theorised that, in the West, a transition occurred in the seventeenth and eighteenth centuries that shifted power from being imposed externally by rulers (the monarch/church), to a modern form of regulatory power. This comprised systems of surveillance and normalising mechanisms, administered by the State, that both acted on individuals and became internalised by them. As a result, the modern subject exercised
self-control, self-regulation and self-management, that resulted in the same ends as external regulation. This effectively decentralised power, so that the modern citizen–subject carried out the function of external rule. Foucault termed this decentralised form of power ‘bio-power’, and he saw the body as the primary site where it was exerted (Foucault, 1973). His use of the term biopower concerned:

… the technologies, knowledges, discourses, politics and practices used to bring about the production and management of the state’s human resources. Biopower analyses, regulates, controls, explains and defines the human subject, its body and behaviour (Danaher, Schirato & Webb, 2000, p. ix).

Foucault’s primary investigation into forms of power took place in prisons and asylums for the mentally ill. He identified four types of ‘technologies’, within which human behaviour can be understood:

(1) technologies of production, which permit us to produce, transform, or manipulate things; (2) technologies of sign systems, which permit us to use signs, meanings, symbols, or signification; (3) technologies of power, which determine the conduct of individuals and submit them to certain ends or domination, an objectivizing of the subject; (4) technologies of the self, which permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way-of-being, so as to transform themselves in order to attain a certain state-of happiness, purity, wisdom, perfection, or immortality (Foucault, 1988, p. 18).

The technologies of the self referred to in this quote were also known by Foucault as ‘care of the self’, which is essentially a social exercise. For him, care of the self was an activity to be practised by individuals, as resistance against normalising effects of biopower (Infinito, 2003). While early in his work Foucault had focused on the capacity for power to dominate individuals, his later work focused on the interplay of power between individuals, and how individuals act to shape themselves, which he called technologies of self. These permit individuals to effect, by their own means or with the help of others, a certain number of operations (Foucault, Gutman, Hutton & Martin, 1988).

The four technologies identified above, production, signs, power and care of the self, do not function separately. They interact to ‘modify’ individuals, who acquire not only skills, but attitudes as a result. The first two technologies are implicated in power-over, or the
domination of individuals, the last two, in the shaping of the self. The contact between the technologies of domination of others and those of the self were called by Foucault, ‘governmentality’ (Foucault et al., 1988, p. 19). His use of the word government refers to the conduct of others and of the self to manage and control; ‘to govern’ oneself. In doing this:

Foucault sketched some pathways for analysing power that were not transfixed by the image of the state or the constitutive oppositions of conventional political philosophy and political sociology. They defined their problem space in terms of government, understood, in the words of Foucault’s much-cited maxim, as ‘the conduct of conduct’ (Rose, 1999, p. 3).

Thus, in Foucault’s formulation, governmentality replaced juridical power in the management of the populace, other than in its narrow functions identified above.

Although Foucault’s early ideas on power focused on its capacity to dominate, later his thinking shifted, and he developed an ‘agonistic’ model of power (Foucault, 1982). In doing this he developed his earlier concept of the ‘docile body’ into a more productive notion of the ‘reflexive subject’ (McNay, 1999). In this view, power is exercised not possessed, its operations are multiple and diffuse, it can be productive as well as repressive, and where power exists, resistance is inevitable (Foucault, 1982). In this formulation, instead of operating as a force exercised over others, power operates in relations between individuals and/or groups. In these relations power circulates in ‘discursive networks’ or chains through the whole social structure (Otto, 1999). Power is a mode of action that does not act directly or immediately on others, but on their actions, and exists only when it is put into action. In this formulation, the exercise of power is not in itself violence; it operates in diverse and complex ways: “It incites, it induces, it seduces, it makes easier or more difficult; in the extreme it constrains or forbids absolutely” (Foucault, 1982, p. 789).

According to Foucault, power operates locally, circulates in institutions of the social body, and emanates from every point in the social field. He described power as a way of behaving within a more or less open field of possibilities: “Faced with a relationship of power, a whole field of responses, reactions, results and possible inventions may open up” (Foucault, 1982, p. 789). Otto (1999) argued that in this view, juridical forms of power (such as State power and the law) are only the end result of power, not its source.
Foucault saw discourse as consisting of more than linguistic meaning; for him discourse was material, located in institutions and practices which define difference, and shape the material world. Meaning is produced within a range of institutionally located discourses which operate to shape social relations that are culturally produced, plural, and ever changing. He described his position on discourse:

In examining the statement what we have discovered is a function that has a bearing on groups of signs, which is identified neither with grammatical ‘acceptability’ nor with logical correctness, and which requires if it is to operate: a referential (which is not exactly a fact, a state of things, or even an object, but a principle of differentiation); a subject (not the speaking consciousness, not the author of the formulation, but a position that may be filled in certain conditions by various individuals); an associated field (which is not the real context of the formulation, the situation in which it was articulated, but a domain of coexistence for other statements); a materiality (which is not only the substance or support of the articulation, but a status, rules of transcription, possibilities of use and re-use) (Foucault, 1972, p. 115).

In his agonistic formulation of power, Foucault (1982) argued that the starting point for understanding power relations, was an analysis of “forms of resistance against different forms of power” (p. 780). In this view, meaning and subjectivity are ongoing sites for political struggle. Individual subjectivity is shaped in discourse, for example, what it means to be a man or a woman, or the available range of gender and sexually appropriate, or transgressive behaviours. There is no unitary self, but the individual becomes a site for competing and often contradictory modes of subjectivity which are shaped through discursive practices (Fairclough, 1998). Because of the potential for multiple subjectivities (shaped by personal experiences: gender, race, class, and sexuality to name a few), the concept of positioning is also relevant. Positioning is a discursive process whereby:

… selves are located in conversations as observably and subjectively coherent participants in jointly produced story lines. There can be interactive positioning in which what one person says positions another. And there can be reflexive positioning in which one positions oneself (Davies & Harre, 1990, p. 1484).
Discursive Formations

Foucault posited that discursive formations reside in the disciplines, and interact with social structures in different ways, to allow the transformation of objects. The key to understanding the disciplines as discursive formations is to see them as structures that have clear rules and regulations, which are not fixed, but establish limits and exclusions in line with contemporary views. They are affected by the constraints of institutional power and control within social structures and also determine and limit what is legitimate to say or write, as well as what counts as evidence. They are autonomous and anonymous, being part of an ontological discursive regularity, and go through transformations and ‘radical discontinuities’ at times (although these are never complete). Furthermore, these structures constitute forms of power that shape subjects and assist in regulating social life through the process of normalisation (Olssen, 1999, p. 23). Within the fields constituted by discursive formations, such as biomedicine, dominant discourses are produced by power/knowledge. However, the individual subject’s subjugated knowledges constitute another field in which subversive discourses are produced. The space in which these two fields meet (such as the consulting-room) produces a discursive field in which power is played out. The result of these interactions is not pre-determined, however, because of the individual’s capacity to resist.

Health sciences, education, the law, the family, the church and other institutions that exert power/knowledge can be seen as discursive formations that function performatively to shape the social subject. Discourse also has a performative function that resides in discursive formations. According to Butler (1993), performativity can be seen as that aspect of discourse that has the capacity to produce what it names:

Performative acts are forms of authoritative speech: most performatives for instance are statements that, in uttering also perform a certain action and exercise a binding power … If the power of discourse to produce that which it names is linked with the question of performativity, then the performative is one domain in which power acts as discourse (Butler, 1993, p. 225).

The iterative power of performatives acts to delimit what is ‘normal’, and to constitute as deviant (‘the other’) those who transgress ‘normality’.

Post-structuralist theories of power, discourse and subjectivity provide a means of understanding the ways in which sexual subjects are produced, and come to embody the effects of hegemony. Hegemony was used by the Marxist philosopher Gramsci to
describe the ways in which ideological control was perpetuated by repressive structures. He identified two forms of political control: domination, by which he meant direct physical coercion by the State, and hegemony which he used to refer to both ideological control and more crucially, consent. He posited that no regime could maintain power only through authoritarian means and theorised that to maintain stability, popular support and legitimacy from the masses were also necessary (Gramsci, 2001). According to Boggs (1976):

Hegemony in this sense might be defined as an ‘organising principle’ that is diffused by the process of socialisation into every area of daily life. To the extent that this prevailing consciousness is internalised by the population it becomes part of what is generally called ‘common sense’ so that the philosophy, culture and morality of the ruling elite comes to appear as the natural order of things (p. 39).

In this sense, hegemony can involve several of Foucault’s technologies at once, but is most germane here for the production of the sexual self. According to Foucault (1982), power:

… categorises the individual, marks him by his own individuality, attaches him to his own identity, imposes a law of truth on him which he must recognise and which others have to recognise in him. It is the form of power which makes individuals subjects. There are two meanings to the word ‘subject’: subject to someone else by control and dependence; and tied to his own identity by a conscience or self knowledge. Both meanings suggest a form of power which subjugates and makes subject to (p. 781).

Rather than automatically constituting lesbians as oppressed by the hegemonic practices of a discriminatory health-care system and promoting increased visibility for lesbians as a remedy, it may be more relevant to seek to understand “how difference is established, how it operates, how and in what way it constitutes subjects who see and act in their world” (Scott, 1993, pp. 399–400).

**Bourdieu: Habitus, Capital and Fields**

Like Foucault, Bourdieu was interested in the local, multiple and diffuse technologies of power. Whereas Foucault’s focus was on the reflexive subject, Bourdieu insisted that practice is always informed by the individual’s actions as an agent. He asserted that the possibilities of agency must be understood and contextualised in terms of its relation to
the objective structures of a culture, which he referred to as cultural fields (Webb, Schirato & Danaher, 2002). In Bourdieu’s theory of habitus, an agent might be predisposed to act in certain ways, but her/his potential for adaptation and change is never foreclosed, because of the ever changing experiences of the individual within the social field, which constantly reinforces and modifies the habitus (Bourdieu & Wacquant, 1992).

Bourdieu posited that individuals are shaped by their experience, initially by the inculcation of culture and values, which are learned through exposure to signs. This constitutes a kind of collective habitus, which is constituted in ‘things and minds’, and is embodied (Bourdieu & Passeron, 1990). Habitus, however, is more complex than the collective. Bourdieu argued that an individual’s experience continues to shape his or her habitus throughout life, which both parallels and extends the Foucauldian concept of care of the self. The habitus is not fixed, but is:

… an acquired system of generative schemes objectively adjusted to the particular conditions in which it is constituted (Bourdieu, 1997, p. 95).

The habitus is not consciously learned, but is embodied, and is continually in development, therefore it is not immediately amenable to change:

A habitus organizes the world and the choices available to agents so that they do not need to actively think about it: the ‘habitus is spontaneity without consciousness’ (Bourdieu, 1980, p. 56).

The habitus results in a number of subjective ‘dispositions’. Through these dispositions, values, norms, and ideas come to be fixed in the body as ways of being which manifest in postures, gestures, ways of standing, walking, thinking, and speaking. They are ‘embodied social structures’ (Bourdieu, 1997, p. 467). Dispositions are principles that classify the social world, which are internalised by individuals through socialisation. Because habitus and dispositions constantly interact with structures in the social and material world, they are continually changing and generate a potentially infinite number of possibilities for behaviour, thought and expression that are not only unpredictable, but also limited in their diversity (Bourdieu, 1990). An example Bourdieu has used to explain habitus and dispositions is gender roles. He argued that ‘knowledge’ about normative gender roles for men and women is not conscious or memorised, but is enacted at a pre-reflexive level through bodily dispositions. These dispositions are not mechanically
learned, but are lived categories (Bourdieu et al., 1992). The embodiment of the habitus makes it inseparable from social practices, whereby individuals exercise agency. The embodied habitus is temporal, and not immediately amenable to self-fashioning. That is, it is produced by social experiences over time, and actors are oriented to behave in certain ways because of their past, which is set in the durable structures of the habitus. Despite the structures of the habitus being durable, there is always potential for innovation, because this is an open system which makes it possible for behaviour to be modified by experience (Bourdieu et al., 1992).

Foucault (1980) posited that fields of knowledge take their forms as a result of the power relations of discursive practices. In Foucauldian terms, the field is the social and cultural ground, such as education, politics, science and sport, which is occupied by people. Danaher et al. (2000) likened this to a “piece of territory” (p. 33) or space within society, with rules that regulate behaviour and produce hierarchies. Danaher argued that roles within these fields precede the individuals who occupy them, and that discourse is the means by which the field ‘speaks’ of itself. As such, discourse play a major role in how the field operates. Bourdieu took the concept of the field further and used the term to define the structure of the social setting in which the habitus operates. For Bourdieu the field was:

A network, or configuration of objective relations between positions. These positions are objectively defined, in their existence and in the determinations they impose upon their occupants, agents or institutions, by their present and potential situation (situs) in the structure of the distribution of species of power (or capital) whose possession commands access to the specific profits that are at stake in the field, as well as by their objective relation to other positions (domination, subordination, homology etc.) (Bourdieu et al., 1992, p. 97).

According to McNay (1999), even though his later work focused on the reflexive subject, the materiality of the body remained untheorised by Foucault. She argued that, embedded in Foucauldian theories of care of the self and the reflexive subject, is an assumption that the individual is wholly capable of self-fashioning. Infinito (2003) appears to disagree with this position, and argued that care of the self is a social project, influenced by external and internal factors. While theorists disagree on whether or not Foucault’s theories answer questions about corporality, the work of Bourdieu does address these issues, and can be seen to complement Foucault’s theories in a number of ways. Like
Foucault, Bourdieu argued that social inequalities occur not as a result of institutional domination, but through the subtle operations of power on individuals (McNay, 1999). Bourdieu theorised that fields of power are the primary site for struggle. He contended that actors struggle within fields to increase their capital (power), or change the rules, or boundaries of the field. Bourdieu argued that cultural resources have come to act as a kind of capital; thus the two main kinds of capital that operate within any field are cultural capital and economic capital (Swartz, 1997). However, capital is not limited to these, Bourdieu (1985) identified

… economic capital (in its different kinds), cultural capital and social capital, as well as symbolic capital, commonly called prestige, reputation, renown etc., which is the form in which the different forms of capital are perceived and recognized as legitimate (p. 784).

Practice results from the encounter between the habitus and the individual’s dispositions. For Bourdieu, practices occur in structured arenas (fields), occupied by actors, who assume different positions, as a result of varying levels of economic, cultural or symbolic capital, or access to power. These positions are not consciously taken; individuals unconsciously acquire systems of classification and social behaviour within a field, which conceals their dependence upon distributions of social power and different types of capital (McNay, 1999). Bourdieu argued that society is neither the result of structures nor interactions, rather relationships of power are a result of both objective structures and subjective social interactions (Bourdieu, 1977, p. 81).

The embodiment of the habitus links bodily dispositions to the positions that individuals occupy in social spaces or fields of activity, and the individual’s habitus and dispositions are tempered by the constraints, demands and opportunities afforded by the field (Bourdieu, 1990). The individual is deeply embedded in the field; the objective conditions of the field structure the habitus, and in turn the cognitively constructed habitus gives the field meaning and value. Accordingly, habitus is:

… a mode of knowledge that does not necessarily contain knowledge of its own principles and which constitutes reasonable but not rational behaviour. It is a form of knowledge that is learnt by the body but cannot be explicitly articulated (McNay, 1999, p. 101).

Bourdieu described the embodied habitus as a “feel for the game”: 
These are so many ways of ignoring what seems to me to be the anthropological foundation of a theory of action, or of practice, and which is condensed in the notion of habitus: the relation which obtains between habitus and the field to which it is objectively adjusted (because it was constituted in regard to the specific necessity which inhabits it) is a sort of ontological complicity, a subconscious and pre-reflexive fit. This complicity manifests itself in what we call the sense of the game or ‘feel’ for the game (or *sens pratique*, practical sense), an intentionality without intention which functions as the principle of strategies devoid of strategic design, without rational computation and without the conscious positing of ends (Bourdieu, 1988, ¶3).

He used the example of a skilled tennis player to illustrate *le sens pratique*, describing how the tennis player’s strokes assume a spontaneous and relatively unpredictable form in a match, although they are consciously and mechanically practised. Thus this skill is a form of knowledge learned by the body but not explicitly articulated in practice (McNay, 1999).

Foucault’s theorising of power operating in social networks and of technologies of the self and Bourdieu’s work on fields of production, capital and habitus are complementary. In the context of this study, they provide a useful framework for interpreting the dynamics of relationships within clinical spaces, and the behaviour of the actors. By examining the ways in which clinical spaces such as consulting-rooms and hospitals operate as fields of power, it is possible to start to understand the ways in which the different players within the field seek to assert or increase their capital. By understanding some of the ways in which different women are constituted, and constitute themselves as sexual subjects, it is possible to start to appreciate their actions as complex and fluid, born of an embodied sense for the game, and not motivated by straightforward decisions about disclosing sexual orientation. In the chapters to come, I use these theories to analyse the data. Foucault provides a way of interpreting the way power plays out in clinical spaces, and in resistance against domination. His work makes it possible to see silence and speech as speech acts, an important factor in seeking to deconstruct the dominant activist discourse about lesbians as invisible victims. Bourdieu’s theory of embodiment, habitus and disposition reveals the effects of discourses about lesbianism on constructions of health and willingness to come out/disclose in clinical spaces.
6. Shaping the Sexual Subject

In seeking to answer the research question that asks about the ways in which discourses about lesbianism influence the ways in which lesbians construct and manage their own health, it is necessary to explicate the ways in which discourse can shape the sexual subject. The first section of this Chapter examines the ways in which individuals become sexual subjects. The focus in this Chapter is on power, how it plays out in the sexual subjectivity, is embodied by individuals, and influences the way they construct their own health and their interactions in clinical spaces. Foucault’s theories form the basis of this interrogation of power.

To introduce the Chapter, I discuss discourses about sexuality, and the ways in which they are used to explain contemporary constructions of human sexual life. To enable a more comprehensive appreciation of the processes at play for the lesbian in clinical spaces, I examine the ways in which sexual subjectivity develops and is embodied by the individual, using Bourdieu’s concept of habitus. I then introduce the voices of the participants, who, during the interviews, described how they came to understand that not conforming to normative sexual thoughts, desires or behaviours, could lead to exclusion (albeit via different pathways). I introduce the concept of dividing practices, and through the participant’s stories about exposure, particularly in childhood, to a range of heteronormative discourses. I examine the ways in which these discourses might be seen to have influenced their habitus and disposition to act in certain ways in response to perceived threats of exclusion or exposure. I go on to discuss how the habitus – embodied knowledge of heteronormative ‘rules’ – disposed different participants in different situations to sometimes speak and at others to remain silent about their sexual orientation. Using a critical, deconstructive lens, made it possible to see that both silence and speech involve agency.

Schematically, the body is subject to a “material/discursive divide” (Ussher, 1997, p. 1). Those who view the body simply as a material entity, tend to focus on the physical aspects of experience – juridical forms of power and the impact of the environment – while those who focus on discursive elements have taken the view that the body is constructed externally by culture, power and knowledge. In the former view, sexuality is seen as a set of drives and instincts. In the latter view, the body is seen as being subjected in and by discourse. Constructionist theorists have argued that it is through discourse that
regimes of power and knowledge are effectively internalised by the individual; culture thus produces and disciplines the body, and it is through this process that “subjectivity and consciousness arise” (Winter, 2001, p. 176). With regard to lesbians, Ussher (1997) argued that, rather than being polarised, discursive and material elements are “always intertwined in the negotiation of being lesbian” (p. 132).

Constructing the sexual subject

Since it was introduced into discourse in the late nineteenth century, the ways in which sexuality is conceived and constructed has become increasingly complex and multifaceted. The concept has been used in a number of ways to refer to matters relating to sexual expression. Sexuality can be seen to operate along the main axes of attraction, behaviour (or practice), and identity (Laumann et al., 1994). However, it has also been asserted that sexual identity, attraction and behaviour can be varied, complex and inconsistent for women (Peplau & Garnets, 2000). In critical theory Grosz (1994) argued that it is possible to understand sexuality in at least four different ways:

First sexuality can be understood as a drive, an impulse or form of propulsion directing a subject towards an object. … Second sexuality can be understood in terms of a series of practices or behaviours involving bodies, organs and pleasures … Third, sexuality can be understood in terms of an identity. The sex of bodies, now commonly described by the term gender, designates at least two different forms, usually understood by means of the binary opposition of male/female. And fourth, sexuality commonly refers to a set of orientations, positions and desires, which implies that there are particular ways in which the desires, differences, and bodies of subjects can seek their pleasure (p. viii).

Grosz extended Laumann et al.’s (1994) construction of sexuality by introducing the concepts of gender and desire, and she also alluded to the complexity and ambiguity of identity. Heath (1982) drew attention to the difference between the everyday lived experience of the sexual, and the ways in which it has been discursively constructed by science and medicine:

‘Sexuality’ is the term of our conception and systemisation, specific and historical, how we represent the sexual – sex – as an entity, with sexology its study. Sexuality, human experience of the sexual, is as old as language, as old as human being; ‘sexuality’ particular construction of that experience goes back little
more than 100 years. One of the difficulties we face is the slide under the same word between the two references: we need the word sexuality in the first sense but we cannot say or write it today without bringing with it the assumptions, the representations, of the second (p. 11).

The complexity of the ways in which sexuality is understood, implied and practised has consequences for how the constitution of sexual subjects is understood, and for how individuals come to understand their sexual feelings as acceptable or unacceptable. Halperin (1995) argued that Foucault conceived sexuality as:

\[ \text{\ldots part of an apparatus or device (dispositif) that serves to connect new forms of power and new domains. It can therefore be described as a great surface network in which the stimulation of bodies, the intensification of pleasures, the incitement to discourse, the formation of special knowledges, and the strengthening of controls and resistances, are linked to one another, in accordance with a few major strategies of knowledge and power (Halperin, 1995, pp. 40–41).} \]

This view of sexuality as a discursive apparatus makes it possible to see subjectivity as a set of mobile potentialities and capacities. The complexity and flexibility of the processes involved in shaping the sexual subject were apparent in the stories of a number of the participants in this study.

Foucault (1988) posited that technologies of domination act on the body in two ways, externally via dividing practices and internally via practices of the self. Dividing practices work through the operation of expert and authoritative knowledge, which objectifies and classifies the individual on the basis of difference, by separating her from the group and also separating her within herself. Practices (or technologies) of the self are operated by individuals, who possess agency to exercise strategies of power to manage and shape their constitution as subjects (Foucault et al., 1988). The individual also has the capacity to recognise the range of possible subject positions available through resistance, which may result in internally conflicting or fragmenting positions (Olssen, 1999). Thus subjectification is an active process within the individual, and constitutes a relationship between the subject and her world.

Subjectivity is also relational, and connected to knowledge/power, or as Foucault (1984c) described it, games of truth. While the formation of subjectivity is an ongoing process, it is not something that the individual invents, but is connected to patterns found in the
culture, society or social settings. Subjectivity is part of a scheme of relationships of power that are changeable, reversible, unstable and capable of modification, and is therefore not given once and for all (Foucault et al., 1988).

**Dividing Practices and the Sexual Subject**

In discussing the ways in which individuals are made subjects, Foucault (1982) identified three modes of objectification, which he argued transform them into subjects.

The first is the modes of inquiry which try to give themselves the status of sciences … the objectivising of the productive subject, the subject who labours, in the analysis of wealth and of economics. In the second part of my work I have studied the objectivising of the subject in what I call ‘dividing practices’. The subject is either divided inside himself [sic] or divided from others. This process objectifies him [sic]. Examples are the mad and the sane, the sick and the healthy… (Foucault, 1982, p. 777–8).

The third mode identified by Foucault is “the way a human being a human being turns himself [sic] into a subject” (Foucault, 1982, p.778). He chose the domain of sexuality and its historical manifestations as a site for this analysis – how individuals learn to recognise themselves as subjects of sexuality.

Three aspects of dividing practices emerged in the analysis of data from this project: the implications of transgressing gender norms, the internalised processes of embodied knowledge and the more public experiences of exclusion and bullying. Next, I discuss dividing practices under the headings Intelligible Genders, Embodied Knowledge and Exclusion.

**Intelligible Genders**

Stereotypes, assumptions and representations of lesbians transgressing gender norms can operate to shape the lesbian sexual subject by delimiting acceptable feminine appearance and behaviour. Norms for appearance and behaviour shift over time. For example, while today women wearing trousers is considered beyond comment, it was not long ago that only men could wear pants, and women who did not comply with these norms were seen to be either cross-dressing or sexually deviant. Either way they transgressed gender norms for women. Regardless of the time, the limits of acceptable expressions of sexuality appear to be inextricably linked with the limits of normalised femininity and gender roles, and the threat of transgressing these norms also functions to regulate homoerotic
attraction and desire. In relation to this Butler (1990) introduced the concept of ‘intelligible genders’:

‘Intelligible’ genders are those, which in some sense institute and maintain relations of coherence and continuity among sex, gender, sexual practice and desire … certain kinds of ‘identities’ cannot ‘exist’ – that is, those in which gender does not follow sex and those whose practices of desire do not ‘follow’ from either sex or gender (p. 17).

Butler also argued that subjects who transgress the limits of normative gender are constructed through exclusion, because they fail to conform to unspoken normative requirements. These unspoken normative requirements can be seen as hegemonic, in that they constitute a common, meaningful material framework within the social order (Binford, 1998). Understanding unspoken rules about gender transgressive behaviour was addressed by several participants who, during interviews, identified experiences that had at some stage influenced the way they saw themselves as sexual subjects.

As discussed in Chapter Two, the stereotype of the mannish lesbian has a long history of functioning to delimit the boundaries of acceptable gender and sexual expression for women. Colleen (64) and Jenny (32), while being a generation apart in age, both identified this stereotype as having an impact on them as sexual beings. Colleen’s mother’s disapproval of women who transgressed gender norms played a key role in Colleen’s perception of her own sexuality. In the field constituted by her family, Colleen’s mother was vocal in her disapproval of women wearing what she saw as ‘masculine’ clothes. I asked Colleen in the interview if there was ever a time in her life when she had discussed sexual orientation with her mother, to which she replied:

Oh, no, no, she didn’t approve because, you know, we used to go and watch the tennis and I wanted Navratilova’s autograph on the book which I’ve got in there. I did get it, but [mother] said to me, oh, you’re not going after that man, are you? So I said, oh, mum, you just don’t like sport, and she didn’t, you know. That’s all she said about it. She didn’t approve of her. She thought that was sort of too mannish. In fact, looking back … we were on the station one day … and a lady came on in slacks and mum said, tut-tut-tut, isn’t that terrible. I can hear her now saying that. She didn’t approve of slacks … mum thought that was wrong, you know. She never wore anything like that, she never wore shorts. She always had
a skirt and blouse or a dress, yeah. Never, you know, if I’d go to, you know, put anything on like that she’d go, tut, she’d just shake her head, you know.

Colleen’s mother made it clear that she disapproved of women wearing pants, and the presence of Navratilova as a high-profile lesbian and a strong muscular woman became a focus for her disapproval. Her disapproval, of what she saw as masculine women, appears to have been connected with a perception of a deviant performance of gender/sexuality. It is not possible to know the force of the original interpellation by Colleen’s mother when she said “you’re not going after that man, are you?”, or indeed, whether she actually used those words. Colleen’s style in relating this was mild. The force of this phrase only became apparent in the text, where it appears to have sexual overtones, and to imply a degree of forcefulness that did not appear to be in keeping with Colleen’s personality. Nonetheless, the reference made by Colleen’s mother to Navratilova as “that man” communicated that ‘lesbian’ was understood in these terms. As a strong competitive woman, and a public lesbian, Navratilova was constituted by Colleen’s mother as not ‘existing’ as a woman (as described by Butler above). Colleen represented her mother as a strong woman, with definite ideas about acceptable gender roles for women. In the way she related her mother’s position, Colleen characterised her disapproval in strong terms. However, she also minimised the force of her mother’s disapproval with more mild comments such as “that’s all she said about it” and ‘she didn’t like sport”. This way of framing her mother’s disapproval may act to excuse, or soften the impact of her mother’s position. As a woman who already recognised herself as sexually different, these comments must have impacted on Colleen’s habitus. She was certainly disposed to position herself as a ‘good daughter’ within the field constituted by her family. She continued to live with her mother until her death, and from the comments she made during the interview, her mother remains a strong force in her life. By remaining silent, positioning herself as a good daughter, and not overtly challenging her mother’s strong opinions about gender and sexuality, Colleen did not risk diminishing her symbolic capital in the family. One possible way of viewing Colleen’s mother’s disapproval of women wearing slacks is as an effect of her generation, in which women did not wear slacks. However, the association between lesbianism and masculinity also affected Jenny (32) who was half Colleen’s age.

As a young woman, Jenny believed that her sexual attraction for other girls would bring her mother’s disapproval. In the following passage it is apparent that Jenny’s habitus had
already been structured to understand the limits of acceptable and unacceptable behaviour in the field of sexuality:

I was nine I think when I had my first sexual experience, and it was with a girl … it was, I felt dirty, and really I was terrified that she was going to tell my parents … I was terrified that um, two things. I was terrified that my mum would be really ashamed of me and I was terrified that she would make it stop.

While there had been ‘masculine women’ in sports prior to Navratilova, for example, Billie Jean King, the height of Martina’s success (and fame) occurred after the liberation movements of the 1970s, and when she was open about her lesbianism. Jenny related how her mother communicated her disapproval, and saw Navratilova as the epitome of the masculine woman.

I started thinking about what being homosexual is … And I could only use the word gay, ‘cause lesbian, that word was just so foreign. Lesbians … the visible ones that I saw would be the ones that my mum would be quite horrified with. [She would say] ‘that Martina Navratilova, she’s really butch [laughter] and she looks like a man’. And so lesbians to me were people who wore steel cap boots and short hair and leather jackets.

What is clear in this quote is that Jenny had access to language and concepts that were not available to Colleen. Although Jenny and Colleen both related this experience in relation to Navratilova’s tennis ascendance, their responses were quite different. Whereas Colleen was disposed to be the good daughter, Jenny drew on a political position that does not appear to have been available to Colleen. However, deviance still became part of her construction of lesbians, despite her disposition to politicise her sexuality. The complexity of the habitus meant that Jenny could laugh about her mother’s calling Martina butch, and at the same time constitute all people who wear masculine clothes (steel cap boots, short hair and leather jackets) as lesbian. This stereotypical image of lesbians as ‘butch’ is an example of what Grosz (1994) described as bodies being social surfaces inscribed with meaning, and capable of being deciphered, interpreted and understood. Nonetheless, despite the multiplicity of gay/feminist political discourses about lesbians available to Jenny, she constructed the stereotypical image of the ‘mannish’ lesbian, invoking an older

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17 Navratilova was at her peak in women’s tennis between the mid-1980s and mid-1990s. She came out to the media in 1980 as bisexual, and with the public ending of her long-term relationship in 1991, details of her sexuality and relationships were put under the microscope by the US media.
discourse in which, because of their ways of dressing, lesbians were constructed as belonging to an unintelligible gender.

It was apparent that for both of these parents the emergence of Navratilova served as an archetype of the mannish woman (read lesbian). She thus provided an exemplar they did not want their daughters to emulate. However, there is also a difference in the ways that Jenny and Colleen responded to this stereotype. Even though the experiences were contemporaneous, at the age when Jenny was grappling with issues of sexuality in her teenage years, there was more discourse in the public domain about lesbians than there had been when Colleen was a similar age. The influence of culture’s normative boundaries (the collective habitus), was likely to have been somewhat different when Colleen’s individual habitus was being shaped. When Colleen’s mother asserted her disapproval of Martina’s ‘masculinity’, it served to reinforce the discursive control that had already been instituted years before. After the liberation movements of the 1970s, the constitution of the field in relation to sexuality in general, and lesbians in particular, was more complex, and a proliferation of discourses existed that were not readily available in the 1950s. By the 1980s there were cultural influences at play that would have contributed to shaping Jenny’s habitus, which gave her access to discourses and language to help her articulate her feelings.

While there are elements of control and domination in the proliferation of discourses that construct lesbians as deviant, they also have productive elements for the subjects they seek to pathologise. This can be seen in Jenny’s response to the ontological threat posed by her recognition of her sexual attraction and her embodied knowledge about deviant constructions of the lesbian. She was able to resist these discourses and her mother’s disapproval precisely because she did have access to language to define herself. While in the early days of her struggle to come to terms with her sexual orientation Jenny was unable to identify with that label, later this changed:

… over the years I’ve just become much more comfortable with the word lesbian, and have much more ... My experience of the lesbian community has given me – the breadth of diversity in the lesbian community has given me permission to slot myself under that label. Which has been really good and very affirming. But it was quite isolating to start off with.

The prevalence of the discourses that existed in Jenny’s formative years provided her with a framework within which to think and speak about being homosexual, that Colleen
appears to have lacked. Unlike Jenny, Colleen had no language with which she felt comfortable to describe her (sexual) self. When I asked her about whether her friends knew she was a lesbian, she responded:

If they know, they know. If they don’t, it doesn’t worry me. You know, I don’t know what I’d prefer because, you know, it depends on who I’m with at the time, I suppose. … I suppose it’s two lives I lead, but to me I’m thinking, oh, gee, [with] that lot I’ve got to be this and [with] this lot I’ve got to be that.

One way of reading Colleen here might be to assume that by dividing her life into those who know and those who do not know, she created an ongoing tension for herself, whereby she had to constantly monitor her behaviour so that she presented appropriately. However, it can also be seen that Colleen was free from the constraints of identity politics that demand visibility; she had a flexibility in relation to identity, that allowed her to move between social groups without locking herself into a particular category, with associated exclusions and limitations.

In Jenny and Colleen’s stories, older discourses about lesbians transgressing gender boundaries are apparent. Their mothers’ use of these discourses sets limits on ‘normal’ gender and sexuality for their daughters. In this way, they act to regulate their daughters sexuality from their own embodied understanding about normality and transgression. In this way, they used dividing practices, not from conscious understanding, but from their own embodied understanding about the ‘rules of the game;’ knowing that if their daughters did transgress, they would be separated from the group.

**Embodied Knowledge**

Dividing practices can be operationalised by the family, social group or culture, and internalised by the individual who is subject to these practices, as a result of recognising difference within herself. The subject who comes to understand that her innermost sexual feelings and desires are constituted as deviant by those around her can experience exclusion, shame and fear, and in an attempt to fit in and belong, can go through various stages of hiding, or not acting on her desires. Research with young same-sex-attracted women has demonstrated that many who recognise their desires as homoerotic engage in heterosexual relationships in an attempt to fit in and avoid the disapproval and rejection associated with homosexuality (Hillier et al., 2005). Although sexual subjectivity is shaped by many influences over time, a number of the participants in this project alluded
to early knowledge that their sexual feelings were unacceptable. A range of dividing practices can be seen to act on the individual, separating her on the basis of difference and shaping her habitus. This can create a kind of ontological crisis for some, however, because the habitus is flexible and amenable to change, the outcome is by no means pre-determined. To illustrate some of the ways in which dividing practices act on the individual, I turn to stories of some of the women I interviewed.

Colleen (63) said that she had felt attracted to other girls’ from when she was very young, but that she was always under scrutiny to ensure that sexual contact of any kind was precluded. An only child raised in a strict Catholic family in the 1940s and 1950s, Colleen was sent to an all-girls school, where the nuns effectively policed sexuality by ensuring that the girls were never left in situations where they might transgress, by having contact that could become sexual with boys or with each other. She said:

You’re brought up with girls as girls, yeah, but we weren’t allowed to go round two together. Always had to be more than two together and we never understood why, you see. Till you grow up you don’t realise that, but they did, yes, yes, you know, girls, two of you together. No. The nuns watched that very carefully. Even to go down the street. Oh, if you went down the street to get anything there always had to be two, never one. There was always two then, but never two to hang around together. There was always three or four or five of us, you know, little groups. Yeah.

Colleen made it clear that she always knew that it was women to whom she was attracted. She was shy about discussing her sexual history, but said she had never married. I asked if she had ever had a relationship with a man, to which she replied:

No, not really, no. Never been, couldn’t be bothered, you know, yeah. I was sort of always home under the watchful eye of mum and dad who watched me like a hawk all the time, yeah.

Colleen went out with a woman (Betty) for five years, from 1968 to 1973. In the interview she was not clear about whether this relationship was sexual; the friendship survived for 30 years, until Betty’s death. They remained close, and in Betty’s will, Colleen was named as her next of kin, even though she had living family members. After Betty’s death, Colleen was executor of her will. In discussing who knew she is a lesbian,
Colleen mentioned that she also has a cousin who is lesbian. I asked how she had found out about this:

I did go to … the Midsumma [gay and lesbian festival], I was standing looking at the boot-scooting, a girl came and stood beside me and it was my cousin. … she said, what are you doing here? I said the same as you. She’s a solicitor, and so, yeah, she was there with her partner. But I’d heard about her in the family because I heard mum talking to her mother and saying, oh, she ran off with another woman. My mother never told me that. I just sort of overheard her say, you know, yeah.

It was only when she was in her late fifties, after the death of her mother, that Colleen started associating openly with other lesbians and identified herself as a lesbian. Since then she has been an active member of a lesbian social group. The covert, yet strict regulation of sexuality in all its forms that she experienced as a child, as well as her understanding about the limits of normalised gender performance described above, was internalised by Colleen, who appears to have constituted herself as asexual rather than be excluded from the family. After she was relieved of family obligations, by the death of her parents, Colleen was able to start openly associating with other lesbians, although only in a social group, not in a relationship.

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Shona’s story was different, although she also experienced early foreclosure concerning lesbianism. Shona (35), did not come out to her family until she started her first serious lesbian relationship at age twenty-five, even though she had been ‘exploring her sexuality’ since her first year of university seven years earlier. Her first recollection of homophobic foreclosures, were in the form of comments made in her hearing, by her father:

I had heard [my father] make a lot of homophobic comments as I was growing up and I just couldn’t deal with telling him …

Shona heard her father’s homophobic comments as containing an implicit message, that if she was like the people he vilified, he might hate her, or stop loving her. This foreclosed the possibility of her speaking about her feelings with her family as she struggled to come to terms with her identity. When she went to university, she sought counselling:
When I was first thinking about my sexuality I did see a, um, psychiatrist for a while. It was in the context of sort of broader depression really and, and probably associated I think in part with the stress of university. But I, clearly I was sort of concerned about sexuality, but when I brought that up, she was kind of very dismissive [and said] “oh, no, I’m sure that you’re not a lesbian”.

The psychiatrist’s dismissal of the possibility of her being lesbian constituted another foreclosure, and in counselling the issue of her depression was never explored in the context of her sexuality. In doing this, the psychiatrist placed lesbianism outside the domain of speakability, and rendered it deviant and pathological. Shona internalised these seemingly minor incidents, and it was not until she was in her first serious relationship that she was able to broach the matter of sexuality with her parents. Both her father’s homophobic comments and the psychiatrist’s dismissal can be seen as dividing practices, separating her on the basis of her difference. I asked her about how she came out:

To other people. Um, well I, I was sort of – ah, yeah, I – I was really trying to decide if I was or if I wasn’t and I sort of thought well until I’ve actually had sex with a woman, how could I even know? So I sort of went and tried to find someone [laughs] to have sex with. Which is a pretty funny thing to do in a way. So I guess that was how I came out, was just sort of go to um, ah, I went to [a women’s collective at university] … which was known to, you know, have quite a few lesbians and sort of went to that and made some friends and kind of came out to them, so. And that wasn’t too hard because it was a sort of a safe space um, so that – and that was – and that was sort of an exploration for me I guess, and it wasn’t exactly um, well it didn’t really resolve things [laughs] but um, so and then I didn’t come out to anyone ah, from my sort of previous life really for another couple of years, I guess. I – ‘cause then I also went – I took some time off uni and went overseas and then I was able to sort of explore my sexuality away from family and my historical friends. Um, and then really when I came back from overseas which was – I would’ve been about twenty-three probably, I sort of told my friends and then it really wasn’t until I was about twenty-five, yeah, twenty-five and actually started my first serious relationship that I told my parents.

Shona, unlike Colleen who avoided her sexuality altogether until after the death of her parents, spent time working through her sexuality with the safety of distance, thereby
avoiding the potential rejection she feared. She was disposed to find supports and explore her sexuality away from the dividing practices that had confused and confounded her.

It is interesting to note that Shona’s coming-out did not lead to the kind of homophobia she had feared from her family:

… having been kind of very homophobic, [my Dad would] be now sort of like ‘well I just don’t understand why they won’t let you marry’, [laughs]. And so – ah, and I have them, you know, writing letters to politicians around gay law reform and stuff so that all – it was much more positive than I expected …

In the field constituted by Shona’s family, the familial bonds appear to have been stronger than the homophobia that had such a powerful influence on her before she came out to them. Viewed through the lens offered by Bourdieu, the symbolic capital of family connection overrode homophobic attitudes. By waiting to come out until she had fulfilled the heteronormative expectations of the family, by having a partner (and subsequently a child with that partner), even though her partner is a woman, she was able to establish her capital within the field and gain family acceptance.

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Deb (39) is from a working-class rural family and is a survivor of childhood sexual abuse. Her mother died when she was seven, and she was raised by her older siblings and a largely absent alcoholic father. She related how in her childhood the object of her desire was always other girls:

… that sexual experimentation stuff, for me, um, it was always girls that I was sexually interested in and I say that, you know, I was sexualised at a very young age um, and there was another little girl up the street that I went through primary school with and … we had pretty constant sexual contact with one another …

Deb’s reference to being “sexualised at a very young age” was about being sexually abused.

… as I said, the abuse for me started at six months old, um, with my step-father and my brother together, my eldest brother together.

When she went to secondary school, a Presentation convent, Deb formed a close friendship with another girl:
… I developed the biggest crush on this girl. I still feel really fondly towards her, but it was an all girl secondary school. It was [a Catholic girls’] college and we were called Presto less [laughs] and so the negative connotations of what it would mean to have emotional or sexual feelings towards a girl were just not worth it …

Because she was sexualised at an early age, Deb did not immediately question her feelings for other girls, but the teasing she experienced at school about her friendship with this girl, and being called a ‘les’ made her question the normality of her sexual attraction for other girls. Her self-doubt was compounded by the attitudes of her family towards women’s sexuality:

Oh, my family. Um, my two brothers-in-law, always had this standard joke um, about um, my family ‘Oh those, those randy [family name deleted] girls’. And they would talk about their wives in those terms you know. And as I got older, … [I learned that] female sexuality was for the purpose of men’s pleasure and men were in charge and women had to be available.

Thus, even though she felt attracted to other girls, the message in her family was that women were to be available for men, and that the demands of men were superior to the desires of women. Deb reacted to being branded a lesbian in public and having (and acting on) feelings of sexual attraction for girls, by becoming sexually active with boys

I was, by the, you know, the end of Form Two [around age fourteen years], I was already [largely seen as] the town bike and I found out later, me among every other girl … I thought it was just me. Oh, yeah, that was, that was what I understood about myself … I had a lot of shame about sexual feelings, which is not surprising um, no sexual boundaries and very much this perception of myself as a whore you know, which I wasn’t.

When pressed to elaborate on her comment about being the “town bike”, it emerged that Deb had never had intercourse with any of these boys. She reflected retrospectively that for her the behaviour was:

… how little can I get away with [doing]. Like how much, what do I have to do to make you love me and how little can I get away with um doing.

I asked her whether she saw herself as the “town bike” or if it came from others, to which she replied, “that was what I understood about myself”. I then asked where she thought
that came from. Deb indicated that it came from her family and their attitudes towards women’s sexuality. Her sexual behaviour was coherent with her family’s attitude towards women’s sexuality being for the purpose of men’s pleasure. I asked her, when did you know sexual contact between women was not acceptable?

I’ve asked myself. When did I know that it wasn’t okay to be a lesbian um [pause seven seconds] [sighs] I think [pause two seconds] I felt, I feel like I didn’t learn it in a cognisant sense, but I absorbed it through my skin, um, not that it wasn’t okay to be a lesbian, but that female sexuality was for the purpose of men’s pleasure and men were in charge and women had to be available …

In this passage Deb’s pauses were long and reflexive. Her sexuality was constructed through a number of violent foreclosures, both discursive and material. Her experience of sexual abuse, her sexual experimentation with other girls, being bullied at school for having a close friendship with another girl in her teens, her family’s attitudes towards women and sexuality and the way she enacted this by being sexually available to boys, all pathologised her as a sexual subject. Her consequent shame about her sexual feelings led to her denying her feelings for other women for many years, during which time she was unhappily married to a man, and had a child. Deb was the first person in her family to finish high school, and she valued her education. At age thirty she went to university, and a chance event there constituted a discursive break for her:

I had a university tutor and we all used to have coffee, you know [he was a] very bohemian sort of man. And in the caff one day and he said ‘well I go both ways’ and for me if a guy could accept themselves as being bisexual, I though ‘oh my God, he’s not ashamed, he doesn’t hate it’. And I grabbed that term within a framework of recovering from sexual assault. [I thought] I’m allowed to explore this because I’m going through this recovery process.

Being exposed inadvertently to a subversive discourse about sexuality from someone she saw as having power (as a man) and authority (as her tutor) gave Deb permission to shift her perception about her own sexual feelings away from being deviant and unacceptable to being something she could explore. This is an example of how a seemingly minor experience can lead to changes in the embodied habitus. Her tutor’s statement that he ‘goes both ways’ sexually, allowed her to start a process that would allow her to come to see her own sexual feelings as acceptable:
It was like I could breathe, I had this voice in my head that said ‘okay, now you be who you are’. And I rang up Gay line and my fear was still that my sexuality was some monstrous thing, and I use that in an academic sense, I had this monstrous sexuality that would devour other women and, and was wrong …

Comments such as “I could breathe”, “I heard a voice in my head” and “now be who you are” are linked to the permission she found in her tutor’s comment. During the interview, it became clear that Deb was not only telling her own story, but that she was narrating it in academic terms. This can be seen in her translation of her story (possibly retrospectively) into academic discourse, when she refers to having a “monstrous sexuality” capable of “devouring other women”. However, echoes of ancient discourses are also apparent, early Christians constituted female homoeroticism, as “monstrous and unnatural” (Brooten, 1996, p. 191).

Deb’s chance encounter with the tutor’s subversive discourse set in motion a series of changes that enabled her to act on her sexual feelings for women after years of repressing them. It is apparent that she created a discourse to give order and understanding to her experience – yet echoes of the discourse that produces homosexuality as deviant remain. Her statement that she heard a voice telling her to “now be who you are” suggests that Deb constituted the changes engendered by her tutor’s comments as enabling the emergence of her true, or essential, identity.

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While some may experience violence and exclusion, dividing practices also play out in more subtle ways, that act both internally and externally to shape the sexual subject. Unlike the foregoing examples, in which the women felt objectified and separated on the basis of their difference, other women in the study had no recollection of overt experiences, but “just knew” that their sexual attraction to women was wrong. For these women there was no specific experience that they could recall, but their embodied knowledge still had the power of external dividing practices to separate them on the basis of their difference. As a child, Sandy (52) recalled having erotic dreams about a woman that evoked feelings of shame:

18 In her 1993 book, The Monstrous-Feminine: Film, Feminism, Psychoanalysis, Barbara Creed refers to the portrayal of women’s sexuality, in popular culture, particularly in relation to reproduction, as ‘monstrous’.
I had dreams when I was about fourteen and I was, you know, dreaming about a woman in the Sunday-school group [laughs]. I didn’t talk about it with anybody but I felt really, you know, like ‘oh my God, that shouldn’t have happened’. Like I shouldn’t be dreaming like that [laughs] … I knew there was definitely something not acceptable about that… Just ah, you know, it really sort of frightened me…

Sandy’s first sexual relationships were heterosexual, but she came out as a lesbian in her early twenties, when she was at university. Although she said she was comfortable about coming out, there was also an associated sense of loss:

No [laughs] I was comfortable about myself, I was really not comfortable about how people saw me. I mean it was really hard to tell people. Ah, mostly because of the reactions I got. It [laughs] ’cause I’d always been a bit political and, you know, some people, well, like my best friend said ‘oh, you’re gonna look at me like men look at me now’ [laughter]. You know, as a sex object um, and you know, I knew that I’d disappointed a lot of friends. You know, because there were lots of couples and I wasn’t fitting in there any more …

Foucault’s (1982) argument that individuals are subjectified by dividing practices that categorise and impose a ‘law of truth’ that must be recognised by the individual and others, has relevance for Sandy’s story. The ways in which control is inscribed on the surface of the body and incorporated into the self can operate at an anonymous and invisible level, as it did for Sandy. Furthermore, once she came out, Sandy felt herself divided from her friends because of her difference. Her habitus disposed her to feel uncomfortable about sexuality, while her political position was that lesbianism was acceptable, and this created a conflict within Sandy. Furthermore, her social field was constituted by mostly heterosexual couples, and by placing herself outside this normative space, her symbolic capital was diminished. The response of her friends to her coming-out can be seen as a kind of symbolic violence. Not only did her friends reject her and treat her with suspicion because she was a lesbian, her best friend placed her outside the domain of intelligible genders, by suggesting that she would start to act like a man and be sexually aggressive towards her women friends.

Each of the women whose stories are analysed in this section ‘just knew’ that her desire or behaviour was not normal. This kind of regulation was not understood as being imposed externally, but the power of the dividing practices (authoritative knowledge which objectifies and classifies individuals on the basis of difference) that regulate
sexuality was completely accessible to them, even at a young age. In this case, they felt separated from the group by these feelings, because they had an embodied understanding about the consequences of difference.

**Exclusion and Bullying**

Being out or passing are both options for sexual minorities, unlike some other minorities such as people of colour; unless they choose to be visible, lesbians can go unrecognised. Recognition was addressed by Butler (1997) when she raised the issue of “survivable subjects”:

> One ‘exists’ not only by virtue of being recognised, but, in a prior sense by being recognisable. The terms that facilitate recognition are themselves conventional, often through exclusion and violence, the linguistic conditions of survivable subjects (p. 5).

Exclusion and bullying are commonly practised as technologies of domination to regulate and control the limits of acceptable sexual expression, and this commonly happens at school (see, for example, Hillier et al., 2005).

Lesley (47) discussed how witnessing others being victimised through homophobic bullying at school acted as a foreclosure in relation to her sexuality. She described herself as being aware of “quite strong attractions” to a girl at her school whom she “kept thinking about for a long time”. Although she had feelings of same-sex attraction while she was at school, she did not act on them until much later. I asked her, “was there a point when you started to think that being a lesbian might not be seen as normal, or might be seen as different in some way that was negative?” She replied:

> Oh, yeah. I mean I think I probably would have come out a lot earlier if this hadn’t happened. I can remember at school, and it’s one of those things that I feel really shameful about. There were these two girls and everybody talked about them, being in a relationship … they were labelled and they were sort of slightly ostracised, and in order to sort of be part of the bigger group I participated in that.

While Lesley minimised the isolation of the girls from the group (they were “slightly ostracised”) she also expressed shame about her part in the exclusion of these girls. The way in which Lesley’s peer group labelled the two girls (who may or may not have been in a lesbian relationship) also operated indirectly to inform Lesley about what could
happen if she broke the unspoken rules about the limits of acceptable intimacy between girls. The girls who transgressed were regulated by exclusion and name-calling. This also acted to constrain others who might transgress. Lesley’s peer group gave violent voice to the dominant discourse that constitutes homosexuality as deviant, and made clear the potential consequences of transgressing heteronormative sexuality. Thus, she says, she would have come out a lot earlier if it had not been for witnessing and participating in ostracising the other girls on the basis of their perceived difference. The violence of the exclusion of the girls did not need to be explicitly identified as homophobic, the inference of the transgression was sufficient to get the message across to Lesley, who already saw herself as experiencing sexual feelings that were outside the norm.

Unlike Lesley, who participated in bullying, Candace (28) directly experienced bullying at school because of her sexuality. At fifteen she and a girlfriend fell passionately in love. Candace was a naïve fifteen-year-old who had never heard of lesbianism and acted only on her desire:

I was at school and it was my best friend actually and she said, Have you ever had lesbian tendencies? and I didn’t even know what a lesbian was. I’m like, and this was at 15, I was very sheltered. I said, oh, what’s a lesbian? and she said, oh, well, you know, it’s a woman who loves a woman, and I’m like, oh, yes, I love women all the time, you know, not realising. And then a few nights later it was like, oh, this is what a lesbian must be.

She and her girlfriend went to the same school and because they were openly affectionate, others quickly found out they were a couple. I asked her about the bullying:

That was shocking. Shocking. Because I was with my partner and we both went to school together, and it was very, it was a very, very intense relationship, very, you know. I suppose passionate would be the word. And I think what happened was, it caught on. … I think [first] it was name-calling and then they found a letter … but in that sense we were also discriminated against by the school. What else? So yes, so that got around the school and the teachers – and that was fabulous – and yes, just the usual name calling, I guess. We were never like, bullied in a violent way or, you know, anything like that, thank goodness, but verbally is pretty bad anyway especially over three years. It can get to you after a while, yes, so I came away feeling pretty crappy about myself and left school, you know.
Candace’s reference to the teachers being “fabulous” was sarcastic, perhaps facetious. She felt unsupported by the teachers and she and her girlfriend were interviewed about the content of their letters by the principal. The bullying was not limited to the couple. Candace’s younger brothers attended the same school, and they were also teased and bullied about having a lesbian sister.

Being violently recognised and publicly humiliated by her peers because of her difference had an effect on her emotional health and Candace described being depressed because of the bullying, to the extent of planning her suicide. This extension of the bullying to her brothers also performed a regulatory function; not only was she excluded from her peers, but the exclusion was extended into her family life as well as in her school life. Thus two fields in which Candace constantly operated, her school and family, became battlegrounds in which her symbolic capital was diminished. At one point the loss of capital caused Candace to be depressed and suicidal, which can be seen as a way of escaping an intolerable loss of capital. It is interesting that this storm only took in Candace and her brothers, and her parents appear to have been unaware of the problem. In the interview, Candace said that her parents, who were immigrants, worked long hours and that she and her brothers were expected to take care of themselves. She finally came out to her mother at age eighteen, when she told her she was bisexual, presumably because this would be less traumatic than saying she was a lesbian. Her mother’s response was to have “a pink fit”, however, her father’s response was quite different:

… my father just said, Oh, well, whatever makes you happy, and my mother was, Oh, my god, who made you this way, oh? Was it so and so or was it so and so?

While Candace does not preclude the possibility of falling in love with a man in the future, she now identifies as a lesbian, though she says she hates labels. Her family have been supportive about her lesbianism. At the time of interview, Candace was the single mother of a two-year-old son, conceived by self-insemination, and her parents have supported her and welcomed her son into their family without question.

As the sexual subject is shaped by external and internal foreclosures, sexual feelings and behaviour are regulated and controlled both internally and externally in a variety of ways that become embodied in the habitus. The reflexive subject constructs her habitus, which engenders patterns of behaviour that are versatile and flexible, depending on the vulnerability or resilience of the individual. This is mediated by the structure of the social fields she inhabits, and by the available constraints, demands and opportunities. A range
of dividing practices have acted both discursively and bodily on the women whose stories have been told above to shape them as reflexive sexual subjects. These early experiences of shaping sexual subjectivity can be seen to be significant for women when they think about coming out or disclosing their sexuality to others.

For lesbians, visibility and invisibility are the products of speaking out or silence about sexual orientation. Individuals who constitute themselves as different experience a number of foreclosures that delimit the boundaries of what is acceptable and ‘speakable’ in relation to sexuality, which contributes to their constitution as sexual subjects. These foreclosures happen emotionally, through homophobic or sexist discourses, and physically, through actions such as bullying and exclusion. Speaking about sexual orientation can constitute a political act (coming out) or the disclosure of a secret. For most lesbians speaking and silence are employed contextually depending on the circumstances and how they are disposed to act in any given situation. Despite the technologies of domination that have operated to shape them as sexual subjects, Colleen, Jenny, Shona, Sandy and Deb have all successfully negotiated ‘being’ lesbian on their own terms. Lesley and Candace not only survived bullying, but have gone on to thrive as lesbians. These women have negotiated their sexuality, both as they have recognised their feelings of sexual attraction, and as they have negotiated being lesbian in their social worlds. It is of note that the resulting way of being for each of these women is quite different. In this they can be seen as reflexive subjects in Foucault’s (1982) terms, and also as being agents in Bourdieu’s (1990) terms. They have used power productively and demonstrated a range of responses, reactions and results; in doing this they are agents who act to shape their own social worlds.

Reflecting on theories about the construction of sexuality and dividing practices, and the fragments that emerged from the interviews about the constructions of sexual subjectivity, it is apparent that dividing practices are not always intentionally enacted upon individuals. Subjects are regulated and controlled both discursively and physically, however, it can be argued that discursive regulation is more insidious and therefore more difficult to resist than physical regulation. The examples provided by women like Colleen, Shona and Lesley of parents and peers enacting homophobic or sexist foreclosures, grew out of the habitus and dispositions of the perpetrator, which were shaped by earlier technologies of power. These exert a powerful influence on how decisions are made about passing/being out, and are particularly relevant when attempting to understand in/visibility in clinical spaces.
Invisibility or Silence?

While the dominant discourse in lesbian health literature is about lesbian invisibility, the women’s narratives about dividing practices led me to reconceptualise in/visibility as speaking and silence. This allowed me to understand the agency women used in deciding whether to come-out or pass as heterosexual. In/visibility is usually produced discursively in binary terms; an individual is either ‘out’ (achieved by disclosure) or ‘in the closet’ (remains unidentified by passing as heterosexual). Griggers (1992) argued, in the context of discussing the ubiquitous nature of the appearance of lesbians in popular culture in the late twentieth century, that ‘lesbians are inside and outside, minority and majority at the same time’ (Griggers, 1992, ¶13). Griggers’ statement aptly describes the dilemmas faced by many lesbians in relation to identification. The complexity of speaking and silence as processes was addressed by Foucault when he argued that:

There is no binary division between what one says and what one does not say; we must try to determine the different ways of not saying such things, how those who can and cannot speak of them are distributed, which type of discourse is authorised, or which form of discretion is required in either case. There is not one but many silences, and they are an integral part of the strategies that underlie and permeate discourses (1978, p. 27).

Visibility is primarily achieved for the lesbian by speech acts, in the form of coming out or disclosure. There is an important difference between each of these speech acts; the former can be seen to represent a political act, while the latter has implications of secrecy. In lesbian health discourse, naming one’s sexual orientation is usually conceived as disclosure. The implication of disclosure in this context is that sexual orientation is a secret that needs to be brought into the open. According to (Horsley, 2003):

The (in)visibility of lesbians in society in general and medicine in particular, is inextricably associated with the individual’s act of ‘coming out’ or ‘disclosing’ their sexuality. The more common colloquial term, ‘coming out’, is coloured with the exhilarating messiness, passion and historical power of its political roots. ‘Come out’ … was a rallying cry for Gay Liberation; mass visibility on the streets was constructed as a key weapon for overcoming private shame and challenging hatred and fear. The term disclosure, … preferred in professional settings, embodies the more recent, clinically flavoured description of this act of revelation (p. 19).
Coming out has been described as a process of public self-disclosure of gay identity, or positive acceptance of one’s self as having a gay identity (B. Taylor, 1999), which implies that it is both a private and public process. A number of authors have described models that constitute coming out as a linear process of self-recognition, which follows a number of stages through which the person passes to achieve full acceptance of the self as homosexual (B. Taylor, 1999; Troiden, 1989). Although these models to some extent acknowledge that coming out may not be a neat, sequential process, they tend to deny the day-to-day experience of gay and lesbian people, who are forced by heterosexist assumptions to come out over and over again in a range of different settings (Farnan, 2001). Indeed heterosexism attests to society’s ‘ghosting’ of the lesbian (Castle, 1993), and by constituting her as non-existent, heterosexist assumptions do render her invisible and force her to come out or remain silent about her sexual orientation.

The participants in this study were pragmatic about their positioning in clinical spaces. A number of narratives were apparent about responsibility for health and whether or not to come-out/disclose. These can be seen to depend on a complex range of considerations, at the heart of which are resistance and relationships of power. The extent to which individuals may or may not be able to resist biopower is constrained by a range of factors to do with their embodied habitus, and the limitations and demands of the field. For the individual lesbian, all of these factors are mediated by how she is disposed to respond to the potential consequences of difference, which may be either conscious or pre-reflexive. The phenomenon of heterosexism excluding those who are sexually different has been theorised in social geography:

The process of hetero-sexing space is naturalised through repetitive and regulatory performative acts, of both heterosexual desire and gender identities ... The heterosexualization of space and place regulates “sexual dissidents” who are made visible through deviant gender presentation and/or acting on/out their sexuality (Corteen, 2002, p. 146).

Identity is shaped by recognition or its absence (Butler, 1997; C. Taylor, 1994). The experience of heterosexism, the assumption that everyone is heterosexual, means that the lesbian, who cannot be recognised without naming (or identifying) herself, is repeatedly misrecognised. According to C. Taylor (1994) a person or group of people can “suffer real damage, real distortion, if the people or society around them mirror back to them a confining or demeaning or contemptible picture of themselves” (p. 25).
The potential for ontological harm from misrecognition, or absence of recognition, can constitute a kind of censorship by placing subjects outside the domain of speakability (Butler, 1998). In a conventional view of censorship, power is presumed to be wielded by a subject who speaks and declares that another will not speak, which supposes a juridical understanding of power. However, Butler (1998) argued that censorship is a productive form of power which may work in implicit and inadvertent ways. The operations of power rule out, often in unspoken or indirect ways, what will remain speakable (and therefore unspeakable), therefore no explicit regulation is needed.

Heterosexist assumptions operate to rule out speech in relation to non-normative sexuality. This means that whenever a lesbian comes out or discloses, it is a political act of resistance against a heteronormative system that relegates lesbians to the margins, and deems lesbianism to be unspeakable. Butler proposed that given the usual understanding of censorship as oppressive, the notion of foreclosure may be a more useful term than censorship, to understand how this discursive ruling-out occurs:

To move outside the domain of speakability is to risk one’s status as a subject; to embody the norms that govern speakability in one’s speech is to consummate one’s status as a subject of speech (1998, p. 253).

As discussed in Chapter Two, throughout time lesbians have been produced in discourse as invisible, while simultaneously being represented and regulated in a variety of ways that bring them into the view of those who choose to see them. Because she has an embodied understanding about heteronormative rules, the almost daily dilemma for the individual lesbian, is how to represent herself to others. Questions such as will it be safe and what will be the result if I do come out/disclose can cause considerable stress. As argued by Wendy Brown (1998), when sexual orientation is discussed in professional literature and named in spaces such as the consulting-room, intimate knowledge about the subject is revealed, which has the potential to become a source of regulation. While silence and speech are generally produced as binary opposites, they are both ‘constitutive and modalities’ of each other:

Silence calls for speech, yet speech, because it is always particular, vanquishes other possible speech … Speech harbours silences; silences harbour meaning (W. Brown, 1998, p. 313).
However, as discussed in Chapter Five, power is productive, and the potential for regulation that exists when sexual orientation is named also creates a space in which there is the possibility of resistance. The notion of silence as discursive, multiple and diverse, implies that remaining silent is itself a speech act, and that silence does not simply render the individual who does not speak invisible and powerless. Rather it potentially constitutes both a strategic capacity, and a subversive discourse. Silence can be seen as harbouring the power to resist:

A challenge to the convention of equating speaking with power and silence with powerlessness pertains to the practice of ‘refusing to speak’ as a mode of resistance. Even as silence is a response to domination, it is not enforced from above but deployed from below: refusing to speak is a method of refusing colonisation, of refusing complicity in injurious interpellations or subjection through regulation (W. Brown 1998, p. 324).

Brown hastens to caution not to value this kind of resistance too highly, because it is a defence, and a strategy for negotiating domination, rather than a sign of emancipation from it.

In discourse, lesbians (as invisible subjects) are frequently referred to as marginalised. The notion of marginality was formed in relation to activism and social capacity-building, and was not simply about resistance to dominance (Hurley, in press). It is important when considering concepts about invisibility and marginality as effects of, or resistance to power, to understand that strategies are used in power relations. These can take different forms, but the intention is to reach a goal or gain an advantage (Foucault, 1982). Thus invisibility, silence and marginality can all be strategies of a struggle to gain power.

The lesbian individual’s knowledge about the risks involved in breaking silence can be seen as a form of subjugated knowledge, and as part of a struggle for power (in the form of recognition, fair treatment, acceptance etc.). Perception of risk may be produced by personal experience of homophobia, or be due to exposure to discourse. There is a degree of jeopardy in this strategy, however, and for many lesbians the silence that follows the assumption of heterosexuality (which may be communicated directly via either speech or by the way in which space is heterosexually) forecloses the possibility of later speech, which is required to correct the assumption. But it also constitutes a way of resisting exposure. Once an individual has remained silent about her sexual orientation, there is a
constant potential (and concomitant pressure) of having to speak about, or name it, not only in clinical spaces, but in other aspects of life, which many experience as a burden.

In this Chapter I have identified some of the processes that subjectify individuals as sexual subjects, and influence their ‘sense-for-the-game’, in relation to being disposed to speak out to identify their sexual orientation or practices, or remain silent. It is in these interactions that the ways that deficit discourses about lesbians can be seen to impact on these women’s sexual subjectivity. Just as these dispositions play out in everyday life they are taken into clinical spaces and influence how individuals position themselves. In the next Chapter I will discuss how this plays out in clinical spaces, discuss clinical spaces as sites of power, and the ways in which the women exercised resistance to this power.
Clinical spaces are constructed physically and discursively. Corteen’s (2002) concept of heterosexualised space is apparent in clinical spaces, by the ways in which the posters, leaflets and magazines in waiting areas and in the consulting-rooms only portray normative (heterosexual) images. It is also apparent in the interactions between the parties to the clinical encounter. In this space discursive interactions take place between the individual and a range of health-care workers and ancillary staff, and tests, physical examinations and minor procedures may be carried out. To further understand what shapes these interactions and how they play out, it is necessary to consider some of the factors that have contributed to shaping clinical spaces in general, and the consulting-room in particular, as well as to shaping relationships between the doctor and patient. I introduce this Chapter by tracing the ways in which the field of medicine has developed over time, and how this has contributed to shaping contemporary clinical spaces. I first briefly describe the major shifts that have occurred in the practice of medicine in the past two hundred years, and then discuss some of the ways in which power operates within the space of the medical encounter.

In Chapter Six, I discuss how I reconceptualised in/visibility as speaking and silence, which the women employed as agents, here I focus on the ways in which they employed speaking and silence as forms of resistance. To focus on the strategies participants used, and how they positioned themselves as they negotiated clinical spaces, I introduce the stories of six of the participants in an extended, case study format. In the interviews I asked about their experiences in health care services. Participants took a broad view of this, and their stories in this Chapter reflect this. Therefore, here I use a broad definition of clinical space, as described by Hurley & Pitts (2002) as extending well beyond the consulting-room, into everyday life. This expanded notion of clinical space encompasses the ways in which the patient’s well-informed medical gaze now operates as an ordinary part of everyday life, and the brief medical encounter, that takes place in the consulting-room, is only one element of the clinical spaces in which individuals operate (Hurley & Pitts, 2002). In Chapter Nine, will I narrow the focus to concentrate on experiences in the women’s accounts in the medical consulting room.
Transitions: the development of modern medicine

In the eighteenth century, the practice of medicine (as it is known today) came into being with the introduction of hospitals in Paris (Ackerknecht, 1967). Ackerknecht described the shift, from what has been termed bedside medicine (in which the physician provided a service, to mainly wealthy people, by managing the symptoms of illness in the patient’s home), to the institutionalised practice of medicine in clinical settings, more or less as it is known today. This is known variously as hospital medicine, clinical medicine, Western medicine or allopathic medicine, all of which Foucault (1973) included in the term biomedicine. In allopathic medicine the role of the doctor is to observe the patient’s presenting symptoms, signs and pathology, to identify any underlying disease or lesion, to interpret the findings of these observations to the patient as a diagnosis, and to provide treatment (Armstrong, 1995). It was in the clinic that the individual body was able to be subjected to unprecedented levels of intense observation, (the clinical gaze). This capacity to observe the individual produced a new power relationship between the doctor and patient which, according to Foucault (1973), operated by making the body of the patient visible and known to the doctor.

It was not until early in the twentieth century that another shift occurred in medicine, which involved a different way of viewing illness and health, and moved the focus away from individual patients and their bodies, to the population as a whole (Armstrong, 1995). This approach has been termed surveillance medicine, and with it, new disciplines developed. Thus, the field became increasingly complex and varied, and has come to be known as health care, of which medicine is only one part. New disciplines included professions such as hygiene, public health, and later, health promotion, as well as a wide variety of services ancillary to medicine such as nursing, physiotherapy, radiography and social work. The introduction of hygiene, public health and health promotion has shifted the emphasis of health care away from disease and the individual body, to potential illness and the maintenance of health. Along with this shift away from the individual body and its pathology, the concepts of wellbeing and lifestyle were introduced. Armstrong (1995) posited that to identify the precursors of illness (often represented by the notion of lifestyle), surveillance medicine led to a position whereby the individual and the community began to lose their separateness:

The blurring of the distinction between health and illness meant that healthcare interventions could no longer focus almost exclusively in the body of the patient.
in the hospital bed. Medical surveillance would have to leave the hospital and penetrate into the wider population (Armstrong 1995, p. 398).

In population medicine, the nature of illness was reconstructed so that any clear distinction in the clinical categories of healthy and ill were dissolved, and a new entity known as the risk identity, was constructed. In the early twentieth century the child became the first target of this new technique. Physical and psychological growth were monitored and height and weight charts were introduced to define the normal child:

Child health services were incorporated into a permanent program of the health department and an essential element of the project was universal health education in schools. The shift realised a new public health in which surveillance of the population brings everyone into the benevolent gaze of medicine through the medicalisation of every day life (Armstrong 1995, p. 399).

With the successful mapping of normal established in children, health authorities shifted their attentions to the whole population. In its early days, one of the problems identified with surveillance medicine was that there were persistent pockets of resistance to screening and surveillance in the population. The solution to this resistance was to shift responsibility for surveillance, from the central locus of the State to individuals in the population. Concerns such as diet, exercise, stress and sex became the means of encouraging self-surveillance among individuals, as the population internalised surveillance. Signs and symptoms, which had been the diagnostic tools of bedside medicine, were transformed in surveillance medicine into factors that pointed to, but did not necessarily constitute a potential future illness. Through self-surveillance and vigilance, in the surveillance model of medicine, the individual became cognisant of potential risk and responsible for her or his own health. This brought the entire population, not only patients, into the view of the benevolent gaze of medicine. Thus health became a precarious state in which the patient was inseparable from the person, and health no longer existed in a binary relationship to illness. In this formulation, health and illness belong to a scale in which the healthy can become healthier, and health can coexist with illness, for example a person can have a disease like cancer and still consider her/himself to be healthy (Armstrong, 1995).

In the surveillance formulation of medicine, monitoring and observation of the general community focused on the “gaps between people to establish that everyone was normal yet no-one was truly healthy” (Armstrong 1995, p. 397). This required individuals to
become self-observing actors, monitoring their own bodies and lifestyles for signs of abnormality and deviation from the role of responsible individual, which was defined by “prescriptive texts … whose main object, whatever their form – is to suggest rules of conduct” (Foucault, 1982, p. 790). These rules of conduct are part of “a broader pattern of governance which aims to promote certain socio-political objectives through managing the subjectivity of citizens” (P. Harris, 1997, p. 28).

The citizen-subject emerged in the early modern period when a transition occurred that shifted citizenship, as a practice or activity characterised by an attitude of mind, to being a formal status assigned to a select group of individuals, such as male land-owners. This was influenced by concepts of sovereignty and political obligation (Burchell, 1999). According to the seventeenth-century philosopher Hobbes, the citizen-subject was not, as Aristotle had posited, born “fit for society’ but would be ‘made fit for society not by nature but by education” (Warrender, 1983, noted in Burchell, 1999, p. 510). Burchell argued that Hobbes’ original Latin was translated as “education” but that it should be more accurately translated as “instruction, tuition and teaching” (p. 510), which, he argued, is a much broader concept than education. Thus citizen-subjects were prepared to assume their role in society, so that by the twentieth century the modern citizen-subject increasingly emerged as prepared to act as a responsible citizen, capable of being shaped through instruction. This provided an essential precondition for the transfer of responsibility for surveillance of the population from the State to each responsible citizen-subject who would be capable of acting as an informed consumer, carrying out surveillance on her/himself to achieve the ends desired by the State.

As with any discursive shift, the transition between these different formulations of medicine were never complete. The introduction of surveillance medicine has not replaced the practice of clinical medicine, and each formulation continues to operate in tandem with the other, albeit with different aims: one to promote health, the other to cure illness. I argue that these two formulations of health are co-articulated within clinical spaces, but that the role of the individual in each formulation is different; in allopathic medicine the individual is produced as a patient, in surveillance medicine as a consumer. In contemporary clinical relationships, these two roles have become blurred, so that the distinction between them is unclear to both the practitioner and the patient. In the context of the medical encounter, the patient is defined as someone who is being given medical treatment or one who is acted upon. A search of Roget’s Thesaurus reveals synonyms for patient (the noun) include sufferer, case, invalid, crott, weakling. A consumer is defined
by the *Compact Oxford Dictionary* as someone who buys a product or service for personal use, and synonyms include customer, patron, shopper, buyer, user and purchaser. The implications of each of these terms position the individual presenting to the doctor very differently, but fundamentally, the patient is constituted as passive and the consumer as active.

The origins of the use of the terms patient and consumer in contemporary medical and health discourses may stem from the different ways in which health-care provision has developed in the USA, with its system that emphasises market forces and the rights of the individual, and in countries like the UK, Canada and Australia, which have had more social democratic traditions. It should be noted, however, that the US system can be seen to be increasingly influencing the administration of the Australian health-care system. In the last third of the twentieth century in the USA, the delivery of health-care developed essentially in the private sector, providing managed care to individuals covered by insurance (Tufts Managed Care Institute, 2004). In countries like the UK, Canada and Australia, medicine has been funded largely by the public purse, which has resulted in a system (to a greater or lesser degree) of public health, in which universal care is (theoretically) available to all regardless of ability to pay. Under the US system individuals are constituted as consumers of services delivered by doctors who are constituted as health-care providers, who are often employees of large profit-making companies. Under the social democratic systems, doctors who are usually paid in part from the public purse have been constituted as healers dispensing clinical treatment to patients. Regardless of economic and political pressures and the ongoing transformation of these systems of health-care delivery, the discursively constituted patient has a very different relationship with the doctor from that of the discursively constituted consumer with the service provider.

In Australia the use of terms such as doctor and service-provider have become blurred, and doctor/service provider and patient/consumer, appear to be used interchangeably by all parties to the medical encounter, without regard to the major differences that underpin each construction and the concomitant understandings of each. The lack of clarity concerning whether the individual is seen (or sees herself) as patient or consumer in the space of the consulting-room has implications for the clinical relationship. In Australia the formulation of the assumed consumer and the assumed patient govern the expectations and beliefs of the doctor/service-provider and patient/consumer in the space of the consulting-room in very different ways (Race, McInnes, Wakeford, McMurchie &
A 1997 report by the Royal Pharmaceutical Society of Great Britain identified two distinct formulations of the clinic to illustrate the embedded nature of discourses that shape these practices. In the first formulation, identified as a “traditional problem/solution model of the clinic”:

The patient presents with a significant clinical problem for which there is a potentially helpful treatment. What the doctor or other health-care professional brings to the situation – scientific evidence and technical expertise – is classed as the solution. What the patient brings – ‘health beliefs’ based on such qualities as culture, personality, family tradition and experience – is classed by clinicians as the impediment to the solution. The only sensible way out of this difficulty would appear to be to bring the patient’s response to the doctor’s diagnosis and proposed treatment, as far as possible into line with what clinical science suggests [italics original] (quoted in Race et al., 2001, p. 8).

In this model the doctor has the knowledge (scientific evidence and technical expertise) and responsibility to bring the patient in line with what clinical science suggests. The role of the patient is more passive: to convey her/his health beliefs and entertain (and ultimately agree with) the doctor’s proposed course of action. The other more liberal model identified by the Royal Pharmaceutical Society of Great Britain (1997) is termed the consumer model:

The medical encounter is concerned with two sets of contrasted but equally cogent health beliefs – that of the patient and that of the doctor. The task of the patient is to convey her or his health beliefs to the doctor; and of the doctor, to enable this to happen. The task of the doctor … is to convey his or her (professionally informed) health beliefs to the patient; and of the patient, to entertain these. The intention is to assist the patient to make as informed choice as possible about the diagnosis and treatment, about benefit and risk and to take full part in the therapeutic alliance (quoted in Race et al., 2001, p. 8).

While in the liberal model there is an assumption that the doctor and consumer are on an equal footing, Race et al. argue that authority is retained by the doctor in both models of the clinic. These formulations of the clinic focus primarily on communications between the doctor/service-provider and patient/consumer.
Power Relations in Clinical Spaces

Foucault (1982) posited that there is more to power relationships than communications (language, signs or other symbolic media) and that “power relations, communications and objective capacities should not be confused” (p. 786). Not that these are distinct domains, rather they always overlap and at the same time “support one another reciprocally and use each other mutually as means to an end” (p. 787). In clinical spaces, these overlapping domains constitute what Foucault described as blocks of capacity-communications-power. When they are operationalised, technical capacities, communications and relationships of power are adjusted to one another, within a structure that produces a discursive formation.

It has been argued that the concept of clinical space extends well beyond the consulting-room. An expanded notion of clinical space encompasses the ways in which the patient’s well-informed medical gaze now operates as an ordinary part of everyday life, and the brief medical encounter, that takes place in the consulting-room, is only one element of the clinical spaces in which individuals operate (Hurley & Pitts, 2002). Clinical spaces are discursive formations, and within this expanded notion of clinical space, Foucault’s theory of capacity-communication-power blocks can be seen to function through the processes of (hetero)normalisation, as well as through surveillance and self-care mechanisms. These blocks are no less apparent in the consulting-room which, depending on the ways in which the private and public spaces are used to regulate the interaction between doctor and patient, can create a space that is hierarchical, with the doctor holding a dominant position, or retaining authority (Race et al., 2001). The activities that take place within the space of the consulting-room include history-taking, in which the doctor enquires about family and sexual information, physical examinations, and minor medical or surgical procedures. Increasingly the consulting-room is also a space in which individuals who are well are expected to present themselves for preventative tests and screening. The consulting-room is also where the results of these activities and personal information are recorded, held and even disposed of as the property of the practitioner or the practice. These activities assert the capacity of the doctor as superior to that of the patient. Communications are regulated in this space. Any woman may be required to reveal her shortcomings, which might include dietary and exercise transgressions as well as having to deal with sexist treatment or assumptions. For the lesbian, there is an added dimension to this interaction. As well as having to reveal her shortcomings in relation to her health, and deal with sexist assumptions, she may also be exposed to assumptions
about her sexual orientation or practices, that can place her in a position of having to
decide whether to come out/disclose, or remain silent. These complex interactions are
features of the way in which the space of the consulting-room is used and governed, and
constitute blocks of capacity-communication-power.

Foucault (1980) asserted that an analysis of power should occur, not at the level of
regulated forms of centralised control, nor at the level of conscious intention, but in real
practice. He defined this as the processes by which bodies are subjected, gestures
governed, and behaviours determined. He asserted that any analysis of power should occur:

… at its extremities, in its ultimate destinations, with those points where power
becomes capillary, that is, in its more regional and local forms and institutions (p. 96).

The consulting-room is the point at which power becomes capillary, the point at which
the individual patient interacts (usually one-on-one) with the doctor, or health-care
worker. In this setting it is possible to see the range of ways in which resistance plays out
for lesbians, not at a systemic level but in the space that forms the basic unit of practice.

Foucault’s (1982) conceptualisation of power emphasised its positive and productive
nature. According to Foucault, at issue in the operations of power is not so much how it
operates, but what happens when power is in play, or exerted by individuals. He described
power as an “assemblage of actions, which follow one form or another’ and power
relations as ‘the ways in which certain actions modify others” (p. 786). Thus, the conduct
of individuals and groups is governed by authorities (or technologies of power). He used
the term govern not to refer directly to the power of the State, but to the ways in which
the possible fields of actions of others are structured. Foucault asserted that to understand
power relations, it is necessary to investigate the various forms of resistance (and attempts
to disassociate from these relations which are both versatile and inevitable). While
doctors can be seen to be in a dominant position within the discursive formation
constituted by the consulting-room, the patient’s subversive knowledges make the two
parties participants in a set of power relations. Although the space is constructed to
operate as a hierarchy, power within this space can be seen to operate from the bottom up,
as well as from the top down. Using Foucault’s construction of power, doctors do not
exclusively exercise power over patients. The parties to the medical encounter can be
seen to collude to reproduce hegemonic medical dominance, but the patient/consumer also has the capacity to resist medical dominance in a variety of ways.

Lupton (1997) discussed two investigations that used a Foucauldian theoretical framework to study doctor/patient interactions from the patient’s perspective. In both studies, the context in which the patient interacted with the doctor was found to be a critical factor in shaping the clinical relationship. Lupton cited factors such as the age, ethnicity and gender of both the patient and the doctor, as well as the presenting condition, as all being significant in structuring the encounter. Other factors included emotional dimensions, the accumulated embodied experiences of the patient (which parallels Bourdieu’s concept of the habitus), and the desires that motivate them (which parallel his concept of dispositions). Another clinical study in Scotland reported that individuals under surveillance:

… responded to the external strategies of medical power … in various ways, including direct rejection and attack on the value and legitimacy of the health workers’ attentions, non-cooperation, silence, escape, avoidance and, most commonly of all, concealment (Bloor & McIntosh, 1990, quoted in Lupton (1997) p. 105).

Similarly Lupton reported that in her Australian study:

… at times [patients] sought to dominate their doctor, to adopt explicitly consumerist positions, sometimes directly expressing hostility and anger. At other times, they were apparently quite happy to give themselves over to the doctor without question. … In the relationship between carer and cared-for, there is a continual tension on the part of the cared-for between wanting and appreciating care and resenting it (Lupton, 1997, p.105).

The responses of individuals to perceived medical dominance described by Lupton and Bloor show the complexity of factors and the variety of responses in play in contesting perceived medical dominance. Many such complexities can be seen to influence the ways in which the participants in this study interacted with their doctors.

The Foucauldian framework for analysing power in clinical relationships, suggested by Lupton and Bloor, can be expanded by drawing on Bourdieu’s theories about the ways in which power circulates in the field. As discussed in Chapter Six, in Western culture a series of foreclosures occur to shape the sexual subject and set limits concerning what is
acceptable and speakable in relation to sexuality. For those who find themselves transgressing these limits, there is an embodied knowledge (as part of the habitus) about the consequences of transgression. As a result, individuals are disposed to respond in various situations based on this embodied knowledge. The objective limits of the field constituted by the consulting-room are socially imposed by a range of factors including the use of space, the role assumed by the doctor and the vulnerability or resilience of the individual presenting to the doctor. These factors are not fixed and can shift from encounter to encounter. In the context of this study, resistance can be seen as the individual lesbian’s struggle to increase her capital within this field.

In lesbian health literature, lesbian identity is usually produced as uni-dimensional. However, for the women in this study, identity was multi-dimensional. For example, identities at play in the consulting-room might include woman, lesbian, mother, partner and lover (to name just a few possibilities). This is further complicated by the intersection of race, cultural and linguistic diversity, class, age and dis/ability with sexual orientation. Positioning within the space of the consulting-room is a discursive process, whereby individuals locate themselves in interactions as observably and subjectively coherent participants with a fluid, dynamic sense of multiple identities. These social identities are discursively constructed in historically specific contexts that are complex, plural and shift over time. Referring to the multiple subjectivities of the lesbian, Griggers (1992) argued:

… Our understanding of lesbian bodies as minority bodies – [is] a definition that locates lesbians within the discourse of identity by their differences from majority bodies of the hetero woman or man. … It’s undeniable that lesbians are also, at the same time and sometimes in the same bodies, lesbians bearing arms, lesbians bearing children, lesbians becoming fashion, becoming commodity subjects, becoming Hollywood and becoming the sex industry (p.10).

The lesbian entering a clinical space brings with her an embodied understanding of social rules such as sexism, heterosexism and homophobia, of the roles implied in the doctor/patient relationship, and of the hierarchical nature of clinical spaces. Because she has an active and creative relationship with her world, albeit sometimes at a pre-reflexive level, she responds in ways that are reasonable, given her embodied knowledge and experience, but not necessarily thought-out consciously. The ways in which lesbians resist this power and employ both pre-reflexive and reflexive strategies based on their habitus are influenced by these multiple, fluid subjectivities.
Perceptions of In/visibility

As the research questions for this project grew out of discourses about lesbians being invisible in the health system, in the interviews I explored the women’s reactions to the idea that lesbians might be invisible, both in general, and in clinical spaces.

With Melanie (38) I explained that I was interested in trying to understand what invisibility meant to her, to which she replied:

The reason why I contacted you was because yes, I’ve seen some surveys etc. about other lesbians, talking about how they perceive the health system … And I was sitting back thinking, I’ve never been discriminated against in the health system. And I wanted this heard, that there is another side to it. I’ve met some fabulous doctors who were straight as the bloody day is straight, who have been incredibly accepting of it. I mean so accepting that they don’t even talk about it. You know what I mean, it’s like a natural thing. So I haven’t had it.

Melanie shifted in this passage from talking about how others perceive the health system to her own different experience with doctors, which she wanted heard. Melanie’s experience of being out with doctors has led to acceptance. It can be read from her statement that for her the issue is not just about how lesbians are not seen, but about how they see the system. Melanie produced other lesbians as assuming the worst from their doctor. When I asked what she had heard from her friends about their experiences with doctors, she had difficulty recalling any specific stories, but said:

… there’s certainly hyper vigilance, I would say, with the friends that I’ve talked to about it, have got, which I’ve not experienced. I just assume that I won’t get that response from the doctor, they assume they will.

Because she sees herself as normal (and says she presents that way in the consulting-room) she believes she is accepted to the point where in her experience, doctors don’t even need to talk about her sexuality. There is an implication in her statements that other lesbians have a problem, while she does not. Melanie’s perception that her sexuality is normalised to the extent that the doctor does not have to talk about presents a conundrum. Does the doctor not talk about sexuality because there is nothing more to say? Or does he not talk about it because he is avoiding the issue?
There is a connection between Melanie’s being assertively out in the consulting-room, and her childhood experiences of racism. Her habitus appears to have been shaped by her siblings’ experience of racism and her mother’s way of handling it (“it’s a dog-eat-dog world and you look after yourself”). These experiences can be seen to have disposed her to look after herself in relation to being sexually different, by being assertively out and presenting herself as normal. Her mother’s axiom worked for her in relation to race, and appears to work for her in relation to her sexuality. Melanie’s early experiences will be explored in greater details later in this Chapter, in the section entitled Resistance in the Medical Encounter.

I asked Monica (42), do you think that lesbians are invisible? She responded:

I have to say in my experience, up till coming out, yes. Post coming out, no. So go figure that one. No, I think in the last, since I’ve come out I think both gays and lesbians have um, developed, received, gained ah, a lot more public profile.

Monica described herself as coming out in her thirties, and it is possible, in the decade since she came out, that there had been increased visibility about lesbian and gay issues. However, it is also possible to see her perception of increased homosexual visibility after coming out as being related to her own increased awareness of gay issues. What had previously been outside her range of what was visible and speakable became accessible to her once she identified with other homosexual people. Monica identified a number of examples of increased lesbian and gay visibility, particularly the fertility case that was in the news when I interviewed her, and a case reported in the news about two gay men who had a baby from a surrogate mother:

… you read about straight families every day in The Age [newspaper. It’s], not often you have two boys on the front of the paper. Yes, so I think certainly, you know, the stuff um, the fertility stuff … so that’s sort of given the community a lot more profile. And even just, you know, with, oh, the Midsumma festival. I mean I’d never heard of Midsumma festival [before I came out], but now I read about it in The Age, as opposed to just the, gay papers. So um, I think there is a greater visibility. But on the other hand, visibility also relates to the individual. So if you want to see it, it’s there, but if you, if you don’t want to see it, or you don’t know what you’re looking for, it isn’t there. … I have probably known lesbians, but I just didn’t know [that] they were. And they didn’t self-identify for whatever reason. And when I think about it, there was two people I worked with in my past
Here Monica responded (inadvertently) to her own earlier statement about increased gay and lesbian visibility after she came out. Visibility is about perception. Heteronormative discourses largely erase or ignore gay and lesbian issues, other than to pathologise them. Identifying as a lesbian shifted Monica’s awareness, so that she now has access to subjugated discourses in which lesbians and gay men are visible. Her increased awareness can be seen as a way of her resisting heteronormative discourses. One way of reading the passage above is that before she came out, Monica did not have access to the (hidden) knowledge about gay and lesbian issues, but once she came out she became a member of the group, with access to privileged knowledge (vision) that was not available to her in her “past life”, before she came out. Yet she also acknowledged the possibility that this new knowledge is not complete, and that unless she chooses to speak and identify herself, knowledge about a woman being a lesbian can remain hidden.

Kelly (33) had a long history of negative experiences as a lesbian. She was exploited as a school student by a lesbian teacher, and later by a lesbian counsellor. She has a number of health problems, including chronic tiredness, and was on anti-depressants when I interviewed her. When I interviewed her, Kelly had been reluctant to make her lesbianism visible under any circumstances, however, a recent experience had made her re-think her position. She explained:

I think there’s a sort of nice thing about being invisible, but you know, ah, ah, there’s two sides to it. … I came out to my um, you know, my – one of my lecturers recently. And you know, she had a really nice response. And it actually made me really happy for about a week. And I think and I had a lot of energy and that sort of thing, so I think also there must be something really important about being recognised and accepted you know. … [Usually] you get so much bad reaction, I guess that visibility then becomes a problem. So I guess, yeah, if it were a visibility where you got a nice response, yeah.

Kelly raised the dilemma lesbians face: speaking, making yourself visible to others requires taking a risk. Having negative reactions can cause emotional and physical harm and in general, Kelly was not prepared to take this risk. But having a positive response had the opposite effect; she was happy and had energy as a result of positive recognition. For Kelly, secrecy about her lesbianism acts as both a shelter for, and a shelter from,
power. She equated visibility with coming out (which requires speech), and invisibility with passing (which is produced by silence). But Kelly was also clear that it is the way that others respond, that for her dictates the outcome. Because of her accumulated bodily experiences, her habitus disposes her to expect a bad outcome, but she recognises that the experience of coming out and receiving a positive response lifted her mood and made her feel better.

Sally also reflected on invisibility:

Mmm. I think I [pause two seconds] yeah, I wonder, I ask myself [pause three seconds] does it matter, is that really the issue whether lesbians are invisible or not? What I think is important, what is important for me, is not so much that I’m visible to the big world out there, but that I am visible to, and need contact with, um [pause two seconds] other lesbians, other women … the networks, the supports, the sources of care …

Sally took time during the interview to consider her responses, and at times a number of pauses were apparent. The importance of belonging, which was raised earlier by Monica, emerged again in Sally’s interview. Whereas Monica alluded to the privilege of knowledge as an insider to the lesbian community, Sally took a stronger stance. She appeared to see belonging as more important than public recognition, and the lesbian community as a source of support and care.

For each of these women the notion of invisibility was complex and multifaceted, but it is clear that within each of these stories are embedded strategies of resistance and care of the self. Dividing practices and misrecognition operate to separate each of these women (in some cases from the larger world, and in some cases from other lesbians) on the basis of feelings of difference. This sense of difference is not only in respect of sexuality, but involves many aspects of the individual’s life, and the outcome at an individual level is not predictable. At times, the sense of being different, divided from others, results in strategic resistance that has positive outcomes, at others it has negative outcomes. As a shelter from power, silence leads to invisibility and may achieve the immediate aim of protection, but can also leave the individual feeling misrecognised and devalued. While the intention behind remaining silent stems from a desire to protect oneself from harm, the outcome can be harmful. This can be seen in the following two women’s stories.
In relation to invisibility two women raised the experience of misrecognition, which was connected in both cases to their roles as non-biological parents. Six years prior to this interview, when he was three years old, Lesley’s son was hospitalised with a fever, during one of the weekends he was in her care. His birth-mother was unable to get to the hospital until the following day, and Lesley stayed with him overnight in the hospital and was present for the paediatrician’s first visit:

So, the paediatrician comes round, sees him, you know, like talk, talk, talk I don’t know what it was, and she said that she thought he was all right, but that if he just stayed in she’d come back and see him in the afternoon.

During the first consultation, the paediatrician related to Lesley as the boy’s parent. By the following morning his birth-mother had returned:

So she was there for the second consultation with the paediatrician. And it was really interesting, the pedi … [laugh] and I don’t know why, I don’t know what was kind of written down, [but] the paediatrician ignored me completely [laugh] even though I’d sort of done this, you know, sitting in casualty and mostly been, done all the sort of done all the talking before he was admitted. That was difficult.

Although the child was in Lesley’s care, it appears that on her return, his birth-mother asserted her parental dominance. In these passages the ambiguity of Lesley’s position is apparent. In the first instance, she was positioned as mother, and therefore powerful, in the second, as non-mother, with no rights, or power. Lesley felt that, because their relationship with each other and their child was different from the norm, that her ex-partner had a role to play in advocating for her, which became a stressor in their relationship:

… we used to have arguments, because I would say to my ex that it was her job because she, she you know, they just go, you’re the mother. She actually needed to take some responsibility, but she didn’t agree with me. You know, for standing up for me, you know, like for putting the paediatrician on the spot.

As a result of her partner’s refusal to acknowledge or include her in the medical encounter, Lesley felt that she was ruled out of the interaction with the paediatrician. In this case, silence about the nature of their relationship and the doctor’s silence (by not seeking details), left her suspicious about what was written down, and why she was excluded. The consequent accrued silence was detrimental to her involvement in her son’s
health-care, and ultimately, repeated silences appear to have been harmful to the women’s relationship, as they had separated.

It is interesting to compare Lesley’s experience with that of Shona (35), when she took her twelve-month-old son to the Royal Children’s Hospital. Shona is not the baby’s birth-mother, however, she and her partner both identify themselves as his mother, and he was in her care when he burned himself. When she attended the emergency department with him, she was quite distressed because of his injury. As the child already had hospital records, and has his birth mother’s last name, there was some confusion when Shona booked him in and identified herself as his next of kin. The situation was saved by a nurse who provided an opportunity for the situation to be explained:

… the nurse said ‘so who’s the mother?’ and normally I – if we’ve been confronted with that question, normally I just say ‘we both are’, and you know, sort of deal with it. But this was a very stressful situation and I – in hindsight I feel quite annoyed with myself, but I just said ‘Mary is’, um, ’cause I knew that’s what [the nurse wanted to know] – I mean if I said we both are, she would still have persisted and probably, you know, I think she wants to know who gave birth. And then she said ‘so are you the legal guardian?’ and happily I was able to say yes. ’Cause I do have a parenting order, which I didn’t have to actually produce, although I do carry it around in his little medical book.

Under stress, Shona was disposed to relinquish her symbolic power as mother (in the form of her legal Parenting Orders). This did not predetermine the outcome, however, as the nurse was disposed to ask questions that clarified Shona’s relationship with her son. As a result, the outcome of Shona’s experience was more positive than Lesley’s. By the speech act of asking about the child’s parenting arrangements, the nurse was able to establish that Shona was the legal guardian of her son and acknowledge her role as a parent. In situations that are stressful for the patient or patient’s family, there is some onus on the health worker to ask questions that clarify, as the nurse in Shona’s story did. These questions do not have to be directly about sexual orientation. Lesley’s choice to remain silent was a situation in which her embodied knowledge about heterosexualised space, and heterosexual hegemony, meant that she used silence as a shelter from perceived dominance. In terms of her role as a parent being recognised, this strategy backfired; as a result of her silence, Lesley felt hurt and misrecognised. However, in Shona’s case,
because the nurse asked questions, Shona was able to achieve recognition and the encounter had a more positive outcome, in which Shona’s role was recognised.

The ways in which the women in this study negotiated coming out and disclosure were situational and varied, and most were pragmatic about identifying their sexual orientation depending on the context. The lesbian brings with her a sense (because of her embodied habitus) about the potential for a negative reaction. She can choose to speak out about these matters or remain silent, allowing the assumption of heterosexuality (often implicit) to remain unremarked and unchallenged. Rather than producing these ways of being as in/visibility, it may be more productive to think about them in terms of active or passive resistance. Active resistance can involve coming out, speaking about, or naming sexual orientation; passive resistance can involve disclosing information about sexuality under certain circumstances as a secret, or remaining silent and passing as heterosexual. Rather than always being either active/or passive, in every new situation, each individual chooses whether to name her sexual orientation, or remain silent, depending on a wide range of circumstances, such as safety concerns, past experience and a range of other contemporaneous personal judgements. These choices are not necessarily conscious, and are shaped by the individual’s habitus and the ways in which she is disposed to struggle in the field to increase her capital.

**Resistance in Clinical Spaces**

It was apparent from the stories the women related in the interviews that at some times in clinical spaces, naming sexual orientation took the form of a political act, at others of a confidence to be shared with caution, and at still other times sexual orientation was produced as being of no relevance at all to the interaction. In the consulting-room there is an implicit expectation that the individual who presents to a doctor will provide information about her complaint and symptoms and that the doctor will elicit further information, make a diagnosis and offer treatment. Sexual practices or choice of partner may or may not be deemed to be relevant to this exchange by either the individual or the doctor.

The models of clinical practice discussed at the start of this Chapter draw attention to the patient/consumer’s health beliefs being influenced by culture, family tradition, personality and experience, and these can be seen as shaping the individual’s *feel for the game*, and mediating her actions in clinical spaces. In Chapter Six I discussed the ways in which, despite a range of physical and discursive foreclosures including bullying, censorship, and
heterosexual hegemony, the women in this project negotiated their emergence as sexual subjects. To further explore the ways in which some of the women in this study used resistance, I focus in this section on eight of the stories that best demonstrated experiences of coming out, speaking and silence. To do this I draw on Foucault’s theories about power, subjugated knowledges and discursivity, and Bourdieu’s theories about habitus, dispositions and the field.

Melanie

Melanie (38) grew up the youngest of four children of an Asian mother and Anglo-Australian father in country Victoria, and witnessed her brothers and sister, who “look more Asian” than she does, being bullied at school. I asked if she had experienced racism, to which she replied:

… they got the racist comments. Yeah. By the time I came through I was swimming. It was fine. I guess I’m giving you that history because when you do talk about sexuality it buffered all of us I suppose, gave us a hard skin.

Witnessing her siblings being bullied because of their racial difference, and her mother’s maxim about looking after yourself, constituted a subjugated knowledge that was embodied in Melanie’s habitus. She was able to draw on these experiences later, when she recognised herself as sexually different. I asked Melanie how she described sexual identity, to which she replied:

I know I’m doing this [being interviewed] for the lesbian, as a lesbian, cause I’ve been in a same-sex relationship for many years, and see myself as a same-sex person, but I don’t call myself a lesbian. Yeah, call myself gay or queer. Bisexual sometimes, but probably queer is what I’m most comfortable with. But I know I’ll always be with a woman …..Yeah, just I have difficulty with the concept of lesbian. It’s so narrow. I find it quite derogative at times.

Despite volunteering to participate in this project as a lesbian, Melanie distanced herself from the group. Her discomfort with the concept lesbian, and with applying the term to herself, can be read as being at odds with her statements about being comfortable with being gay or queer, but it can also be seen as a way of caring for herself. She indicated that she saw the term lesbian as “derogative”. Synonyms for derogative suggest it implies belittling, detracting, taking away from, diminishing or lessening in some way. Rather than risk being belittled or diminished, her strategy was to refuse to apply the term
lesbian, that is so often used to denigrate women, to herself. Professionally, Melanie worked in the field of mental health. In the medical encounter she said she presents as “normal”, and it might be read that the common construction of lesbians as deviant, in some way diminishes her sense of normality, which she raised in the next passage. Her use of gay and queer have implications of being political, although they also represent competing discourses.

In the interview Melanie positioned herself within the lesbian health field as a political actor who participated in this project because her views differed from the dominant (lesbian) discourse, and she wanted to have her voice heard. She said:

> Look I think [lesbian health activists have] got a skewed view which, as I said before, is what propelled me to be interviewed. And I, you know, would like to just balance it up a bit. It’s just not one way, that you’ve got all these horrific health professionals out there. I don’t think that’s the case, I think it’s got to come from us as well as users, consumers. That word. That we go in there and yeah, have some confidence and also be informed and know your rights and be assertive. I mean being assertive has been a very successful thing for me. I’m very confident I know what I want out of the health professionals.

This passage reveals the force of Melanie’s position; she represented herself as strong, confident, well informed, knowing her rights. At the same time, she advocated for health professionals, who she argued have been misrepresented (“it’s not just one way”). She placed some responsibility for a medical encounter having a successful outcome back onto the patient/consumer (“its got to come from us as well”). In her childhood Melanie was able to avoid racism by not looking different from the mainstream. The above passage could be read as her using a similar strategy to avoid homophobia, by aligning herself with those with power, people who are “normal”, in this case health professionals. In doing this, she wanted to address an imbalance by speaking in support of health professionals, who she represented as being vilified by activists (“all these horrific health professionals”). Melanie challenged the use of the words user and consumer to describe the individual’s role in the medical encounter, and asserted that she has the key to a successful engagement with health professionals. When she comes out she does not position herself as confessing a secret but as being assertive, confident and presenting as normal, and she seeks to balance relations with health professionals, thereby increasing her power in the field.
Although Melanie’s partner Jill was not interviewed, her way of being with doctors did come up. According to Melanie, Jill had been suffering from migraines and went to see a doctor who was also a friend of her parents. Jill did not come out to the doctor:

So of course the doctor asked Jill with all her migraines, have you got any stress? You know, which of course was stress with being in a relationship with me and the stress from her parents, but she couldn’t say that to him. So he couldn’t give a proper diagnosis of course, because she said, oh no. [Laughs] Now to me that was terrible. That was terrible. In fact that was a waste of time even going to see him. Because you know, as a clinician myself, you can’t make a complete diagnosis unless you get the complete information. And she didn’t give it to him. So, actually that was before she told her parents, that’s right. But even now that they know she went back to him one more time and still didn’t tell him, so, well it’s a waste of time.

Jill’s health-care may have been compromised as a result of withholding information from the doctor; not necessarily about her sexuality, but that her headaches were due to stress associated with her relationship with her parents. This raises a question about whether coming out to this doctor would have relieved Jill’s stress or improve the quality of her care. From Melanie’s account it can be read that Jill was disposed to keep her sexuality a secret to protect herself and her family. Her parents were still not comfortable with her lesbianism, and by withholding this information from the doctor, who is a friend and colleague of her father’s, Jill may have been attempting to protect not only herself, but her parents, thereby maintaining her symbolic capital within the field constituted by her family. This posed a dilemma for Jill. Loss of capital in one field would lead to an increase in another, forcing her to choose between her family of origin and her family of choice. Although both Melanie and Jill can be seen to employ strategies to care for themselves, or increase their capital, based on their embodied experience, the way that they do it and the outcomes are very different. Unlike Jill, Melanie’s habitus disposed her to be assertive about her sexuality, and from her point of view, Jill’s refusal to disclose was a “terrible waste of time”. Melanie asserted her privileged position when she said that she is a clinician herself. Aligning herself with the doctor can be seen to increase her symbolic capital in the field constituted by the medical encounter and affirm her political position, in which coming out is a superior choice.
I asked Melanie whether she had ever talked with friends about their experiences with the health system. She responded:

I have, as I demonstrated before, been quite incredulous at what other people’s experiences have been … Umm, not being heard. Their symptoms not being heard well enough. A coldness. Demonstrated by the practitioner … An uncomfortable I guess. It’s hard to know whether or not that person was uncomfortable or whether their doctor is uncomfortable. They talk about this uncomfortable feeling between us. Like an embarrassment by the doctor …

Melanie’s deficit view of lesbians can be seen in this response in which she separated herself from the group. She has no problem, others are uncomfortable, embarrassed, and waste time. She sees herself as “normal” and other lesbians as having problems. While she questioned in this passage whether what she has heard from others is because of the doctor or patient being uncomfortable, later she dismissed this and placed responsibility back on other lesbians.

During the interview, Melanie was disposed to demonstrate her access to symbolic power in the form of education, authority and skills.

My qualifications and status, coupled with my sense of assertiveness, has helped me without a doubt in bridging my relationships with the GP.

Her childhood experiences, education, assertiveness, qualifications have all contributed to shaping her habitus in relation to sexuality and the medical encounter, in which she is disposed to care for herself by presenting as normal, and claiming a privileged status with the doctor. She aligned herself with doctors and described how she used her symbolic capital (qualifications, assertiveness and status) to assert dominance. When she goes into the consulting-room she prepares herself by writing down her issues on a piece of paper, which she expects the doctor to read, and if this does not happen she “asserts her authority”. She recounted an experience with a new doctor that demonstrates how she actively resisted dominance, and struggled to increase her capital in the consulting-room:

… when I was telling him my symptoms, he had no eye contact with me, whatsoever. And I said, look I’ve got this paper I’ve been writing stuff and documenting it for the last few weeks, and I shoved it under his nose, and he took one look at it and then didn’t continue reading it. So I moved my chair further and I grabbed his hand [laughter] and I put it back in his hand, and I said, I’m not
going to answer any more of your questions until you read what I’ve written, because everything’s there. And so it made him sit up and have a read and ever since then we’ve got on really fine. But I actually had to do that. I had to assert my authority I suppose with him, and say, you’re going to listen to me; I know what I’m talking about too.

Despite this example of asserting her authority, Melanie’s positioning of herself as someone with authority and standing in the consulting-room was not consistent. It was disrupted when she found herself vulnerable after an abnormal Pap test. She has two GPs, one whom she trusts and with whom she has developed a positive relationship, whom she travels some distance to see, and another, local doctor, she sees for what she determines to be minor matters. After a Pap test with the local doctor, she received a notice asking her to return to the clinic because the result was abnormal. She made an appointment for a follow-up test with the same doctor:

> It took ages to try and get in to see her … and then on the bloody day I get a phone call saying, oh look, she’s off lecturing. She can’t see me. So I stopped seeing her for about a year after that ‘cause that really upset me.

Rather than confront the doctor who had “upset” her, she avoided her and went back to her trusted doctor. This strategy of avoidance is in contrast to her assertion of authority in the earlier example. In the first instance she was prepared with notes and observations and exercised control in the consultation, whereas in the latter example, she was distressed about an abnormal Pap test and dependent on the doctor for follow-up. By going back to the familiar territory of her trusted GP, she avoided the doctor who had upset her. In both of these examples Melanie used agency, but quite differently; in the first she asserted her authority, in the second she used avoidance and retreated to familiar territory.

**Kelly**

Kelly (33) was born in England and raised in Perth. She came from a family in which her father was long-term unemployed. She said:

> I’ve been kind of on some form of welfare for lots of me adult life and I, I suppose that gets to me a bit …

From the age of nine Kelly experienced poor health, and described herself as being fragile, and tired all the time. Ultimately she was diagnosed with anorexia and later
bulimia, which lasted for many years, although at the time of the interview, she said she had recovered. She identified as a lesbian and said she first came out to other girls at school when she was in year nine [around fifteen to sixteen years]:

I first told a couple of kids that I, a couple of my friends and I had this crush on this girl, and ah, they sort of ignored it, I mean I think they thought it a bit weird and just ignored it. And I felt a bit weird so then I ignored it for a while and then I came out again properly in Year um, 11.

The next time she came out was to a teacher:

… it’s not the best, coming out at high school. 'Cause there’s no, nowhere you can go, … there was a teacher who sort of – so I don’t know if she was questioning her sexuality – yeah. So I talked to her a bit … Um, ah, in Year 11 I had a relationship with the [same] teacher and that was a bit traumatic … like I used to come home from school, like she’d kinda be a bit off and on, and worried about her job and that sort of thing, so I’d come home either on a high or devastated …

When the relationship with the teacher ended, Kelly started to see a (female) counsellor, which also resulted in another exploitative lesbian relationship:

… I saw [a counsellor] at school and there’s an issue because she then ended up sort of coming on to me. Um, and kind of, you know the whole relationship then changed.

When she was eighteen Kelly left Perth to live in Melbourne, in part to get away from her family. I asked whether they know she is a lesbian:

Oh, they don’t talk about it, they accept it in, you know, let’s not talk about it. I wouldn’t say, you know, they’re not happy about it, I know that. I don’t know what me dad thinks and I don’t care really. Um, but me mum’s not happy about it, um, … I think they kind of now think it’s not a phase [pause two seconds] you know, yeah, yeah.

As discussed in Chapter Six, Kelly’s experience of being out has been mixed. She usually avoided disclosure, because of her negative experiences, but when she received a positive response to disclosing her sexual orientation from a lecturer at university, she felt buoyed up and generally well for a week afterwards. In relation to this, when I asked her about
whether she perceived any risk or danger in disclosing her sexual orientation she answered:

Kind of saying in terms of how it affects health. I think being a lesbian … I think it wears you out a lot more. I think, I, I think I feel that um, maybe the drainedness [sic] is like that kind of constantly being outside and - but, you know coming to uni and, you know, sort of thinking ‘do I come out, [or] not come out?’ You know, it’s a different experience. So I think that, that affects your health, just being worn out by that sort of stuff.

Kelly’s life experience of being “constantly on the outside” shaped her habitus, and the foreclosures she had experienced – being misrecognised and abused because of her sexual orientation – led to her positioning herself as an outsider, which had direct implications for her health and sense of wellbeing. Whether she came-out or remained silent she treated her sexuality a secret. Both of these ways of being constitute passive resistance. I asked her about how she went about disclosing:

[If] I get kind of close to someone, and it comes up and I just tell ‘em. Um, actually the e-mails helped, ‘cause I’ve done it a bit more in e-mail lately, yeah. Recently … there’s some really nice ones in there [at university] and I kinda came out to them only recently, so. Yeah, I think I gauge it pretty well, I don’t want to come out just as a kind of statement because I think you get screwed around a lot you know, everyone projects on to you … and I just think I can’t be bothered with that, you know it’s like, … I just can’t be bothered with that stuff.

Her disposition to remain silent can still be read as a kind of resistance. Her intention was to care for herself, and although this had not always been effective, it did involved agency. Kelly’s approach to disclosure was to do it carefully, and if possible indirectly, for example, by e-mail. She was cognisant that there was a risk involved in disclosing directly (“you get screwed around”) and although she described herself as a feminist, she avoided taking a political position on disclosure – “I don’t want to come out as a statement”.

Kelly’s family life, her experience of being sexually exploited by both a teacher and a counsellor, and her experiences of ill-health and with biomedicine, had all contributed to shaping her habitus, and her way of being in clinical spaces. She described how she had extensive contact with a range of health-care workers over the years, including:
… normal doctors, naturopaths, um chiropractic um, acupuncture. Oh, what do you call it, homeopathic, yeah, tried everything.

Rather than feeling helped and supported by these service-providers, Kelly was sceptical about their ability to help, and cautious about trusting them. She said:

… when I was bulimic I had lots of bad experiences of um, doctors who used to scold me a lot. Ah, I got sent to a hospital and um, I don’t know, [they] made me take off all my clothes and put me in one of those [gown] things. I sat for hours waiting for something – I mean I wasn’t quite sure why I’d been sent there. Sat for hours, they didn’t know what to do with me, and then someone came and sort of said ‘you know, if you just stopped throwing up and then you’ll be right’, you know. I was really angry and felt I was taking up time and that was quite common, I had a lot of them just saying ‘you know, if you just stopped doing it’, you know ‘why do you do it’ … I found that when I was younger they treated me a lot worse. You know I think now I’m a bit older I think they don’t treat me so bad, I think being young and going to health practitioners is a, is a bad thing. Especially with things like that where they can’t quite – you know they feel a bit powerless I think. … it’s a bit psychological maybe, they feel they have to punish you ’cause they can’t fix it.

Kelly appeared to experience the (biomedical) field as a dangerous place, which was not surprising, as she has been subjected to humiliation, abuse and punishment. When I interviewed her, she saw a doctor at a community health centre, with whom she was out. She also used local drop-in clinics occasionally for minor matters when she could not get to the community health centre. Of her doctor at the community health centre, she said:

… there’s just limitations to that kind of medicine. I mean I often have to tell [my GP] things that I’d discovered, you know, … I feel I get more from trial and error with you know, what do you call it, health-food shops and that sort of thing and reading books from the library and that, you know? So she’s [the doctor is] very good and she you know, she’s really, you know, talked me through everything, but I think there’s just a limit in that kind of medicine, like they’re looking for a disaster. They’re not looking for subtleties.

Kelly was disposed to view doctors as ill-informed and medicine as inadequate to her needs. She saw doctors as not being interested in the “subtleties” to help her recovery, and
of only looking for “disasters”. The term disaster suggests misfortune, or calamity. In medical terms, illnesses with these qualities might be seen as being of great interest, in need of extensive testing and examination – the stuff of which television shows are made. For Kelly, the root of her health problems was in the subtleties. While she appeared to like her regular doctor (“she’s very good … talked me through everything”) she had no respect for the doctor’s ability to get to the root of her problem, to see the subtleties. Given her bad experiences in the past with biomedicine, and with others in relation to her sexual orientation, it is not surprising that Kelly was disposed to lack trust, even in the doctor she likes. She was out with this doctor, but felt the need to control the flow of information to the doctor to ensure she addressed the subtleties.

When she needed medical attention and could not get an appointment to see her usual GP, she went to local drop-in clinics to see a doctor. In these consultations she withheld information about her sexual orientation:

… there’s been a few times when I’ve gone with things, I can’t actually remember what now, and they’ve said ‘oh, is there a possibility you’re pregnant?’ and ‘are you on the pill?’ and they badger you about it … when I’ve gone to one of those twenty-four hour [clinics] you know, supermarket ones I don’t bother saying, you know, I’m a dyke or anything, I just ignore ’em.

Here Kelly demonstrated hostility towards doctors in this kind of consultation. She referred to being badgered, and later to hating being quizzed by a doctor. I asked her what she did when the doctor “badgered” her about pregnancy and contraception, to which she replied:

I think I just stop talking to ’em [laughs] Only I usually go to those ones for a specific purpose and I just think do whatever I’m coming for and leave me alone I mean I hate, um I hate it, you know or they ask you, is your boyfriend, or your partner? I don’t know yeah, are you married or? And I can’t remember why these questions come up, but um, it just annoys me, I hate it.

This kind of position can be, and usually is, interpreted in simple terms as passivity, but it can also be seen as passive resistance. Kelly was disposed to resist the perceived dominance of the doctor by remaining silent and withholding information about herself. I asked her, are you out with your usual GP? To which she responded:
… one time I went [to the community health centre] with a friend um, and the, the next time [I went the doctor] said ‘was that your partner?’ and I said ‘no, me old partner’, girlfriend or whatever. So I mean I guess that tells, tells her yeah [speaks softly] she must’ve known somehow [laughs] it’s usually on my file I think, at some point, yeah.

Rather than answer my question directly, Kelly indicated, somewhat defensively, that she thought that her sexual orientation was recorded on her file. It was apparent in the interview that the doctor’s enquiry about her relationship with the person she was accompanied by made Kelly suspicious.

While Kelly could be seen as a passive victim of a homophobic social system and an inadequate health system, she appeared to be far from passive. Although she withheld, concealed and remained silent about her sexuality, she did this actively. Nonetheless, there were some things that she needed the doctor for, so she continued to use the health system, but set limits so that she retained control. When necessary she tried to increase her capital in with the doctor. This struggle for power in the medical encounter may not have had positive outcomes for Kelly, but it was her way of asserting a degree of control when she felt vulnerable.

Kelly also positioned herself in her relations with doctors as an educator. She resisted the doctor’s attempts to elicit personal information from her, and also assumed a degree of responsibility for her own health, by reading and exploring alternatives to traditional medicine, which, because of her embodied habitus, she holds in contempt. In relation to Race et al.’s (2001) description of models of the clinics at the beginning of this Chapter, Kelly’s way of being with doctors fits neither the doctor/patient, nor the service-provider/consumer model. Within these formulations, a certain degree of co-operation is called for by both parties. Kelly’s mode of resistance suggests another way in which the clinic operates in practice. Under certain conditions, to solve her health problems, Kelly sought answers from books and alternate sources, and brought them to the consulting-room in an attempt to collaborate with, or perhaps control, the doctor. From her story, it appeared that her dominant way of being was silence but she had the flexibility to adjust this, when she was sufficiently motivated, in seeking answers to her problems. While a psychological reading of her story might suggest that Kelly’s tiredness and depression (and even her physical problems) have resulted from keeping her sexuality a secret, a
post-structuralist reading suggests that she was not a passive victim, but actively resisted domination within the medical encounter and beyond.

**Monica**

Monica (42) was an only child, whose early experience of health was of her “over-protective” mother “dragging her off to the doctor” every time she sneezed. In retrospect, she saw her mother’s vigilance about health as having made her more prepared to act when she felt something was amiss with her own health.

I think it probably made me far more ready to get things checked out when I thought there may be a problem, far earlier than I might otherwise [have] done so. … So it probably has made me a bit more anxious about my health than is probably necessary. Like other people say, yes I’ll go to the doctor next week or next month, but even now [when I feel like something is wrong] it’s like oh, I think I’ve got an issue here. I go straight to the doctor, get a referral and get it sorted out. So it probably has made me a bit more anxious about my health, um, than is probably necessary. [pause two seconds] But you know, sometimes I think it’s better to be over anxious and then, um, be satisfied that there is nothing amiss than to go the other way and finding out too late that there’s something amiss.

In this statement, Monica revealed a view of health as precarious, and the risk of ill-health as present in the smallest symptom. Even waiting can mean it may be too late. If she felt that something was wrong she put herself in the hands of experts who could reassure her that all was well. Throughout Monica’s interview she revealed contradictions, both when she talked about her health and being out about her sexual orientation. On the one hand she presented as strong and assertive, speaking out on behalf of those weaker than herself, on the other, vigilant about the risk of being exposed, and to an ever-present danger of domination. Monica’s resistance was active and at times aggressive when she saw herself in an advocacy role, but she could also appeared to slip into a more passive role from time to time.

Monica was married to a man, and came out as a lesbian in her thirties. I asked her about what happened when she came out.

… I was quite bitterly unhappy ah, in the [marriage] relationship, had been for a long time, um, and probably quite seriously in the last twelve months before I left. I finally came out to myself and then I left him and then I came out um, and ah
I suppose it has a lot to do with who I am, it was like when I came out, it wasn’t sort of like, you know, just sort of creeping out. You know, … once I told one person, you know it was on for young and old. And I suppose given the nature of who I am, I’ve always been a little bit out on the edge, and it’s like, well ‘like me this way, or it’s your problem’ [laughs].

Monica’s statement that it was “on for young and old” implied a certain devil-may-care attitude in relation to how others saw her shift from married woman to lesbian. However, her representation of herself as not caring about how others perceived her was almost instantly contradicted when she went on.

… at work I’m a, well not actually [out] at work with my colleagues. I’m fine, but when I’m dealing with people that I represent, I’m a little more careful. But I think that’s fine, because I’m not there to, to preach anything. … so some of them work it out, and they’re fine, and those who don’t work it out, it’s not an issue. So it’s sort of that split, you know, which box am I in at the moment?

The reference to feeling split between “two boxes”, suggests that she felt that she had to position herself with others, in ways appropriate to the moment. It can be read as alluding to the tension of having multiple identities, for example, patient, mother or worker. Depending on which role she was in, she had to review the most appropriate way to present herself. One reading of this is that each of her different identities demanded a different way-of-being. I asked her what kinds of considerations influence her to be out or not, and she replied:

Oh, safety is of course a, a primary one, one doesn’t go and hold hands in public in an area where one thinks might get, one might get beaten. Having said that um, if the environment is safe, in general I’m out [pause two seconds] everywhere. Um, in new situations I’ll hang back because I wanna, I wanna judge um, whether or not I think it’s ah, emotionally and psychologically safe to come out, not, you know. And, you know, sometimes I’ll make a choice not to come out because, just the vibes I pick up, um, suggest to me that um, that’s not ah, a safe thing for me to do

Here it was apparent that she saw being out as risky, even exposing her to the potential for violence. Her reference to “picking up vibes” suggested that she had an embodied
sense about what is safe and what is not safe. In Bourdieu’s terms, this represents her habitus, or sense for the game.

Monica’s twelve-year-old daughter had a condition that requires regular specialist medical care. The sense that Monica’s sexual orientation could pose a risk was apparent when I asked her about whether she was out as a lesbian with her daughter’s doctors.

… it’s like, this is my daughter, my sexuality is irrelevant. I kill anybody who gets in the way of my daughter getting good care … if you piss me around while I’m actually trying to advocate for my family [laughs] then get out of my way, I’m gonna torch you. … we can be sensible cooperative adults, or not. We can fight about it, and even if I don’t win, I’m gonna cause a lot of damage on the way.

Although she chose to remain silent and constructed her sexuality as irrelevant to her daughter’s care, she presented as being prepared to do battle, should someone make an issue of her sexuality. This represents an interesting split: on the one hand she had chosen to remain silent, on the other she spoke aggressively about what she would do should it become an issue. This division of the self was a recurring theme in Monica’s interview, and raised again the complexity of representing oneself in a world where communicating non-normative sexuality is usually presented as a binary of being in or out of the closet. Monica had to assess each situation and decide what to do, based on her embodied knowledge or sense about what might happen if she is out. I asked her about her current health-care arrangements, to which she replied:

My GP is a straight boy, um, but he is incredibly gay-friendly. Ah, I wouldn’t go anywhere else, um, and he’s just the best GP I’ve ever had. … I’ve just got a really good rapport with him. I can ask him anything, even what I consider to be blindingly stupid questions and I don’t ever feel like I’m being talked down to … [or] patronised … from the great lofty heights of doctorness [sic].

Here she spoke about the high-quality relationship she had with her doctor, but also about her understanding about the power of doctors. Rather than position herself as passive within the field constituted by clinical spaces, she sought out a positive relationship. But underlying her attempts to equalise the power of the doctor was a willingness to fight for herself and the others in her life for whom she advocated. She produced the health-care system as a game that cannot be won by the weak:
It’s like the health-care system, it’s almost like there’s this big labyrinth and you know, you go in the wrong door, you’re stuffed you know … once you’ve gone in the right door, then your next choice is which door do you choose after that, so it’s always a case that if you go the wrong way, you’re stuffed and you have to keep coming back … the stuff that the [mental health] system’s put [my partner] through ah, it’s just horrendous … the personalities of the, of the male doctors, you know, who, who run the show, ah, and I mean that’s the other thing about the ego, … medical egos can be huge, you know, … and they think they’re God, and they’re used to people bowing and scraping and treating them like God, so when you turn round and question their mortality, they don’t like it, um, and that makes it very hard, if you, if you piss them off it makes it very hard to operate within the system.

Monica constructed the health system as a labyrinth where there are winners and losers, that is dominated by egotistical doctors, who will always win. In this understanding of the system, the power is retained by the doctors, who are elevated (elevate themselves?) into god-like positions and who must be revered (by being bowed and scraped to) by the patient if they are to get anywhere in the system. As a result Monica is disposed to struggle within the field to increase her own capital, and achieve good care for those she represents. She believes that her knowledge and skills give her an advantage over others, and thus increase her capital in the field.

… for someone who was a bit quieter, a bit more reserved, a bit less ah assertive, and not as skilled in the, the, you know, the black arts of bureaucracy, I can’t, I can’t say that it may be that experience you know if you’re not prepared to stand up and put your foot down, then people will tend to walk over you irrespective of what gender you are and what sexuality you are.

Monica appears to have succeeded in achieving a level of symbolic capital with her own doctors, and she, like Melanie, claims privileged information because of her lesbianism. From her position of power (holding privileged knowledge about being a lesbian) she positions herself as having a responsibility to educate doctors about this:

As a lesbian, if I want my doctor to understand me, in context of not just my physical health but my sexuality and my health, then I have to tell him, or her. But you know, I can’t expect a straight person to understand, or do anything if I don’t tell them, and if I don’t attempt to educate them.
By positioning herself as someone with special knowledge not available to straight people, she asserts her symbolic capital and increases her status with the doctor in the field. But she is also aware of her continued need to struggle to maintain this status.

Despite Monica’s construction of herself as a strong, skilled, assertive woman who was prepared to struggle with the all-powerful health-care system to ensure her own family’s success, some inconsistencies were apparent. One way of interpreting the force of Monica’s interview is that she is waging a war against injustice on behalf of the oppressed. Another reading suggests that she protects herself by being aggressive, attacking the legitimacy of the system and dominating those from whom she wants to receive a service. Multiple identities were also relevant for Monica: when she presents to her own doctor, she does so as a lesbian, however, with her daughter’s carers she presents as a protective mother. Monica can be seen as having interpreted the rules of the health-care game as combative and as being disposed to play the game accordingly.

**Georgia and Mandy**

Georgia (43) and Mandy (33) are an Aboriginal couple who elected to be interviewed together. Georgia is of mixed Aboriginal and Maltese descent and during the interview she related many experiences of racism, at the hands of doctors and hospitals.

… as soon as I got sick or something they’d always sort of classify it as a typical Aboriginal thing. An example of that is when I was about five, I had dermatitis through nerves from being picked on at school for being a different colour, and we went to the Western General Hospital and they presumed because I was Aboriginal, I had scabies. They used to throw me in the bath and just scrub me and stuff like that. It didn’t go away, so mum took me to the Melbourne Hospital and didn’t say I was Aboriginal. She actually went in on the Maltese thing and they found out that I had a bad case of dermatitis because of nerves and then treated it and got rid of it.

Georgia’s habitus has been shaped by these kinds of experiences, to distrust health-care professionals. She indicated early in the interview that she “hates” going to the doctor and “just totally give[s] the health system, whenever possible, wherever possible, a miss”. Her sense for the game is one in which she has been stereotyped and discriminated against because of her Aboriginality. Mandy’s experience was different:
I guess it was fine, just because I grew up here in a small country town. I just had the local doctor and, yeah, that was where you went sort of thing, yeah. So no, that was fine.

Mandy came out as a lesbian when she was twenty, Georgia had identified as gay from as early as she can remember, but came out when she was nineteen. They both said that they had experienced homophobia from within the Aboriginal community as well as outside, but are accepted, and celebrated as a couple by both of their families. Mandy’s great-aunt is lesbian:

She’s still alive and lives in Sydney. So yeah, we had a gay thing within our family anyway. But yeah, my mum and dad never, they don’t stereotype people, they don’t, you know, that sort of thing. So, yeah, no, having those strong independent women as a stereotype to look up to sort of thing, I never really had, yeah, issues with that sort of thing.

When I interviewed them, Mandy was pregnant with a baby that she and Georgia had conceived by IVF. I asked about how their families had received the pregnancy.

**Mandy:** Yeah, we’ve got very supportive families, very, I mean, you know my sister and that, yeah, so both my sisters are really supportive and that and [Georgia’s] brother, yeah, he’s very, for a truck driver, he’s very supportive.

**Georgia:** My father’s a bikie, you know, so, yeah, so it’s really unusual, but my dad loves her [Mandy] more than me, and Mandy’s dad loves me more than her, you know. Our fathers just adore us.

Beyond the love and support of their families, life had been more difficult for Mandy and Georgia, both in relation to their Aboriginality and their lesbianism. I asked Georgia whether there was a time when she learned it was unacceptable to be gay.

I didn’t know what gay meant. I probably didn’t understand it till about the age of, maybe, sixteen, seventeen, even eighteen. Like, I’d go out with boys but didn’t want to kiss them or that. You know, and I’d look at the teacher and I’d get a crush on a teacher or my love was always, you know, it’s [always been girls]. … I was never accepted anyway because I was black, see. So you know, like, if I got home from school without getting the shit kicked out of me, I was happy, you know what I mean.
Mandy indicated that she did not know what being gay was until after she left school:

I never really knew what a gay person was until I moved to Melbourne. But I knew I had different feelings about people, like, you know, all my friends would go off and sleep with the boys and that sort of thing and I’d just go, you know, fuckin’ stupid sluts sort of thing, and yeah, I wasn’t really into that sort of stuff. But yeah, I probably was looked upon as being different at school but I didn’t know in myself why I was different, yeah.

Perhaps because they have struggled against adversity as Aboriginal women, both women are strongly out in their lives. Mandy said:

Georgia’s funny, though, like, if she’s got a [business] meeting with important people, and it’s, um, you know, her and her partner [are invited]. She’ll always take me, sort of thing, and people will go, you know, some people will presume that we’re just friends. But she’ll say no, this is my, you know, partner. And her mum will do the same, you know. They’re very, yeah, yeah, open.

The two women live in a small country town and for their health-care, they see a local GP, whom they have come to trust and value. Like many of the women in this project, Mandy and Georgia found a local doctor for convenience and have continued to see her because she is accepting and provides good service. Mandy described their GP as “fantastic”:

She’s very gay-friendly and very supportive … we just went to her because she was our local doctor and it just happened that she was, you know, really nice and that, like, yeah.

Georgia and Mandy have a strong sense for the game, their experiences of being marginalised as Aboriginals and as lesbians have disposed them to struggle against domination. Within the field constituted by clinical spaces, the outcome of their struggle for symbolic capital shapes the quality of their relationship with the doctor or health-care worker. Georgia and Mandy’s struggle appeared to be more complex than that of others in this study. Their expectations of their GP were that she be fair and accepting, but also that she exercise her skill without fear or favour. The first time they saw this doctor, they went together as a couple because they needed a referral for IVF treatment. I asked them to tell me about how they came out to her, to which Mandy replied:
Yeah, we just said that we were gay, um. We’re not, we’re fairly open about our relationship. Like, the bank here knows that we’re gay and, you know, and basically in life you’re, if you’re a couple you can’t get away from the fact that you’re a couple and you have to do things like heterosexual people do. And, you know, we’re very supportive of each other … So, no, in life you have to be open or you’re lying to yourself. Yeah.

In this passage, Mandy constituted secrecy about sexual orientation as lying. Not only lying to others, but to yourself. A sense of honesty and fair play were strong themes in their interviews. The doctor’s acceptance of them as a couple established that she was fair, and could be trusted. They discussed what they expect from their doctor:

**Georgia:** … she’s really hard too, that’s what I liked about her. She’s a hard woman ... she doesn’t believe in pumping you full of drugs. She’ll tell you straight.

**Mandy:** Yeah, yeah. Don’t be a sook [cry baby]. I really like her. I like a hard doctor.

**Georgia:** … she is very gay-friendly. I mean, we’re really lucky being in the country and, you know, having a doctor like that.

I asked what Georgia meant by the doctor being “hard” and she responded by saying “she doesn’t take any shit”. Georgia perceived this doctor as benevolent yet firm, she liked that the doctor will not prescribe medicine when a good talking-to will suffice. When Georgia saw the GP to get a certificate for some stress leave from work, the doctor was unsympathetic. Rather than feeling upset, she appreciated the doctor’s advice to “get off my arse and go back” and confront the cause of her stress. Thus, they constituted the doctor as someone to be trusted, because not only did she accept them as a couple and show no sign of discrimination, she also practised medicine as a kind of tough love, by speaking her mind and taking no nonsense. Their good relationship with the GP does not transfer to others in the field, and does not extend to all doctors. When the GP referred Georgia to a counsellor, rather than prescribe drugs, Georgia was scared:

**Georgia:** I wouldn’t go [to the counsellor] without Mandy, because I was scared …

**Mandy:** … [the counsellor] was picked out by our GP, yeah, yeah,
Georgia: … for being gay-friendly. Because if she had have sent me to a counsellor who wasn’t gay-friendly I wasn’t going to get anywhere…

Georgia was disposed to overcome her fear of the counsellor in two ways: by taking Mandy along for support, and by trusting the doctor to refer her to a gay-friendly counsellor.

Becoming pregnant meant that Georgia and Mandy were exposed to medical intervention, and their struggle to gain capital in the field can be seen in their stories about attempts to conceive. Mandy said:

Like, we both go into the doctor and we’ll both, you know, if she’s at the doctor I’ll be sitting in there with her, sort of thing, and like, you know, when I had the eggs transferred out of me Georgia was a bit funny about, you know, holding my hand or something like that and she said as soon as I jumped, you know, she just grabbed me and didn’t care what anyone thought sort of thing.

Their shared desire to have a child motivated a shift in their relations with doctors and the health-care system. When Mandy was undergoing artificial insemination, and Georgia was present during the procedure. Georgia said:

It was really funny, there was this [doctor] fella there and I didn’t want [Mandy] to lose her dignity or that … He walked up to her and I just eye-balled him all the way and he sort of couldn’t look at what he was doing. So it was really funny about that. I suppose I shouldn’t have done it, but you know the last thing I wanted her to do was lose her dignity. So I always do those eyeball things with the doctors, you know; what are you doing?

Georgia saw the procedure as making Mandy vulnerable, and was disposed to defend her. This “eyeballing” technique represents a form of domination, which Georgia used to challenge the power of the doctor.

Mandy and Georgia were disposed to work together, when one was vulnerable or stressed, the other took a position as protector. Working in this way, they were able to jointly struggle to increase their capital within the field. The strength of Many and Georgia’s relationship may be related to them having had to face a life-time of adversity because of their Aboriginality. This was the only group interview I did in this study, which may have influenced the outcome to some extent, but none of the other women
who spoke about their relationships appear to have worked in such a united way. Both Mandy and Georgia appeared to be assertively out in all of their dealing with doctors, at times these have been trusting, productive relationships, and at other times they have struggled against perceived domination by the doctor. But by working together, they appeared to have developed a strategy that works for them.

Sally

Sally (59), who was single, did not speak about her sexuality with her doctors, although she indicated that she was open about her sexuality with her family, friends and at work. I asked what influenced her decision to be out, or not, in social settings:

… it would be things like [pause three seconds] ah, whether I think this is, um, that I like them enough to trust them with me. There are a lot of people I don’t want to know me well um, and [pause five seconds] and adding to that first statement and I don’t want to develop the relationship any further, um [sighs] um, and in fact it might be often, I don’t talk about me in, in terms of my sexuality because I’m like resisting. I, I have this experience quite often, I notice people don’t ask me about me, um, don’t ask me sort of, how I am, or am I happy or, you know …

Sally’s considered statement about liking people enough to trust them with “me” might be read as implying a kind of withholding of her inner self, that can only be exposed once trust has been established. Sally’s use of the term resisting is interesting. She said that she resisted being seen only in terms of her sexual identity, and wanted people to demonstrate an interest in her as a person, by inquiring about her health and happiness. This can be read as Sally seeking to be viewed by others in a holistic way, recognising her as someone with joys and sorrows. I asked her if she had come out to any of the doctors she had seen and she responded: “It’s never come up um, and I haven’t kind of made the announcement … my story is I don’t have an experience of being a consumer of the health-care system as a lesbian”. There are several ways of interpreting this statement. Coming out is constructed as an “announcement”, which implies there is something significant about herself that she must make public. In this reading, not having made the announcement means that she had no story of being a lesbian in the health-care system. Another reading might be that speech has been withheld and the announcement is waiting to be made. This also raised the issue of multiple identities, and for Sally the most
important aspect of her identity might not be her lesbianism. We discussed at length how she interacted with doctors, and she said:

I think I’d also like them to think about … you know, who am I other than the patient in this consulting-room? I think that is one of my practised ways of being. I, I do perhaps um, protect or guard myself, um, quite carefully and often want the other person [pause two seconds]. I think I do this socially too, [I want them] to demonstrate to me that there is um, the warmth and interest and opportunity rather than my doing that [pause two seconds] yeah.

Sally’s reference to “practised ways of being” can be seen in terms of a disposition that is characterised by considered carefulness. Sally had never been disposed to come out to a doctor, although she did say that should she think it necessary, she would come out. She reflected on the conditions under which this might be likely, and how she would do it:

With my usual ones, um [pause three seconds] I can’t imagine doing it. ’Cause I think if I had specific concerns about my sexuality, I’d be talking with friends first. But just suppose that I did, um [pause two seconds] I wouldn’t be going to mine, ’cause as much as I like and respect him, I would be asking again for a female practitioner um. [pause two seconds] But I’m, yeah, … I’d be hesitant just to go there and ask for a, a women’s practitioner, a female practitioner because the last time I had my Pap smear done, was by a very competent but very young, ah, Vietnamese woman. I would want to be talking with about, me, the sexual person, sexual concerns with a same-aged person, so I’d probably choose to go to some of the practitioners that we know who are lesbian-friendly or lesbian-identified, I, I’d actually choose the person rather than go to my usual place.

This could be read as Sally conflating sexuality (as identity) and sexuality (as sex) in this passage when she said that if she had specific concerns about her sexuality she would be talking to friends first. The passage also reveals the complexity of contextual factors that limit Sally’s willingness to speak about sexual orientation; she raised age, gender and ethnicity as issues that would influence whether or not she would be prepared to speak about sexuality with a doctor. Later in the interview Sally revealed more about how she positioned herself and what she expected from the medical encounter. I asked whether she had ever contemplated telling a doctor she is a lesbian:
No, never, never I should [pause four seconds] I, I have a very strong thing about I am taking care of me and, and my use of health-care services is for specific things that I cannot do for myself. Um [pause three seconds] so I, and, and again, if I wanted access to um, information, advice or support caring, around anything that, that was related to my identifying as a lesbian, I, I’d go to my friends, so I can’t imagine my going to a health-care provider for, for those sorts of concerns. But if it was health concerns and I felt um, could be better addressed by them knowing about my sexuality, I would tell them, I think I would tell them very easily, you know, I don’t think, but I’m making decisions about whether it’s relevant or not maybe I’m being a bit precious about me, but I, um [pause four seconds] … [when I go for my regular check ups] I don’t tell them about the, the ah, the, my eating regime, it’s about keeping me healthy too, or my exercise regime.

Here, and throughout the interview, she positioned herself as being a consumer, responsible for her own health; doctors have a place, but only to take care of the things she could not do for herself. As a responsible consumer Sally can be seen to present herself to the benevolent gaze of the health-care system for preventative breast and cervical screening. From this position, she saw no need to discuss her health with her doctor, only potential illness. When she consulted the doctor she did not discuss her diet or exercise regimes, and for her, sexuality was in the same category, only to be discussed in the context of potential illness or disease. Sally also constituted her sexuality as a social issue, not to be raised with doctors, but with supportive friends. She retained the power to decide whether, or when, sexuality might be relevant in a medical encounter. Her statement “maybe I’m a bit precious” suggests several readings. Precious can imply something of great value, or held in high esteem. In the vernacular it can also imply affectation, putting on a pretence or over- emphasising one’s own importance. As a responsible consumer Sally might be seen as valuing herself by being responsible and taking care of herself. Another way of reading this statement is that she saw her decisions about withholding information and deciding what is relevant for doctors to hear as an affectation.

Sally’s silence about her sexual orientation is congruent with her positioning as a responsible consumer. She controlled the flow of information, presented for the necessary screening and otherwise did not have any need to communicate about herself to the doctor. It should also be noted that the “announcement” has never been invited. Sally’s silence may be a kind of resistance against being seen narrowly, or as a stereotype.
Looking back, her earlier statement about not being out, or revealing her true self, until a level of trust had been established, was as relevant to her experience of the medical encounter. In the time allowed for the medical consultation, which is usually around ten minutes unless specifically booked for a longer time, the level of trust Sally desires is unlikely to develop. As a healthy woman whose use of medical services is limited to preventative screening, it may be that Sally has never had the need or desire to come out to a doctor.

**Lesley**

In the interview, Lesley (aged 47) described how, like a number of other women in this study, she had a regular doctor, with whom she was out, and another she sees from time to time with whom she was not out. She reflected on this:

… it’s kind of an interesting thing, that not everybody needs to know all. You know, if I’m feeling tired I don’t need to explain to everybody, and you can see there’s this sort of grey area between that and just doing that kind of talking around, so you don’t have to say. But you kind of, I suppose I’ve learnt to do enough. Even though I sort of think I’m out everywhere, like it’s somehow still I must not be.

With doctors, Lesley has “learnt to do enough”, and has constituted a “grey area” where her sexuality is of no importance. When Lesley went to school, she witnessed girls being bullied and excluded because of their perceived lesbianism. She embodied a sense that there can be negative consequences for being different. When viewed through this lens, her construction of a “grey area” and withholding information about her sexual orientation can be seen as a protective strategy – “not everybody needs to know”. The implication of her statement here is that it is hard (tiring) work coming out. For Lesley, coming out might be seen as a burden, something she needed to “talk around”, and decide whether she needed to say anything or not. Kelly also described feeling drained and worn out by “sort of thinking do I come out, [or] not come out?” Coming out was thus produced by both Lesley and Kelly as a burden.

There is also a sense of wariness and caution in Lesley’s statement above, about learning to do enough. As discussed in Chapter Six, coming out is not a one-time, linear process. Discourse about lesbian health demands increased visibility, and implicit in this is an expectation that each lesbian needs to disclose to her doctor. There are several ways of
Lesley’s wariness (and weariness) could be attributed to the implied demand to come out repeatedly. Her comment “even though I think I’m out everywhere … somehow I still must not be” suggests this. It could also be read as surprise that in spite of coming out many times, still everyone does not know, or as acknowledging the grey areas, in which not everything needs to be said, and not everyone knows everything about her. By producing coming out as a binary (in the closet/coming out) Lesley could be seen as being forced into an either/or choice, but her recognition of the grey areas suggests that she has another way of seeing coming out as being not either/or, but as something she can choose. Her wariness may also result from her embodied knowledge about the consequences of coming out. Her habitus was shaped in her early years by an awareness about the negative consequences of being sexually different, and while at a conscious level she said she had no problem with being out, her statement that “somehow she must still not be out everywhere” suggested that her habitus disposed her towards wariness in situations where she might be at risk.

Imogen

Imogen (aged 22) described herself as “switched on” to health issues. Her father, a doctor, had always discussed health matters with her, and until she was in her teens, he also provided her health care. She had a good relationship with her father and trusted him. Imogen came out when she was sixteen, her older brother is gay and came out before her, and while her mother was at first upset about her daughter being a lesbian, both parents are now accepting of their two children’s sexuality. One of Imogen’s earliest experiences with a doctor other than her father was when she went for her first Pap test.

… I was probably about eighteen and the doctor didn’t want to give me an STD test when I said I was a lesbian, she said that you didn’t need them, didn’t need a Pap smear and all that sort of stuff … I took her up on that – I said ‘don’t be ridiculous’ and I just said ‘I want these done’ and that was fine and yeah, it was all fine, but I never went back.

Imogen positioned herself as a consumer with this doctor; she saw herself as well-informed and demanded the service she wanted. When the doctor questioned whether she needed this service, her strategy was to assert herself. But having confronted the doctor in that consultation, she never went back. These two positions appear to conflict. I asked whether she is out with her current doctor:
I don’t think I’ve mentioned it to my current doctor … I, I guess I hadn’t thought it was relevant because they haven’t, they haven’t questioned me or I don’t know why. I know that my doctor’s gay-friendly, but … well she didn’t ask. I went in for a Pap smear and, and I had irregular periods so it came, that sort of stuff came up. But I just said I didn’t want to go on the pill, because that would’ve been the option, and she didn’t really question it, so either she, she guessed or, I don’t know – it, it didn’t – it wasn’t – it, it didn’t come up, so maybe that’s why – if it had, I would’ve said.

After her assertive stand with the first doctor, Imogen had been disposed to withhold information about her sexual orientation in her subsequent dealing with doctors, even when the practitioner was purported to be gay-friendly. Imogen indicated that she chose the practice she currently attended because it was known to be gay-friendly. It is possible that in this setting, homosexuality was assumed to be the norm, as heterosexuality is in most places, but the doctor had not raised sexuality and Imogen had not spoken of it. With the first doctor who told her she did not need a Pap test, Imogen was assertive and challenged the doctor’s authority. With her current doctor it appeared that sexuality was not mentioned, or even avoided. Imogen’s refusal of contraception was accepted at face value by the doctor. However, it is also possible that she did not volunteer information because she had to assert herself with the first doctor. Using the theory of habitus, throughout her life Imogen has embodied a positive, trusting attitude towards doctors which disposed her to trust them. One reading of Imogen’s story is that her disposition to trust doctors was disrupted by the doctor who gave her misinformation, so that she is now disposed to be more careful. Another reading is that in a setting where she felt comfortable and that acceptance was implicit, such as the practice she believed to be gay-friendly, she was disposed to trust the doctors, but that in the situation where she felt she was given misleading information, she was not afraid to confront the situation and assert control. It was clear though, that Imogen produced herself as a consumer in health-care settings.

Colleen

Colleen (64) described herself as being an intense, only child who was often “rushed off to the doctor” by her mother in case anything was wrong, but who was essentially healthy. When I interviewed her she had a number of health problems and saw her doctor frequently. She had also had a number of admissions to hospital for a range of surgical
procedures including, recently, thyroidectomy and hysterectomy. Because she was recruited while attending a lesbian health forum, I asked her how she saw herself in relation to the lesbian health issues she had been learning about, to which she replied:

I sort of don’t think of myself, well, I don’t sort of think of myself in that because I’m sort of not out, you know, with the doctors and that. I just sort of, you know, I think, oh, I wonder what other problems other people have got. Yeah, I just sail along with the breeze sort of thing. I’m not much help to you, am I?

She had a regular doctor who treated her for diabetes, with whom she was comfortable, but she had never considered coming out to this doctor. One way of reading her statement might be that Colleen withheld information about her lesbianism from the doctor. Given Colleen’s history of a controlling mother, and waiting until her mother’s death to make any kind of public statement about being a lesbian, it is not surprising that Colleen withheld information about her sexual orientation in the consulting-room. She had never come-out to a doctor. Her sailing metaphor could be read as implying that she is at ease with this. However, another reading might be that by keeping her sexuality secret she was able to keep the clinical relationship in calm waters.

The only time she has ever been in a situation in which she felt at risk of being outed, she was roused to anger. She had been referred to a chiropractor by another lesbian friend:

Oh, the chiropractor. So this night she’s working on me and I thought, I don’t know if I stiffened up, but she did, and I thought, I don’t sort of want to go out and tell people straight off. And she was working on me and I happened to mention a [lesbian] friend that she worked on too. And she said, I said, I’m a friend of hers. And she said, oh, kissy, kissy friends? And I said, we weren’t. I said, oh, no, oh, no … I thought well, there’s no need to tell her …. I thought well, if I said yes or anything, that would have put her away and she [the chiropractor] probably didn’t know about her [my friend]. Yeah, I didn’t think she should have said that to me. … I thought, no, I couldn’t say that to put the other person away anyway. I wouldn’t do that, yeah, yeah. If I’d have said oh, yes, she’d have said, oh, both of them? But then again, I thought, oh, gee, and they’re supposed to be sort of confidential when you go, you think that the doctor and all those people are going to be. So you know, that surprised me …. I had a little chat, I told the other girl and she went, oh, did she now? Kissy kissy friends?
The chiropractor’s reference to “kissy kissy friends” was taken by Colleen as an allusion to lesbians. It is possible that the chiropractor was attempting to make a connection with Colleen by asking this question. Rather than making a connection, Colleen saw the question as posing a threat to her and her friend. Rather than using a term like outing, Colleen described this as being “put away”, which could be read as some kind of imprisonment, as being cast aside, or even as a death sentence. She also saw a the chiropractor’s statement as a threat to the confidentiality of the clinical relationship. Colleen’s sense for the game told her that exposure carries risk; her embodied experience of difference, and the silence she had maintained to keep the affection of her family, could be seen to have been transferred to the health-care workers upon whom she was dependant. With her friends in the lesbian group, Colleen was one person, with her family and health-care workers she was another. There were similarities between her position and Monica’s reference to being split, “which box am I in at the moment?”. However, Melanie attacked, while Colleen kept the waters calm for plain sailing.

Discussion

In this Chapter I have discussed some of the factors that contribute to constructing the medical encounter for some of the women in this study. To assist in understanding the dynamics in the consulting-room between lesbians and medical practitioners, I have drawn on Foucault’s theories about power circulating within fields, post-structuralist notions of speaking and silence as discursive and Bourdieu’s theories of embodied habitus and dispositions, to analyse and interpret the complex interactions that occur between the lesbian and the doctor in the field constituted by clinical spaces. Rather than being invisible and passive, as lesbian health discourse suggests, each of the women in this project demonstrated a capacity for agency in medical encounters, but there are infinite varieties of ways in which this agency can play out. Each woman had a sense for the game based on a combination of cultural “common-sense”, and her own accumulated life experience. The individual’s habitus is not conscious but embodied; why she remains silent in some situations and speaks out in others is mediated by her understanding about the implied ‘rules’ about what is acceptable and what is not acceptable. This plays out both discursively and materially and is shaped by a range of historical discourses, as well as by personal experience, and the influences of family, culture and religion, and through shared social rules such as sexism, heterosexism and homophobia. There are also shared expectations concerning roles in the doctor/patient, consumer/service-provider relationship, that position the doctor/service-provider as more powerful. This is mediated
by the ways in which each party to the medical encounter (both doctor and patient) is disposed to act, each based on her or his habitus, as well as how each produces her or his role, as doctor/service-provider and as patient/consumer. Rather than being invisible victims of a homophobic system, each woman in this project can be seen to play an active role in deciding whether or not her sexuality is relevant in interactions with doctors, thus demonstrating agency.

The stories of the ten women in this Chapter show the diversity of ways in which different women approach the medical encounter, some assertively identified themselves as lesbian, others sometimes did and others did not, and one woman had never identified herself as a lesbian to a doctor. What was common to each of the women was a ‘fall-back’ position in the face of perceived risk of danger. This involved strategies to either remain silent about their sexual orientation, or going elsewhere to a practitioner who was known to be ‘safe’. The principal strategy, whether it involved identifying or concealing sexual identity, was care of the self - or resistance against normalising effects of Biopower (Foucault, 1980).

While each of the women’s stories are different, some commonalities and differences are also apparent. All of the women, whether they are assertively out (like Monica and Melanie), remain silent (like Kelly, Sally and Colleen) or decide whether or not to come out depending on the situation (like Lesley), view the medical encounter as being potentially dangerous. Because of this, under threat, they all had some kind of fall back position so they could retreat to safety. For Melanie, this involved going to a ‘safe’ GP when she had a negative Pap test and the GP who did the test was unavailable, for Imogen, a negative experience with a GP was enough for her to leave that practice and not return. Thus, even though the women each had very different ways of being, contradictions were apparent in each of their stories, as they attempted to resist the normalising effects of biopower in clinical spaces.

In the next Chapter, I examine issues about resistance in clinical spaces in the very specific field relating to conception, pregnancy and birth experiences of lesbians having (or attempting to have) children within their lesbian relationship.
8. Conception, Pregnancy and Birth Experiences

One of the effects of the interviews being semi-structured was that at times, unexpected themes emerged. Conception, pregnancy and birth experiences were examples of this. As it happened, these provided examples of the use of agency in a very specific context, and emerged as examples of capillary instances of power relations. This context is highly specific, women enter it with a sense of purpose; to conceive or give birth to a wanted child. Reflecting the research question about the ways in which lesbians position themselves as they negotiate clinical spaces, this context provided an example not only of ways on which women positioned themselves in the spaces related to conception and birth, but also the ways in which changing discourses influence this positioning. Therefore, in this Chapter, I describe the experiences of five women, who attempted, or achieved conception without having heterosexual sex (as opposed to the other women in the project who had children from prior heterosexual relationships), over a twenty year period. Here I explore the ways in which the discursive field concerning lesbian parents was influenced by a series of contemporary issues. I then discuss the ways in which the women used agency in clinical spaces such as fertility clinics, hospitals and doctors’ offices over the twenty-year span of time represented in their stories. Some of these stories relate to attempts to conceive, others to prenatal and birth experiences with hospitals and still others to interactions with doctors. As all of the participants in this study lived in Victoria at the time of interview, I focus mainly on the Victorian context in this Chapter, whilst acknowledging the impact of wider resources and discourses on the field.

In recent years there has been perhaps no more contested field of health than that in which lesbians have asserted their right to conceive and parent children within same-sex relationships. Lesbians have always had babies, but until around twenty years ago, these children were almost exclusively conceived within heterosexual relationships or from heterosexual sex. With the advent of reproductive technologies such as artificial insemination by donor and in-vitro fertilisation, the possibility opened up for babies to be conceived without the involvement of men beyond the donation of sperm. In the space of the past two decades, a shift occurred in which lesbians increasingly seek to have babies within their lesbian relationships.
As a result of recent political and legal events concerning lesbians using assisted reproductive technologies (ART) to conceive babies, the construction of lesbians as suitable/unsuitable to be parents has been played out in the public arena, and the impact of these discourses was apparent in the stories of a number of the women.

**Background**

Throughout the twentieth century, lesbians were stereotypically produced as sad, lonely, masculine women unable to have children and lacking family supports (Saphira, 1984). The advance of ART, including artificial insemination by donor sperm (self or assisted), and in-vitro fertilisation (IVF), revolutionised the reproductive field for lesbians and opened up possibilities that only a few decades earlier were not available. Motherhood without male involvement is not a new idea. This is apparent in the lesbian feminist futuristic fantasy genre of literature from the 1970s, wherein writers envisioned a future in which parthenogenesis made reproduction without the involvement of men possible.¹⁹

In the fertile political environment of second-wave feminism, the vision of a woman-centred and controlled future constructed by this literature created a discursive space in which the developing reproductive technologies could be embraced by lesbians (and single women) who wanted to have babies without the involvement of a man. Prior to the introduction of ART, the easy way for lesbians to conceive outside heterosexual relationships was through one-off, and often anonymous, sexual liaisons with men. This option remains, but the emergence of HIV and the possibility of the transmission of the virus through sexual contact made this less of an option by the mid-1980s. The co-occurrence of HIV and the introduction of the new reproductive technologies created a shift that led to women, particularly lesbians, embracing ART. However, their path to either self-insemination or assisted conception was not to be easy.

In the 1980s, the new reproductive technologies created a stir in legal, medical, ethical and religious circles which quickly filtered through to become more general community concerns. From a review of four hundred and sixty abstracts on assisted reproduction published between 1981 and 1985, a picture emerges of concerns about assisted reproduction in the early years of ART (Daniels, 1996). Debate raged about the future of the family, of fathers, and how to tell children who had been conceived by ART about the means of their conception. Of the 460 articles reviewed by Daniels, only thirty-two papers

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¹⁹ See, for example, *The Wanderground. Stories of the Hill Women* (1978), Persephone Press; and *Motherlines* (1978) by Suzy McKee. Also see www.feministf.org for a comprehensive list of publications in this genre.
(7%) that specifically mentioned lesbians were identified, and of these only twelve were actually supportive of lesbians using ART to conceive. This did not, however, stop lesbians from trying.

Publications that describe self-insemination techniques appeared in the 1970s and ’80s in the USA (Boston Women’s Health Collective, 1975), New Zealand (Saphira, 1984) and the UK (Foster & Hascombe, 1981). In her doctoral thesis, Dempsey (2006) discussed how some Adelaide-based women in her research had difficulty getting information about self-insemination in the 1980s. These women sought help from fertility specialists and GPs to no avail, and eventually achieved conception through self-insemination with the help of a book from the USA called Having A Baby Without A Man: The Woman’s Guide to Alternative Insemination (Robinson & Pizer, 1985). A Melbourne-based lesbian self-insemination collective group called Great Expectations, which was established in the early 1980s, reportedly used a British self-insemination guide (Feminist Self-Insemination Group, 1981) to help members to conceive. In the early 1980s lesbians in the UK were accessing artificial insemination by donor (AID) services, and at least one publication aimed at lesbians provided a detailed description of AID and addressed legal and ethical issues for lesbians and donors (Foster, 1981, noted in Saphira, 1984).

No data is available about how many de novo families exist, or when this phenomenon first appeared. It is likely that the professional and community concerns that emerged in the early days of this technology led to legal, medical and moral restrictions on access to AID fairly soon after its introduction. Anecdotally it is understood that several Melbourne lesbians accessed the services of the AID program in the early days, prior to access being restricted to heterosexual married couples. There was, however, a requirement by the two Melbourne-based clinics that provided AID services (at the Royal Women’s and the Queen Victoria Hospitals), for lesbians to undergo psychological testing prior to being accepted into the program (Dempsey, 1999). The shift to de novo families gathered pace in the 1990s. Two surveys of readers conducted in 1995 and 1999 by a lesbian magazine in New South Wales (NSW) (Lesbians on the Loose, 1996; 2000) demonstrate the shift in attitudes among lesbians towards de novo family formation in this period. In the 1995 survey 14.5% (106) respondents wanted children in the next five years. In the 1999 survey, there were markedly fewer respondents overall (386), however, a greater proportion of these (19.7%) indicated that they wanted children in the next five years. Of these, 70% intended to use donor sperm (presumably by self-insemination) and 15% to use a donor insemination service (McNair, 2000b).
Access to ART varies between states in Australia, and between Australia and other countries. This means that the field abounds with conflicting and contrasting discourses about lesbians, ART and parenting. The 1984 *Victorian Infertility (Medical Procedures) Act* limited access to ART to married couples, however, in 1995 it was amended and renamed the *Victorian Infertility Treatment Act*. In 1997 the Human Rights and Equal Opportunity Commission (HREOC) found that restricting access to married people was discriminatory and the legislation was amended in 1998 to include de facto heterosexual couples (Fertility Access Rights Lobby, 2000). Single women and lesbians still had no legal access to ART in Victoria. Lesbians were defined by default in the act as single women, as lesbian relationships had no legal recognition.

In 2000 a challenge was mounted against this restriction on behalf of a single woman seeking access to IVF, and the Judge ruled in the case of McBain vs. the State of Victoria, that provisions of the *Victorian Infertility Treatment Act 1995* were inconsistent with the *Commonwealth Sex Discrimination Act 1984*. The Victorian Act refused to give IVF treatment to any woman who was not married to, or living in a de facto relationship with a man (Del Villar, 2000). Under this law, single women and lesbians were excluded from receiving IVF treatments. This case sparked a national controversy, with the focus of the public debate being on lesbians having babies without the active involvement of a man, thus denying a child the right to a father. The Prime Minister swiftly moved to amend Commonwealth legislation so that IVF treatment would be limited to heterosexual couples (O’Brien, 2000). So far these attempts to change Commonwealth legislation have been unsuccessful.

After a 2002 challenge in the High Court of Australia, the Federal Court’s decision was upheld. While access is now available to IVF regardless of relationship status, a requirement remains that to be eligible it is necessary to be ‘medically infertile’. Lesbians continue to be restricted from accessing IVF unless they are medically infertile; inability to conceive because of refusal to engage in heterosexual sex has been constructed as ‘social infertility’, which is excluded as a basis for seeking assistance, under the Government-funded (through Medicare\(^{20}\)) IVF program. The result is that some lesbians who fail to conceive using donor insemination and are subsequently diagnosed with conditions such as polycystic ovaries are able to access IVF because they have a diagnosis that constitutes them as medically infertile. These women have still not had to

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\(^{20}\) Medicare is the Australian ‘universal’ health care system. It is partially funded through a taxation levy, provides some free hospital and medical services, and in some cases, a co-payment is also required from the patient.
have heterosexual sex, yet are able to access the IVF program, while others who do not achieve such a diagnosis are denied access. IVF is only one of a number of ART procedures available to assist conception. In Victoria it remains illegal for lesbians to self-inseminate outside a licensed medical clinic, although this is currently under review (Victorian Attorney-General’s Advisory Committee on Gay, Lesbian and Transgender Issues, 2000).

**In/visibility and Agency: Changes over Time**

Lesbians were having babies without men in their lives well before the 2000 McBain case, and there were women in this project who had sought to start de novo families twenty years before, starting in 1983. During this period, considerable changes occurred in the field concerning lesbians, ART and de novo families. The introduction of the new reproductive technologies created a new discursive field in which lesbians struggled to change the rules and extend the boundaries in order to gain access to insemination, fertility and birthing services, as well as to be seen as authentic parents in the absence of a male. These shifts can be seen in the stories of the women in this project who attempted to become pregnant and/or had babies in this twenty-year period. In some ways the actions of these women to achieve their goals were ground-breaking, but echoes of earlier heteronormative discourses in which a woman can only be fulfilled by a child and the true family is the nuclear family also remain apparent.

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Sandy (52) and her then partner had tried in the early 1980s to get assistance to conceive. Her first attempt was when she was living in Sydney and attended a hospital fertility clinic for AID. According to Sandy:

… they um, said that, they were worried that I was the vanguard of the movement [laughs]. I mean they were really worried that I was doing it for a political reason and not for um, the reason I wanted a kid … they said we didn’t, me and my girlfriend at the time didn’t constitute a family and that I wasn’t infertile and, you know, there was this suspicion that I was doing it for political reasons.

The hospital’s reluctance to help Sandy is indicative of the moral and ethical concerns reflected in Daniels (1996) summary of literature described above. Sandy had remained angry because she and her partner were rejected on the basis that they did not constitute a family. This rejection implicitly produces lesbians as unhealthy subjects, unfit to be
parents and reflects the discourses that circulated during this period. The suggestion that Sandy’s attempts to conceive were political, whether expressed directly by the hospital or produced retrospectively by Sandy as a way of explaining the rejection, is in one way risible. The image of a woman becoming pregnant to prove a point is far-fetched, but when viewed through the lens of fear and uncertainty that the new reproductive technologies had aroused in the community, and in conjunction with the social changes being demanded by the women’s and gay pride movements, it is possible to see this as a reflection of deep-seated sexist and homophobic discourses.

Not deterred by the Sydney hospital’s refusal to provide AID services, Sandy moved to Melbourne and tried again to get assistance to conceive. Through the lesbian community she heard about a doctor who had helped another lesbian to get pregnant and consulted him.

… he was sort of helpful to me for a while and, you know … what times I should get sperm and all that kind of stuff. And then he referred me to a woman who worked at the Free Masons [hospital] and she worked in, in fertility too and she gave me other stuff, you know, to take to find out when I was ovulating and all that, but then, in the end, nobody actually took that extra step of doing anything about, you know, helping me to get, and she, she almost did for awhile, but then ah, she said ‘look, you’re not really in a’ – I was in a relationship at the time, but she said ‘you’re not really in a, you know, you have to assure me that this relationship’s going to last’ and she kind of, it was strange, she kinda changed at the end.

Agency can be seen in Sandy’s attempts to get medical assistance to conceive, both in getting information from other lesbians about helpful doctors, and in her repeated attempts to get help from doctors and clinics. However, when no doctor was prepared to take “the extra step” to assist her, the challenge to the validity of her relationship presented a foreclosure that she was ultimately unable to break through. For Sandy, the force of this foreclosure had resulted in her never taking the steps necessary to become a parent.

Twenty years ago, in spite of the public debate about ART, and the undercurrent of sexism and homophobia that surrounded the debate when women without male partners sought to use the technology, in the lesbian community discourse about lesbians conceiving babies in de novo families was essentially subjugated. In her 1984 report of a
survey of seventy lesbians about AID in New Zealand, Saphira referred to the reluctance of lesbians who achieved conception with AID to talk about their experience for the fear that the technology would be restricted as a result (Saphira, 1984). When these subjugated discourses did erupt into the mainstream, they appear to have caused some discomfort among doctors and other ‘gate-keepers’ of ART. This can be seen in the way that Sandy described being refused assistance by the Sydney fertility clinic because of the political ramifications, and in the way that the doctors in Melbourne attempted to help her and later withdrew their assistance. It is impossible to say that this was directly associated with Sandy’s being lesbian, but in her mind there was a direct association between the doctors’ refusal to help and their lack of recognition of the validity of her same-sex relationship – and that feeling has endured for over twenty years. It also coincides with a more general realisation that the new reproductive technologies have ramifications beyond those that had been envisaged by those who controlled them.

The production of lesbians as unhealthy subjects has not been limited to reproductive technologies. It is likely that, influenced by the women’s movement and gay rights, and before the new reproductive technologies became available, lesbians who wanted babies outside a heterosexual relationship conceived through anonymous sex (Dempsey, 2005). Many of these women are likely to have passed as single mothers, but as societal changes brought more lesbian couples into the open, they have sought recognition of their relationships in clinical spaces like hospitals. In the 1980s, HIV made casual sex with strangers more risky for mother and baby, and ART made it possible for de novo families to expect to be recognised in the whole range of maternity settings.

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In 1994 Lesley (48) and her partner conceived a baby and proceeded to follow a traditional path for antenatal care and birthing though the Royal Women’s Hospital (RWH). Lesley indicated in the interview that she was motivated to participate in this study because she had a “need to tell” someone the story about her painful experiences around the birth of her son. Lesley is the non-biological parent of a nine-year-old son and she described herself as one of a “small, but growing” group of separated lesbian families. Her son now lives with his birth-mother but Lesley had regular contact with him and continued to be involved in decisions about his life. She reflected on why she had decided to take part in the interview:
… as soon as I saw the flyers [for this study] … [I thought] I need to tell someone about this, so there was a real – and even just noticing that reaction I sort of feel like I should have followed this through more at the time.

For the birth she and her partner booked into the birthing centre at the RWH. At their first visit to the hospital prior to starting antenatal classes, they told the staff they were a lesbian couple, and received a positive response, which led them to believe that they would be accepted. Lesley said:

I was the support person … that’s how they do it because at the birthing centre you have to have someone, they call it a support person. So it was an interesting experience, I’d go along to the antenatal classes and it’s so heterosexual, I don’t know if you’ve ever been to one of those things, but it’s not just the heterosexual couples, they’re all over each other. It’s sort of weird. So I sort of felt a bit brave. But there was a, there was a woman there who was there with her mother, and so there was one other kind of odd couple, as it were. So that sort of required a bit of bravery [laugh] going along.

It is apparent from this statement that Lesley and her partner followed the rules; they came out before the classes and established that they would be accepted in the hospital as a couple. The language used by the hospital was not heterosexist, and Lesley and her partner assumed that they could participate as equals in the class. The space of the antenatal classes were, however, heterosexualised in the extreme, and having “braved” the heterosexual dominance in the classes with some discomfort, in the final antenatal class they realised that their assumption about acceptance was premature:

… the midwife who took [the last class], she hadn’t taken any of the other sessions and she just talked about the father the whole time. And I left and I went downstairs and I just cried. I cried and cried. And I, it was like I’d never felt so invalidated in my whole life, it was just awful. I mean we did, we did sort of make, well, in an informal way, a complaint. [We] spoke to the [head nurse] because it’s against their policy in fact to [use the word father]. Their policy is to use the word partner.

Lesley and her partner understood that the terminology ‘support person’ was a gender-neutral term used by the hospital for those who are present to support the mother during labour and birth. It is interesting to note that despite a majority of the participants in
antenatal classes being heterosexual, in 1994 when Lesley’s son was born, the hospital had already adopted a policy of using the word ‘partner’ to refer to the person supporting the mother during labour. Whether this was because of the entry of lesbians into the field, or because of the more likely scenario that unmarried heterosexual couples had become increasingly commonplace in the previous decade (which is why in 1998 the Infertility Act was changed), is unclear. If the policy about language was in relation to unmarried heterosexual couples, then the use of the term ‘father’ was not a breach in the way that the term ‘husband’ might have been. It is possible, even likely, that same-sex parents were not yet highly visible in the field.

Regardless of why the hospital used the inclusive term ‘partner’ in preference to father, Lesley and her partner took it as a sign that the hospital was open to non-traditional couples. Their hopes were dashed, however, by this one incident, which implies that their trust was misplaced at best. When their hopes that their relationship would be recognised were not realised, Lesley retreated to a more protected position, which can be seen as playing into heterosexist discourses. Lesley constructed the lesbian couple and the mother–daughter couple, those who did not conform to the heterosexual norm in the class, as the “odd couples”. For her this difference created a sense of vulnerability; being visibly different in the group and being exposed as different required bravery.

The space in the antenatal class was heterosexualised by the overt shows of affection between the couples and the exclusive language used by the midwife. This acted as a foreclosure that limited Lesley and her partner’s willingness to be out with hospital staff for the rest of their pregnancy and birth experience. The experience of being visibly different in heterosexualised spaces can evoke feelings of discomfort, displacement and not belonging, thereby threatening the individual’s ontological security (Corteen, 2002). Thus when Lesley described feeling “invalidated” by the midwife’s reference to ‘fathers’ in the antenatal class it posed a threat to her sense of self, and to the validity of her role as a parent.

Corteen’s (2002) study investigated violence, sexuality and space with lesbians in the UK, and reported that lesbian focus-group members found it difficult to distinguish between feeling safe and feeling comfortable in heterosexualised spaces. As a result of the ontological crisis initiated by their experience in the antenatal class, Lesley and her partner felt neither safe nor comfortable enough to disclose the nature of their relationship during labour or later in hospital, so they effectively rendered their relationship invisible.
This, however, does not represent passivity on their part; they actively withheld information about their relationship because they felt uncomfortable in the hospital. Lesley explained why her partner was not willing to be out with the nurses at the hospital:

‘Cause she felt so vulnerable, she just didn’t want to have to deal with it. Well, not vulnerable, she was sick and weak and she didn’t want to have to deal with that. And that meant that I was, I was very invisible, and I noticed on the notes at the end of the bed in the section under social support they had nothing. ... So yeah, that’s another negative one. And I don't know what people thought when it was just, you know, that it was only women who kept kind of coming in. They didn’t twig.

One way of reading this narrative is that Lesley was rendered invisible by heterosexist staff who were not able to see the possibility of two women being parents. In this reading Lesley is a victim of an oppressive system with little room to move without exposing herself to increased danger. Another way of reading it is that recognising the potential threat, as a result of their own embodied experiences, the women protected themselves by not naming their relationship and passing as friends. Either way, the impact of having not only their relationship, and her relationship to the baby erased, but her role as supporter and carer, was devastating for Lesley. Almost ten years later she needed to tell her story.

In choosing silence, Lesley attempted to protect herself and her partner against homophobic attack. Silence can be seen as a self-care strategy, or a tactic of her habitus, fear disposed her to remain silent. While the intention of this choice was understandable, self-care strategies are not always successful and do not always have positive outcomes. The cumulative effect of the discourses that shape the habitus can dispose individuals to resist in different ways, and the outcome is not predictable.

Lesley’s invisibility in the birth experience was constructed mutually by the hospital staff and by Lesley and her partner. The hospital staff were unable to conceive of the possibility of two women being parents, and this lack of recognition meant that no opportunities were provided for them to come out or be recognised. The (male) midwife in the delivery room spent a considerable amount of time with them in an intimate setting, in which he must have recognised the relationship between the two women on some level. Staff involved in the mother and baby’s post-natal care could have asked questions about home support, although it is not clear whether Lesley’s partner at the time lied to them about her relationship. Staff in the antenatal classes asked Lesley and her partner not to
complain about the midwife they felt discriminated against them, essentially pitting one minority (women from culturally and linguistically diverse backgrounds) against another (lesbians). In this case, the hospital privileged not only the women from culturally and linguistically diverse backgrounds, but also their staff, over lesbians. Each of these situations represented opportunities lost. Comparing Lesley’s experience with Shona’s, of taking her son to hospital and being asked, “so who is the mother?” discussed in Chapter Seven, the potential for small acts to make a difference is apparent. With a simple question, in Shona’s experience, a nurse was able to establish the relationship between a non-biological mother and her son, and at the same time make the whole experience less stressful.

Expecting the lesbian to speak out when she feels vulnerable can place her in an untenable situation. Lesley and her partner remained silent about their relationship in the hospital as a self-care strategy, and the accumulated silence on both sides rendered their relationship invisible. Having risked openness (in the antenatal class) and experienced a foreclosure, they felt vulnerable and chose to remain silent to protect their safety and comfort. In this way the women attempted to make the space safe for themselves.

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Candace (28) self-inseminated in 2000, at around the time of the McBain case. At the time of our interview her son Daniel was two years old. By the time Candace wanted to have a baby, she had access to information about self-insemination and had benefited from the formation of groups such as the Prospective Lesbian Parents group, that advertises in the gay press in Melbourne. Her donor was a gay man who offered to provide sperm through this group. Candace continued to have a cordial relationship with her donor, whom she acknowledged as the child’s father.

When she decided she wanted to have a baby Candace went to her family GP, who knew her to be a lesbian, for advice. She was provided with a specimen jar, syringes and advice by the doctor to assist with self-insemination. For antenatal care she attended a major teaching hospital and her experience was markedly different from Lesley’s six years earlier. She was open about her sexuality and rather than feeling invalidated by her experience, she felt that her difference was respected and that she and her (then) partner were accepted as a legitimate couple. She said:
… no one ever treated us any differently … even when we went to the birthing classes we were the only you know, lesbian couple and they all sort of were quite accepting.

I asked whether she had felt included and accepted in the antenatal classes when the term father was used.

They always talked about the father purely because, although the midwife I must say did make sort of, you know, did try and make amends with that and sort of saying father, partner, whatever, you know, used different words. But generally because they were all fathers bar us, then they would say the father … Actually she talked to us about that and she said what do you prefer and we said, well, we don’t mind, because the majority, like, nine out of ten of the families had fathers. I don’t feel like we were discriminated against in that sense.

While the midwife used the term father, she openly acknowledged to the lesbian couple that she understood it to exclude them. By this acknowledgement she included Candace, who acknowledged that she and her partner were a small minority in the class. The use of the term father was not experienced by Candace as a foreclosure, as it was by Lesley and Shona. This sense of inclusion was not universal, though:

… there were still the times, more so with the doctors than with the midwives, when they automatically assumed heterosexuality … I didn’t like that. And I would often say, well, actually I’m a lesbian and I have a partner and some would go, oh, okay, or, sorry, or whatever. But it sort of went like a 747 over their heads and they just chose to ignore it most of the time.

Here Candace was disposed to speak out against misrecognition, rather than being harmed by it. This may have been because of her embodied sense of justice, or it may have been due to a more general sense of openness about sexuality at the time. I asked Candace whether her outspoken correction of these assumptions of heterosexuality had ever backfired on her in any way to which she replied, “I don’t think so. I wouldn’t have noticed it anyway, well, I was so happy to be pregnant”. Rather than feeling she needed to be silent about her sexual orientation Candace positioned herself as assertive, which was a radically different position from that assumed by Lesley or Sandy in the earlier years of the lesbian baby boom. The hospital staff also appear to have positioned themselves differently from those described by Sandy or Lesley. It is difficult to know whether or not
this is because there was an expectation on the part of Sandy and Lesley that they would be rejected because of their sexual orientation; it could be read from Candace’s statement that she was so happy to be pregnant that she would not have noticed if there had been any negativity, that this expectation created a prophecy that was fulfilled. Although there were assumptions of heterosexuality, there was also at least one instance in which a nurse seems to have overlooked the fact that Candace’s partner could not have been biologically linked with the baby. Candace explained:

My partner at the time … she had a twin sister. We were talking to the midwife. The midwife goes oh, so you might have twins, completing forgetting that, like, she wasn’t the father. So that was really great. Like, that was how much we were accepted and so yes, and very, very, very, just fantastic and I suppose I shouldn’t be surprised, but I am, but they had her name on the card for the hospital and yes, so they were very open and it was a good choice.

Thus Candace and her partner do not appear to have been produced as unhealthy subjects in this case, and in some respects their relationship was normalised by many staff members. Her positive experience was not only related to her treatment by the hospital staff, but also to her own joy at being pregnant and becoming a mother. Her capacity for agency meant that rather than being vigilant and fearful, Candace was able to enjoy her experience and assert herself to correct assumptions of heterosexuality. While there are different ways in which women position themselves, and in which they are disposed to act, the changes that had occurred in the field since the early 2000s may have contributed to more openness in antenatal services.

Another issue that emerged from the analysis of Lesley and Candace’s stories, is the production by the hospital staff of the partner who is not giving birth as the ‘father’. This reflects a heteronormative bias that plays out, regardless of whether lesbian relationships are accepted openly or repressed – either by the hospital staff or the lesbians themselves (as occurred in Lesley’s case). The imposition of this heteronormative bias leaves no space for parenthood that does not include a male father, or a father figure in the form of the birth mother’s partner. In the absence of a space for a role (such as lesbian partner/parent) that transgresses heterosexual norms, the lesbian partner can only be conceived as ‘father’. This reflects the emergence of older discourses about lesbians and role-playing heterosexual style relationships that were discussed in Chapter Two, and in the discourses described in Chapter Six, in which Martina Navratilova was used as the
epitome of the ‘mannish’ lesbian by both Colleen and Jenny’s mothers to limit the acceptable performance of gender for their daughters.

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Shona (35) and her partner had a son who was just over a year old when I interviewed her. These women, unlike Candace or Lesley, were economically in a position to use the private health system for their birth experience. They accessed a fertility clinic interstate with the assistance of two private sperm donors from overseas (gay men who are personal friends), and had a private obstetrician for their antenatal care and to deliver the baby. They adopted a consumerist approach to the birth, checking out several hospitals against specific criteria they had identified. One of their requirements was to be able to deliver in a birthing centre and they established that they could use the facilities they chose in the public system, and still have their own private doctor. Their first choice for the birth was the RWH, where they went for a site visit:

… at the Royal Women’s birth centre um, the midwife who showed us around kept asking questions about where the father was, and so that was a bit off-putting, and then we went to the Mercy and ironically enough, I mean it’s a Catholic hospital, but they were completely fine about having a lesbian couple there, I mean I’m sure – we – no, we weren’t the first because friends had gone there.

At the Mercy hospital, Shona and her partner were impressed by the inclusive language used by the staff. I asked whether they had come out as a lesbian couple, to which Shona replied:

I can’t remember what we said, but we would’ve – we certainly weren’t hiding, I mean we went together and would’ve said something along the lines of, you know, ‘well we’re having a baby’ something, um. I’m sure we presented as a couple, yeah, in fact I think maybe we did – maybe we even asked some sort of question about, you know, ah, same-sex couples and I – but I, and I distinctly remember in one of the – they have prenatal sessions, um, the midwife was quite careful about using non-discriminatory language and I actually said to her after ‘oh, look, thank you I really appreciated that you did that’, so they were very um, you know, not always referring to father and mother, um, sort of thing. … we had a double room, you know, all the midwives were, as far as we could tell, they
were fine with it, and certainly no one said anything or did anything that made us think there was any problem.

From Shona’s difficulty recalling how they communicated with the hospital staff about their relationship it appears that for her their same-sex relationship may have been normalised to the point where it did not need to be explained. The staff at the Mercy hospital not only accepted them but also apologised when they used exclusive language, and Shona later acknowledged her gratitude for this recognition to them. Rather than being vigilant about discrimination, Shona and her partner assumed that they would not be perceived as anything other than normal, and this worked for them. Shona’s story demonstrates the productive nature of this consumerist position. By asserting themselves the women were able to claim capital in the field, articulate their desires and achieve a positive outcome. It also suggests that more general access to economic and symbolic power such as that already accessible to Shona and her partner positions the individual as more powerful from the start than those who are more self-deprecating or disadvantaged.

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Georgia (42) and Mandy (32), the most recent of the participants to enter this field, were five months pregnant at the time of interview. They are an Aboriginal couple, and as described in the last Chapter, Georgia had had a lifetime of negative and racist experiences with the health system, while Mandy’s experience had been more positive. Having been forced to engage with the health system to achieve conception, Mandy and Georgia related a number of experiences with medical staff in which they resisted domination and struggled to gain capital in the field, in order to achieve their goal of pregnancy via ART. They first attempted to conceive through AID using a fertility clinic. They were very cautious about revealing how they had achieved this in Victoria, given the legal exclusion of lesbians from AID programs, because they felt that it might cause problems for the friends who had helped them. The AID experience was not one they felt comfortable about, rather one to be suffered to achieve their desired end.

Mandy: … to begin with I did just the inseminations where they inseminate the sperm into you and, um, like, the very first doctor, and it had to be the very first doctor we got, was this very old, old English, um, you know, very stereotyped man and he sat there and he explained to me how, what he was doing was simulating sex.
Georgia: Intercourse was his exact words.

Mandy: Yeah, intercourse, he didn’t use sex, it was intercourse and I just felt so revolting when I walked out of there. I said, Georgia, I hope that never happened and I went in there, I said I never want that man to do it again. So, like, probably I’m a pretty outspoken sort of person, but you know, I had to go in there and say I don’t want that man again because he made me feel revolting.

The way in which this doctor suggested he was simulating intercourse was experienced as shocking, and both women felt uncomfortable about it and his general attitude towards them. But rather than being put off, they demanded their right to see another doctor. While they found the first doctor “revolting”, they did not experience this behaviour as a foreclosure but asserted their right to continued treatment with another doctor. After failing to conceive with AID, it was established that Mandy had polycystic ovaries and was therefore medically infertile and eligible for the IVF program. Through (heterosexual) friends they located a gay-friendly doctor who entered them into the IVF program.

Georgia was present with Mandy throughout the insemination and IVF procedures, which were not done by their private gynaecologist, but in a clinic. They related how had been treated in a number of different clinics. Prior to being entered into the IVF program they had been required to go for counselling. Mandy said:

… the whole process is you have to go through counselling and you have to be interviewed by one of their directors and, um, he must have known we were gay, but he’d just forgotten. I presume he’d be a very busy man sort of thing, so he just, he asked me where my partner was and I said well, she’s sitting there and he got very embarrassed and just ticked all the boxes and rushed us through sort of thing, yeah.

Despite their surprise when one of the senior doctors expressed ignorance about their relationship, rather than experiencing it as a foreclosure Mandy was assertive about including Georgia as her partner. This was not the only account the women had about doctors being demonstrably uncomfortable with their relationship. For example, Mandy related another experience with a doctor at the IVF clinic who also appeared to be uncomfortable with them:
… we had an Indian doctor and that was a cultural thing for him. I don’t think he could cope very well though with us being lesbians. … but he didn’t work there very long. I think he had a lot of cultural differences overall, but us in particular being lesbians he felt very uncomfortable around and you could tell, yeah.

In this statement, Mandy made an assumption about the Indian doctor’s cultural preferences, in doing this she appeared to be searching for a way to explain her sense that he was uncomfortable with them as a couple. The accumulated bodily experience of being treated as inferior, may lead to a kind of vigilance and sensitivity to the dispositions of others. Georgia discussed an experience at the RWH, where they were treated dismissively by several of the nurses:

… one or two nurses were funny with us too at the Women’s, in vitro nurses. …

They just thought we were wasting sperm and stuff like that.

In comparison with the experience of being excluded by heteronormative language or the assumption of heterosexuality, some of these experiences could be seen as outright prejudice. Yet rather than being put off, Mandy and Georgia were able to pursue their goal with a united front. They did this at times with humour, at times assertively and at times with aggression. Unlike Candace, who was disposed to see positiveness, Mandy and Georgia saw prejudice and discrimination, however, their sense for the game disposed them to be creative in their approach to these situations; at some times they chose to dominate, at others to hand over control to the doctor. Because of the habitus is a system open to change, the outcome of these dispositions is not predictable.

**Legality Discourses and Fears about Disclosure**

Because of the restrictive laws in Victoria concerning self-insemination, it has been suggested anecdotally that a number of lesbians elect to travel interstate and even overseas to clinics to conceive through donor insemination, although only two of the women in this project had been interstate to use fertility clinics. During interviews several of the women raised issues concerning the legality of their conception. Given the degree of debate in the public domain that resulted from McBain vs. the State of Victoria (2000)\(^\text{21}\), it is not surprising that confusion emerged about some of the legal issues

\(^{21}\) In 2000 the Judge ruled in the case of McBain vs. the State of Victoria that it was discriminatory to refuse access to fertility treatments to a woman on the basis of her marital status. Subsequent to this decision, attempts to amend Commonwealth legislation to exclude women on this basis were unsuccessful. However, there remains a requirement for women to be ‘medically infertile’ to be eligible to access the IVF
concerning self-insemination, or that certain myths and misconceptions arose as a result. Two examples of this emerged during interviews with women who had conceived post-2000. Mandy and Georgia were pregnant when I interviewed them. In their attempts to conceive, they had located some gay men who were willing to donate sperm, but they believed it to be illegal for gay men to be sperm donors:

\[ ... we had a couple of gay fellas who we were going to use as our donor, but they had to say that they weren’t gay because it’s illegal for gay men to donate sperm. So they would have to lie on the form and a lot of them didn’t feel comfortable with that [Georgia]. \]

After unsuccessful attempts to conceive using AID, they found a gay-friendly doctor who would enter them in the IVF program. As he was a gynaecologist they were required by law to obtain a referral from a general practitioner to claim Medicare benefits for these treatments. They went to a gay-friendly general practice in Melbourne to get a referral. According to Mandy:

\[ ... they wrote out a referral for me and sat there and told me how illegal I was being and I sat there and said, yes, yes, yes, just write the referral. \]

Post-2000 the discursive field concerning lesbians and conception was confused. Whereas prior to that time there were laws that excluded lesbians from being assisted to conceive through public or private clinics in Victoria, the publicity about the court cases made the field more confused, and discourses abounded about whether self-insemination was legal or illegal. In the lesbian community, anecdotally doctors who advised lesbians on self-insemination were said to be breaking the law, and it was even said that it was illegal to transport sperm from one room to another to assist a lesbian to conceive. Some of these discourses were based in reality, others in half-truths, and yet others were erroneous. It is not illegal for gay men to donate sperm, although AID clinics may exclude them because of the perceived risk of HIV infection. When the doctor Mandy saw for a referral to a gynaecologist suggested there was something illegal about her attempts to become pregnant, it is not clear to what she was referring, but for Mandy it compounded her fears about the legality of their attempts to conceive. This could have constituted a foreclosure for Mandy and Georgia – they accepted without question that it was illegal for gay men to

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program, which excludes lesbians whose only reason for requiring treatment is that they refuse to have sexual relations with men. This is classed as ‘social infertility’.
donate sperm – but it did not prevent them from pursuing their goal, because rather than feeling oppressed by these discourses, they were disposed to find a way around them.

A similar capacity for finding ways around barriers was also demonstrated by Candace, whose son was three years old when I interviewed her. She raised the issue of feeling that she had conceived outside the law. Candace met a donor through the Prospective Lesbian Support Group and subsequently conceived through self-insemination, without any medical assistance. However, during her antenatal care and later while she was in hospital, she felt constrained by the belief that she had broken the law:

… I was so happy to be pregnant and so, well, the hardest thing [when] I think about it, was that I couldn’t really say how I got pregnant. People would automatically assume that I slept with a man to get pregnant, even though I was a lesbian.

I asked why she felt that she needed to keep the method of her conception a secret.

… because it was illegal. I thought it was illegal or, you know, you can’t move sperm from one room to another or some crap, god. You're screwed if you’re walking from one room to another having sex, you know, but you know, yes, so I sort of felt like that was the hard part, was that I had to, you know, keep that a secret, yes, and, yes, I guess that was the hardest thing now that I think about it.

Once the matter of lesbians and ART had entered the public domain, the discourses about illegality appear to have affected the ways in which these women approached conception. Whereas in the 1980s (when the discourse about ART was focused on moral and ethical issues which can be seen as having defeated Sandy through lack of support) after 2000 women were able to take a much stronger stand. This is not to say that women were not capable of taking strong stands in the 1980s, but because the discursive field was as yet undeveloped and essentially subjugated, resistance was more limited. After the McBain case, the field was visible because the discourse was more structured. This created a space in which lesbians were able to contest homophobic discourses in a wider variety of ways. Rather than letting the discourse about illegality constrain them, the women discussed here were able to become more active agents and find ways around the barriers placed before them, as they attempted to conceive. They did this not by becoming invisible and passing as heterosexual – which was eminently possible – but by confronting the gate-keepers in the clinical spaces they were forced into to access ART.
In each of the examples discussed here, while they may have felt the need to conceal the details of their conception, the women were out about their relationships with doctors and medical staff and forceful about getting what they wanted.

What emerged from these stories is what Sally described in another context as practised ways of being. The ways in which individuals respond to any given situation is complex and fluid, depending on the time and context in which it occurs, as well as on their embodied experience, and access to capital. The politics of the women’s movement and the gay pride movement had shifted community attitudes towards lesbians in the 1980s and 1990s, and the discursive break caused by the McBain case provided a space in which individual lesbians could contest the repressive discourses promulgated at the political level. This is another example of politically negative discourses creating a discursive space in which resistance can occur, as described in Chapter Six in the case of Colleen and Jenny and “intelligible genders”. When Colleen was growing up, lesbian and gay discourses were virtually completely subjugated, and Colleen found no space to resist, whereas for Jenny, twenty years later, anti-lesbian discourses created a space in which she could contest her difference. The homophobic discourses in the 1990s about lesbian parenting created a space in which women like Candace and Shona, who came later, could assert themselves and resist.

While not complete, the discursive break constituted by the McBain case led to wider community support for lesbians and single women, and can be seen to have constituted a discourse in which lesbians were produced as women who desire the same things as heterosexual women, to settle down and raise a family. In this discourse, the only difference between lesbians and heterosexual women is that lesbians want to do it with a same-sex partner. It can be argued that this discourse enabled lesbians to assert themselves in clinical antenatal and birthing spaces. They were no longer the Other, but similar to everyone else, with one difference, they were in a same-gender relationship. The discursive break brought about by the McBain Case brought lesbians into view in ways that had not occurred before. Despite the discourse that produced them as unhealthy, and unfit for parenthood, another discourse also gained purchase in which lesbians were just ordinary people. According to Scott (1993), knowledge is gained through vision; the visible is privileged and what we see and how we see it is structured by discourse. The McBain court case, and the associated political and media-driven debate, structured a discursive field in which lesbians in Victoria gained visibility in ways that had not occurred before, and de novo lesbian families started to gain credibility.
Discussion

In this Chapter I have used the experiences of lesbians who have attempted to conceive, and those who became parents using ART, to illustrate the ways in which the interaction between discourses and the field impact on individuals, and the ways in which the actions of individuals can impact on the field. The field constituted by fertility and birthing services has been subject to rapid changes in the last fifty years, and de novo lesbian families are recent entries. By understanding the discourses that impact on the field through the stories of some of the women in this study over a twenty-year period, it is possible to see how these discourses influence the field, the ways it is rearticulated, and the factors that influence the opportunity for resistance available to individuals within it. It is also possible to see that negative discourses need not be repressive, and for some they can be productive. The kinds of resistance apparent in the women’s stories relating to conception, pregnancy and birth are to some extent different from those about experiences in the general practice consulting-room. In relation to conception, pregnancy and birth experiences, the women in this study had a strong sense of purpose, and increasingly over the twenty-year span covered by their stories, they found ways around the barriers, to achieve their ends.

In the next Chapter, I will turn to the discourses and experiences that influenced the ways in which the project participants positioned themselves in relation to the general practice consulting room. The main difference between the context described in this Chapter, and that of the next, relates to the ways in which the women positioned themselves in the field, and the impact of discourses about women’s health and lesbian health on this positioning. This will be discussed in detail in Chapter 10.
9. Constructions of health and choosing a doctor

In Chapter two, I discussed discourses of lesbianism and lesbian health and how they influence the ways lesbians construct and manage their health. I further explored these matters in Chapter Six, indicating how these discourses are implicated in sexual subjectivity, and coming out/disclosing in clinical spaces. In this Chapter, I again turn attention to the impact of discourses on health and health seeking behaviours in the specific space of the general practice consulting room. This is where the most frequent contact between doctor and patient is likely to occur. It was in this setting that the complexity of the ways in which the participants in this study produced and managed their own health was most apparent.

In addition, in chapter five, I discussed the notion of governmentality, which Foucault (1988) described as the connection between technologies of the self and technologies of domination. This makes it possible to begin identifying the intricate procedures and practices involved in the monitoring and regulation of the self, which might be understood as intimate self formation. This is a refinement on how subjectivity and positioning were discussed in earlier chapters. It is in this sense that Rose (1999) described the practices involved as being closely involved in the invention of the contemporary self. The regulatory ideal of the self calls for profound inwardness and concomitant personal autonomy. According to Rose (1996), representatives of biomedicine, in the form of therapeutic authorities (doctors, psychologists and other health care providers), work in the service of liberty and personal choice. In this framework, the effects of the biomedical ‘apparatus’ are profoundly subjectifying. That is, they are affective embodiments rather than manifestations of innate psychological characteristics. This is not a simple matter of external imposition. As a result of the productivity of self formation, regulation emerges from inside ourselves, from our desire for happiness and our striving for fulfilment (Rose, 1996). The political rationality of neo-liberalism (Chapter 8, ‘surveillance medicine’) requires citizens to be active, healthy and self steering (Keane, 2000). Regulation is not practised via domination and control, but through the promotion and installation of autonomous self-hood. In other words individuals experience the effects of the organisation of political power, which governs them in terms of their freedom (Rose, 1999).
The effects of governmentality were apparent in the interviews in the ways in which the women constructed their own health, and produced an idealised picture of lesbian health. Discourses about lesbian health and women’s health might be described as imposing particular truth/knowledge regimes of an idealised healthy self for the participants in this study - both as women and as lesbians. In order to understand this, it is necessary to account for how collectivity manifested in the interviews. References to collectivity were produced by questions about what characterises healthy and unhealthy women, and lesbians, and what characterises a quality health care relationship. These questions produced self-examination, and self-assessment in relation to an ideal.

In relating what they wanted from doctors, the participants revealed how these constructions of health affected the ways they positioned themselves. I report here on the themes that emerged in relation to general practice consultations. I start by identifying the different constructions of women’s health and lesbian health that emerged during the interviews. This is relevant to how the women understood their interactions with doctors. I then use the issue of Pap tests to look at the interplay between the women’s understandings of health and how they recounted their clinical interactions. In the second half of the chapter, I discuss what the women identified as desirable qualities in doctors and their services, and how these issues affected choosing a doctor.

**Constructions of Women's Health/Lesbian Health**

To explore the issue of constructions of health, in the interviews, I asked participants what came to mind when they heard the statements ‘healthy woman’ and then, ‘healthy lesbian’. I also asked them to tell me what they had heard from other lesbians about their experiences with the health-care system. Together these questions provided some insight into the ways in which the participants produced their own health, and the health of lesbians in general.

Images of women who are tall, blonde, slender and beautiful dominate advertising and popular culture, and contribute to a production of the ideal woman that has entered the collective habitus. Given this, it is not surprising that several of the women called on these images, when asked what came to mind when they heard the phrase ‘healthy woman’. Melanie responded:

Sandy said:

curvy and voluptuous, um free-spirited, um, intelligent, you know, more or less in control of her life, um [pause three seconds] gorgeous-looking ...

And Jenny:

Um, healthy woman. Comes to mind, good glowing skin, nice, slim figure ….

From the very small number of non-white participants in this study, it appeared that images of a healthy women are also white women. Mandy and Georgia, the Aboriginal couple interviewed together said:

Mandy: Well, probably someone who’s, you know, who looks healthy. Like, your skin looks healthy and your, you don’t look like you’re totally obese sort of thing or that, yeah, sort of, yeah, more the looks I think. Like, um, as long as your skin looks healthy.

Georgia: Mine would probably be rich, upper class because no one from where I come from is healthy.

Mandy: Yeah, so, yeah, you know. If you say rich, you know, I’d think middle-class white Anglo-Saxon. No one around our area, no one.

Images of models and beauty have, to some extent, come to represent health for women. The images put forward here are idealised, and represent a narrow view of health in the sense that they refer only to physical beauty and vitality. Melanie’s reflexivity (‘isn’t that terrible?’) and Georgia and Mandy’s references to class and race (‘middle class white Anglo-Saxon’) are indicative of wider frameworks. The WHO social model of health has for many years promoted a view of health in which equity, freedom from discrimination, and access to the resources necessary to live a full and satisfying life, are paramount (World Health Organisation, 1948). This broader view of health can be summarised as wellbeing. The first images that came to mind for these women were supermodels,
slenderness and clear (white) skin, but even as they identified these images, they acknowledged that they were problematic. In these women’s initial responses some conflict was apparent between the influence of the embodied habitus, and their individual capacity to reflect at a conscious level on their immediate, pre-reflexive responses. Melanie laughed and reproached herself “isn’t that terrible”, acknowledging that she was aware that the image was not realistic. Sandy amended her statement by adding “in control of her life … confidence and self-assurance”, and Jenny went on to discuss her discomfort with this construction of a healthy woman.

[That] just shits me [laughs]. Because you and I both know that that’s a load of rubbish [laughter] I don’t think that in order to be healthy you have to be the Elle MacPhersons or the whatever of the world. But because the media portrays women as that, it’s very hard to get past that visual image of the healthy woman being the girl running along the beach in the Carefree tampon ad, you know [laughter].

Other women expressed a broader concept about women’s health than this idealised view.

**Mary**: Healthy woman? I suppose someone that just enjoys life, that sort of thing.

**Monica**: Somebody who’s holistically healthy not just physically but spiritually um, emotionally and psychologically.

Imogen introduced the ideas of wellbeing and lifestyle:

I would think of things like um, food and exercise and physical, general wellbeing, I’d also think of um, ah … Just well, I guess well balanced life-style as well …. These responses appear to reflect a more reflexive position, that is closer to the social model of health than the earlier response. The age, qualifications or field of employment of the women interviewed did not appear to shape their responses, as might be suspected. For example, Mary had not finished high school, Imogen was only twenty-two when I interviewed her, and Monica, Sandy, Jenny and Melanie all had post-graduate qualifications.
In most of the participants’ responses, constructions of a healthy lesbian were different from those of a healthy woman. In response to being asked what came to mind when she heard the words ‘healthy lesbian’, Jenny responded:

Someone who doesn’t move in with her girlfriend on the second date [laughter]. Oh, to me that conjures up far less physical imagery. Healthy lesbian for me conjures up someone emotionally in touch with themselves. Who is assertive but not aggressive necessarily. Who is um, who is able to articulate what her needs are, and if she doesn’t, if she finds that they’re not being met somewhere, then she will go elsewhere.

Jenny’s reference to there being less “physical imagery” of lesbians raises again the issue of recognition, and its importance for identity development discussed in Chapter Six. Butler (1998) and C. Taylor (1994) both argued that absence of, or distorted, images of the self can lead to ontological harm by placing the subject outside the domain of speakability. It is possible to read Jenny’s statement about being able to conjure less physical imagery of lesbians, than of women in general, as reflecting an absence of recognition. Another way of reading it might be as reflecting the relative absence of images of lesbians in popular culture with which the average lesbian can identify. For Jenny, the healthy lesbian must be articulate and able to find ways to have her needs met. Her reference to a healthy lesbian as one who does not move in with her girlfriend on the second date, reflects a stereotype that is prevalent in the lesbian community, typified by the joke: ‘What does a lesbian bring on the second date? A moving van’. The dual impacts of the lesbian subculture, and her work culture (she is a psychologist), are likely to have contributed to shaping Jenny’s habitus, which disposed her – perhaps because she expected lesbians to present well and be considered positively by the wider community – to hold lesbians to higher standards than other women.

Other women raised more physical images of lesbians in their responses than Jenny, but stereotypes were still apparent. For example, when asked what came to mind when she heard the phrase ‘healthy lesbian, Melanie said:

A little bit different [from the healthy woman]. Still smiling and good-looking. Umm, and appealing to the eye, but strong. Muscular. Fit and muscular. More toned. Yeah, vibrant.
This statement produced lesbians as stronger and more fit than women in general. Sandy’s response was similar:

Um [pause two secs] less curvy [laughs] funnily enough, um, you know, probably more sporty, um, we’re also strong. [pause two seconds] At peace with herself and promoting peace in the world. And a person who knows herself pretty well. Oh and intelligent and well educated too, I’d say [laughs].

In each of these responses the women might be seen to draw on the stereotype of the muscular, sporty (butch) lesbian. But the force of the stereotype was softened by Sandy, who, by taking time and reflecting on her response with some humour, added intelligence and world peace to her answer.

When, in the interview, I asked ‘what makes lesbians sick?’ some responses revealed broader concerns about the health of other lesbians.

Imogen: I probably think more about drugs and stuff like that, [lesbians] let out the steam, because a lot of women I know smoke and drink and, and take drugs. I’d say the health issues in terms of young women and young lesbians, I’m pretty sure that there’s a higher incidence of that sort of stuff amongst lesbians, so that would be something I would think of. But again, I guess it’s not specific to lesbians, but it’s the women I know and um, and the, and the sort of areas and the, the things that they do and the fact that it’s such a scene-based culture and things like that.

Imogen’s reference to a “scene-based culture” raised the issue that most social venues for lesbians are in bars, known in the vernacular as ‘the scene’. In this passage, to identify what makes lesbians sick, Imogen looked to her friendship group and social venues. She allowed that alcohol and drug problems may not be lesbian-specific, but that they were problems in her experience.

Sally also raised the issue of problematic alcohol and drug use in the lesbian community:

I think of, well this is awful what I’m going to say, I don’t like that I think this, but I do, I think of the number of lesbians that I know of who are unhappy and therefore unhealthy, ah, because they’re drinking too much, or they’re ah, raging at the world and behaving in unhealthy ways, um.
Imogen and Sally’s references to their own social experiences in relation to drugs and alcohol are supported by research. In Australia lesbians have been found in several studies to smoke and use alcohol and drugs more frequently than their heterosexual peers (Pitts et al., 2006; Hillier et al., 2005; Murnane et al., 2000). Imogen’s reference to lesbians using drugs to “let out the steam” and Sally’s to them raging against the world, suggests that they both know of other lesbians who are stressed and who act this out socially. This may be related to living as part of a group (collectivity) who experience, or fear, prejudice or discrimination because of their sexual orientation.

Reference to the impact of living with the effects of discrimination were apparent in other responses. When asked ‘what makes lesbians sick?’ Candace expressed it with strength and clarity:

Good question. What makes lesbians sick? Well, I think what makes lesbians sick would be what makes women sick. Except that lesbians have to deal with problems like discrimination and, I don’t know, depression in some instances. Yes, what makes lesbians sick? Yes, I would say if you have to hide your life and you have to hide yourself, repressed anger makes anyone sick. I think, I fully believe that, and yes, not being able to live your life the way you want to. Yes.

Discrimination is defined by the WHO as a health issue, and while lesbianism is not a health issue that has received much attention in the mainstream, it was understood as one on a personal level by these women. Hiding and misrecognition lead to stress and anger, which can have serious implications for health. But misrecognition for lesbians may not be one-sided. Heterosexism results in misrecognition because heterosexuality is assumed, however, the lesbian may also have gone to lengths not to be recognised. In the previous passage, Candace reflected on the effect of misrecognition, not from assumed heterosexuality, but from hiding and passing, which can be constructed as social isolation, and the burden of this leading to anger and depression.

Mary, who lived on the outskirts of Melbourne, also identified geographical isolation as a health issue:

Well, down this way, I have to say there’s not enough activities, not enough groups that are going for lesbians. And they feel isolated, um, so they just lock themselves up in the room and, you know, they don’t know where to go, you know. Or I didn’t, until my psychologist come through with the lesbian group,
you know, um. I’d look in the local paper, you know, to try and pick up, you know, and to me that was unhealthy, you know, so, yeah. So, yeah, I’d have to say being isolated especially down this way because everything’s up the other way or in the city and some women just can’t get there, yeah, so.

Lack of lesbian social contact led to Mary attempting to make casual contacts, and perhaps risking unsafe sexual practices or being vulnerable to violence. For Imogen, Candace and Mary, the experience of isolation, discrimination and stress were produced as serious lesbian health issues. These more socially oriented issues affect lesbians, not because of their sexual orientation, but because of the way lesbianism is reviled and pathologised. This more social view of health is not apparent in much of the lesbian health literature, with its focus on a biomedical model of health.

**Pathologising the Lesbian Other**

Another theme that emerged as relevant to how women positioned themselves, was one of refusing to identify with, while at the same time adhering to, deficit views about the lesbian other. When I asked the participants what they had heard from other lesbians, about their experiences with doctors, much of what they reported was negative, but not specific. Imogen said she had heard about:

… doctors who aren’t necessarily switched on to lesbian health. Again, a lot of people, a lot of friends of mine have family doctors, … so if they’re seeing … their family doctor that sees their parents, or that have known them all their lives. There’s issues around, they just don’t feel comfortable saying to this, you know, [to a] seventy-year-old man [doctor], that they’re a lesbian or, or things like that. Um, *I can’t think of any specific stories of* like bad doctors, but I – a lot of people have the same experience as me with, with doctors who just don’t know about lesbian health. And so they’ll say to you, well ‘you know, you don’t need a Pap smear’, or they just won’t know. And so they won’t be able to tell people, they’ll just have that befuddled look of ‘what do you mean, it’s different?’ [laughs] ‘what do you mean I’m supposed to know something?’ so yeah [italics mine].

Whether to come out, or remain silent, about sexuality may be a daunting prospect for a lesbian seeking health care, particularly if she is young or uncomfortable with her sexual orientation. Imogen was twenty-two when I interviewed her, and had some knowledge about health. As the daughter of a doctor, she described herself as being “switched on” to
health issues, and she mentioned the experiences of her friends a number of times during the interview. In the passage above, Imogen raised the issues of coming out to a family doctor who might also see the rest of the family, and doctors’ lack of understanding about lesbian health. Australian research with young non-heterosexual women supports Imogen’s observations. In one population-based study, non-heterosexual women aged eighteen to twenty-three were found to be more likely to have visited the doctor often, but to be less satisfied with the service they received, than their heterosexual peers (McNair, Kavanagh, Pitts, Horsley & Agius, 2004). It is of note that Imogen was unable to think of any specific stories from others she knew about negative experiences with doctors, but that she was aware of the discourse about negative experiences. Like Imogen, a number of other participants could not recall specific stories in response to the question about what makes lesbians sick, although discourses about the difficulties experienced by other lesbians were readily available. For example, Anna said:

“I’ve found lesbians who have been lesbian, you know, from the word go, they haven’t ever been het[erosexual], to be really terrified at ah, the prospect of um, smear tests and um, things like that. Um, you know, things, examinations that involve speculums and stuff like that. And um, have found it difficult to find doctors that are supportive … The first woman that I had a relationship with, she spent time in a drug rehab and this particular drug rehab, um, … [The counsellors made] comments like, you know, you just need a good fuck you know, that kind of thing [pause several seconds]. With regards to the health, specifically health and lesbian stuff, those are the only things that I can think of” [italics mine].

Like Anna, other women knew stories about the negative experiences of other lesbians, but struggled to recall specifics. For example, Melanie said “I’ve heard some terrible stories, they’re not staying in my head though. … Definitely doctor shopping, so being really selective …” (italics mine).

In an interesting manoeuvre, most of these women did not see their own relations with doctors as terrible, it was other lesbians they saw as having problems. While several of the participants described distressing or disturbing experiences with doctors, most were relatively satisfied with their medical care, and saw themselves as essentially healthy. However, some of these passages suggest that they produced other lesbians as having problems and being unhealthy. For example, Monica’s response to my question about what she had heard from other lesbians about experiences with the health system was:
I mean we all know so many fucked lesbians, I’m not sure it’s, I, I don’t, I don’t know whether it’s a chicken and the egg thing. Because it takes a while to come out and by the time you’ve come out, you know, you’ve sustained a fair bit of psychological damage. Particularly if you’ve been married or what-have-you. Um, or whether being a lesbian then causes a societal pressure on you and that upsets your equilibrium um … [italics mine].

Sally reflected on her earlier response about lesbians being unhappy and therefore unhealthy. She said:

… I don’t want to think lesbians as unhealthy that’s not what I mean I, I can see the, the [sighs] [pause three seconds] words, I suppose it’s almost like a stigma that I, I I’m, I have embedded in that …

Sally’s statement may reflect the reality of her experience with other lesbians, who are unhealthy and “raging against the world”. The image of her attitude being a “stigma” she had “embedded” was a powerful one, perhaps a conscious awareness of her embodied habitus. In this instance, by being disposed to take the time to consider her response, Sally was able to access this with a sense of discomfort. Because the habitus is an open system which can be modified (Bourdieu et al., 1992), Sally’s conscious reflection on her initial pre-reflexive response made it possible for her to see it as a kind of discrimination.

In the above passages, Imogen, Anna and Melanie each claimed that they had heard “terrible” stories, but could recall few specifics, and Monica and Sally constructed other lesbians as unhealthy or psychologically damaged. Other women in the study produced similar narratives about what makes lesbians sick, for example Candace and Shona raised the issue of fear and apprehension about coming out, and the associated potential for depression and anxiety. Yet, while these women had negative stories about other lesbians and health, they narrated their own experiences in more positive terms. It would be surprising, given the strong prejudice against homosexuality in Western cultures, if these women had not embodied some prejudice against lesbians. In a culture that reviles lesbians, it would be difficult not to embody some of the stigma, and the embodiment of the cultural prejudice against lesbians is unlikely to be automatically revised or eliminated by being lesbian. It is thus not surprising that some negative discourses were apparent in these interviews. The result of this appears to be that some lesbians hold other lesbians to a higher standard of health and wellbeing than themselves, within a logic that argues that if one is seen as emotionally damaged, angry with the world or indulging to excess in
alcohol or drugs, that it reflects badly on lesbians as a group. Within this logic, if the
group is seen in a negative light, it is likely to have implications for individuals within the
group.

Given the collective discourses of identity within the lesbian community\textsuperscript{22}, a tendency to view those who do not conform to high standards of behaviour in negative terms is not surprising. The discourse of responsibility in these stories – that each lesbian is responsible for behaving well and being healthy so that the group is not threatened – might be related to identity being produced in simple binary terms (heterosexual woman/lesbian). The narratives of the women in this study concerning constructions of health suggested diversity rather than homogeneity, yet in interviews the notion of a self-evident lesbian identity was repeatedly naturalised. Ackelsberg (1996) argued, particularly in relation to marginalised communities, that women have been taught to either ignore differences or view them as causes for separation and suspicion. Following Ackelsberg, it might be more productive to accept that lesbian community is at least multifaceted, if not fragmented – a position from which to organise and act – rather than assuming an exclusive and continuous shared ground.

The women’s accounts of what makes a healthy woman and a healthy lesbian, can be seen as being produced by an idealised kind of self-formation. This appears to be at odds with their diverse, highly individualised constructions of the self. This might be explained by the construction of the field, in particular, tensions between political discourses of lesbianism as a collective sociability and individualising discourses of governmentality. Lesbianism as a collective political identity (‘we’) links the individual with the group, whereas the internalised dialogue of governmentality calls for the profound inwardness and concomitant personal autonomy (agency) referred to earlier (Rose, 1996). In this way, regulation is achieved. Rather than appearing to be imposed externally, biomedicine’s ‘therapeutic authority’ seems to emerge from ‘inside’ (Rose, 1996). Regulation is not practiced via domination and control, but through the promotion and installation of autonomous self-hood. However, the field ‘lesbian health’ is more complicated, emerging as it does from the women’s and gay pride movements, as well as the women’s health movement. As such, the field of lesbian health is a politicised space, and the women’s individual narratives of the self appear to sit at odds with their idealised narratives about lesbians as a group. This has implications for how the women in this

\textsuperscript{22} Fuss (1991), following Lacan, argued “that any identity is founded relationally, constituted in reference to an exterior, or outside, that defines the subject’s own interior boundaries and corporeal surfaces”. (p.2)
study positioned themselves in the medical encounter, and this was particularly clear in the accounts they gave of having Pap tests, which I address in the next section.

**In the Consulting Room: Lesbians and Pap Tests**

As discussed previously, lesbians are less likely to participate in Pap screening than heterosexual women (Kunkel & Skokan, 1998). There has been a persistent rumour that lesbians do not need Pap tests, which may be based in the assumption that lesbians never have sex with men. Regardless of the origin of this rumour, doctors have reportedly been influenced by it, and have anecdotally been known to tell lesbians they do not need these important preventative cancer screening tests. In Victoria there has been a campaign called *Lesbians Need Pap Tests Too*, promoted by the Anti-Cancer Council. This social marketing and health promotion campaign targets lesbians, as well as a health-care professionals such as general practitioners, to try and increase the number of lesbians having Pap tests, and convince doctors that lesbians do need Pap tests. Pap tests were difficult for a number of women I interviewed. Discomfort and avoidance of Pap tests among lesbians is also common among women in general, however, the discourse about lesbians not needing Pap tests, and the social marketing campaign to encourage them to participate in screening has increased awareness of the need to have tests, but does not appear to have made them any easier.

In the interviews, I asked the women to identify their most negative and most positive experience with a doctor. Five women recounted negative experiences about having Pap tests. Shona recalled an incident that had occurred at the student health service, when she was still a university student some years before:

… well they’d sort of take the sexual history and yes I would say that I was not having sex with men and I was having sex with women. So, yes, I was out with them, and their conclusion was I didn’t need a Pap smear. Except for one doctor who said ‘no, you do still need a Pap smear’. But it was very difficult to do and I felt that was quite invasive in fact. That she didn’t sort of stop the process when I had said ‘no, can you not do this please’. I didn’t really know if that was a sort of – whether that was related to my sexuality or not, but I came away feeling a bit like it might have been.

While this doctor was correct to assert Shona’s need for a Pap test, her refusal of Shona’s request for her to stop the internal examination, is an example of unacceptable practice.
While Shona experienced the procedure as difficult and invasive, it is not possible to know the reason for the doctor’s refusal to stop. It may have been because the doctor was being rough, because she was incompetent, or even because she was being punitive. As discussed in Chapter Six, the lesbian has an embodied awareness about the potential harmful consequences of her difference. In the above passage, the way that Shona represented asking the doctor to stop was somewhat understated – “can you not do this please?” – and she was uncertain about the reason – it felt “a bit” like it might have been related to her sexuality. This understatement may be an effect of the passage of time, but there is another way of reading this text. Because Shona had come out in the clinic, the actual reason for the doctor’s refusal to stop the procedure was irrelevant – she felt like it was because of her sexuality – because of her embodied knowledge about the potential for lesbianism to lead to negative treatment. In the medical encounter, however, there is always another dimension that has not been explored in this project, the doctor’s habitus. In the space of the clinical encounter, these will play out differently for doctor and patient, and it is in this interplay that conflict can emerge.

When she was eighteen, Imogen went to a doctor for a Pap test. In the consultation she came out as a lesbian, and the doctor told Imogen that a Pap test was unnecessary, because she did not have sex with men. Knowing this was untrue, Imogen asserted herself and successfully demanded the test. Despite this, the experience has stayed with her as an uncomfortable memory. When I asked about her most negative experience, Imogen replied:

It, it would have to be that woman telling me that I didn’t need those [Pap and STI] tests. Because I already didn’t want to be there, and I already felt uncomfortable, but I decided that’s what I had to do. I, yeah, I must’ve been eighteen and I knew that I had to get a Pap smear and all that sort of stuff, and um, and the fact that I had to insist, I felt really uncomfortable.

Imogen was already uncomfortable about having her first Pap test, and having to argue about it with the doctor added to her discomfort. Imogen’s habitus is likely to have been shaped by her close relationship with her father, a doctor. This has disposed her to know what she needs, and to assert herself with doctors if necessary. Regardless of this disposition, the incident with the doctor related above appeared to have had a great impact on her. As discussed in Chapter Seven, she had not returned to that doctor, and while she
now went to a clinic she described as gay-friendly, she had not come out with the doctor 
she currently saw.

Gillian also related a negative experience concerning a Pap test. She had seen the same 
GP for many years, both when she was married and after she came out as a lesbian. When 
I interviewed her, she was in the process of finding a new doctor. She said:

    When I took up with my current partner, I just continued on having Pap smears 
regularly, and because I had an episode of cervical cancer, I had a cone biopsy, 
and so I thought that was really important to keep that up. But [my doctor] 
managed to make so many sort of crass and awful comments that I’ve now 
stopped going to her. And I haven’t actually found anybody else … she’d ask 
about contraception and I said, no, look I don’t need contraception now, my 
partner’s a woman. [the doctor said] Oh, you mean, you’ve never had sex with a 
man? [so I said] Yeah, yeah, you know very well I’ve been [small laugh] married. 
[She said] ‘Oh, oh right, oh right’… And then comments about, you know, what 
sort of sex do you have? Issues about the nature of the examination. Or her 
competence to know what, you know, how many vaginas she’s seen and stuff like 
this. I mean, this whole series of really crass comments.

The behaviour of Gillian’s doctor in relation to her sexual health appears to have been 
completely inappropriate. One way of explaining this might be that the doctor’s sense of 
appropriate was compromised by her disposition to see lesbianism as fixed binary in 
opposition to heterosexual woman. In this construction, the heterosexual woman is 
constituted as being married/need contraception/having sex with men, versus the 
lesbian who is not married/does not need contraception/does not have sex with men. The 
rigidity of this position does not accommodate a woman whose sexual orientation shifts 
between heterosexuality and lesbianism. In response to her doctor’s inappropriate 
behaviour, Gillian was disposed to be assertive, but at a cost. The experience made her 
unwilling to go back that doctor, and cautious about finding a new one; her trust was 
shaken. She described her dilemma, saying “I just don’t know, should I keep going to her 
and try to re-educate her around this? So looking for somebody else becomes a really 
major problem”.

For a doctor to insist on an internal examination and proceed without active consent, as 
was Shona’s experience, or to make inappropriate comments, as happened with Gillian, is 
unacceptable under any circumstances. Feelings of vulnerability may be heightened if a
woman is uncertain about her standing with the doctor in relation to her sexuality, or if the doctor makes inappropriate comments, or is insensitive in other ways. The result of the kinds of poor medical practice described by these women is that Imogen and Gillian had both stopped seeing the doctor with whom they had the bad experience, Imogen had not come out to a doctor since, and Gillian had not yet had a Pap test, although it was more than two years (the recommended frequency for Pap tests in Australia) since her last one.

It is possible that the question that elicited these Pap test stories (‘what was your most negative experience?’) may have influenced the theme of negativity that emerged, however in response to the question ‘what was your most positive experience?’, there were no Pap test stories. The responses to that question will be discussed later in this Chapter. In the interviews no direct questions were asked about Pap tests, however, for two of the participants, the gender of the doctor carrying out the Pap test was raised. Candace and Mary were both uncomfortable about having them done by a male doctor.

Candace had attended the same general practice since she was a child. She had always seen the same woman doctor at that clinic, who had advised her when she was attempting to self-inseminate, but this doctor had recently retired. Candace decided to stay on at the same clinic, where she happily sees most of the doctors for most of her health-care needs. I asked her about her current medical care.

[I still go to] the same medical centre, just around the corner, thank goodness. Yes, fantastic, and they’re all very good there. I mean, there’s one dude there that’s a really old dude and I go to him only if there’s no one else to go to. But I just avoid using, well, I don’t generally go there to him if I need something. I’d rather wait. Like, I would never go to a man for a Pap smear, yes, or any sexual health stuff.

It was clear that Candace, while happy with the practice she attended, was uncomfortable with a specific male doctor who is much older than she is, and with the idea of any male doctor performing a Pap test. She got around this by always seeing a woman doctor in the practice for her sexual health needs. Like Candace, Mary was uncomfortable about having a male doctor do a Pap test although Mary’s needs in this area were more complicated. Mary was raped as a young woman, and vaginal examinations had been traumatic for her ever since. She was very uncomfortable having Pap tests, and in the past had needed to be tranquillised to have one done. She had told her usual (male) GP about
the rape, but, using a similar strategy to the one described by Candace, made an appointment to see a female doctor, at the same clinic for her Pap test. She said:

Last year when I went for a Pap smear I’d asked to see a female doctor and [my male doctor] saw me sitting there [in the waiting room] and he said, oh, are you here to see me? And I said no, I’m here to see, whatever her name was, and he said what for? And I said oh, a Pap smear. Straight away he went in to her and explained to her about my concerns, about my needs and, you know, he came out and said don’t worry, I’ve taken care of it for you. And, you know, with the female doctor I didn’t need to be doped up. She talked me through it, she kept talking to me while she was doing it and that, so I felt relief. But also I felt more relief because my doctor and gone in and spoken to her and said, well, you know, you’ve got to understand Mary’s situation, you know. So it was good.

Mary made it clear that she knew her body and how painful vaginal examinations were for her, and she acted to find a way of minimising the trauma, by making an appointment to see a woman doctor, although she had not discussed this with her usual doctor beforehand. While the intervention made by the male doctor may not be acceptable to everyone, Mary and the doctor appear to have established a level of rapport that made her comfortable with him in the role of advocate in this situation. Furthermore, for Mary, having a doctor take a decisive action, such as intervening to explain her position, was a relief – as she did not have to explain anything she could relax. His intervention on her behalf benefited both Mary and the other doctor who carried out the Pap test, by smoothing the way and ensuring that it was made as easy as possible. It may also have been a relief to Mary that her male doctor was understanding about her preference for a female doctor for an intimate test such as Pap smear.

What was apparent in all of these five accounts was that each woman approached Pap tests with trepidation. For three of the women, there was a degree of fearfulness about whether they would be judged or poorly treated because of their sexual orientation. This arguably brings out another dimension of the field: medical assumptions about what is involved in lesbian identities and behaviours cross over with how the respondents position themselves as women to create understanding, misunderstanding and potentially unmet expectations. For two, the gender of the practitioner was paramount. It was in relation to Pap tests that these women appeared to position themselves as most vulnerable.
It is of note that while there is a considerable body of literature about lesbians and pap tests, the main focus is biomedical, not social. Therefore concern is expressed about low rates of lesbian participation resulting from myths about lesbians not needing pap tests, rather than developing an understanding about why lesbians might be reluctant to participate. The accounts of the women in this Chapter reveal the ways in which bad experiences with practitioners can cause anxiety and lack of willingness to submit to such an invasive procedure. Rather than focus only on encouraging lesbians to have pap tests, pre-service (and in service) training for medical practitioners in providing high quality service to women who seek pap tests might also assist building women’s confidence in the future.

**Choosing a Doctor**

It was apparent from the interviews that the women had a wide range of complex ways of being with doctors, and that these factored in who they chose to see, and when they chose to see them. The environment of the medical encounter can be complex and shifting, and both the doctor’s and the patient’s sense for the game, are different, shaped by cultural habitus and personal experiences. These factors, as well as convenience, comfort and how resilient or vulnerable an individual felt at any given moment, were all apparent in the accounts participants gave about how they chose their medical practitioners. A number of themes emerged about how they chose a doctor.

**Location**

The majority of the participants had found doctors with whom they were happy and had ongoing relationships. In this group three had two separate doctors or clinics they used for different kinds of services: one was their primary physician with whom they had an ongoing relationship, another they used for convenience in minor matters such as certificates for sick leave from work or when their primary doctor was unavailable. With the latter, the consumer/service-provider formulation of the clinic was foremost, in that they appeared to expect nothing more from the relationship than the specific service they sought. For example, the following exchange occurred in Melanie’s interview:

**Melanie:** I have a regular two doctors. I alternate.

**SD:** Do you use them for different [things], in different ways?

**Melanie:** Look, I see David [my usual doctor] most of the time. But occasionally, it’s more to do with accessibility. If I’m really desperate I
go and see someone who’s closer to home. And that’s a woman, but primarily it’s David.

SD: So you see David as …

Melanie: He would be my primary doctor.

SD: Your first choice?

Melanie: Yes. Without a doubt.

Similarly, Monica had two doctors, one she travelled some distance to see and another one closer to home. Monica was full of praise for her regular GP:

Monica: [He] is incredibly gay-friendly ah, I wouldn’t go anywhere else, um, and he’s just the best GP I’ve ever had.

SD: In terms of the location of your GP, does he live close to where you live?

Monica: Nup, no, … he keeps moving around town so I keep following him, yeah.

SD: And so it’s a fair distance from where you live?

Monica: Oh, yeah (yep) yeah. The GP I’ll go to … close to home, is like a bulk-billing23 doctor, when I, when I need a certificate because I’ve got a cold, um [that’s where I go] …

Anna, who lived in the country, also saw different doctors on occasion, but this was more because she had very limited choices available because of her location.

… it’s very hard to get to see a decent doctor in [the town where I live] … I’ve never been able to get to see a decent doctor [here]. Um, there’s a lot of doctors here, but the quality of them is extremely poor. Um, so if I’m too sick, and I have in the past, if I’ve been too sick to get myself down to [the next town] to see my regular doctor, who is in demand because she’s now the only woman doctor in the area. And so I might have to wait a few days before I get to see her as well, then I might go, oh, okay, I’m gonna try [the local doctor] again.

23 Bulk-billing is the process by which doctors in Australia bill the Department of Health directly for a service, with no extra charge to the patient. This service is not provided by all doctors, in general, patients must pay for the service they receive, and claim a refund for the service themselves. Most doctors in Australia charge above the scheduled fee for service, thus the patient only gets a refund for the amount scheduled by the Department of Health.
Unlike Monica and Melanie, Anna did not see different doctors by choice, but because she was forced to by geographical isolation and limited services. For her, need and vulnerability due to illness led to compromise. She had a choice of waiting to see her preferred doctor or going to a local doctor she did not know. Anna made it clear she was willing to travel the fifty kilometres to the next town to see her doctor of choice, but that this was not always an option.

Other women had no particular doctor, and saw whoever was closest for convenience. When I asked Sandy what she did when she needed to see a doctor, she replied:

I drive down to the clinic at the end of the street. Look I, I did have, I did go and see a good doctor, it was a guy um, his name was Bruce, he worked at a local clinic. He was very thorough and he was, he was good and um, I would have kept going to see him, and I did after I moved, but um, not still.

Although Sandy saw Bruce as thorough, and a good doctor, this was not enough for her to keep seeing him when she moved. For most of the women there was more to maintaining a doctor’s services than his technical skills.

**Lesbian-friendly doctors**

Two of the participants had chosen to attend a gay-and-lesbian-specific practice for their regular medical care. For each of them, having a lesbian doctor was in itself a positive experience, because attending a gay/lesbian service normalised their sexuality.

**Shona:** I would say the most positive experience is having a lesbian doctor and just knowing that you don’t have to explain you know, that it’s sort of – I mean you have to come out, in the sense that the doctor knows, but you just – it’s more comfortable. I guess um, you, you can sort of make assumptions that your doctor knows and understands stuff about your life, so that I’d say is my most positive experience.

**Jenny:** I go [to the gay and lesbian practice], it’s fantastic, they’ve got the gay and lesbian newspapers there, they’ve got, you know JOY [the gay station] on the radio, it’s terrific. I often wonder about the locals that come in, the heterosexual locals that come in and I often think I wonder what it’s like to sit in a waiting room for them with all this stuff around. And then I think well shit, I’ve done it for the last twenty-eight years. And I like that, and I don’t think that every medical clinic needs to emulate that in order to be gay-and-lesbian-friendly. Um, but my
choice if I’ve got a choice about where I go, I’m going to choose somewhere where it’s affirming for me.

In these examples, the normalising of their sexual orientation that occurred in a gay practice made the clinical experience positive. These women found comfort in being recognised and having their identity reflected both in the consulting-room space and in the doctor’s unquestioning recognition of them. Another participant, who lived outside the city, expressed a preference for a lesbian doctor, although she had not found one. Deb had recently moved to the country. She had been seeing a woman doctor in the university health clinic prior to her move, but since then she had not found a particular doctor. I asked if she had a preference for gender or sexuality in a doctor.

Always prefer a lesbian, um, if there’s not a lesbian available, then a woman. My partner had to go to the doctor the other day and she came back and said ‘oh, there’s a nurse there that I think is a dyke’. So in lieu of not being able to have a lesbian doctor, at least a place that has an out lesbian. So somewhere that’s, so I guess there’s a hierarchy of lesbian, woman, lesbian-friendly.

Like Jenny and Shona, not needing to have to explain herself was important for Deb. Here Deb expressed her ideal for a health-care provider who was lesbian even though she had not yet found it. Imogen also attended a lesbian-friendly practice, although she had not come out to the doctor she saw there. I asked her why, to which she replied:

I guess I hadn’t thought it was relevant because they haven’t, they haven’t questioned me [about it]. I don’t know why. I do know that my doctor’s gay-friendly.

It is interesting that in this gay-friendly practice she had not been asked about her sexual orientation. Even though she had Pap tests with this doctor, she had not been asked about her sexual practices. Unlike the women who preferred a gay/lesbian-friendly service, Gillian (who lived in the country) was more sceptical about the potential for gay-specific services to provide higher quality care than mainstream services. She said:

Often people have fairly pragmatic relationships with the GP and they separate out what they go for. So they might go to Melbourne and see someone who’s nominally a lesbian or a gay doctor, but they might not be any better. They might have a whole set of other stereotypes.

Given Gillian’s experience with her last GP assuming her lesbianism to be in opposition to heterosexuality, her fears about “a whole set of other stereotypes” may be related to
that experience. Gillian had been married and was now with a woman, but she did not embrace the notion of possessing a unitary lesbian identity. She may have feared being judged by a lesbian or gay doctor for not being a “real” lesbian. Wendy Brown’s (1998) suggestion that coming out/disclosing in professional settings reveals intimate knowledge about the subject that carries with it the potential for regulation, might be reflected in Gillian’s statement. Naming sexual orientation opens the possibility for mainstream doctors to discriminate, but there is also potential for gay/lesbian doctors to discriminate – albeit on different grounds – against those who do not embrace lesbian identity.

**Provider’s gender and sexuality**

While some of the women expressed a preference for a woman or lesbian doctor, for most this was not a pre-requisite for a positive and satisfactory relationship with a doctor. For example, Monica expressed a theoretical preference for a woman or a lesbian doctor, but had found a male GP, and indicated she was more than happy with him.

I would have a gender preference for a female, um, and, and a dyke, but as it turns out my GP is a straight boy, um, but he is incredibly gay-friendly. I wouldn’t go anywhere else, um, and he’s just the best GP I’ve ever had. … I’m not particularly gender-fussy. All I want is the best person to do the best job. In terms of um, seeing a psychologist ah, that gets a bit different I, I would prefer, oh, in fact I only go to women counsellors or poof counsellors, I wouldn’t go to straight males, no way.

Despite her theoretical preference for a woman or lesbian doctor, the relationship she had developed with her doctor, and the quality of service she received more than satisfied her needs. For Monica, the quality of the interaction in the medical encounter was more important than the gender of the doctor:

[I look for] someone who actually respects what I have to say. Respects my knowledge base as well. Who isn’t patronising. That’s why gender hasn’t been important for me.

Unlike Monica, Sally had not found a doctor with whom she was satisfied, although she expressed a strong preference for a woman doctor. During the interview, Sally’s style was to take time to answer the questions. This was characterised by frequent and long pauses as she considered her responses. This could suggest that she had not previously thought through and articulated her preferences, and that she had to make a conscious effort to do this; that the knowledge was not immediately accessible. She said:
My preference is for a female and sort of similar age, um, by which I mean, you know, late thirties onwards but um, are important to me, and um [pause four seconds] and I do, ah, hope for someone who will demonstrate ah, regard for me as a person [pause three seconds] yes. [pause two seconds] Ah, she would um welcome me warmly, you know, join with me, set that scene that, that ah, in a way that says, I’m interested in you, not just your um, cervix or your breast or your, you know, your, your whatever, um [pause four seconds] and then I, I do want a woman [doctor] to demonstrate a high degree of professional competence too.

In the previous Chapter, I discussed resistance in clinical spaces; the complexity of the contextual factors around Sally’s willingness to discuss sexuality were discussed. She raised the issues of age, gender and ethnicity of a doctor as factors she would consider if she did decide to come out in a medical encounter. These requirements had never been met, and as a result, the matter of her sexuality had “never come up”. In the passage above she again raised age, but also asserted that she wanted the doctor to demonstrate interest and regard for her, as well as being professionally competent. None of these requirements had been met in Sally’s experience, so she had never engaged with a doctor for her regular health care, although she participated in preventative screening and took care of her health by maintaining a good diet and exercising regularly.

What emerged from these accounts was that preferences and experiences differ, and sexual orientation was not the only, or even the most important factor in choosing a doctor or judging the quality of the clinical relationship. Some of the women had an excellent relationship with a doctor, which was typified by rapport, trust and respect. Others had never found such a relationship. Most fitted somewhere between these two extremes. Establishing a satisfactory relationship with a doctor was generally more difficult for the rural lesbians in this study. Overall, what emerged was that there were a variety of different ways of being with doctors, that were complex, fluid and dependent on the ways in which space was constructed, the habitus of the woman (and of the doctor), past experiences and the current presenting condition.

Where the women did reach a degree of accord was in the qualities they sought from a doctor. What occurs in the space of the consulting-room was constituted by the women as personal and intimate, and as such they had a number of expectations. Several themes emerged from the interviews. The most often-mentioned qualities related to their relationship with the doctor, and the quality of services (mentioned by all of the women in various ways). Other factors included the doctor’s communication skills, the use of space
or the environment, cost, time, a holistic approach, and openness to complementary and alternative therapies. Other qualities identified by the women as desirable in clinical settings were that the doctor maintained good records, did follow up, and met their expressed needs. In terms of technical skills they identified such qualities as someone who did not prescribe unnecessarily, was well informed and professionally competent. These qualities will be discussed in this section.

**Doctor/patient relationships**

Different women had different ideas about what they wanted from a relationship with their doctor, however, there were some consistent themes. Recognition and interest in the individual was important. This extended beyond sexual identity, which for some was less important than being seen as a whole person, and being acknowledged as such by the doctor. For example, Candace said:

… they sort of ask … how do you feel now? And ask about work and know about your life, yes. So taking an interest in the person’s life and not just their health and their medical condition that they’re coming to see you for, that you’re actually a whole person.

Being seen as a whole person was also important to Colleen, although she had never come out to a doctor. Of her usual doctor she said:

She makes you feel good as soon as you walk in there. Yeah, yeah, … she’s got the gift. Some people have got a gift and some haven’t. She’s not like a doctor. She makes you feel relaxed when you go in there, you know, straight away, how are you, you know, and how’s the dog ...?

In response to my question about positive experiences with a doctor or other health-care worker, the importance of communication skills became apparent. Melanie described an example that illustrated this:

Again it would have been with [my doctor] David where I had an issue where it would impact on my other partner, where I did have to talk about a previous relationship I was in, and I was terribly stressed about how that relationship was going … I wanted to get a doctor’s certificate, some stress leave. And so I talked to him about how the relationship was going. Had a good sob and cried for the entire fifteen minutes, twenty minutes or thirty minutes I was there. And for me to do that, one, it’s hard because of the field I work in, but two, to do that with your GP, it’s more like a friend. He’s not [a friend] by the way, but that’s a close connection I’ve got [with him]. Yeah it was great. He didn’t bat an eyelid. He’s a great listener. So that’s probably the one that comes to mind.
It was that the doctor listened and was willing to take the time needed for the consultation, that qualified the experience as positive. For Jenny, rapport, feeling safe, equal, and having an emotional connection with a doctor were important:

You know, I look for a GP where I can strike up a sense of rapport and relationship with, and I think that’s about being able to feel emotionally safe with them. Because I think my physical health is amazingly personal. And GPs, you know, they see all sorts of things day in and day out. But I don’t do this day in and day out, [so] that’s really important for me. That they are aware that we exist, there is an emotional connection and that they have, don’t play the total expert. That they work towards levelling out the power imbalance, and that it’s not all my job to do that. That they respect my information about my own health, and that if I go to them with a particular concern, and say look, I think it’s this, that they don’t dismiss it out of hand.

Jenny had very high, but not unrealistic expectations of a doctor. She not only sought a good relationship, but to be recognised as having expertise in her own life. Jenny appeared to have found this with her current doctor, who worked in a gay/lesbian service, and had also had it with her previous GP, a woman in the country town where she had lived before moving to the city.

Because what the women wanted in a relationship with a GP, and how they defined a positive relationship with a doctor, varied, it is not possible to suggest that there is one way, or even a best way, that this can be developed. What works for some might not work for others. For example, Mandy and Georgia had a doctor with whom they were very happy, but whose approach some might not like. Of this doctor they said:

**Georgia:** She’s hard but nice. Um, she doesn’t take shit, you know. Like, I’ve been with her through this whole stress thing and she sent me to a counsellor. They had me convinced that I should take a week, you know, another month off work. And I went back to her and she looked at me and she knew that was the easy way out. And I really didn’t like it but she had me convinced I was going to drop [punch] someone in the work place. She told me to get off my arse and go back and front them, you know, like, what are you doing. And I thought, well, that’s a really good idea.

**Mandy:** No bullshit. She’s very straight to the point, you know. Like, a few times I went in there over this IVF stuff and she’d just go oh, look, you know, what are you being a sook about, you know, sort of thing.
Georgia: Wake up to yourself.

Mandy: And you sort of go, oh, yeah, okay. She’d go, you know, heterosexual couples have problems having kids sometimes, what are you sooking\(^\text{24}\) about. You know, some people can’t even produce eggs and it was like, oh, okay. Yeah, so I’m not that bad off. So, yeah, she is very up-front about things.

Georgia: Won’t let you feel sorry for yourself. She’ll make you feel guilty about feeling sorry before she’ll let you feel sorry.

Some might interpret this doctor’s approach as unsympathetic, but for Mandy and Georgia the approach was exactly what they wanted. They respected the doctor’s no-nonsense approach and her refusal to let them get away with self-pity. Unlike Jenny who sought equality, they wanted a doctor to assume a strong, and if necessary dominant position with them. Mandy and Georgia’s position is closer to Mary and Lesley’s. These women also sought a doctor who could take a lead when necessary.

**Communication**

Regardless of their preferences for how interactions in the consulting-room should ideally work, a quality that was seen by all of the participants as being important in a doctor was good communication. This included that s/he be a good listener and took the time necessary to allow them to talk (and feel heard) during the consultation. Mary expressed it thus:

Well, one of the things I found with my GP was that I can go there just to talk. Like, if I can’t get a hold of my psychologist and I’m feeling down, I just ring up and [they] make the appointment for me on the same day. I go there and I just sit there and talk to him and he just sits there and listens and, you know, he might offer a bit of advice, or he might, you know, [just] listen. That’s one of the things that I like with my doctor, is that he’ll take the time out to sit and talk, … another thing too is he doesn’t like giving out medication unless it’s absolutely necessary and you know, he’ll try different methods before he’ll give out medication, you know, that’s what I like about him as well.

For Gillian, listening skills were also important.

\(^\text{24}\) An Australian slang term for whining, or making an unnecessary fuss.
The ideal doctor could be either a man or a woman, but they’d be open and a good listener. So, keep the comments to a minimum, talk about, yes talk about what you do, but in a listening kind of way to get more information about who you are and how that’s going to affect your health. So I guess more of an active listener and I guess that’s what we want.

Melanie sought similar qualities:

Someone who’s warm and friendly … Someone who’s thorough. Someone who listens. I know my body pretty well, if I think I need antibiotics, I want antibiotics. I don’t want an argument as such about it. Unless they can give me a good informed explanation for it.

While Melanie expected similar qualities to the women discussed above, she also expected high-quality service, and was prepared to tell the doctor what she needed. In this she constituted the clinical relationship as consumer/service-provider. Yet, at other times she expected a doctor/patient relationship, as in the example cited above where she went in distress and was pleased that the doctor took the time to comfort her. The requirement to have a doctor who took time, listened and treated the patient with respect was one that was shared by most of the women. It was in the details of their needs and desires concerning the medical encounter that the different formulations of the clinic emerged. At times they presented as patients in need of care, at other times, as consumers requiring/demanding a service. In the doctor/patient mode, there was an expectation that the doctor be strong and assertive when they felt weak or vulnerable. In the consumer/service-provider mode, they sought equality and recognition of having expertise in their own health. For the doctor, the shift between these two positions can be difficult to deduce, and good communication would be a way of ascertaining the needs of an individual in any given encounter. It is also likely that the individual presenting to the doctor shifts unconsciously between these two positions.

**Quality of service**

While communication skills contributed to a positive relationship between doctor and patient, quality of service also emerged as important. For example, Rebecca wanted:

Somebody who I have confidence in. That they will actually do appropriate follow-up. You know, send reminders if you need another blood test or things. So technical points. Somebody who knows how to warm up a speculum. Umm, somebody with good communication skills who is forewarning in terms of an examination. Who is forthgiving with information, somebody who is prepared to say, I don’t know when they don’t. And
somebody is validating me in terms of, you know, if I feel the need to see, get a second opinion or get a referral to a specialist and they hesitated to give that referral.

One way of reading Rebecca’s requirement for the doctor to send reminders might be that she wanted the doctor to assume some responsibility for her health-care, within the doctor/patient formulation of the clinic. Another reading suggests that she seeks a partnership within a consumer/service-provider formulation.

Sandy also expressed a preference for a doctor to take time and send reminders:

Um, welcoming [laughs] um, and polite, um, open-minded, um, you know, take a bit of time to, well, you know, they’ve, they’ve, they’ve got good records of your time there, they pick up on things that need to be picked up on like how’s this going on, how’s that going um, that they might keep an eye on if you need tests, or if it has been a long time since you’ve had this test, like um, you know, when you have a cervix swab thing.

In a climate that increasingly locates responsibility for health with the individual (Minkler, 1999), this desire for partnership between doctor and patient may appear naïve, as it is unlikely to be a reality. When an individual feels resilient, taking personal responsibility for health relatively easy, yet when one is unwell, or vulnerable, having a doctor who is prepared to share responsibility, or even take the lead becomes important. This was apparent for women like Mary, Mandy and Georgia. In other circumstances, such as the child-birth experience, when the individual may experience less of a sense of control, it was also important.

Lesley used an example of an experience that occurred during the birth of her son to illustrate how, in a clinical space, advocacy and intervention by a health-care worker was important. As discussed in Chapter Eight, Lesley’s birth experience was devastating for both her and her partner, yet in the midst of this, a midwife who was willing to take a strong advocacy role stood out as a positive experience. Lesley said:

The midwife … look he was fabulous. So there was, the doctor had to come in and do the sort of doctor thing, and then as soon as he’d gone I just had this image of him, you know, the nurse, as he was shutting the door, he said, good [the doctor’s] gone. Now we can actually get down to sort of doing what we need to do for the baby. And in terms of experiences about the health system, that was very good.

The nurse taking command of a situation, which was out of Lesley’s control, made her feel reassured and safe. It might be read that in this situation Lesley and her partner
presented passively as patients. Nonetheless, in this passivity there was agency. By keeping quiet about their relationship during their hospital experience they avoided any repeat of the foreclosure they has experienced in the ante-natal class (discussed in Chapter Eight). For them, this strategy was fraught with difficulty, and for the most part their silence led to them feeling fearful and vigilant about the possibility of exposure. However, the experience in which the nurse took control and asked questions that made disclosure easy, the result was that they felt safe and protected. This is an example of how a health-care worker can assist to make the experience easier.

**Time**

In terms of services, time was mentioned over and over again as being an important factor. Most of the women said that they wanted to feel that there was adequate time for them in the consultation, and that they were not rushed through. For example:

**Deb:** Someone who’s not [pause three seconds] not a slave to the system, and open-minded and not part of that system that forces them to churn patients through.

**Melanie:** Someone … who will take the time, more than the fifteen minutes Medicare pre-requisite.

**Colleen:** She doesn’t rush you out. [with my doctor] you’ll go in the morning and … there’s a stack like that in her tray of people she has to see. So she must be the most popular there, you know. But she just makes you feel good.

**Lesley:** One thing I like about the GP that I have at the moment is that she manages to give the impression that she has all the time in the world that you need. And I don’t know how she does it cause she’s quite efficient but you never feel hurried and she will always ask about other things and follow up, that kind of thing.

Adele, who was retired, had a different approach to time.

I think my doctor’s brilliant. He employs no receptionist, no bookings, you just pop in and you can decide there’s too many there, I’ll go home or whatever. You take your chance of it that type of thing. Whereas in the other practices there’s all the booking in etc. Much time is devoted to people ringing in for an appointment, then fixing up the appointment or whatever I don’t know.
Adele saw her doctor frequently, and had good rapport with him. For her the availability of direct contact with the doctor, even if she has to wait, is preferable to being managed by a gate-keeping receptionist or nurse. This was, however, a minority view, and again raises the issue of the complexity of the clinical relationship. While it needs to be a dynamic, respectful interaction, the form and structure cannot be prescribed. What works for some will not necessarily work for others.

**Recognition**

Implicit in most of the women’s expectations was that they could be open about their sexual orientation, and that it would not be seen as an issue. Rebecca expressed this when she said that in a doctor she expected “somebody who is not fazed by the information that I am in a same-sex relationship”. It was apparent that all of the women wanted to be seen as more than their presenting condition, and for those who were out, more than simply a lesbian. They wanted respect, validation and to feel comfortable and at ease with their doctor. For all except Colleen, who had never come-out, recognition was important because having their sexual orientation accepted made the encounter easier. Jenny explained:

> Its very important to me, that if I’m seeing a professional for my health-care needs, that they know who I am. So, her knowing that I was a lesbian, even if my sexual, my issues that I was going to see her about were completely unrelated to being lesbian, it was vital that she knew. For me personally ’cause otherwise I feel like I’m lying, or that I can’t be totally honest. Yeah, so what I find, I guess what’s most important to me when I’m talking to my GP, is that I don’t want to spend time and concentration thinking about how I need to phrase things.

Recognition by a doctor who was open-minded made it easier for the women to discuss any aspect of their lives, including intimate matters. Melanie explained how she was able to discuss anything with her regular GP:

> I thought I had thrush, [and with my doctor] I’ve talked about, you know, is it possible, when Sue’s got her fingers inside me, penetrating me? You know, so, it just rolls off your tongue to ask, and he just answers. Is it possible that I got it that way? If I’ve got a cold sore and I’m having oral sex with Sue blah, blah. So again I’m quite comfortable talking about it and he’s been, he just answers. It doesn’t matter what I ask. Yeah. I really think I could ask him anything. And I’m quite comfortable to ask him anything.
The ways in which women choose a doctor has been the subject of a number of activist/practitioner based reports in the grey literature (see, for example, Boardman, 2001; Sneddon, 1999), but academic literature has remained predominantly focused on the biomedical aspects of lesbian health and health care delivery. By investigating the social aspects of lesbians’ interactions with health care providers, it is possible to understand the complexity of the interaction, and to start to identify ways in which services can respond to their needs in fairly simple ways.

**Discussion**

The women in this study most of all sought to find a health care provider with whom they felt comfortable. Comfort was constructed in relation to lesbianism, gender, health and well-being, safety and quality of care. Teasing out the qualities and skills they sought provided a description of the kind of doctor they wanted, but ultimately, a high quality relationship was based on one where power was equalised, and where the woman felt relatively safe. These women were disposed to resist being seen as unhealthy, or being identified with the ‘flawed’ other.

I have focused on the different constructions of health suggested by the participants in the project, and how discourses about lesbian health and narrow representations of health for women impact on these constructions. The contrasting, complex preferences and needs discussed by the women mean that high-quality lesbian health-care practice cannot be codified in rules – there is no ‘right’ way of being with lesbian patients for a doctor or health-care worker. How to work effectively with lesbians is more likely to be established through the development of rapport between the parties to the medical encounter. To achieve this, doctors need to have good interpersonal and communication skills to meet the different needs of their patients/service-users, and be committed to providing high-quality service that recognises and is sensitive to diversity.

The narratives in this Chapter suggest that in a clinical relationship, rapport means different things to different people. Regardless of individual meaning, agency was apparent in the ways in which the women selected a doctor and in how they sometimes managed more than one doctor according to need. To get what they need from a doctor, different women were disposed to act in different ways, but two main themes emerged. Some asserted themselves directly with doctors who did not provide appropriate services, and others did so indirectly, by withdrawing from services with which they were uncomfortable and seeking elsewhere. Regardless of the diversity of approaches that were
noted, the qualities the women here agreed upon as being desirable in a doctor, did not differ from those qualities that any person might seek. In this, the lesbian patient/consumer is no different from any other patient in the consulting-room. This does not suggest that sexual orientation should be ignored, rather that by asking open-ended questions, seeing the patient as a whole person, listening and taking an interest in them, and ensuring that adequate time is allowed to do this, the details of their lives will unfold naturally, and sexual identity and practices will be normalised within the consulting-room.
10. Conclusion

The goal of this project was to understand how a group of lesbians from the state of Victoria, Australia, produced and managed their own health, and to understand their interactions with doctors and other health-care providers. I initially approached the project as fairly straightforward. I assumed that I knew about the field ‘lesbian health’ and would describe the experiences of lesbians as they negotiated the health care system. As the project and my thinking progressed, I saw that these assumptions were underpinned by a simplistic view of the category lesbian, and a limited understanding of the health care system, and the field of lesbian health. My research questions asked, in what ways do discourses about lesbianism and the construction of the lesbian health field influence the ways in which lesbians produce and manage their own health, and in what ways do lesbians position themselves as they negotiate clinical spaces? These questions are different from the questions I originally posed, which reflects the changes the project underwent, but they more clearly address the project goal. In this Chapter, I reflect briefly on the reflexivity discussed in Chapter One, summarise the overall findings of the research, and discuss some possible ways forward for lesbians, activists, workers and the field.

As I discussed in the introductory Chapter to this thesis, while the project was an academic pursuit, it grew out of a personal interest. The result has been a journey, during which I moved from being a practitioner and an activist to being a researcher and theorist, and which changed my world view as a lesbian. It was not an easy transition, and involved paradigm shifts and challenges as it progressed. These shifts occurred largely as a result of the reflexivity I practised throughout the project, during which I focused not only on the participants, their contexts, the methodology and data analysis, but also on myself. I developed an awareness of the discourses that had shaped my thinking in the past and as I deconstructed these, new ways of seeing emerged that influenced both my thinking and my practice.

As a feminist, I had always understood power as a possession that operated in a hierarchy; a (usually negative) force used by those who held it, to oppress those under them. Based on my reading of the work of Foucault, I came to understand power as not a possession, but as something that circulates in networks. This re-conceptualisation of power gave me a different way of understanding the wide range of attitudes and experiences expressed in
the stories of the women I interviewed. Lesbian health activists have tended to describe lesbians solely in terms of identity, yet while the women in this project had no problem identifying with lesbians as a group, a minority actually claimed a lesbian identity, preferring instead to identify as dyke, queer and gay. These discourses of identity, rather than conforming with dominant lesbian health discourse, were more closely aligned with what Foucault would term subjugated knowledge, or minority discourses (Foucault, 1980). The women also differed in other ways from the ways in which they are produced in lesbian health discourse. Few saw themselves as invisible. Rather they chose to come out or remain silent strategically, depending on whether they judged contemporaneous conditions safe or not. Comparing the ways in which lesbians are produced in lesbian health literature with the stories the women I interviewed led me to ask whether the categories produced by the dominant discourse fit their stories. Lesbian health literature focuses on a biomedical model of health and risk; the stories the women told me were more social, and as such were nuanced, complex, multiple and varied rather than unitary and straightforward. In this, they better matched the Foucauldian notion of care of the self (including resistance against the normalising effects of biopower).

The work of Bourdieu on habitus (embodied ‘knowledge’ about social rules, and how this plays out for the individual as disposition, which I discussed in Chapter Five.) provided me with a way of thinking about the stories the women told me about coming to recognise their sexual ‘difference’. According to Bourdieu (1977) experiences and discourses are embodied by individuals, and constitute a form of ‘knowledge’ which disposes them to act in ways that are not always predictable when they encounter a situation. In this way, the embodied habitus influences the ways in which power plays out. By taking this wider view, I was able to see the connections between heteronormativity, and what occurred in the space of the consulting room. The data revealed constructions of health, and ways of being in the medical encounter that were quite different from dominant lesbian health discourse constructions of lesbians as invisible, lacking control, and at risk. Rather than constructing health in narrow, negative terms, the data revealed minority discourses about health and engagement with the health care system, that were contextualised, multiple and multifaceted.

To answer the research question that asked how discourses about lesbianism might influence the ways in which lesbians construct and manage their own health, I realised I needed to look outside the immediate experience of the medical encounter, and to think about clinical spaces in the terms identified by Hurley et al (2002), as extending well
beyond the consulting-room, into everyday life. In Chapter Two, I traced a genealogy of the origins of negative discourses about lesbianism. This provided me with insight into the ways in which, rather than disappearing, these discourses continued to re-emerge, albeit in slightly different forms. These impacted on interactions in clinical spaces, where most of the women had to decide whether or not to come out. Because dominant lesbian health discourse urges women to come out, for many of the women, this decision created a dilemma: to speak, or remain silent.

Rather than taking increased visibility as a way of addressing lesbian health, another way of understanding lesbian health is as a proactive site for agency, influenced both by the regulatory functions of governmentality and by political imperatives of feminism and gay pride. These factors have implications for lesbian health promotion, the training of health care providers and the delivery of health care services.

**Reflections on research as a journey**

This new way of seeing the women’s stories had a personal, as well as a professional impact on my own ‘way of being’. For example, at the start of this project I felt a responsibility to come out when I saw a doctor, in the belief that by making myself visible, I would improve health care services for other lesbians. An experience I had during the course of the project made me re-think this position. I returned to a (woman) doctor I had seen before, and to whom I had come out personally and professionally. This doctor had invited me, in my capacity as a lesbian health worker, to speak to a group of women GPs about lesbian health, and I was also a patient at her clinic in the few times I had needed to see a doctor. During the consultation, I explained that I had back pain, which was exacerbated by carrying my grandson. She sat back with a surprised look on her face and said, ‘but I thought you were a lesbian?’ The incredible naiveté (or ignorance) of her statement shocked me, she had assumed that because I was a lesbian, I had no children, therefore, no grandchildren. At that point I realised that my coming out (and efforts to educate) had not had any impact on her heteronormative attitudes. It left me feeling tired and vulnerable. In that moment I realised that, despite the activist position, individual lesbians identifying themselves to doctors was unlikely to change attitudes, or improve health care services to lesbians.

The field ‘lesbian health’ is complex and multiple, constructed by a number of twentieth century social movements and discursive formations, as well as by older discourses that constitute lesbians as deviating from society’s (hetero) norm. Despite the changes that
have resulted for lesbians as a result of second wave feminism and the gay pride movement, deficit discourses about lesbians continue to emerge and impact on the willingness of individuals to come out/disclose. Images of lesbians as mannish, sad, lonely and isolated, unable to maintain a relationship or be connected to others impact on individuals and their sexual subjectivity. Fears about discrimination, prejudice and poor treatment, and stories about abuse and poor treatment from doctors and health care workers circulate among lesbians. All of these discourses are embodied, and individuals may be disposed to respond differently, depending on their own experience and how they position themselves in relation to these discourses. Thus each individual’s ‘history’ comes with her to clinical spaces and impacts on the medical encounter in unpredictable ways.

Medicine, as a discursive formation, also contributes to constructing the field ‘lesbian health’. The effect of twentieth century surveillance medicine and governmentality constitutes individuals as responsible for striving for health and happiness – accountable for their own health and conforming to society’s norms. This creates a tension for lesbians, by definition they deviate from society’s norms, yet they still strive to achieve governmentality’s goals. The challenge for health care workers that emerges from theorising lesbian health in this way is to see and respond to the health needs of lesbians within the larger context in which they are marginalised and affected by heterosexism, sexism, racism, and other power effects, without producing them as invisible, passive victims.

In theorising lesbian health, a paradox emerges. I have repeatedly asserted that the identity category ‘lesbian’ does not adequately define women whose sexual attraction, behaviour or identity is not exclusively heterosexual. Yet to address the health issues of women who can collectively be categorised as lesbian, such a category is necessary. This inconsistency is apparent throughout this thesis, in which I both problematise the notion of identity category and resort to using the category. I acknowledge this paradox, but assert that as a field called lesbian health exists, to address the problems that this throws up it is necessary to collectively categorise lesbians, while at the same time acknowledging and maintaining an awareness of the problems contained in doing this. The problem arises when the collective adjective is used to assume that everyone in the group shares the same qualities and practices, rather than seeing individuals in the group as diverse, and approaching them in this way.
Efforts to improve health care services for lesbians will be more effective if practitioners, researchers and activists develop an understanding of how identity categories can both include and exclude those assumed to belong to the category. It is important to recognise that lesbians are diverse agents whose primary focus is care of the self. Rather than hyperbole about increased lesbian visibility in health services, and exhorting individual lesbians to come out to increase the visibility of all lesbians, workers and activists might benefit from considering such critically reflexive questions as:

Who produces ‘stories’ about lesbian health? From what social position?

Who benefits from lesbian health discourse?

Whose voices are heard/not heard? What difference does this make?

These questions can make us more accountable. They acknowledge that, as workers and activists, we have a limited and partial perspective, and if considered reflexively, can provoke us to open ourselves to the possibility that there are things going on within the field, that we do not fully understand.

**Future Directions**

**Implications for the field**

It is important for lesbians to know that they are the managers of their own health, and that decisions about speaking/silence are theirs to make. Pressure should not be exerted on lesbians to come out or disclose to doctors or other health-care providers. Messages such as trust your instincts, expect the best, and be assertive about seeking the health care you want, are important health promotion messages for lesbians. The focus of change should be on health-care providers and services.

There are a number of counter-discourses that could be mobilised to address issues about exclusion or marginalisation of women whose sexuality is not normative, either in identity, attraction or behaviour. For example, sexual orientation and identity are not necessarily synonymous; sexual behaviour is multiple, fluid and more relevant to health care than the matter of sexual identity. Another strategy would be to take the focus of lesbian health research and practice away from the dominant biomedical model of health, and recognise that discrimination, exclusion and misrecognition are health issues, and that health care practitioners who practice any of these, intentionally or unintentionally, are harming the health of those in their care. Basing health care services on the WHO social
determinants of health, and training workers to understand this model would contribute to this shift in perspective.

**Implications for health-care workers:**

Health-care workers and services have a responsibility to understand that the way in which space is constructed and the approach of workers can exclude some individuals, and diminish the potential for a productive clinical relationship. Reflexivity is essential in the practice of health-care. Doctors and other health-care workers need to be aware of their own values and attitudes in their practice, including sexism, homophobia and heterosexism. Paying attention to the way in which space is used, for example including posters, flyers and brochures about lesbian health and services, including in statements in the service purpose, or mission statement, about being lesbian friendly and displaying these in public spaces, and ensuring that patients/consumers know about privacy practices, are all ways to make the space more lesbian friendly. Learning ways of taking a history that uses open questions, and inclusive language can also foster improved relationships between doctors/service providers and lesbian patients. The way in which clinical relationships are constituted can also govern dealings between the worker and the individual patient/consumer. The terms doctor and service-provider each implies a very different role. Lack of clarity about these roles can lead to confusion. If the doctor/service provider is aware of these dynamics, and recognises or clarifies the role that the presenting individual has assumed, it may assist making the outcome of the consultation more productive.

The findings of this study suggest that it is in the detail of the health-care providers’ approach, and the relationship that is built between the parties to the medical encounter, that the trust and rapport is likely to be established that will assist doctors to provide holistic and effective care for their lesbian patients. At the heart of the high-quality clinical relationships are clear communication, and a desire to develop a relationship that benefits all parties.

Requirements for reproductive support and preventative care for lesbians are no different to those required for heterosexual women. Understanding the social context and supporting family, however it is constructed, is essential for good care. Acknowledging and including the birth mother’s partner, regardless of gender, is another aspect of good care. Approaching Pap tests with sensitivity is crucial, as this is the most difficult aspect of preventative screening for many lesbians. Supporting women who find these tests
difficult, regardless of sexual orientation or practice, is also fundamental. Taking time to know each woman’s history and address any concerns or anxiety she expresses will diminish the likelihood of Pap tests causing distress.

Research has identified mental health as a significant health issue for lesbians. This includes the misuse of tobacco, alcohol and other drugs. These issues do not stem from any essential psychological, physical or genetic difference between lesbians and heterosexual women, but from the stress of living in a society that labels those who do not conform to gender or sexual norms deviant. Providing opportunities for lesbians to feel comfortable about being out, and recognition of the social context of their lives, will assist in the delivery of appropriate and effective health-care. However, assigning individuals to categories based on their sexual orientation or practices can be harmful if they establish normative assumptions about human behaviour. The desirable relationship between the lesbian and her doctor/service-provider is one in which a relationship forms in which openness is a probable result, not only about sexuality but a whole range of lifestyle matters.

Lesbian health has focussed on lesbians coming out in the consulting room and supporting environments which make this possible. One problem associated with this is that doctors assume they know what lesbianism involves. Service providers should be aware of never making assumptions, firstly about orientation, and secondly about her sexual practices, both past and present. Even if a woman comes out as a lesbian in a consultation, she may have children from a heterosexual relationship, or within a lesbian relationship. She may have sex only with one woman, with a number of other women, or with women and men. She still needs pap tests, and may need STI tests.

In the dynamics of a developing clinical relationship, for the doctor/service-provider, knowing what works with a person presenting for care is territory that cannot always be clearly articulated. Responsibility for the relationship lies with both the doctor and with the patient, but no formula or ‘map’ exists that provides information about how to make the clinical relationship work. The doctor/service-provider who tries to successfully negotiate this relationship is likely to find that what works well with one person will not necessarily work with others. The participants in this project had some ideas about what they wanted from a clinical relationship. This included being seen as a whole person and having a doctor who is interested in them beyond the immediate encounter. It is of note that those participants who had negotiated a clinical relationship that worked had not had
access to longer consultations, or special treatment. The relationship had developed over time in an environment that was inclusive of difference, in which the patient/consumer felt respected and heard, and in which communication was easy and open.

**Implications for activists:**

The production of identity as a definitional field in relation to lesbian health excludes many women who are same-sex-attracted, have sex with other women or do not identify as lesbian. Increased visibility in clinical spaces in no way guarantees acceptance or better service. The residual force of historical understandings about lesbianism has resulted in contradictory and conflicting discourses that affect how lesbians are viewed, and view themselves. Calls for increased lesbian visibility in health services may not have the desired effect of improving the experiences of lesbians in health-care settings, or the health of lesbians.

While lesbians experience some health outcomes that do not compare well with those of heterosexual women, these differences stem from living in a social setting that fosters negative views about lesbianism, prejudice against sexual difference and refusal to acknowledge any other kind of sexuality than heterosexuality. Each of these has a different outcome: Negative views assume lesbians to be essentially unhealthy because their sexual orientation is not normative; prejudice is a form of violence that brings the lesbian sharply into view and inevitably has negative outcomes, and heterosexism is a kind of impaired vision, that refuses to acknowledge the existence of lesbians. None of these can be overcome simply by lesbians coming out in the medical consultation. The onus needs to be on service-providers to change their attitudes towards non-heterosexual sexuality, rather than on individual lesbians to come out/disclose. Calling on lesbians to come out can place them outside their comfort zone, and in some cases may even increase their risk of being exposed to prejudice or discrimination.

**Limitations of the research**

This research was limited to a small group of lesbians, of limited diversity, living in Victoria, Australia. As such, it may not be possible to generalise the findings to all lesbians. It does, however, provide a deeper insight into the interactions of a group of lesbians than has been described in previous research.
Implications for future research

The interactions described and discussed in this thesis represent a one-sided view of what is essentially a dialogic interaction. Research is required to understand how heteronormative attitudes and practices are transmitted during the training of health care workers, so that training can be adapted to be inclusive, and strategies developed to ensure that health care workers do not exclude patients/service users whose sexuality is not normative. Rather than focussing on biomedical models of health and attempting to bring about change by focussing on individuals, changes to the training of health care workers would be more appropriate. This training must focus on diversity of experience and a refusal to make assumptions based on heteronormative attitudes.

Further research is also required to understand what happens in the medical encounter, by focusing on service providers. This would provide insight into the other side of the equation covered by this thesis.

This project also highlighted a lack of theorising about women’s sexuality, and about lesbian sexuality in particular. Further research that investigates the ways in which women experience and express their sexuality in its own right, not in comparison to men’s sexuality, would contribute important knowledge to inform future projects investigating how sexuality is implicated in a range of social issues that impact on women’s (and lesbian) health.
11. Appendices

Appendix I. Recruitment Flyers

Flyer #1.

*Lesbian Health: what’s your experience?*

*Do you have a lesbian-friendly doctor? Are you out with your health-care practitioners? What are your experiences with the health-care system? As a lesbian, what do you want from health-care practitioners?*

A lesbian-friendly researcher would like to interview you for between an hour and 90 minutes, at a time and place that is convenient for you, about your experiences with the health system. Your contribution will be confidential and will contribute to the current discussion about lesbian health. It will also help to inform health service-providers about what lesbians want from health services, the barriers they experience and what is needed to improve access.

Interested? Please contact Sue Dyson at The Australian Research Centre in Sex, Health and Society, La Trobe University (contact details supplied)
Hello,

Are you out with your doctor? What kind of experiences have you had (good and bad) with the health system? What do you want from health services?

I am a lesbian research student at La Trobe University. I would like to talk to other lesbian/gay/queer/or same-sex-attracted women about their experiences of health and with the health system. I would like to interview you for about an hour, at a time and place convenient to you. Your contribution will be completely anonymous and confidential and will help to inform health-care practitioners about what we want from health services.

I am particularly interested in talking to women who are under 30 and over 60, from city, suburban or country areas. Please contact me at the Australian Research Centre in Sex, Health and Society, La Trobe University. Please phone or e-mail me to find out more, I can supply a detailed description of the project on request.

I look forward to hearing from you.

Sue Dyson, The Australian Research Centre in Sex, Health And Society, La Trobe University (contact details supplied)
## Appendix II. Interview themes and questions

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<tr>
<th>Theme/domain</th>
<th>Probe questions</th>
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<tr>
<td><strong>1. Growing up, experiences of health and the health system.</strong></td>
<td>Can you tell me about your childhood? Where did you grow up? What was it like for you? How many brothers and sisters did you have? What was your family like? Where did you go to school? What was that like? Were you a healthy child? What was your health like when you were growing up? Can you tell me about your experiences with the health system when you were growing up? Did you see the doctor much? How was that for you? Did you see other health-care providers? How was that?</td>
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<td><strong>2. Sexuality</strong></td>
<td>Who were your friends? Did gender matter? When did you start ‘dating’? What was that like? Can you remember when you started to think you might not be straight? When did you come out? What happened? How was that for you? In relation to your sexuality, how do you identify yourself now?</td>
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<td><strong>3. Stigma, discrimination and prejudice</strong></td>
<td>Was there a point where you realised that being a lesbian might be seen as different or not normal? Have you ever been discriminated against because you are a lesbian? Have you ever felt at risk or in danger because of your sexuality?</td>
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<td><strong>4. Invisibility/disclosure</strong></td>
<td>Relationship status? Are you out with family? Friends? At work? In general, what influences your decision to be out? How have you come out to people in the past? Is it different for different people? What influences this decision? To what extent do you think lesbians (in general) are visible? Are there any highly visible lesbians you can think of?</td>
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<td>5. Lesbian community and activism</td>
<td>Can you tell me about your social circle? Who does it include? How would you define your family? Who would you include? Do you see yourself as politically active? In what ways?</td>
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<td>6. Information</td>
<td>Would you say you are well informed about women’s health issues? Where does that information come from? Do you think there is a difference between women’s health and lesbian health? Do you think you are well informed about lesbian health? Where does your information about lesbian health come from?</td>
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<td>7. Mapping constructions of health</td>
<td>What comes to mind when I say healthy person? ‘healthy woman’? ‘healthy lesbian’? What health issues are important for lesbian women? What affects your health? What does it mean to you to be healthy? What makes lesbians sick/unhealthy?</td>
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<tr>
<td>8. Mapping constructions of health</td>
<td>Can you think about any experiences where you felt you were invisible? Have you had experiences where you concealed or chose not to disclose your sexual orientation with a health-care provider? Are you out with your regular health-care provider (all, any, some)? Under what circumstances do/would you disclose your sexuality to a health-care provider? When wouldn’t you? In general, what influences your decision to be out or not? What kinds of things do you take into account when you decide whether or not to disclose to a health-care provider? How do you disclose to a doctor or other health practitioner? Can you tell me some of the ways you have heard about others doing it? If you decide not to come out, how do you handle questions about sexuality, partners etc.? When is it relevant to come out to a HCP? Why?</td>
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9. Experiences with the health system

What typically happens with your regular doctor when you make an appointment/present at the office/surgery and during a consultation? What about with other providers?

Describe your most positive experience as a lesbian in the health system.

Describe your most negative experience as a lesbian in the health system.

In what ways do you think your sexual orientation might be relevant in your health care?

Is disclosure or exposure an issue in any of the dealings you have with support staff? (for example, receptionists/office staff)

What things do you think about/dread/look forward to when you need to see a doctor?

Have you or your partner ever been in hospital or in a setting where you needed to see a practitioner together?

Did you disclose? If you did, how did you handle it?

If you didn’t what effect did it have on you and your partner? (if relevant).

Was your partner recognised as family?

Do you have children? Are you out with your children’s health practitioners? How would you rate their acceptance of you as a family?

What kind of experiences have you had around being accepted/respected as a family by staff in health-care settings?

Do you have Pap tests? Who does them for you? Are you out with them?

Have you ever seen a counsellor? Was your lesbianism seen as an issue in counselling? How did you deal with that? What happened?

What have you heard about other lesbians’ experiences with the health system?

10. Lesbian health and activism

Do you think the things you have read/heard about influence the way you approach the health system?

Do you see yourself as politically active?

11. Closing questions

Is there anything you would like to add?

I’d be interested to hear what this discussion has been like for you?

Would you like to receive a copy of the transcript of this interview and have the opportunity to review your answers?

I may need to do some follow up interviews with some participants in this study. Would you be willing for me to contact you about that?
Appendix III. Participant Profiles

Melanie

Melanie was thirty-nine and worked as a psychologist when I interviewed her. She grew up the youngest child of an Australian father and Asian mother in a rural city with two brothers and one sister. She said that her brothers experienced racism at school, but because she looked ‘less Asian’ she ‘got picked on’ less and that this ‘gave her hard skin’ and later ‘buffered’ her against homophobic attitudes. Melanie said she was aware of being attracted to women from the age of nine, but married a man in her early twenties. She said they married knowing it would not last, and agreeing that ‘this will be till we go our separate ways because he knew that I preferred women’. At the time of the interview, she had been in a committed lesbian relationship for six years and lived with her partner and her two children, aged eight and twelve. In terms of her identity, Melanie avoided calling herself lesbian, preferring instead to identify as queer. She described herself as being in a ‘same-sex relationship for many years’, and she said that although she sometimes called herself gay or bisexual she knew that she would always be with a woman. She indicated that she found the concept ‘lesbian’ narrow and ‘derogative’. Melanie was open about her sexual orientation at work, and with family and friends. She says she comes out by ‘just doing it … it’s not an issue’.

Melanie was a frequent user of the health system, and described being healthy for her as ‘not feeling sick’. For health care, she alternated between two general practitioners, saw several different specialists and regularly used ancillary health services such as massage and osteopathy. Melanie said that there are ‘some fabulous doctors out there’ who are ‘incredibly accepting, so much so that they don’t talk about it, like it’s natural’. She indicated that she had volunteered to participate in this study because she wanted to balance what she described as ‘skewed views’ about lesbians and doctors and that she wanted her story heard.

The qualities Melanie sought in a doctor were warmth and friendliness. She wanted someone who would take the necessary time, was thorough, listened, and respected her knowledge. She was not concerned about whether the practitioner was a man or a woman, and she prepared herself prior to going to the doctor by ‘doing some research’ and ‘writing things down’. She was prepared to be assertive with doctors when necessary to get what she wanted and said that she assumed that she would not be discriminated
against. She comes out in the consulting-room by talking about the gender of her partner and said she had never been discriminated against by a doctor.

**Gillian**

When I interviewed her, Gillian was a fifty-year-old academic who worked at a university; her area of interest was mental health. She was married for many years, but since the end of her marriage, had been in a lesbian relationship for seven years. She lived with her partner in a rural area. She is an only child who was born in England and immigrated with her parents to Australia as age six. When she was two years old Gillian spent ten months in hospital and she has subsequently hated going to doctors. Since her childhood health problem she has remained healthy and only sees doctors now for preventative tests such as Pap smears and breast examination.

She said that falling in love with a woman was not a concern for her: ‘I never thought about it one way or the other … it just happened’. She described herself as gay or in a lesbian relationship, but also that she was probably bisexual. She comes out by referring to the gender of her partner, ‘I’d normally say that … my partner’s a woman’. Lesbian is her ‘least favourite’ term. Although falling in love with another woman was not an issue for her, since coming out she had heard many stories about discrimination from other lesbians and was unsure about whether she had experienced discrimination directly because of her current sexual preference.

Gillian was well informed and aware of the discourse about lesbian visibility, which had created a dilemma for her personally. She had little confidence in the ability of doctors to see patients as individuals and said that most doctors use a ‘checklist approach’ and ask the ‘same questions every time’, ignoring or forgetting what they may have learned about the individual in previous consultations. Even though she was out with her doctor, whom she saw for Pap smears and breast examination regularly, she said she still gets asked regularly about contraception, which she finds ‘really annoying’. She said that while ideally it is important to be out with doctors, in practice it is probably not necessary. She sees this as ‘tricky’ because although it is a good idea for people to be open, there are a ‘lot of strange doctors out there’. She says that her change in sexual orientation had a major effect on her relationship with doctors, in part at a personal level, but also professionally. She was unhappy with her current GP who was located in the country near where she lived and sometimes thought that she should find a doctor in the city, which
Rebecca was fifty-two and was born and raised in Australia. She had two adult children from two different heterosexual relationships, but had been in lesbian relationships for most of her adult life. She lived in an inner suburb with her partner of many years, was a health worker and women’s health activist. When she was ten, her family moved from the semi-rural area where they had lived, to suburban Melbourne. When she was fourteen, Rebecca was ‘date-raped’ by an older boy. She never told her parents about the experience, and subsequently started to ‘act out’ for several years, during which she said she ‘was genuinely experiencing a lot of emotional health distress. I think most of that was around lost virginity and acting out through sexual promiscuity’.

Rebecca saw her lesbianism as a conscious political choice, influenced by the social milieu of the 1970s. While she has been out as a lesbian at work, with friends and at her children’s schools when they were young, she had never overtly come out to her family, opting to introduce her partners to her family and make it obvious that they were in a relationship without actually saying so. She said ‘I figured that my family kind of knew that because they would visit the house from time to time’. Although she was critical of her family, she said that they had always been ‘incredibly gracious and kind and welcoming and accepting of any partner that I have introduced them to. It’s just not something you talk about, you do it, you do the tolerance thing but we don’t talk about it’.

Rebecca described herself as a lesbian and a mother, and said she is ‘not into same-sex-attracted, I’m a lesbian’. She said she cannot recall an experience where she has been discriminated against because of her sexual orientation, but wondered whether she has had her ‘head in the sand’ about this and whether she had ever missed employment opportunities because of her sexuality.

While she said that she had ‘reached the point now’ where she never introduced herself by saying ‘hi, my name is Rebecca and I’m a lesbian’, she also said that never withheld information that might reveal her sexual orientation. If she did come out, it was in terms of the detail of her life, for example, by referring to her partner using the female pronoun. She was well informed about women’s health and took a broad social view of health for
Lesbian women, identifying such issues as financial security as significant health issues. She saw lesbian health and women’s health as being generally synonymous, except in relation to ‘lesbian wellbeing issues’.

Rebecca saw a local woman GP who practised in the suburb next to where she lived, who she chose because ‘her reputation was quite good’. While her preference was to have an ongoing relationship with a woman doctor, she had no problem with occasionally seeing a male doctor. She also saw other health-care practitioners from time to time, according to need. In her selection of these medical practitioners, she sought those with the ‘best technical expertise’. For example, she said she wanted a doctor who was a skilled communicator, who respected her knowledge, and took as much time as needed for a consultation. She also sought someone who would do appropriate follow-up after the consultation, like sending reminders for tests, and who was not ‘fazed’ by her same-sex relationship.

**Lesley**

Lesley was a forty-eight-year-old woman who lived in the inner city and worked in a welfare agency, and identified as a feminist and a lesbian. She had a nine-year-old son, who was conceived within a lesbian relationship which had ended. Her son was living with his birth-mother in the country and spent alternate weekends with Lesley. She was currently in another relationship and lived with her female partner in an inner-city suburb. Lesley’s first lesbian relationship was when she was twenty-seven, but she indicated that she had been ‘thinking seriously about it’ for some years before that.

Lesley was careful about with whom she was out, and although in most of her jobs it had been safe, she preferred to allow people to ‘figure out’ her sexual orientation for themselves. To avoid coming out with people at work, she said her work relationships had been ‘very business-like’ that she was ‘really cautious’ about engaging in discussions about family with co-workers. Instead, she preferred to be ‘really vague’ about her social and living arrangements, and was careful to use non-gender-specific pronouns when she talked about her partner. Her position was that ‘not everybody needs to know’.

Lesley experienced chronic back problems for some time and had sought relief from many different doctors and therapists. While she had a preference for a woman doctor, she had also had good experiences with male doctors, and clinical expertise was more important to her than lesbian-friendliness when she was ill. She was out with her GP, a
woman located close to where she lived and who ‘manages to give the impression that she has all the time in the world that you need’. She also had regular massage, saw an osteopath and acupuncturist and was out with all her health-care practitioners. She chose these practitioners on the basis of recommendations from lesbian friends. In a GP she sought someone who would ‘be my advocate’ with others in the health system if necessary. She looked for ‘someone who is clinically good’, who ‘knows their stuff’.

Although lesbian-friendliness was not her main criteria in selecting a doctor, she said she was more comfortable with a doctor if she could ‘be herself’ and not have to ‘censor’ herself in consultations. Her preference was to be open about her sexual orientation, because in some cases it might be relevant to the reason she presented to the doctor. She described how she came out with her current GP during her first visit. The doctor asked about contraception, to which she replied ‘I don’t have sex with men’. The doctor followed this up by asking ‘is that because you don’t have sex at all, or you’re in a relationship with woman?’

Lesley volunteered to participate in this study because of the experience she had as a non-biological parent around the birth of her son, who was born at the Royal Women’s Hospital. The hospital promoted the use of the term ‘support person’ to refer to the person partnering the woman giving birth, regardless of the gender or relationship. In prenatal classes she felt that they were the ‘odd couple’, and in the session on taking the baby home the midwife consistently referred to the father, which made her feel ‘invalidated’. After the session they complained informally but were asked not to ‘make too much fuss’ because although it was hospital policy to use the word ‘partner’, the midwife was from a non-English-speaking background and it was ‘important to keep nurses like her there’. During the birth experience the relationship between Lesley and her partner was never disclosed because her partner felt ‘vulnerable’, and didn’t want to have to deal with it. This meant that Lesley felt ‘invisible’ and that her role was not recognised. The lack of recognition of her role as a parent had continued, and she related an experience during a contact weekend when she had to take him to hospital because he had a high fever. She stayed with him in the hospital casualty and when he was admitted for observation. In the morning the paediatrician discussed his condition with her, but in the afternoon his birthmother came back for the second consultation with the paediatrician, who proceeded to ignore Lesley completely. When they were together, the relationship between Lesley and her ex-partner was fraught with tension about disclosing her parenting role to health-care practitioners.
Sandy

Sandy was fifty-one, a secondary-school teacher who had recently taken leave from work to explore other options. She grew up in the country and her twin sister was born with some disabilities which involved her being hospitalised a lot during their childhood. As a result, Sandy was separated from her twin, because the hospital would not allow children to visit. Sandy was currently single, had no children and lived in the inner suburbs of Melbourne. She identified herself as a lesbian and a feminist but preferred to call herself a dyke. She started to identify being attracted to other girls when she was in her early teens, and said she always knew that her feelings were not acceptable, but had no idea where that knowledge came from. She had some relationships with men when she was at university, but at the same time participated in lesbian groups on campus. By the time she was in her first lesbian relationship she said she was comfortable with herself, but not with how other people saw her. Sandy felt that she had disappointed many of her straight friends when she came out and that although she had been a lesbian for most of her adult life, she still found coming out to new people difficult.

One of Sandy’s great disappointments was that she had never had a child, and for several years from the early 1980s she sought assistance to become pregnant from a number of doctors and clinics, without success. She continued to be angry about these experiences and felt that they had caused her to be ‘pretty disconnected’ from the medical profession in general. Sandy had high expectations from doctors and sought someone who is ‘welcoming and polite, open-minded’ and who takes enough time and follows up with reminders when necessary.

Monica

Monica was born and raised in Melbourne; she was forty-three years old when I interviewed her. She had been out as a lesbian for five years, and prior to that she had been married to a man, with whom she had a twelve-year-old daughter. She and was currently in her first ‘live-in relationship’ with a female partner. Monica was an only child who was born after her mother had a number of miscarriages. Her childhood experience of health was one of living with a mother whom she described as being ‘hyper-vigilant’ about health. Her mother took her to the doctor ‘every time she sneezed’. She felt that her experiences as a child had made her more apprehensive about her own
health and ‘more ready to get things checked out’ when she thought there might be a problem.

Monica worked in a health advocacy position in a large organisation. She was out at work with her colleagues, but not with the people for whom she provided services. She described this as being ‘sort of split, which box am I in at the moment?’ She came out by mentioning her partner’s gender, but said that she ‘gets sick’ of doing it like that. Monica said she has never felt homosexuality to be ‘pathological or peculiar’ and can’t understand why ‘people get so hung up about it’. The main issue she took into consideration in deciding whether or not to be out in any situation was safety. With her daughter’s teachers and friends she is more pragmatic and generally does not come out.

Monica said she would always prefer a health-care provider who was gay or gay-friendly. While theoretically her preferred health-care practitioner would be lesbian, she currently saw a straight man with whom she was very comfortable and whom she had followed several times when he had moved his practice. This meant that while when she first saw him he was close to where she worked, she now travelled some distance to see him. Monica also used a number of allied and alternative health-care practitioners and saw a gynaecologist, chiropractor, acupuncturist, and Chinese herbalist. She made decisions about with which of these practitioners she was out, based on the degree to which she thought they needed to know.

The qualities she liked in her regular GP included that he was accepting of her sexuality, that she had ‘good rapport’ with him, could ‘ask him anything’ and that she did not feel that he patronised or talked down to her. Monica related how she was a strong advocate for both her daughter and her partner with their mental-health-care providers, and she was highly critical of the treatment each of them had received in the mental health system.

**Sally**

Sally was fifty-one years old, with post-graduate qualifications in science that led to her working in the health field as an educator. She lived in an inner-city suburb of Melbourne. Sally married and raised two children, and at the age of forty-seven with her children grown, she ended her marriage and subsequently fell in love with a woman. At the time of this interview, she was not partnered. Sally’s health was generally good and she attended a private women’s health clinic for general medical matters, had regular massages and
saw an osteopath occasionally for neck and back pain. She participated in regular screening for cervical and breast cancer. At the medical clinic she had no particular physician, and saw a number of different practitioners, depending on who was available when she made an appointment. Sally was out at work and with family and friends, but had never come out to a doctor because ‘it had never come up’. In the interview she said ‘I don’t have a story of being a consumer of the health-care system as a lesbian’. Sally wanted to be treated as an individual, and seen as a whole person by doctors. She said she wanted the doctor to know ‘who I am other than the patient in this consulting-room’. She was very clear that she was responsible for the maintenance of her own health and expected doctors to provide specific services that she could not perform for herself, such as Pap smears and mammograms.

Deb

Deb was thirty-nine when I interviewed her, with a twelve-year-old daughter from a heterosexual marriage. She was living in country Victoria with her lesbian partner. Her daughter had been living with her father, but was due shortly to start living with Deb and her partner. She was a full-time student working part-time.

Deb grew up in an economically depressed rural area, the youngest of six children. Her siblings were much older than her, and after the death of her mother, when Deb was seven years old, she was cared for by her alcoholic father and older married sisters. Deb said that she had experienced both physical and sexual abuse from her earliest years. She had seen doctors a lot as a child and had memories of being dropped off on her own at the doctor’s office by her father when she was sick, because she had throat and vaginal infections. She hated these experiences and said her memories of going to the doctor were associated with feelings of shame and embarrassment. Although she was left alone to see the doctor, and believes that the doctor knew she was being abused, no action was ever taken. As a young adult she also had a number of negative experiences with the health system, and after the birth of her baby she sought counselling, and started the process of recognising and recovering from her childhood abuse.

Deb said she was always more interested in girls than boys from a very early age. At her all-girls’ high school, Deb had a close friendship with another girl, and the two friends were called the ‘lezzos’ by other kids in town because of their close friendship. Deb believes that this was where she learned that there were ‘negative connotations’ associated with having ‘emotional or sexual feelings’ for girls. When she was 30 Deb
returned to university and was exposed to more liberal attitudes about homosexuality. After ten unhappy years of marriage, Deb left her husband and came out, first as bisexual and subsequently as lesbian. For Deb, coming out was a freeing experience, she said ‘it was like I could breathe, I had this voice in my head that said okay, now be who you are’.

When I interviewed her, she was out with family, friends, colleagues and doctors. Her preference was to see a lesbian doctor, but if no lesbian doctor was available she would see a non-lesbian woman. In a doctor she sought someone who was open-minded and took time. She preferred someone who would be prepared to use both western medicine and alternative therapies. Deb was assertive about her daughter’s health-care, and was out with all of her daughter’s health-care providers. Her attitude to this was that she had no problem with her sexuality and did not expect others to either. ‘If they do, then they have to deal with it, not me’. She was not comfortable about the services in the area where she now lived and felt that although many lesbians lived in the area, the town had an unchallenged culture of homophobia. She compared this to her experience of living in the city, where she found access to lesbian-friendly services was easy.

**Adele**

Adele was a sixty-five-year-old retired school librarian, who grew up in country Victoria with five siblings, and experienced severe asthma as a child. Adele was married to a man for sixteen years, and had three children. She was a devout Catholic who went to church every day during her married life. During the interview Adele explained that in 1994 she had seen an advertisement in her local paper for a lesbian group, and thought ‘I’ve got to try this out before I die’. She had been out as a lesbian for nine years, and lived with her current partner, Jill, in an inner-city suburb of Melbourne.

She described herself as having ‘had a lot to do with doctors over the years’. After the birth of her third child, she had postpartum depression, and had more recently been diagnosed with bipolar disorder. She was currently in the care of a general practitioner, a psychiatrist and a physician who worked together to co-ordinate her care. She felt the quality of her care to be good and said that she had never experienced any discrimination as a lesbian with her doctors, or in hospital. She was out with her doctors, who were all male, and involved her partner in her medical consultations when she thought it to be necessary. She suspected that one of the doctors at the general practice she attends might be homophobic, but did not have any contact with that doctor. From a doctor Adele
wanted someone who would meet her needs, and if that was not possible, who would refer her another practitioner.

**Jenny**

Jenny was thirty-two, lived in an inner Melbourne suburb and worked as a psychologist. She identified as a lesbian. At the time of the interview, Jenny was not partnered, and had recently separated from a partner with whom she had lived in a country town for several years. She was the oldest of three children and grew up in an outer suburb of Melbourne. She was living in a share house in an inner suburb of Melbourne when I interviewed her.

Jenny was heterosexually active in her teens, and came out as a lesbian when she was twenty-two, as a result of working through sexuality issues in therapy. The first person she came out to was her mother, although it was not done directly. Jenny was upset about the ‘loss’ of a good friend, and her mother guessed. Jenny said ‘it was all very unspoken’, her mother guessed that her distress was related to another girl, although she wasn’t really sure herself at that stage. Coming out was a slow process for Jenny. She associated lesbians with ‘people who wore steel cap boots and had short hair and leather jackets’, an image with which she could not identify, so she initially called herself gay. Her subsequent contact with the lesbian community had made her more comfortable with the word lesbian, which was now how she identified herself. She described coming out as a young woman as ‘isolating’ but this changed over time, as a result of her connection with the lesbian community, which she had found ‘very affirming’.

After she came out Jenny was very open about her sexual orientation and unconcerned about showing affection in public. Her most recent relationship was with a woman who was ‘very butch’ and she had witnessed a number of occasions when her partner experienced homophobic harassment and bullying, which had ‘coloured her way-of-being’. She had since become careful about how much she drinks, likes to always feel in control in public places, and was less trusting about being accepted as a result of these observations.

Jenny had a preference for a woman doctor, and she saw a counsellor who was a straight woman, but would have preferred her counsellor to be a lesbian. She related that she had a number of negative experiences with male doctors, and for a long time, she did not have a regular doctor. When she lived in the country, she started seeing her partner’s doctor, a
woman whom she knew was lesbian-friendly. Because her partner referred her she did not need to come out to this doctor with whom she had developed good rapport. Jenny had become very assertive about being out with doctors and expected to be treated with respect as a lesbian. She had an experience where she was referred to the Royal Women’s Hospital for an investigation of irregular vaginal bleeding, and rather than leave it in the hands of the doctor’s surgery, she made contact with the hospital herself. She was adamant that she wanted the hospital to know she was a lesbian because ‘I wanted them to be sensitive about the fact that the whole process was scary and foreign to me’. She rang the hospital, and said that she wanted to have a female gynaecologist who was sensitive to lesbian health issues to do the procedure. She was happy about the care she received during the whole experience. She attended a gay and lesbian medical clinic for her general medical care.

For Jenny, it was ‘very important’ that any health-care professional ‘knows who I am’, even if the matter she saw them for was completely unrelated to her sexuality. She felt that if she was not out then she had to ‘spend time and concentration thinking about how she needs to phrase things’. She did not want to have to ‘censor or monitor’ what she said, or ‘try to pick the right time to tell them’.

**Shona**

When I interviewed her, Shona was a thirty-six-year-old woman who lived in an inner Melbourne suburb with her long-term partner and the child of their relationship, a fourteen-month-old boy. She was an academic who worked in a large university law school. She volunteered to participate in this study because she felt that ‘a lot of issues around lesbian health have not been fully addressed by the medical community’. She grew up in a family that was ‘slightly medical’, both sides of her family having doctors. She was generally healthy and had few recollections of illness or of seeing doctors as a child. In her late teens, Shona experienced a considerable amount of stress related to her studies, at a time when she was also starting to question her sexual orientation. At this time she started to see a psychiatrist about her stress and depression. When she raised the issue of her sexuality the counsellor said ‘oh, no, I’m sure that you’re not a lesbian’, foreclosing any further discussion about the matter. Shona felt that much of her contact with the medical profession had been with people ‘who are not understanding about sexuality issues’. As a university student she was told by a doctor (to whom she had come
out) at the student health service that she did not need a Pap smear because she was a lesbian. She later consulted another doctor in the same clinic who did a Pap smear but found it painful and difficult, and the doctor refused her request to stop. She felt that the whole experience was ‘invasive’ and very traumatic.

Coming to terms with her sexual orientation was ‘pretty difficult’ in the beginning, and Shona identified coming out publicly as happening when she started at university, in her early twenties, however, she had not come out to her family until started her first serious relationship at age twenty-five. She had heard her father make homophobic comments when she was growing-up, so she came out to her mother, who was at first upset because she would ‘never have [grand]children’. However, once they met her partner, they were supportive of the relationship, and have since become supporters of gay rights in general. Shona comes out by referring to her partner’s gender and says she would never actually say, ‘I’m a lesbian’.

When Shona and her partner decided they wanted to have a child, initially Shona attempted to conceive without any success, so her partner became the birth-mother of their son. Their experience of pregnancy and birth was carefully managed. They wanted to have their baby at the Royal Women’s Hospital, but in the prenatal visits, in spite of the fact that they had been open about their sexuality and relationship they found that the constant reference to ‘the father’ ‘off-putting’, so they elected to have the birth at a private hospital where they were given recognition by the staff who were careful to use non-discriminatory language. They booked a double room and felt that the entire experience was one where they were accepted as a family without question or judgement. This was in part because they had chosen a private doctor so that they ‘did not have to negotiate their relationship at a time of crisis’. They managed their parenting arrangements carefully, and had Parenting Orders from the Family Court of Australia that gave Shona the legal status of a parent, which she carried with her in case she needed to assert her legal status with their son.

**Imogen**

Imogen was a twenty-two-year-old woman who grew up in an inner Melbourne suburb, with her European parents and one brother. Her father was a doctor. Since graduating from university, Imogen had worked in professional positions. She has always been healthy and, until she was sixteen, her health-care was provided by her father. She had a
good relationship with her father, and he provided her with a model for good practice in health-care. She came out when she was fifteen, tentatively to school friends at first, and three years later to her family. Imogen’s older brother had already come out as gay, so she felt that the way had been paved for her, and although her parents were not initially happy with her sexual orientation, they have now accepted her and they have a close relationship.

Imogen was an assertive young woman who was knowledgeable about health and resourceful in finding appropriate services. When she became sexually active, she went to a local female doctor, explained that she was a lesbian and asked for a Pap and STI test. The doctor refused, saying that she did not need a Pap test if she was lesbian, and Imogen insisted that she not only needed a Pap test, she wanted it done. She had since had trouble finding a GP with whom she felt happy.

Imogen had been involved for some years in a voluntary group that visited secondary schools and spoke to students about gay and lesbian issues and raised awareness about homophobia.

Anna

Anna was a forty-four-year-old woman who lived in country Victoria. She grew up in a suburban area of a large Australian city, the youngest of three children. When I interviewed her she was unemployed and single. She had a daughter in her twenties, who did not live with her. Anna’s childhood experience of doctors was not a positive one; she described the family doctor as ‘pompous’ and described how he talked over her to her mother, making her feel as if she ‘was not quite real’. The first opportunity she got, when she was thirteen, she took herself to another doctor without her mother. Anna left home when she was sixteen.

Although she recognised her attraction to other women early in her life, she married and had one child. She came out at twenty-one, and described this as easy as she was mixing with feminists and lesbians at a women’s centre. She found being a lesbian mother more difficult, particularly in relation to her daughter’s schooling.

Anna had found access to doctors difficult in the country town where she lived. She thought it important to be out with all her health-care practitioners, but in practice was pragmatic about disclosure, based on the attitudes she perceived in the practitioner. Anna
was out with her family and friends, but had not been accepted by all of her family members. This did not concern her greatly, as she had little contact with them and they live in another state.
Kelly

Kelly was thirty-three, a university student who was born in England and raised in Perth. She came to Melbourne when she was eighteen, she said, to get away from her parents and from her home town. She was the only child of a family in which her father was long-term unemployed, and said that she had been on welfare of some kind for most of her adult life.

Kelly came out when she was fifteen, and what started as confiding in a female teacher at school progressed into a clandestine sexual relationship, which Kelly described as destructive. She became depressed when the relationship ended and saw a counsellor at school, who also ‘came on’ to her. When the relationship with the teacher ended, Kelly said she had a sexual relationship with the counsellor. She came out to her parents when she was still at school, but thought that they didn’t believe her. At around that time she also developed anorexia and bulimia. When she finished high school she moved to Melbourne to ‘get away’ from her family who have now accepted that she is lesbian, but the matter remained unspoken between them. She lived with her current partner in an inner Melbourne suburb and identified as lesbian. She was careful about who she came out to and was not generally out with other students in her course at University.

Kelly did not recall ever having experienced good health, and described herself as a ‘weak person’. As a result of her anorexia and bulimia she had had a considerable amount of contact with the health system including western medicine, naturopaths, chiropractic, acupuncture. She described a number of negative experiences with health-care practitioners, particularly around her eating disorder, which she said was now resolved. Kelly chose her health-care practitioner carefully and she preferred a woman. She currently saw a doctor she thought was lesbian at a community health centre, but was not particularly happy with the care she received. She believed that she had learned more from her own research and alternative therapies about managing her health than she had from doctors.

Candace

Candace was a twenty-eight-year-old single mother of a three-year-old boy. Candace worked part-time, studied community development part-time and was active in volunteer
work. She grew up in a Melbourne suburb, the only girl in the family and the oldest of three siblings, with a European mother and Australian father.

Her parents ran a local store which meant that from the around the age of ten she started going to the doctor on her own. For most of her life she had the same doctor, who she described as being ‘like a family member’. This doctor had recently retired, but Candace continued to attend the same clinic. As a child Candace suffered from severe asthma, which meant that she had frequent contact with the health system, including being hospitalised a number of times. She said she had never had any problem with her health care.

In relation to her sexuality, Candace said she always ‘knew she was sort of different’. She had her first lesbian sexual relationship at age fifteen with her best friend at school, which lasted three years. Her friend stayed with her at her parents’ home frequently, but their relationship was never discussed between Candace and her parents. She was eighteen when she decided to tell her mother she was bisexual, ‘just to test the waters’. Candace asserted that she did not like being categorised into any particular identity, and wanted to keep her options open about future relationships. While she was comfortable with being a lesbian, she also felt that she was under some pressure in the lesbian community to conform to a stereotype in order to be a ‘real’ lesbian.

Colleen

Colleen was a sixty-four-year-old woman when I interviewed her, the only child of a Catholic mother and non-Catholic father. She grew up in a Melbourne suburb and attended an all-girls convent school. She currently lived in an outer suburb of Melbourne. Her childhood experience of health was ‘being rushed off to the doctor in case there was anything wrong’, which she attributed to the fact that she was an only child. Colleen traced her attraction to girls back to her school days. She described how the school had rigid rules and mechanisms to limit contact with boys, and also restricted opportunities for intimacy to develop between the girls. As a young woman, Colleen recalled hearing her mother talk about a female cousin who ‘ran off with another woman’; she was aware that her mother disapproved.

After Colleen left school she went to work in the office of a large company, where she mixed for the first time with other women who were lesbian. She formed close
friendships with the women with whom she worked, but lived with her mother until her
death and never pursued a relationship beyond close friendships with other women.
Colleen identified herself as gay, and was connected with lesbian friends through a
women’s health service lesbian support group, to which she belonged. When asked if she
had ever experienced any discrimination because of her sexual orientation, she answered
replied that ‘not many people know’. Colleen had a number of health problems, which
involved her seeing a number of different doctors but she had never come out to any
doctor.

She was out with her friends from the lesbian support group but not with family and
friends. Colleen continued to be a devout Catholic who went to church every week. Of
her identity she described herself as having ‘two lives’.

**Georgia and Mandy**

Georgia and Mandy were an Aboriginal lesbian couple who were expecting a baby
together when I interviewed them. They elected to be interviewed together. Georgia was
forty-two and Mandy thirty-two. Both women completed high school, and Georgia started
teacher training, but did not complete her studies. Mandy grew up in a rural area as the
youngest of four sisters and part of a large, extended Aboriginal family. Georgia was of
Aboriginal and Maltese extraction, and she also grew up in an Aboriginal family, but in
an urban area. Both women were close to their own and each other’s families and
expressed admiration for the women in their families.

Georgia believed she had always been a lesbian. Although as a child she did not
understand the concept, she knew that she had always had crushes on teachers and other
girls at school. She found out that being gay was unacceptable when she was in her mid-
teens and attempted to get involved with boys, but by the time she was nineteen she was
‘back with women’. However, she had not connected with the lesbian community until
she met Mandy, and she said she did not know there were gay bars until she was twenty-
seven, even though she was in a gay relationship. She said she never felt like she fitted in
to the lesbian scene.

Mandy came out when she was in her early twenties, although she said that she had
always felt that she was ‘different’ when she was at school and had ‘acted like a rebel’ by
shaving her head and piercing her nose. After she came out Mandy’s social life was
centred on the gay women’s ‘scene’; sporting clubs, bars, women-only dances and events. When Georgia and Mandy started to go out together, Georgia found Mandy’s social setting confronting and was uncomfortable in all-women company.

Georgia had many negative experiences with the health system as a child; her early experiences of illness were that they were dismissed as Aboriginal problems. She also described being bullied at school because of her colour. She described how she experienced skin problems as a child, and her mother realised that she was not being treated by the hospital where she was taking her, so she took Georgia to a different hospital and passed her as Maltese instead of Aboriginal, after which they received better treatment. According to Georgia, this improved as she grew up and more Aboriginal health services were funded, however, it had affected her ability to trust health services and she ‘gives it a miss’ wherever possible.

Mandy’s experience was somewhat different. In her childhood, her experiences of health were positive, she attended the same doctor in the country town where she lived. When she came out as a lesbian she avoided the health system and said she had never really liked doctors, in part because of the automatic presumption of heterosexuality.

At the time of interview, Mandy was four months pregnant, and Mandy and Georgia had been through the IVF program after trying unsuccessfully to self-inseminate by AID at home for three years. Both women had a number of stories about negative treatments they had received from fertility doctors, nurses and other staff in the clinics they attended in the process of trying to conceive. Their experience with the GP they saw in the small country town in which they lived had been much more positive and they really liked this doctor, who took a no-nonsense approach to health care. They were out with this doctor, but if they saw another doctor for any reason they said they would be unlikely to come out. Mandy said ‘there’s times when there’s just no need [to come out] because it’s your way of life and that’s, you know, got nothing to do with them’.

In their home town Georgia and Mandy were completely open about their relationship, in general, they believed they were well accepted by their neighbours in the town. Both women’s families were supportive of their relationship and excited about the prospect of a new baby

Mary
Mary was a forty-year-old woman with two daughters aged twelve and fourteen from a heterosexual marriage. She was separated from her husband, but continued to be friends with him. She currently lived alone in an outer suburb of Melbourne. As a child, Mary was one of seven children, and was born with a ‘hole in the heart’. As young girl, Mary recalled being sexually attracted to other girls and teachers, but ‘didn’t take much notice of it’. She had had frequent contact with the health system all her life. As a child she had many negative experiences with doctors as a result of her heart condition, of which she had many unpleasant memories. She was also not allowed to participate in sports as a child because of her condition, and recalls ‘hating doctors’.

As an adult, Mary was a recovering alcoholic and had suffered ongoing mental illness, for which she had been hospitalised a number of times. Her children lived with their father and spent time with Mary on weekends and during school holidays. She was generally positive about the health-care system, and had a team of health practitioners who she trusted supporting her. She saw a private psychologist for therapy, and attended a local GP clinic, where one of the physicians prescribed her medication. After she had a breakdown six years ago, Mary decided that she needed to disclose to her therapist that she had feelings for women. As a result her therapist researched support services for lesbians, and referred Mary to a women’s health service, where she was involved in a number of activities for lesbians and women with mental illness. Mary also went to her local doctor for support and advice when she first came out. The doctor told Mary that while he had advised gay men in the past, he had never had a woman ask him for advice of this nature before. He was open with her that he had little knowledge about lesbian health. The doctor was unable to give her any advice on safe sex, but he did refer her back to the women’s health service for more information, and she was able to get the advice and support she needed.

When I interviewed her, Mary was very happy with her male doctor, who she saw because he was close to where she lived. She believed it was important for her doctor to know about her sexual orientation. For Mary, the qualities that were important in a doctor included accessibility, availability and good communication, trust and acceptance.
12. References


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