HEALTH 'IN QUEER STREET': CONSTITUTING SICKNESS, SEXUALITIES AND BODIES IN THE SPACES OF LESBIAN HEALTH

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ABSTRACT

This thesis explores lesbian health. The appeal of this project is its attention to the constitutions, resistances, and reproductions involved in the construction of 'lesbian health'. 'Lesbian health' provides the context for exploring the meanings of health, sickness, sexuality, and bodies. The analysis takes place in three stages. It begins with a review of gay-positive studies of lesbian health. Second, is a discourse analysis of constructions of 'health', 'illness', and 'sexuality'. It concludes with a critical analysis of the fluid and leaky constitutions of gendered sexualities and bodies.

I conduct a study with 17 self-identified lesbians, using open-ended interviews that cover a variety of topics in the areas of health practices and concerns. Feminist Foucauldian approaches inform the critical discourse analysis of the interviewee's accounts. An examination of the co-constitution of discourses about 'health' and 'sickness' in relation to 'lesbian' sexualities reveals a binary relationship. That is, health for lesbians is constituted as overcoming the societal pressures and exclusions related to 'being gay', avoiding the implication that lesbian 'health' or 'sickness' may be inherent. I draw on Elizabeth Grosz's critical analysis of the corporeal as I examine lesbian bodies in the contexts of cervical screening and dental dams. In these health promotion contexts, 'lesbian' bodies are brought into being, but their presence is potentially threatening. Lesbian bodies are constituted, materially and discursively, as liminal, fluid, and abject. The consequence is that disclosure as 'lesbian' is self-regulated. Other consequences for cervical screening and safe sex promotion are explained by the leaky fluidity of bodies and places, which reinsert 'lesbian' into the hegemonic space and simultaneously render 'lesbian' external to such space.

I suggest that health practices, concerns, and promotion are 'in queer street', literally troubled by the unsettling of hegemonic assumptions. Focusing on the lived, sexed body in health research, using discursive and critical theoretical tools, may offer one more way of challenging assumptions about sexuality and gender, and raise questions in the practice and analysis of health that address diversity and difference.

DEDICATION

During the work on this project, two people known personally to me ended their lives and the struggle with the meaning of sexuality in it. This thesis is dedicated to you.

It is also dedicated to all of us who have ever sought to be recognised in the systems of health care.

WHILE THERE ARE RISKS WITH VISIBILITY
THE RISKS OF SILENCE ARE GREATER

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CHAPTER I

INTRODUCING HEALTH 'IN QUEER STREET'[1]

This is a thesis about lesbian health. In 1996, as part of a working group developing a pamphlet on lesbian cervical screening, I made a submission to the New Zealand National Cervical Screening Programme (NCSP) requesting that lesbian women who were or had been sexually active be specifically targeted as a population for cervical screening, regardless of whether they had ever had sexual intercourse with men. At least one research study had established that lesbian women or women who have sex with women can transmit the Human Papilloma Virus (HPV) between them (Conway & Humphries, 1994). Supporting work from other studies had already confirmed that the presence of HPV has a strong link to cervical abnormalities that can be indicator of invasive cervical cancer.

A number of submissions were made by our working group Outskirts, offering suggestions for the wording of the statement on who should be eligible for screening under the National Cervical Screening Policy. Lesbian women have appeared in the new policy, as a target group and as an area for future research. However, the wording of the statement means that it remains unclear who should be screened. The statement reads:

> all women between the ages of 20-69 years should be offered screening every three years. This includes women of all ethnic groups, lesbians and women with disabilities ... any women who has never had intercourse ... need not be screened (Ministry of Health, 1996, p. 10).

The word intercourse has been retained. Dictionary definitions (included in our submissions) refer to intercourse as meaning the following:

> *Sexual Intercourse* (n) The act of sexual procreation in which the male's erect penis is inserted into the female vagina; copulation; coitus (Gordon, 1982, p. 1058).

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[1] 'In Queer Street' refers to being *in trouble.* In the *Oxford Dictionary* it is referenced to the term *in trouble* ("see *in trouble* 1 (TROUBLE)" (Tulloch, 1997, p. 1251)) which is in turn defined as "involve[ment] in a matter likely to bring censure or punishment" (Tulloch, 1997, p. 1674)

> *Sexual Intercourse* 1. The sexual act, esp. between humans, in which the erect penis is introduced into the vagina for the ejaculation of semen and sexual gratification. 2. Any act of sexual connection, esp. between humans (Landau & Bogus, 1975, p. 671).

Although it is realised that women who have sex with women and never had intercourse with a man are at some risk from cervical abnormalities, the statement of current policy appears as if only lesbian women who have had sexual relations with men are at risk enough to be screened.[2] Our submissions noted that a more appropriate term than intercourse should be used, given that its inclusion appeared to exclude lesbians (who have not, or are assumed to have not, had sexual intercourse) from screening recommendations. The presumption is heterosexual sex was a necessary condition for screening eligibility.

The issue here is decidedly complex. Did OutSkirts and the National Cervical Screening Programme come to different conclusions about the importance of (limited) research on the risk from cervical abnormalities for women who have sex with women, and its importance in affecting policy? Were the reasons for retaining (or removing) the term intercourse different as a consequence? Did OutSkirts and NCSP come to different assessments of who or what a lesbian is, or what her sexual practices are?

It is in the context of these quandaries and concerns over research, policy, and practice that the questions I address in this thesis have emerged and developed. It seems that little has changed since my first encounter with these issues when I 'came out'[3] in 1992 at the age of twenty-three. Health information, particularly pertaining to sexual health, suddenly no longer seemed to be relevant to my identity and behaviour as a lesbian woman. I was at that time at a loss to know where to find verified information, or whether such information might be available.

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[2] There is no grave criticism of the National Cervical Screening Programme implied here. The programme took the submissions on lesbians seriously. The example is intended to show the complexity of lesbian health issues, ignored by most other health agencies and organisations.

[3] Coming out is often used to describe the process in which a person's 'gay' sexuality is confirmed publicly, by telling others that 'I am gay'. In this context, it also literally refers to a coming to one's essential identity, which previously had been 'closeted away'. Used in this project, however, I refer to coming out as occurring when a person realises that their cultural and social environments are explicitly supportive (in the majority of its structures) of heterosexuality. Since a person is experiencing their sexuality as other than heterosexual, coming out suggests the experiencing of ones self in the context of their environment as other than or different from heterosexuality.

The framework for verifying the existence of lesbian health concerns is a relatively new and emerging field of study, simply referred to as 'lesbian health'. 'Lesbian health' is a body of research and writing, comprised mainly of descriptive work. It can be understood as a forum in which concerns raised in lesbian communities have been brought into mainstream (mainly positivist, and epidemiological) discussions about health. Conducting lesbian health research, legitimises lesbian health needs, issues, and concerns. Through research, the issues that constitute the 'field' of lesbian health are formalised, and made available to lesbian communities and to those external to them.

A review of contemporary research and writing on lesbian health begins this thesis. The first part of my project assesses literature from predominately gay-positive researchers who assume that lesbian health is a positive, achievable, and essential quality of lesbian experience. At one level, this thesis is a critique of *lesbian health research*, which has been used to paint a picture of *lesbian health*. Notably, the relationship between the health arena and lesbians can be regarded as a tenuous one. As Miller, Rosga and Satterthwaite (1995) comment, "it might be said that lesbian health is something of an oxymoron" (p. 431). 'Health' has often been a site of oppression for lesbians, because lesbians have often been viewed in terms of sickness and disease. 'Lesbian health' may therefore also be regarded as field of research and study intended to move lesbians away from stigmatising medical discourses,[4] towards 'lesbian issues'.

These concerns over traditional health research and the study of lesbians inform the first aim of the thesis. The intention is to undertake a critical health analysis in which sexuality is regarded as integral to understandings about health. That is, sexuality is viewed as constituting notions of health and health as constituting notions of sexuality. This analysis seeks to pay attention to the constraints (conscious and unconscious) and

[4] Discourse can be viewed as a "system of statements which cohere around common meanings and values..[that] are a product of social factors, of powers and practices, rather than an individual's set of ideas" (Hollway, 1983, p. 231, cited in Gavey, 1990, p. 123). Discourse is concerned with "ways of constituting knowledge, together with the social practices, forms of subjectivity and power relations which inhere in such discourses and the relations between them" (Weedon, 1987, p. 108). This broad concept does not just refer to language or text, but to a structuring principle of society. It is concerned with the exercise and maintenance of power relations as what is permitted to count is defined by the discourse. Multiple discourses offer competing and potentially contradictory ways of giving meaning to the world, and a variety of subject positions to the individual that vary in authority and power. The subject positions that are available are also determined through historical and power relations, therefore discourses also constitute subjectivity (Weedon, 1987). In this way "there is no knowledge which is not produced by power relationships, and there can be no value-free, rational science" (Jones, 1994, p. 40).

resistances to hegemonic notions of health (including those that advise practice), and in doing so contest these health notions. To explore this, the thesis charts a process of examining lesbian health through a number of theoretical frames so that lesbian health is represented in turn, as an area of study, a discursive[5] field, and a lived corporeality.[6]

In the next and second part of this thesis, lesbian health is regarded as constituting and constituted by notions about 'lesbian' and 'health', and is discussed as belonging to distinct ('lesbian' and 'health') and interrelated (lesbian/health) discursive fields. The presumption that lesbian is an identity that is fixed and unchanging and belonging to an essential sense of being, informed the shift in the thesis towards a consideration of lesbian health as a discourse. As Foucault argues, the notion of discourse offers the sense that there exist multiple, competing and potentially contradictory ways of giving meaning to the world, and that these provide for and explain the particular ways of constituting sexuality. 'Lesbian' and lesbian health, are therefore considered a consequence of cultural and historical representations. Lesbian health is no longer only understood as an individual or shared community quality, but rather the manner in which it is constituted or resisted has implications for what are able to be realised as the possibilities for lesbian health.

The competition between discourses can be conceived as produced around a set of coherent arguments in Western philosophy that work in diametrical opposition. Homosexuality, for example, is understood and organised in relation to heterosexuality, and is the subordinate, referenced term. The fundamental opposition under consideration in this thesis, important to philosophical and feminist conceptualisations of the human subject, is that of the mind and body (see Grosz, 1994). In this rigid and dichotomised thinking, the mind is defined by what is expelled from it, so that the body is what is 'not mind' and subordinate to it. Whatever exists outside the privileged term (mind) is regarded as being unruly and disruptive. The mind/body opposition has always been

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[5] "Discursive fields consist of competing ways of giving meaning to the world and of organizing social institutions and processes" (Weedon, 1987, p. 35). Discursive fields attempt to explain the relationship between language, social institutions, subjectivity, and power. These relationships will be described more fully in Chapter Three.

[6] Corporeality refers to attempts to conceive of the body "in terms other than those implied by various dualisms" (Grosz, 1994, p. vii), for example mind/body, inside/outside, nature/culture (Kirby, 1997). Corporeal approaches tend to deny "the 'real,' material body on one hand, and its various cultural and historical representations on the other...(and claim)... that these representations and cultural inscriptions quite literally constitute bodies and help to produce them as such" (Grosz, 1994, p. x).

correlated with a number of other oppositional pairs. Grosz (1994) argues that "lateral associations link the mind/body opposition to a whole series of other oppositional terms, enabling them to function interchangeably" (p. 3). In the particular context of this thesis, 'heterosexuality' is correlated in relation to the mind, public, self, male, individual, culture, exterior, outside, and reason, whereas 'homo-sexuality' is correlated with body, private, other, female,[7] social, nature, interior, inside, and emotion. As a theory and a discipline of study, health[8] is framed in relation to mind and its linking concepts (see Grosz, 1994). As 'health' exists in an already oxymoronic and dichotomised relationship with 'lesbian' (homosex *and* female), the production of lesbian health must be regarded as the consequence of the play of discourses about health, sexuality, and gender. This leads to the second aim of the thesis, to deconstruct the dominant discourses of lesbian health, paying attention to the dichotomies that exist in the production of health knowledges.

In terms of the mind/body dichotomy, the body has been regarded as historically absent, or obscured in the production of knowledge. Feminist theories (particularly liberal and radical feminisms) and other enquiries into health, gender, and sexuality which have relied on understandings about the body, have in fact ignored the body or discussed it in restricted binary ways (making explicit the sexualised (lesbian and female) body as Other to health/medicine). It is argued by a number of feminist theorists however (Bordo, 1993; Butler, 1993; Haraway, 1991; Kirby, 1997; Longhurst, 2001) that not only must the body be made explicit, but that "we need an account which refuses reductionism, resists dualism, and remains suspicious of the holism and unity - a notion of corporeality" (Grosz, 1994, p. 22). Corporeality attempts to problematise dualisms, while running the risk of reifying them.

In the final part of this thesis, the body is central to the analysis. Incorporated into understandings about the representation and constitution of lesbian and health, are

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[7] In the context of this thesis, male is more commonly associated with the public, nature and so forth. Although the term homosexuality is often presumed to refer to men, 'homosexuality' is correlated with the female, social, and so forth, and accounts for the notion of homosexual men as effeminate males.

[8] Health is often claimed as being distinct from medicine with health being related to notions about the social, the body and so forth, and medicine being related to nature, the individual and so forth. However, I take the perspective in this thesis that 'health' is not as distinct from 'medicine' as its proponents would like to claim. I use the term health when it relates to study and a discipline in a contemporary but relatively undistinguished form of medicine. As this thesis will claim, it is in fact the attempts of 'health' researchers in the social sciences which presume that they are offering alternatives to medicine, that is at the root of many of the difficulties faced in terms of the reproduction of health discourses today.

claims for lived and material realties of (lesbian) bodies. Lesbian health is no longer explicitly discussed but is understood as constituting bodies and as producing them, in a reciprocal and changeable manner, as gendered, and sexualised (Grosz, 1994). Distinct from the second aim, and marking the final section of the project, the third aim is to examine the fluid corporeality of lesbian bodies, and their re-constitution through various spaces, and health contexts.

My main question in this thesis now relates to asking whether lesbian health can exist in the hegemony of medicine[9] in which the intersections of sexuality, and gender, and the body have been historically absent or ignored. As author of this project, I have constantly asked, how are lesbians and health understood, and what are the consequences for health promotion[10] when these understandings and corporealities are taken into account? In a theoretical frame, the thesis overall explores the possibilities for the constitution of lesbian health, and how it produces and is produced through notions of health and lesbian (as gendered and sexualised bodies). The implications of this project for wider health scholarship concern the production of hegemonic health knowledges particularly related to sexualised, and gendered bodies.

MEDICINE AND THE SOCIAL SCIENCES: LOCATING HEALTH

A critique of the ideology of health intended by this thesis is not a mainstream way of analysing health. Yet, an examination of the philosophical traditions of medicine and the health sciences has been occurring in the last two decades in an interdisciplinary frame, involving sociologists, anthropologists, feminists, and philosophers, together with psychologists. The current project was initiated in the discipline of psychology. It has drawn initially on sociological constructionist work, as one of the social sciences' strongest proponents for making explicit the perspectives and assumptions that underlie medicine. This provides the context for understanding other critical postmodern accounts of health drawn on in this project (Fox, 1993; Lupton, 1994; Turner, 1995).

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[9] Medicine, broadly defined, encompasses a set of practices (directed towards health, mortality, and social order) (Komesaroff, 1995).

[10] Health promotion can refer to a specific rhetoric that "exhorts people to take responsibility for maintaining personal bodily health" (Lupton, 1994, p. 31). Health promotion in this thesis refers to aspects of the production and sharing of information involved in these rhetorical processes.

Social constructionist perspectives examine historical and social accounts of biomedicine and its development, in terms of knowledge and practice (Lupton, 1994). Social constructionist critiques of biomedicine draw attention to medicine's status as a science, and assumptions or claims about neutrality and unchanging, universal truths. It has documented medicine as moving through a number of stages[11] with medical developments in particular regarded as reflecting progress, and an achievement of the values of science[12] (Cooper, Stevenson & Hale, 1996; Turner, 1995).

One perspective on the constitution of health and illness is also provided by analysis of biomedicine (or scientific medicine). For example, as health or ill health is represented in terms of cellular or molecular events[13] (Atkinson, 1995) biomedicine denies cultural, social, and historical representations of health and illness. Health only has meaning when the body is 'sick' or ill.[14] The analysis of health outside of or in addition to this biomedical critique suggests an expectation of how the body should be.[15] Health is a value laden notion, linked to the belief in Western societies that we all have an inalienable right to health (Lupton, 1994). Thus health is also a social concept, embedded in discourses about social relations, political economy, behavioural and cultural understandings (Lupton, 1994; also Radley, 1994). The aspect of rights is critical to understandings about health in this project.

These apparently opposing views of health, as determined through culture or nature, appear to be distinguishable from the other. Ongoing epistemological distinctions support and sustain the continuing separation of the topics of study in medicine (biomedicine) and health. Yet, while challenges to biomedicine's hegemonic position are often regarded as irrational or misguided (Cooper et al., 1996) the health of the body as a natural state implies that health, as a social construct, is not as distinct from discourses

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[11] For example, the apparent control of epidemic disease in the nineteenth century via the development of germ theory was built on the microanalysis of body mechanisms, i.e., cellular analysis. Modern medical evidence gathering practices reflect shifts from verbal report to mechanical and evidential techniques.
[12] The 'developments' of modern medicine are regarded as reflecting the achievement of scientific medicine in gaining a recognised and powerful position in the social order.
[13] In a biomedical account, when a person is ill they become a problem to be solved mechanistically, and ill-health is thus reduced to fundamental laws. Verification is achieved through established processes such as the count of pulse beats, and temperature graphing.
[14] The divide between the mind and body as objects of study sustains the split between medical and social, and is further reflective of a nature-culture divide.
[15] A notion of *health*, referring to ideas about the state of the body is distinguished here from the *health system* (which is not directly under review).

about biomedicine it first appears. For example, the expectations that citizens of western societies hold about health rights are inextricably linked to their reliance on the view that biomedicine is able to save and sustain life. Social discourses are constrained and resistant to the dominating discourses of medicine. Health and medicine both refer to medical discourse, and medical discourses are constituted through, and constitutive of, social constructs. Attention to the complexity of relationships between health and medicine, illness and sickness is crucial to this project's critical approach.

WOMEN AND HEALTH PROMOTION

Health promotion[16] reflects a particular technology or form of health research and education that has three core aspects relevant to this thesis; the targeting of specific health issues and particular groups, the translation of 'medical' or 'expert' knowledge into everyday understanding, and a practical focus on community 'autonomy' or 'empowerment'. In addressing the health of populations, health promotion determines health and illness concerns as belonging to particular groups or even 'identities', and is engaged in the formal activity of making distinctions between, or homogenising populations such as women. Notably, health populations and concerns appear as if they are homogeneous and distinct from each other, so that men's health concerns, for example, do not include gay or Maori men. The aspect of autonomy in health promotion is limited by constraints in determining who is, and what are, legitimate health groups and concerns.

Feminist writing has been particularly important in discussions about "medicine as an agent of social control" (Lupton, 1994, p. 131), and is particularly concerned with the ways in which gender is constructed in medical discourse. That is, struggles over relations of power and discourses of women's empowerment have occurred in debates over progress in women's health, which has sought to 'unburden' women from reproductive and bodily constraints. Feminist concerns have typically been designated as "gynaecology, women's sexuality, menstruation, menopause, childbirth, contraception, prenatal screening and the new assisted contraception technologies" (Lupton, 1994, p. 132). Prominent attention to the areas of reproductive and sexual freedoms has

[16] Daykin and Naidoo (1995) suggest that health promotion is "a specialised form of provision orientated towards the primary and secondary prevention of specific conditions such as ... cancers" (p. 59).

highlighted the differences between women in terms of social class, ethnicity, and 'development' (for example, 'third' world in relation to 'first' world women). Yet, the assertion of lesbian health concerns as legitimate within this heterosexual imperative can be expected to be challenging.

The links between lesbian and *gay rights* which have included addressing HIV and AIDS may have further isolated lesbians from women's health concerns due to attempts to distance hetero sex from the contagion notions of AIDS. Notably, in the New Zealand context, lesbians are not regarded as a potential interest group when health issues or resources for determining health needs are determined.[17] Therefore, in the arena of women's health and health promotion, it is significant that research on lesbian health is published in a public research forum, or that it gains funding or achieves legitimacy.

QUEERING HEALTH: A DISCUSSION OF SEXUALITY AND GENDER

Eve Kosofsky Sedgwick (1993), a proponent of queer theory from its beginnings, wrote the following in the opening of her book *Tendencies:*

> I think everyone who does gay and lesbian studies is haunted by the suicides of adolescents. To us, the hard statistics come easily: that queer teenagers are two to three times more likely to attempt it and to accomplish it than others ... This knowledge is indelible, but not astonishing, to anyone with a reason to be attuned to the profligate way this culture has of denying and despoiling queer lives (p. 1)

She continues, with a reflection on Christmas:

> It's the time when all the institutions are speaking with one voice ... They all - religion, state, capital, ideology, domesticity, the discourses of power and legitimacy - line up with each other so neatly once a year, and the monolith so created is a thing one can come to view with unhappy eyes (Sedgwick, 1993, pp. 4-5).

Queer, she comments, reflects on what the possibilities might be if meanings and institutions valued *not* lining up, or their being at loose ends with each other. The current consequences on the young referred to above, are that they never get to learn that

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[17] Men's health is increasingly prominent, yet public health activity over testosterone cancers for example, appears out of proportion to the more significant numbers of breast cancers (in women) which received scant attention until only very recently. Furthermore, even where there is a case for equitable resourcing in the context of indigenous treaties (such as Te Tiriti O Waitangi) and other legislative obligations, the health of Maori and peoples of Pacific Islands nations appears to receive an inequitably low measure of resources.

"farther along ... there are worlds where it's plausible" (p. 2). Queer, she adds, can refer to open possibilities and gaps and simulacrums of gender and sexuality not constrained by monolithic expression. It can also, she explains, refer to same-sex sexuality, or gay and lesbian studies. Queer deals directly with heteronormativity and heterosexuality. It offers more than the possibility of understanding for gays and lesbians, despite its attention to the persistence of the homo/heterosexual for organising gender and sexuality. It is a continuing rethinking about the possibilities of and across multiple identifications.

Sedgwick's (1993) opening articulated for me (and I have struggled to express this in my own writing and conversations with colleagues and family) what it is that characterises a queer theory project about lesbian health. As health, gender and sexuality are described in modernist research approaches and theory as relatively fixed categories, 'queering' in this thesis refers to an unsettling of approaches for research and practice in health traditionally represented by mainstream concerns embedded in this monolith. To queer health is used to refer to the process that recognises traditional understandings of sexuality, gender, and health as linked to hegemonic understandings of heterosexuality, and masculinity, including notions of rationality and progress.

Most importantly, queering health in this thesis refers to a return to the body as central to the analysis. The body has not been absent from discussions, for example, work on breast cancer has focused on the microanalysis of cellular material and thus fundamentally assumed to be a material object. Yet, the materiality of the body is not assured. Butler (1990) has queried even the apparently clear division between gender as social and sex as material, or that either are fixed or fixable. Sex is gendered, and gender is not distinct from its construction. Sexuality and particularly the determination of identity, which extend from notions of both sex and gender, are disrupted by these re-representations. Queering explores the spaces of health and bodies, physical and social, permeable and fluid. Queering means that the lived experience of pain and sickness, for example, can be material and social, and these meanings change with the context. Health and sexuality are also regarded as both productive and transgressive.

The implications are twofold. The queering of health is expected to have the potential for rethinking health concepts, simply because it allows for the articulation of commonly

held inconsistencies and silences. Predominantly, queer health in this project is a somewhat tenuous but political discourse (as explained in later chapters). It must be regarded in the context of other institutions that support the maintenance of current systems of health promotion, which have sustained lesbian health representations in particular ways for years. It offers a means of critique these systems. It also has the potential to be so transgressive that it is excluded from any health analyses, and prevented from having any potential impact.

THE PROJECT

This thesis is one of transitions. I began the process of talking with other lesbian women as well as reading in the area of lesbian health. Two things struck me. The first was that the lesbian women I spoke to listed a seemingly inexhaustible list of issues and concerns that pertained to lesbian and health. Second, discussions of lesbian health in mainstream medical journals were notably different from the information that was presented by lesbian writers and the lesbians with whom I spoke.

I had started this project with the hope that I would *describe* physical and mental health issues for lesbian women. However, the diversity of issues that were raised, and the apparent repetition of ideas about lesbian health (such as the idea that lesbian health problems were substantially based in health professionals' lack of education about lesbian issues) made me consider that discourses about lesbian and health needed to be examined. This tension between wanting to describe and 'promote' lesbian health, and a concern about addressing underlying issues about lesbians and their relation to health and sickness, has remained throughout the project. This is not to say that the former project has been abandoned entirely, but that simply describing lesbian health in a way that is reflective of my training in psychology (and later, community psychology and evaluation research) would have remained more closely part of the modernist project - this task having already been well addressed by the body of lesbian health literature currently available. This project is not about describing - it is about unsettling the boundaries.

This shift away from pure description of lesbian health issues was supported by my encounters with the difficulties lesbian, gay, queer, and 'non-identified'[18] women were having in health discussions. Some of the lesbian women I spoke to and interviewed initially struggled to express how health care and practice might relate to their sense of 'being lesbian'. I began to consider that lesbian health might be 'poorly' conceptualised by these lesbian women, particularly in relation to how women's health is understood. Yet, this perspective privileges the 'academic skills' of critically assessing lesbian health 'as if' a field of study. Attempts to describe 'lesbian health' itself are likely to be problematic. It assumes that questions about what constitutes a 'lesbian', 'health', and 'lesbian health' are able to be clearly answered, and that multiple identities, or indeed multiple subject positions are easily managed. When I considered how lesbian health is conceptualised by lesbians, safe sex and cervical screening were two main areas of concern. It was my sense that these areas were dominated by other influences, such as our connections with gay male culture, and women's health. The description of lesbian health concerns seemed inadequate for addressing issues of this nature.

Concerning theory, there were two major theoretical shifts in this project during its development. The shift from positivist research to a postmodern,[19] discursive approach, and its subsequent substitution by critical approaches to corporeality, have already been outlined at the opening. The first transition towards discursive approaches was the more substantial of the two shifts. The influences that made this shift possible are briefly

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[18] 'Non-identified' is a term used in relation to sexuality, to indicate that a person does not identify with or want to be referred to by any of the terms associated with sexual identity (i.e. gay, bisexual, heterosexual). Here, sexuality labels are presumed to associate a person with a particular group, or define someone by their sexuality.

[19] Postmodernism, at first glance, is a set of movements and ideas that are centrally located in a "critique of modernism's underlying assumption that knowledge and science might in some sense be unified methodologically and epistemologically and that an ultimate bedrock of truth, fact or morality might be discovered" (Seidman & Wagner, 1992, cited in Kelly & Charlton, 1995, p. 78). Postmodernism is a challenge to the traditional assumptions of science (including social science). Notions of a knowing subject, a known object, rationality and validity are some of the key notions that the Western sense of truth, knowledge, and progress is based on. These notions are challenged by postmodernism. Postmodernism does not seek to be defined - to do so would invoke the very ideas of science it criticises - but it is clear about what it rejects. Postmodernism does not, however, offer clear alternatives (Roseanau, 1994). In this way, postmodernism can appear to fragment, create a vagueness, or even to absent so-called moral parameters relating to knowledge and truth. In another view, postmodernism can be seen to open the way for political actions and resistance with a visionary approach to difference and knowledge (Fox, 1993). A postmodern position in health can be seen as "part of a formulation of an entirely different position from the modernist sociology of health and healing" (Fox, 1993, p. 6). Central to my understanding of postmodernism is a decentring of the human subject as the source of knowledge, the blurring of disciplinary boundaries, and the unsettling of traditional considerations of authority (Gavey, 1990).

discussed here. The first was the impact of discursive and critical approaches within the discipline of psychology. The second was an article by Samuel Delaney (1991), which articulated how relationships between medical/lay and homo/heterosex binaries might influence the construction and delivery of health promotion messages.

A case in point: The postmodern turn in psychology

Psychological knowledge has significantly influenced comprehension about 'homosexuality', relating to its management and control, and distinguishing it from heterosexuality. This includes, for example, the implication that 'homosexuality is a dysfunction', or that desire does not reflect orientation (meaning that same sex desire can be 'safely' experienced by heterosexuals without risking identity). The theoretical directions of the discipline of psychology have also pervaded areas of mental health, and enquiries into factors governing practices and activities of medicine (such as doctor-patient relationships).

As a discipline psychology has consistently been engaged in questions about the nature of its subjects, models, and methods, and attempts to make divisions between science and non science, the individual and the social (Burman, 1996a). The subject matter of traditional social psychology is the internal states and processes which are themselves unobservable but which have to be inferred from outward behaviour (Billig, 1997). That is, identifying what it is to 'be' lesbian or 'depressed', for example from a set of behaviours. Yet, the causal links between behaviours and internal processes are assumed. Billig (1997) notes that the objects of social psychological research, 'attitude systems', 'social identities', and so forth, take up much of the attention of the discipline, yet they "are ghostly essences, lying behind and supposedly controlling what can be directly observed" (p. 38). The subject and object of social psychology appear to be the same.

Psychology has particular assumptions about language, an assumed mirror for communicating our internal states and processes. The processes of cognition, motivation, and prejudice are regarded as inherent. While their expressions are mutable, they are stable because they reflect shared, conventional social understandings (Gergen, 1997). However, if language is regarded as an interpretative process with communication mediated by the resources available to us, including the social context, then the hope of a value-free psychology is lost. As Billig (1997) argues:

> There is an important implication for the study of social psychology. If social-psychological states are constituted within language and if languages are historical and ideological creation, then so are the topics of social psychology (Billig, 1997, p. 48)

The 1970s were a consolidated period of questioning the traditional hegemonies of psychology, particularly raising questions about identity, language and the construction of knowledge. This 'crisis' in psychology resulted in a new paradigm for psychology that also included a 'turn to language' (Henriques, Hollway, Urwin, Venn, & Walkerdine, 1984). This new paradigm has now acquired a deconstructive twist so that the political effects of the crisis themselves become open to deconstruction (Burman, 1996b; Parker, 1992). Forms of critical psychology which have influenced this thesis are derived from the debates listed here. The aims are broad and diverse, and may be involved in attending "to the welfare of oppressed and vulnerable groups" (Prilleltensky & Fox, 1997, p. 3), as well as challenging values and institutions, attending to individualism, oppression and inequality, and incorporating a responsibility to psychological practice and praxis. It is in the context of developing understandings about the nature of social-psychological phenomena that the current project has examined potentially new subject matter for social psychology.

Lay homosexuals

Samuel Delaney (1991) discussed a set of ideas surrounding knowledge and practices by gay men pertaining to HIV and AIDS, proposing that a medical/lay binary operated in conjunction with a hetero/homosex binary. Delaney (1991) suggested that the assumptions inherent in the discourses and rhetoric produced by these binaries impacts on the construction and delivery of health promotion information between straight, and gay and lesbian communities. Delaney identifies two discourses, 'street talk' and 'straight talk'. 'Straight talk' appears as the discourse of 'the learned'. It is precise and sophisticated, a mediator between truth and knowledge. It attempts to resolve disorder and clarify confusion. Supposedly, it is sexless, though this is the same as saying it is unmarked, male, and materially wealthy. The competing 'street talk' is colloquial. It is a discourse of ignorance, rumour, misunderstanding, and superstition (most likely from the perspective of the dominant discourse). It oppresses and obscures, yet as it operates within the limits of the hearer's discursive field, it can be clear and honest. 'Street talk' is the discourse about which Delaney states that behaviour is often structured. In the context of this project, street talk can be defined as knowledge communicated by lesbians

about their health care and health needs. Straight talk includes discourses about lesbian health that are present (or absent) in academic and/or professional sources.

The following ideas have been particularly important to the thesis. Delaney argued that discourses of street talk and straight talk appear to be distinguishable in the context of *health messages* about HIV and AIDS. For example, in medicine there appear to be clear statements about lesbians as sicker or healthier than heterosexual women are. Yet Delaney raises the possibility that for gay (lay) communities, particularly if a health risk includes a likelihood of death, slippage between lay and medical discourses may mean that messages about 'potential risks' from medical discourses may become so broad and all encompassing that all associated behaviours become risky. For example, statements and messages about HIV and AIDS 'risks' to gay men, lesbians, and heterosexuals, may become overgeneralised in their assertions that 'the safest behaviour is to use condoms always in all situations'. This leads to the greatest resistance and laxity in responses to health messages. Delaney considers that the distinctions between street and straight talk should be maintained to limit the obfuscation of discourses. He proposes a distinction where politics and fears (of death and sickness) are separated from science. He simultaneously acknowledges that this very separation has reasserted a gendered invisibility of women. Delaney is constantly concerned with the inevitable slippage of discourses (and one point explaining his own confirmation of a seronegative status as his lived reality of this), and the potential consequences of maintaining their distinctions.

His work uniquely addresses notions about community, lay, queer and health, as well as health rhetoric (which he distinguishes from discourse). This thesis also initially conceived that lesbian health could be viewed as being located in a binary between medical or professional talk about lesbian health (straight talk) and talk by lesbian women about lesbian health (street talk). Here, lesbian women appeared to talk differently about lesbian health compared to medical professionals. The exploration of such a binary would have needed to begin with the problematic assumptions of its relationships. However, it is not the intention here to maintain an artificial distinction between medical and lay discourses. Binaries are a starting point only for the exploration of the discursive and material realities of this project.

Research interviews

The intention of this research was to analyse lesbian health through accounts provided by lesbian women. This qualitative project selected participants (women who identified themselves as lesbian) through a snowballing process. Participants were interviewed using open-ended questions in a semi-structured format. The research sought a diversity of lesbian experiences. This was regarded as preferable to a possible alternate focus on comparisons with other groups (medical and other health practitioners, heterosexual women).

The interviews explored issues about lesbian, health, and lesbian health. The following areas were covered in the interviews: personal health (health problems, health strategies, risk-taking behaviours), knowledge of lesbian health issues, sources of health information (including difficulties in accessing information), experiences of health services and health-providers (for example general practitioners, counsellors, alternative health care providers), perceptions of how health professionals and service providers perceive health issues for lesbians, and coming out to health service providers. The interviews also included discussions and critiques regarding the notion of the 'healthy lesbian'. Issues from past research initially guided the areas under discussion in the interviews, but were not limited by them.

The theoretical transitions of the project were enabled by the aptitude of the qualitative methodological approach. The theoretical shifts followed the completion of the interviews, primarily because the approaches initially chosen to analyse the material were found to be limited. However, it was the richness and depth of the accounts provided in the interviews which allowed new approaches to be employed in the analyses.

CHAPTER OUTLINE

This thesis is divided into three sections. The first section includes a literature review, theoretical, and methodological chapters. The final two sections of the thesis reflect its theoretical progressions. The second section is comprised of two chapters in which a discursive analysis of 'lesbian' health and sickness accounts occurs. In the final section, a critical analysis of corporeality is undertaken and examined over three chapters, which discuss spatiality, cervical screening and dental dams.

The opening chapter outlines the thesis. Chapter Two describes contemporary research and writing (until the mid 1990s) produced in the academic and other communities on lesbian health. It examines lesbian health topics and provides an account of the features (limitations, strengths, paucity, representativeness, and reviews) of lesbian health research, including the historical pathologising of homosexuality. Topics of lesbian health research are discussed under the broad and preordained areas of physical health and mental health. Chapter Two is concerned with the ways in which health knowledges are represented and produced in relation to stereotypes about lesbians (and *gay-positive* research/ers are included in the complicity). It is argued that only certain health topics are allowed to be discussed, and this occurs in limited ways. Throughout this chapter, the current body of lesbian health research is regarded as unsatisfactory. This is due to limitations of traditional approaches for assessing and collating lesbian health concerns. It is also because gay-positive research in lesbian health reflects similar stereotypes about lesbians to those found in the other positivist work that it is attempting to redress.

Chapter Three outlines, in three stages, the theoretical developments of the thesis. The first stage examines approaches to, and relationships between, conceptualisations of sexuality and gender. Sexuality is mapped as a material construct and a defining characteristic of lesbian identity; and then as increasingly fragmented and diverse, changing under different historical, social, and cultural conditions. The second part of this chapter focuses on historical accounts of medicine, and examines five lines of enquiry through which a Foucauldian-based analysis of contemporary medicine could proceed. This regards medicine in terms of: dividing practices, assemblages, expertise, technologies, and as strategic. The final part of this chapter considers a queer theory approach characterised by a critical analysis of corporeality, relying as it does on theorists who are represented as both (Judith Butler and Elizabeth Grosz). Here, bodies are discussed as central to the production of health and sexuality, and constituted both as physical and material, and as interpretable through history and culture. Psychoanalytic approaches (Kristeva and Irigaray) relevant to the critical and queer analyses are briefly examined. An examination of cultural difference, elaborated in a particularly New Zealand context in a bicultural binary of Maori[20] and Pakeha,[21] raises further questions

[20] Maori is a term referring to indigenous peoples of Aotearoa/New Zealand used since the time of colonial settlers. The term homogenises heterogeneous iwi or tribes.
[21] Pakeha refers to a person or people of a British or European descent (Archie, 1995).

about the constitution of bodies. A critique of postmodern and critical approaches concludes this chapter.

Chapter Four discusses the qualitative methodologies used in this research. It integrates epistemology with ontology, thus distinguishing itself from a traditional methods chapter in the discipline of psychology. Divided into three main sections, the first section is a description of the snowballing, participant selection and interviewing processes used. The second section draws on Miles and Huberman's (1994) account of qualitative data analysis, to describe the analysis of data. The approaches for the critical reading of data are briefly outlined. These include discourse analysis (Burman & Parker, 1993; Potter & Wetherell, 1994; 1987) and the critical analysis of corporeality (Grosz, 1995). The third section comments on the epistemological assumptions that underlie the method. It focuses on representation, and includes discussions about invisibility, safety and confidentiality, difference, representing the other, and reflexivity. This chapter produces an embodied account of the research process, resisting hegemonic constructions of knowledge as objective (Johnston, 1998). The actual process of this project represented a number of shifts in the author's thinking which are part of a dynamic approach where research processes are engaged in and developed as they occur (Stanley & Wise, 1993).

In the second section, Chapter Five and Six deconstruct two dominant and apparently competing discourses about lesbian health - that of the 'healthy lesbian' and the 'sick lesbian'. Particular attention is paid to how participants' accounts and research literature material on perceived causes, consequences, and aetiologies of lesbian health or sickness is informed by dichotomies of mind/body, individual/social, and nature/culture. Chapter Five begins by briefly summarising archetypes of the 'sick' and 'healthy' lesbian produced from the literature review. It explores the representations of 'lesbian as sick' present in the interviews. Notably 'lesbian as sick' and 'lesbian sickness', are rarely distinguished between. Their representation in 'lay' terms as cause or consequence of isolation, social environments, and differences from heterosexual women, are argued as constructing 'sickness' and lesbian subjectivities in particular ways. That is, as inherent and fixed, or changeable and influenced by the social environment. This is more closely considered in an account of 'lesbian communities as sick' where a focus on social and cultural constructions of sickness might appear to avoid the assertion that 'lesbians' are

inherently 'sick'. The discourse of the 'sick lesbian' remains despite historical changes and 'gay-friendly' accounts.

Chapter Six carries out a detailed deconstruction of the contesting discourses of 'healthy lesbians'. It is suggested that the discourse of 'lesbian as healthy' exists in a dichotomy with a discourse of the 'sick' lesbian. The relationship between sick minds and healthy bodies is also examined. Overcoming the societal pressures associated with being lesbian, an absence of sexual relations with men, distinguishing lesbians from others who have sex with men, and exclusion from research into physical health issues (such as HIV and AIDS), are considered in the production of 'healthy lesbians'. These health accounts, it is argued, focus both on bodily similarities between heterosexual women and lesbians, and on differences in sexual practices and societal concerns. Health, like sickness is assessed in terms of its social constitution, in which 'lesbian' health appears to be an effect of individual and agentic action.

The third section of this thesis takes up the suggestion that lesbian bodies are figured and re-figured in the particular contexts of sexual heath promotion and care - via dental dams and cervical smears. Chapter Seven introduces the corporeality of lesbian bodies by exploring notions of space, and gender. The first part makes claims for a material but contentious, lesbian body. This includes raising questions about whether a lesbian body can exist, or whether it must always be understood in relation to heterosexual women's bodies. The discursive and material 'features' of lesbian bodies are discussed in relation to concepts of the body as a space and occupying space.

Chapter Eight explores lesbian bodies in the heteronormative space of the clinic.[22] The first part of this chapter explains the practice of cervical screening, which is used in an account of the spatialisation of bodies and the feminisation of women. Notions of cervical screening as exploring and emphasising the interior of bodies, associated with 'feminine' bodies, is related to lesbians accounts of their bodies in the clinic space. Specifically, the clinic is regarded as a hegemonic space in which heterosexuality is

[22] I use the term 'clinic' following Foucault to refer in future to the spaces in which sexual health checks might be performed. It must be noted that Foucault's use of the term clinic refers to 'la clinique' in which he is referring to both clinical medicine and the teaching hospital (Foucault, 1973). Sexual health checks may be carried out at a women's health centre, hospital associated sexual health services, Family Planning Association service, marae health centre or other medical centre.

assumed and expected. The constitution of lesbian bodies as potentially managing a contradictory interweaving of binaries of interior, exterior, sameness, and otherness, appears to offer an account of both the invisibility of lesbians, and the experience of a lived lesbian body in sexual health discussions. The next part of the chapter explores the constitution of the lesbian body as abject, in relation to its fluidity. Kristeva's account of the process of forming the abject is important to this discussion. It can be seen to have consequences for the re-production (by lesbians) of the lesbian body as rational. This account is used to examine 'choices' to disclose sexuality or not to a health care professional. This chapter proposes to add to understandings about why constructions about invisibility and their solutions (making lesbians visible) may be a simplistic and unsuccessful solution to addressing the lived subjectivities of lesbian bodies in the clinic.

In Chapter Nine, attention is focused on sexual health care messages to lesbians. Particular attention is given to dental dams, which are latex barriers promoted almost exclusively to lesbian populations but are not often used in sexual activity. In the critical examination of relationships between 'public' and 'private' spaces, lesbian communities are considered as existing outside the hegemonic, but as maintaining their own popular (public) culture. Exploring the technologies of dental dams (promotion, availability, use and so forth) offers other insights into the fluidity of public and private space, and bodies. Dental dams appear as a public health practice, and *mimic* this practice, due to their promotion being directed from lesbian communities. By paying attention to the material aspects of dental dams and lesbian bodies (constituted as fluid), the regulatory functions and resistances to the use of dental dams (as a sexual health practice) is considered. The final chapter, Chapter Ten, summarises the research and explores the processes that have attempted to provide a nexus of theory, practice, and research.

NARRATIVES OF THE SELF

The following section is a brief narrative by the author. It is intended to map personal contexts and cultures that have influenced the development of this project, and the establishment of its broad perimeters of the project (Hollway, 1989).

I am a Pakeha woman. I was raised in England, with family in both England and the Republic of Ireland (Eire). I moved with my family of four brothers, sister, and parents to New Zealand at the age of seven.

My interest, involvement, and approach to health is significantly influenced by the positioning of my family in the western medical health system. I was brought up in a family of health 'professionals'. My maternal grandmother and grandfather, my father and (step)father were, or are, doctors. My grandmother was a specialist - a radiologist. My mother was a dental nurse, and my maternal and step-paternal uncles are dentists. My (step)father was also a dentist. My parents ran a dental surgery in our home during my early adolescence, at the time when my (step)father was also training at medical school. It was my intention through secondary school and early university to train as a doctor.

My values and philosophies are feminist. I was introduced to liberal feminism through my mother[23] and the single-sex Catholic high school I attended. My contact with feminism continued throughout my studies at university, involving me in many activities and actions including women's groups on campus. A lesbian researcher in the psychology department at Otago University, Dunedin, first introduced me to poststructuralism. She was undertaking her Masters and remained a significant influence as I read and discussed poststructuralism with her. My feminist philosophies more recently have been strongly influenced by lesbian, queer, and corporeal accounts. This has been concurrent, if not conflicting at times, with my undertaking of a postgraduate degree in community psychology. Incidentally, my undergraduate training started in the pure sciences of empiricist physics, chemistry, and biology, which later in my degree became superseded by modernist psychology teachings when I completed an honours project in psycholinguistics. My own 'coming out' following this time, intersected with my discovery of poststructuralism.

The opportunity to carry out a major piece of research as part of my university study provided me with the opportunity to consider research with lesbians. This was not without some hesitation. During the early process of discussing possible areas of study I

[23] My mother does not regard the form of feminism she raised me with as liberal. Currently working in development studies, she was then affiliated with evangelical, justice and peace work.

spoke with many lesbian women about what it could mean to undertake this research. I was warned that it might be detrimental to a possible academic career or job application. It was suggested that at the very least many colleagues in psychology would be bewildered and discriminate against work that was poststructuralist and lesbian (and I might not know from which discrimination would result). Indeed, my experience in psychology and some health forum has highlighted difficulties that others have had with the subject of this work and the analytical approaches used.

During the process of this thesis I have been active in, and have initiated a number of enterprises in the area of lesbian and health. My on-going involvement in lesbian/health during the time of the thesis has raised a number of issues in practice that have had an impact on how I have chosen to present and work with the ideas of this thesis. For example, a lesbian group that I was involved in establishing (during 1994 to 1995) had 'health' as one of its major tasks. This group defined its objective as promoting the 'happy healthy lesbian'. The use of this discourse, seemingly diametrical to the discourse of lesbian as sick, encouraged me to write a paper for the lesbian forum of the National Women's Health Conference considering the agendas of lesbian health talk (see MacBride-Stewart, 1994).

In a second example of my work with the same group, we decided that we would organise a forum for the discussion of lesbian health issues. This forum took the structure of a weekend gathering or conference in Hamilton. We organised two full days of speakers and workshop facilitators. The feedback from women, both written and from conversation, was sobering. Several of the women that I spoke to about that weekend commented that they had considered their decision to come to a (lesbian) health weekend as something of a risk.

A third example comes from my involvement with research on women's health. A particular research project engendered much discussion about whether 'sexuality orientation'[24] should be asked in demographic survey questions. Sexual orientation, the funding body decided, should not be included. A later decision would have allowed

[24] I prefer to use the term 'sexuality orientation' rather than sexual orientation. The term reflects an attempt to move the notion of being lesbian, bisexual or straight away from their relation to sexual activity or acts, towards a concept which appears broader and more flexible in its concept of identity.

lesbian women to be included as a special population through a focus group method. However, this did not eventuate. This process prompted me to think and reflect further on how lesbian 'populations' are considered in health research.

My perspectives on sexuality and lesbian identity have developed during the process of this thesis, and reflect significant shifts. These changes are reflective of a shift from my involvement in, and understanding of, radical lesbian feminist culture towards a more queer culture as they can be understood in the context of Dunedin university culture in 1992 and Hamilton university culture from 1993 to 2000. This is also reflective of some wider shifts over the past years in New Zealand lesbian and queer communities. This context has been critical to my discussions of 'lesbian', and 'sexuality'.

CONCLUSION

The queering of health causes trouble or, to use the title of this thesis, places health 'in queer street'. As this thesis will explain, it is troubling to researchers, professionals, and even to women who have same sex relationships, because it represents difference, uncertainty, and silence. It is troubling to understandings of health and sexuality, because knowledges about both have been constructed in relation to each other, and to deconstruct and reconstitute these has the potential to reflect that both rest on shaky foundations. The material and lived sexualised bodies of lesbians hold the potential to complicate the technologies of health which seek to manage and control them.

I use an anecdote to express this unsettling. Watching a dawn hot air balloon festival on the morning of my birthday earlier in the year 2000, eating a picnic breakfast (and appearing somewhat out of the ordinary for doing so), another woman in the crowd approached my flatmate and I, and started to chat in a friendly way. In the spirit of the exchange, I answered directly her question about 'what is your thesis topic?' I surprised myself as I often try to fudge it for strangers, but she appeared friendly and had said she was a nurse. "Oh" she said "Oh". A very long silence followed. She finally got out, "Oh, I wouldn't have thought there was anything different for lesbians", and then added "But I wouldn't want to be that strange anyway". No one said anything. The moment was suspended. I think I am most surprised that she expressed herself so frankly in public. I rarely hear these things said directly. I wanted to laugh outrageously, but I did not. I cannot remember how the conversation ended. I think she stayed chatting for a

short while. Yet unexpectedly she had unequivocally and without malice expressed the fears. Why lesbian health? Is it not, and lesbians for that matter, just a little strange, out of the ordinary? Health has definitely become troubled by the insistence on lesbian as both subjects and objects of its study and practice.

CHAPTER II
CURRENT WRITING AND RESEARCH IN LESBIAN HEALTH

This chapter is a literature review of research on lesbian health from the mid 1970s to the mid-1990s. It summarises the key health concerns in the published research. It draws attention to the limitations of this body of research, its methods, its focus on positivist approaches, accessibility (of published and unpublished work), and other issues relating to the availability of lesbian health information. This chapter, though it is presented in the style usual for literature reviews in the discipline of psychology, is not a traditional literature review. Rather, the intention of the thesis project is to provide a critical framework for an evaluation of health research. This chapter provides the reader with a perspective on current lesbian health work, which is helpful to the overall thesis. The epidemiological data included here is not substantially drawn on in later chapters, however it is intended to provide the reader with a useful summary.

'Lesbian health research' in this chapter, refers to research and writing which is about, or includes lesbian women as subjects of its study; and which is associated with health topics, using a broad definition of health. An extensive, but not exhaustive, list of research and writing is covered. This is drawn from the key words 'lesbian' and 'health' typed in on a number of electronic reference databases, including *MedLine* and *Social Sciences Index*. The focus is on work published from the mid-1970s to 1996.[25] The literature that makes up the current body of lesbian health research can be characterised, on the whole, as 'gay-positive'. It is significant, that despite risks of personal stigmatisation for the researcher (Stevens, 1993), and poor understanding and knowledge of lesbian health issues, that these research studies have been carried out.

This chapter does not discuss definitions, in particular, what constitutes a lesbian, health, and lesbian health. It is the intention of later chapters to deal more fully with the assumptions and contesting views that inform this research. Also, this chapter does not intensively explore historical research and writing related to lesbianism; historical

[25] This chapter was prepared in the early stages of the thesis research. Some research published after this period is found in this review (Roberts, Sorensen, Patsdaughter & Grindel, 2000), but its function is to highlight that the perspectives gained on the body of lesbian health literature have remained relatively unchanged from the mid 1990's.

perspectives will be discussed in Chapter Three. However, historical themes resonate strongly in current discourses, and as such historical perspectives will be briefly touched upon in this review. In particular, a critical aspect which cannot be overlooked is the pathologising and stereotyping of lesbians in the medical and health literature which is both an historical and contemporary feature of this field of study.

This chapter is structured to highlight the main areas, issues, and topics raised in the body of lesbian health literature. The first part covers history, limitations, and accessibility of lesbian health research. A summary of the main research topics in the areas of health care, physical health issues and mental health issues follows. The health care section considers service issues including health care provider attitudes, experiences of health care, heterosexual assumption, disclosure, service use and provider preferences. The section on physical health pays attentions to gynaecological issues, sexually transmitted diseases, cervical screening, breast cancer, pregnancy, and childbirth. The mental health section looks at suicide and serious depression, violence, alcohol and drugs. Other issues such as ageing, parenting, relationships, youth and disability are addressed in the final section.

FEATURES OF LESBIAN HEALTH RESEARCH

Historical pathology of lesbians

The most prominent feature of historical research and writing on lesbian health is that lesbians and lesbianism have been characterised and labelled as pathological and sick. This work has reflected, and helped to create, such stereotyped misrepresentations of lesbians.

Caprio, the author of a 'popular' text about lesbianism titled *Female Homosexuality: A Psychodynamic Study of Lesbianism,* which was first published in 1954, exemplifies this approach:

> Many lesbians claim that they are happy and experience no conflict about their homosexuality ... but this is only a surface or pseudohappiness. Basically, they are lonely and unhappy and are afraid to admit it, deluding themselves into believing that they are free of all mental conflicts and are well adjusted to their homosexuality (Capiro, 1954, p. 43).

> Homosexuality ... represents the behaviour symptom of a deep seated neurosis (Caprio, 1954, p. 13).
>
> The homosexual woman is a childish personality, unable to let go of the hand that held her so securely in childhood, afraid to trust herself unreservedly to the life forces that well within her (Richmond, cited in Caprio, 1954, p. 9).

One of his most brutal comments is:

> Lesbians as a group are generally sadomasochistic. Suicides among them reflect their sadomasochism. The lesbian who kills herself is committing a sadistic act and at the same time gratifies her masochism by destroying herself (self-atonement) (Caprio, 1954, p. 174).

Caprio (1954) warns of everything from the dangers to society of lesbians and intense relationships between women, to classifying lesbianism as a neurosis, with descriptions of lesbians as sadomasochistic, lonely, unhappy, childish, deluded, extremely sensitive, emotionally immature, unhealthy, and unwell.

Stevens (1993), reviewing the empirical literature, concludes that lesbians have been represented by the medical profession as "sick, dangerous, aggressive, tragically unhappy, deceitful, contagious and self destructive" (p. 1). Lesbians have also been viewed as pathological and psychologically maladjusted, with lesbianism characterised as an illness, a disease, a mental illness, a perversion, an addiction, and something to be pitied.

Viewing lesbians as pathological and psychologically unwell has lead to attempts to alter sexual orientation. The conversion therapies and surgical 'treatments' employed by the health profession in an attempt to 'contain' this homosexuality have included:

> psychiatric confinement, electroshock treatment, genital mutilation, aversive therapy, psychosurgery, hormonal injection, psychoanalysis, and psychotrophic chemotherapy (Stevens, 1993, pp. 1-2)

While the pathologisation of lesbians is a feature of past writing and research about lesbians, there is an erroneous assumption that this feature does not exist in the present. Because homosexuality was removed from the DSM II (Diagnostic Statistical Manual) in 1973, there has been the belief that this signalled the end of pathologisation of homosexuality - at least within the psychiatric and psychological sciences (Rothblum, 1994). While later chapters consider the impact of the history of pathologisation upon modern constructions of lesbian health it is important to note that the pathologisation of

lesbianism continues to exist in alternative forms. One example is the 1990s psychiatric stigmatisation of lesbian and gay adolescents under the DSM classifications of 'gender identity disorder' and 'oppositional defiant disorder' which occurred during the 1990s and lead to the involuntary commitment of some young people to psychiatric facilities (Mirken, 1994). Furthermore, another diagnostic manual which is widely used including in New Zealand - the International Classification of Diseases (ICD 9) - still classifies homosexuality as a psychiatric disease (Jones, 1996).

Therefore, although current representations of lesbians may be the least conservative and most gay-positive, some caution should be exercised towards generalisations about the present period as less conservative than earlier times. There is a constant need to put history into context.

Paucity, accessibility, and representativeness

Commentators on lesbian health research often refer to the paucity of such research. Welch (1995), in a search of the online catalogue *Medline,* found that 0.02 percent of all articles catalogued under 'female' and 4 percent of all articles catalogued under 'homosexual' were articles that referred to or were relevant to lesbians. Trippet and Bain (1993a) reviewed twenty-two years of literature about lesbians' health concerns and located just four studies published in referred journals, and one other private report published by the American National Lesbian and Gay Foundation (no further details about their search criteria were included). Stevens (1993) located twenty-eight published research studies about lesbians' *experiences* of health care over twenty year period from 1970 to 1990 using indices to periodical literature, as well as catalogues of doctoral theses, and reference lists in published research and clinical articles about lesbians.

Good (1976) extensively searched the literature for work published on lesbianism. Good searched books listed at the University of Miami School of Medicine library under lesbianism and homosexuality, with a second search of articles listed in *Medline* for the three years prior to 1975, and a third search for articles published in two major American Obstetrics and Gynaecological journals over the previous 23 years. She found:

> with the exception of psychiatric journals, medical journals generally and gynaecologic journals in particular have had little or no interest in problems related to lesbianism or the needs of lesbians, as demonstrated by the almost complete lack of material published on the subject (p. 476).

Good found no original published material in the gynaecological journals relating to female homosexuality.

From 1988 on there has been a burst of research activity leading to an increase in the number of lesbian health studies published. This includes a number of special issues on lesbian (and gay health), some of which have subsequently been published as books (for example, Petersen, 1996; Stern, 1993; also *Journal of Counseling and Development* (1989, vol. 68); *Journal of Consulting and Clinical Psychology* (1994, vol. 62); *Women and Therapy* (1988, vol. 8)). However, the amount of published lesbian health research remains exceedingly small, given the figures that propose that the population of lesbians (and gays) may be as high as ten percent (Williamson, 1986 cited in Trippet and Bain, 1993b). Even if numbers are lower, as Lapsley (1998) contests, this is still a sizeable underrepresentation. In 2000, Roberts, Sorensen, Patsdaughter and Grindel commented again that "although there has been increased interest in lesbian health in the last decade, there continues to be little data available" (p. 50).

Some health issues have attracted more attention than others. In particular, there is more published research about and including lesbians in the area of mental health in comparison to the limited amount of work published on physical health.

> While there are numerous references to the psychosocial aspects of homosexuality in the psychiatric literature, there is very little information available about the medical problems of lesbian women (Johnson, Guenther, Laube & Keettel, 1981, p. 20)

The volume of lesbian health research in New Zealand also appears to be very small. There are a handful of reports, commentaries, and unpublished theses (Blomfield, Chapman, & Vanderpyl, 1995; Franklin, 1995; Greenwood, 1996; Kirkbride, 1997; Lapsley & Paulin, 1994; Welch, 1995), but at the time of writing this review there were no published studies about lesbians. The Crown Health Enterprise (CHE) in Midland region funded a study on lesbian and gay health service issues (Blomfield, Chapman, & Vanderpyl, 1995). This government funded CHE was unique in having a portfolio and funding assigned to gay and lesbian health. Certainly, my experiences at health, feminist, psychology, and queer conferences in New Zealand suggest that there has been very little activity in the area of lesbian (particularly physical) health research. However, the

situation did show signs of change with the establishment in 1994 of Pink Health[26], a national lesbian, gay, takataapui,[27] bisexual, transgendered and intersex health group which organised a number of conference forum. Increasing arrays of lesbian health issues have been discussed at this and other conferences. Also, at least two questionnaires have been distributed with the intent of collating the data on lesbian health issues. One had such a low response rate that collation was not an option (New Zealand Federation of Women's Health Council). While a second New Zealand study has been collated, it uses a strongly empirical framework and had a low response rate (29% overall, and below 10% at some venues) (Saphira & Glover, 1999).

> Current lack of knowledge about lesbian health matters and ensuing ignorance promotes and perpetuates myths about lesbians, and makes it difficult for lesbians to get accurate and thorough information about their health (Barnett, 1985, p. 8)

The evidence for Barnett's assertion is in the often contradictory and vague information given about the aetiology, prevalence, and care recommendations for a range of lesbian health concerns. For example, there is only one study on the risk of cervical abnormalities for lesbians. Recommendations in the academic literature range from advice for regular screening, no screening, or screening at a less regular rate than for heterosexually active women. Variations on this 'advice' are based on whether a sexually active lesbian has or has not had sex with men (see later in this chapter for a more extensive discussion).

While lesbians have been and are invisible in health research, there is an additional problem of articles and writing about lesbian health being difficult to access. This may be due to the media in which material is published, the limited availability of some sources, and the possibility that a significant amount of material remains unpublished. Locating published material is the first difficulty. Articles about lesbian health are most often found in less prominent journals which have a small distribution and are not widely read or subscribed to (Welch, 1995). Articles are scattered over a range of publications

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[26] The activities of this group appear to have lapsed in the new millennium.

[27] Takataapui is a Maori term which I understand as referring to people who are bisexual, gay, lesbian, or transgendered *and* tangata whenua (tangata whenua is the "Maori term for indigenous people of New Zealand" (Nursing Council of New Zealand, 1996, p. 42)).

from a variety of disciplines, including health and medical, nursing, AIDS, obstetrics and gynaecology, therapy and counselling, social work, women's and lesbian studies. Welch (1995) highlighted in her study the difficulties in accessing the *Journal of Homosexuality*; the only New Zealand holding is at the National Library in Wellington. This has consequences for access since:

> over one third ... of the articles about lesbians cited in Medline for the period 1990-1994 period appear in the *Journal of Homosexuality* ... and (it) is not commonly read by health professionals (p. 11).

A public archive of collected gay and lesbian writing is held at the National Library of New Zealand, necessitating a special trip to Wellington. The collection holds only a small volume of lesbian material, mainly local material, and its existence is not well known to lesbians and queer women. There are other private lesbian archive collections in New Zealand that can be accessed on request; again their existence is not well known.

A large amount of lesbian health research and writing is not published. Unpublished work includes student research for university papers, university theses, and documents produced specifically for community agencies or institutions. Steven's (1993) search located only unpublished studies of this type, or work published in academic journals. She found nothing in the government or lay press. Certainly, large amounts of New Zealand work remains unpublished.

There is a related issue here of representativeness. Early research about lesbians used 'clinical' populations of lesbian women, commonly women incarcerated in prisons and mental hospitals (Johnson et al., 1981; Stevens & Hall, 1990). Current research usually involves 'non clinical' populations of self-identified lesbians approached through lesbian networks, such as lesbian newsletters and social events.

As Burns (1992) notes, current research represents populations of women who are mainly white, middle class, young, aged 21-40, able bodied, and out to a predominant number of family, friends and work colleagues. Researchers comment that this is a methodological limitation of lesbian health studies because the lesbian population is more diverse (Bradford & Ryan, 1988), and includes other underrepresented and marginalised groups such as youth, aged, Maori, Pacific Islands, and Asian women. Yet as Rothblum (1994) explains, the information gathered from surveys is *accurate* insofar as

it *represents 'out' lesbian communities.* As will be explained in Chapter Three, lesbian may only be one of a number of identities that a person holds, and 'lesbian' may be a term more commonly used by the population described above (white, middle class and so forth). In addition, the traditional snowball sampling approach of lesbian health research may replicate sample characteristics between studies (these issues are discussed further in Chapter Four).

A large amount of material relevant to lesbian communities appears in lesbian, gay, and queer media, a source not often used by researchers. Media developed for lesbian communities has a limited distribution and specific audience. Queer, lesbian, and gay media include magazines, newsletters, pamphlets, television programmes, radio shows (on student or access radio), web sites, internet chat rooms, and publishers such as Queer Press and Scarlet Press. Some of the best sources on lesbian health information are those health pamphlets and articles that have been designed as a community resource with the community in mind (Freedom, 1993; OutSkirts, 1997). These are included here because they are among the few, if not the only ways of getting information about current research and issues in lesbian health.

New Zealand is able to sustain one national gay and lesbian newspaper (*Express,* previously *Man to Man*). The larger and glossier magazines from North America and England are difficult to access in places outside of the main centres. Such publications are often not readily available for sale in shops or for reference in libraries, and where they are for sale, they can be expensive. *Broadsheet,* a long standing New Zealand feminist publication which folded early in 1997, included a substantial amount of lesbian content and was for some time an important resource for the lesbian feminist community.

Lesbian and queer newsletters produced locally are also a good source of health writing. These newsletters have difficulties securing funding, and often operate for short periods, with restricted distribution for reasons of privacy and safety. Their readership is predominately women who are 'out'.

Queer media does more than entertain but may educate and inform their audiences. Queer television in New Zealand has taken the form of a magazine show, *Express Report,* renamed *Out There,* and after a break and supported by yet another funding agency, re-

established as *Queer Nation*. Screened at a late hour and on channels whose frequencies do not reach all areas in New Zealand, these programmes may also be difficult to access, as are queer radio shows. Queer Nation was on air at the end of 2000, but it has had periods when it was canned.

Lesbian publications usually contain writing that is more accessible to lesbian communities than academic writing. The tone is frequently colloquial, likely to deal with research 'facts' as discussion points not as truths, provide a range of arguments, and confirm that little is actually known about lesbian health. Yet it is material that is essential to consider since it shows which health issues are being discussed in lesbian communities, what is being said (both now and historically), and which gaps remain. Notably, mainstream research media presents a more conservative and stereotyped view when discussing lesbian identity and health. Lesbian media manage to discuss as 'diverse' rather than 'deviant', lesbian behaviour which includes sadomasochism, non-monogamy, lesbians who are not born women (transgendered and intersex lesbians) and women who claim lesbian identity while sleeping with men (through sex work or in their personal relationships). While often not academic in content, writing in queer media alerts the researcher to the ways in which lesbian health is discussed in lesbian communities in comparison to books and academic journals.

Review articles and general studies

This section outlines the main characteristics of articles which review lesbian health research, and describes the first large-scale study of American lesbians focusing on lesbian health and health care needs. It highlights why review articles are critical to the field of lesbian health. Summarising key conclusions from the reviews is too substantial a task to do here; approaches and arguments characteristic to lesbian health are presented, by health topic, in following sections.

Review articles make up a large body of work in the lesbian health field, despite a limited number of available research studies. An effect is that the review material appears repetitive. However, these reviews are important in disseminating information to a wide diversity of audiences; the reviews listed in Table One below appear in journals and books, in disciplines covering areas of general medical, nursing and science, women's health, HIV and AIDS, lesbian, gay, and feminist studies.

Review articles usually draw together work published on a topic. Lesbian health reviews consistently highlight the lack of research. The approach in lesbian health has been to extrapolate data from other studies which have not included or specified lesbians, for example studies of heterosexual women, or general populations of women (refer to Horsley & Tremellen, 1993, on lesbians and breast cancer). Other features include drawing attention to gaps and assumptions in existing research, innovative discussions that reframe historical perspectives, posing future research questions, and suggestions for change in the relationship between the medical establishment and lesbians.

Reviews fall in to a number of categories. Some focus on general lesbian health issues, while others review work on a specific topic (see Table One below). Reviews of general lesbian health issues cover a diversity of issues that can encompass physical and mental health, as well as service delivery and access to health care.

Table One: Review Articles in Lesbian Health (1978-1996)

General Lesbian Health Issues	
General Health Issues	Barnett (1985); Berger (1983a); Burns (1992); Council on Scientific Affairs (1996); Deevey (1995); Denenberg (1995); Hepburn (1988); Jones (1988); McClure & Vespry (1994); O'Donnell (1978); Peteros & Miller (1988); Peterson & Bricker-Jenkins (1996); Platzer (1993); Rankow (1995); Roberts & Sorensen(1995); Saltman (1991); White & Levinson (1995); Williamson (1986)
Specific Lesbian Health Issues	
Health Provider Attitudes	Stevens (1993)
Lesbian Health Care Experiences	Jones (1988); Stevens (1993)
Cervical Cancer and Cervical Screening	Winnow (1992); Wray (1992)
AIDS	Braine (1994); Brumby (1988); Califia (1992); Chiaramonte (1988); Cole & Cooper (1991); Gale & Short (1995); Jackson (1993); Kwasnieswska (1995); Leonard (1990); Livingston (1989); Morrison (1994); O'Sullivan & Parmar (1992); Patton & Kelly (1987); Richardson (1989); Ristov (1992, 1997); Short & Gal (1995); Solomon (1992); Vasquez (1994); Winnow (1992)
Safer Sex and Sexual Health	O'Sullivan & Parmar (1992); Short & Gale (1995); Shaw (1989)
Breast Cancer	Brownworth (1994); Horsley & Tremellen (1993)
Mental Health	Rothblum (1994)
Alcohol and Drugs	Faltz (1988)
Violence	Lobel (1986)
Reproductive Issues	Levy (1996)

Table One helps to identify the major topics that have received attention by review articles. The areas which have been specifically reviewed are: health provider attitudes, lesbian experiences with health care, cervical and breast cancer, HIV and AIDS, sexual health (including safer sex), mental health, alcohol and drugs, violence, and reproductive issues. HIV/AIDS, and general work on lesbian health have had the most attention. General health is shown in the table to have been addressed consistently throughout the period of the late 1970s to the present. Sexual and gynaecological health (including HIV/AIDS, cervical and breast cancer) have received specific attention in recent years, reflecting a shift in attention from mental health (violence, alcohol, and drugs).

As the interest in lesbian health has increased, so has the need for research. The first large-scale study of American lesbians on lesbian health and health care needs was sponsored by the National Lesbian and Gay Health Foundation (in North America) and titled *The National Lesbian Health Care Survey* (Bradford & Ryan, 1987). The survey is explained in the full report of the study (Bradford & Ryan, 1987) and summarised in a resource of other readings on lesbian and gay health (see Ryan & Bradford, 1988). A questionnaire was distributed in North America and returned by nearly 2000 lesbians. The importance of this survey is in its size, and its uniqueness. It flags broad areas of health, which are found in the present field of lesbian health. The topics include general health and health care, obstetrics and gynaecology (with attention to pap smear, breast self examination, and reproductive history), sexually transmitted diseases (including AIDS), mental health experiences and concerns (with suicide and counselling), self care issues, abuse, sexual attack and incest, substance use, eating disorders, community and social life, outness and experiences of anti-gay discrimination (Ryan & Bradford, 1988). It is difficult to summarise the findings of such a broad study here. Key findings are incorporated throughout the rest of this chapter. But the study is quantitative, providing 'data' on frequencies of health problems. It also attempts to distinguish some demographic differences in health concerns related to age and ethnicity. This is important, because it is an attempt within the positivist paradigm to address heterogeneity. The 'lesbian community' is usually seen as homogeneous; for example older women were much more likely to have had problems with heart disease, cancer, arthritis, and weight (Bradford & Ryan, 1987).

A number of other large scale studies have been carried out since in North America but they are reports belonging to national and local organisations and thus difficult to access (see Deneberg, 1995, for a review). The Michigan Department of Public Health had a sample of 1,681 lesbians in a 1991 study on general health issues (and included questions on smoking, sexual assault, and parenting). Trippet and Bain, in 1992, surveyed nearly 400 lesbians on the topic of 'why they fail to seek traditional health care'. In 1993, the San Francisco Department of Public Health interviewed 483 lesbians and bisexual women about a range of health behaviours, with questions on topics such as depression, sexual activity with men, and sexual abuse. And in the same year, the AIDS office of the San Francisco Department of Public Health looked at rates of sexual histories, risk factors, and incidences of sexually transmitted diseases in a population of 498 lesbians and bisexual women. A more recent study, is the Boston Lesbian Health Project which surveyed 1633 lesbians about their health status, health related behaviours and health problems (Roberts et al., 2000). The following part brings together topics of lesbian health study, including gaps and contradictions.

Issues of Lesbian Health Care

The research about lesbian health care explores health care provider attitudes to lesbians, experiences of lesbians with health care providers and services (both actual and anticipated), and health care preferences. The consequences of assumed heterosexuality, and disclosure of a non-heterosexual sexual orientation to health care providers, features strongly in the research on health seeking by lesbians. Access to health care and resources, is important in meeting primary prevention as well as diagnostic needs.

Provider attitudes

A selection of studies considered here, in conjunction with Stevens (1993) review of twenty years literature on health provider attitudes to lesbians, indicates that prejudice about lesbians and lesbianism exists among health professional groups. For example, one study surveyed nurses, and analysed responses to questions about lesbians into themes representing stereotypes. It found that the majority of stereotypes raised about lesbians were negative (Eliason, Donelan & Randall, 1993). The most prevalent themes included: that lesbians aim to seduce heterosexual women (28%); that lesbians attempt to proselytise (28%); that lesbians are pushy, and flaunt their sexuality; that lesbians can be

easily identified in a crowd (30%); that lesbians are a bad influence on children (11%); and they spread sexually transmitted diseases. Respondents were generally uncomfortable about lesbians, which was reflected in "expressed feelings of 'unease,' 'anxiety,' 'discomfort', and 'distrust' around lesbians" (Eliason et al., 1993, p. 46).

Lesbian nurses asked about experiences of homophobia and discrimination in their workplaces, gave many (staff to patient) examples (Rose, 1993). More than a quarter had experienced a nurse refusing to care for a homosexual patient, and "most had heard lesbianism being referred to as an illness, or as deviant, and described as sinful by other nurses" (Rose, 1993, p. 51). They had experiences of homophobic joke telling, covert discrimination, prejudice, and "a conspiracy of silence" making it difficult to discuss or challenge the position of lesbians in relation to nursing and care (Rose, 1993). Douglas, Kalman, and Kalman (1985) investigated attitudes of nurses and doctors to homosexuality in response to the AIDS crisis and found that 31% of the respondents felt more negatively towards homosexuality since AIDS. While there were no significant differences associated with religiosity of the participants, women reported greater homophobia than male respondents did.

Rothblum (1994) comments that the removal of homosexuality from the DSM II in 1973 did not improve public and professional attitudes to homosexuality. She notes that 2500 members of the American Psychiatric Association were surveyed in 1978 (*Time*, 1978, cited in Rothblum, 1994). The results indicated that the majority of members considered "homosexuality to be pathological and also perceived homosexuals to be less happy and less capable of mature loving relationships" (p. 213). A more recent survey of 2500 members of the American Psychological Association showed that "biased, inappropriate, or inadequate practice was found in the understanding, assessment, and intervention of a wide range of topics such as identity development, lesbian and gay relationships, and parenting" (Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991, cited in Rothblum, 1994, p. 214).

An early study by Johnson et al. (1981) indicated that issues related to interactions with health care professionals concerned respondents more than issues about specific diseases. Stevens (1993) reviewed nine studies on health care provider attitudes. She comments:

> that deeply entrenched prejudicial meanings about lesbian health remain influential in the education of health care providers, the quality of care they deliver, their comfort in interacting with clients and the institutional policies under which they work (p. 24).

These studies into provider attitudes have predominately taken the form of questionnaires, using convenience samples. This raises questions about the integrity of the responses, given possible attempts to provide socially desirable responses. Because the attitudes of those who chose not to participate cannot be assessed, the assumed direction of responses is thought to be towards more negative attitudes than that recorded by the research (Stevens, 1993).

Assuming heterosexuality

The assumption that women are heterosexual is noted to be one of the most significant things that lesbians must deal with, in their interactions with health professionals (Bradford & Ryan, 1987; Johnson et al., 1981; Stevens, 1993). Respondents in Ryan and Bradford's (1988) study reported this as their most common problem with heath care providers at the time of the study (27%), and in the past (22%).

Heterosexual assumption has been explored in two ways. Good's (1976) survey of gynaecologists found that 44% indicated that they had had no patients who they believed were 'homosexual'. Furthermore, 50% had not knowingly had lesbian clients; and of those who knew that they had treated at least one lesbian, 29% had made their judgement on their own without any confirmation from their clients. What is important about this survey is that it suggests that either lesbians did not use gynaecologists, or that the gynaecologists were on the whole unaware and unresponsive to the possibility that any of their clients could be lesbian. Given that lesbians in the United States, where these studies have been carried out, report preferences for using a gynaecologist it is more likely that the gynaecologists were unresponsive to the possibility of having lesbians as clients (Good, 1978).

It is noteworthy that lesbians do consider that they are identifiable as such to other people. Stevens & Hall (1988) showed 48% of participants reported this, with only 20% believing they were not identifiable by anyone. Another study showed that 31% of nursing students in a study believed that they could identify a lesbian based on her "aura of masculinity" (Eliason et al. 1993, p. 47).

The second area of work on heterosexual assumptions reports lesbians' own experiences of assumed heterosexuality (e.g. Robertson, 1993; Rose & Platzer, 1993). Johnson et al. (1981) write:

> Some ... reported virtual harassment when contraception was refused them (lesbian clients). Others felt reluctant to answer questions related to their sexual activity of physicians who seemed unaware of the possibility of homosexuality (p. 25).

Heterosexual assumption is most obvious in dialogues on sexual activity, contraceptive use and sexual health, including the likely transmission of infections (Robertson, 1993). It also includes assumptions that sexual partners are men, that roles performed are those of wife and mother in traditional family units, and that caregivers and support people include those traditional family units and male partners (Stevens, 1993). Medical history questions usually assume heterosexuality (Dardick & Grady, 1980; Johnson & Palermo, 1984; Robertson, 1993). Mastectomy recovery programmes are often focused upon maintaining a sense of femininity for one's boyfriend or husband (Barnett, 1985).

> Very rarely were there comfortable opportunities for lesbian clients to let providers know that they were not heterosexual. According to lesbian clients, such conditions made them feel invisible, and led providers to misdiagnose conditions, provide inadequate treatment, offer irrelevant health teaching, lecture about birth control, ask insensitive and biased questions, make sexist remarks, and alienate lesbians from the entire health care process (Stevens, 1993, p. 20).

Given the nature and consequences of heterosexual assumptions, it is no surprise that alternative language and behaviours for health care providers are liberally recommended in writing on the topic (Gentry, 1993; Good, 1976; Roberts & Sorensen, 1995; Trippet & Bain, 1993a). Specifically, suggestions for taking health histories that do not presume heterosexuality, are provided in a number of articles (Gentry, 1993; Good, 1976; Roberts & Sorensen, 1995; Trippet & Bain, 1993a).

Disclosure

The disclosure of a non-heterosexual sexuality to others such as health professionals is a feature of the lesbian experience. The focus of the empirical research has been towards determining the proportion of lesbians (in a sample) who have disclosed their sexual orientation, and what the anticipated or actual responses to this have been.

Disclosure is a complex issue. It is a process that mimics the experience of lesbians in a whole range of contexts where lesbian sexual orientation is invisible. Disclosure may require monitoring a situation or environment and assessing personal vulnerability, with predicted negative or abusive responses, humiliation, and poor uninformed treatment (Stevens & Hall, 1990). The context of the power relationships which are exerted in health care interactions and the vulnerability of the lesbian as client in these situations makes disclosure significant in the context of the health system, and the significance increases when someone is acutely ill or injured (Stevens, 1996).

Research has generally shown that lesbians are hesitant to disclose their sexuality to their physician, with only twenty to fifty percent of respondents in a number of studies having disclosed as lesbian (Dardick & Grady, 1980; Johnson & Palmero, 1984; Smith, Johnson, & Guenther, 1985). It is commented on that opportunities to disclose are rarely provided by health professionals (Johnson et al., 1981).

Disclosure may be, but is not only, verbal in nature. Here the literature refers to empirical data collected about lesbian's sense of identifiability. Disclosure may be also be wrongly identified as a choice, yet lesbians may report feeling forced to disclose (Smith et al., 1985; Stevens, 1993, 1996). An often given example of heterosexual assumption and forced disclosure is that of a woman complaining of a stomach pain diagnosed with ectopic pregnancy, or a woman being harassed about lack of contraceptive use when a she legitimately indicates she is sexually active but not using contraception (Stevens & Hall, 1990). In both cases, a woman would have to assert sexuality for correct diagnosis. Disclosure relates not only to factors surrounding medical diagnosis but also relates to issues of next-of-kin relationships and caregivers.

Perspectives on disclosure given in the literature indicate that the context is important (Hitchcock & Wilson, 1992). Features such as being out and being comfortable with her sexual orientation make it more likely that a woman will disclose her lesbian identity to a health provider (Robertson, 1993); as do features belonging to the health provider including gender (female), sexuality (lesbian), and other assessments which may indicate the provider as having supportive attitudes (Dardick & Grady, 1980; Hitchcock & Wilson, 1992). Furthermore, disclosure can be viewed as a political action taken to educate, challenge assumptions, and profile the presence of the lesbian client.

The research indicates that while some lesbian women consider that disclosure of sexual orientation to their health professional might improve their care, there was an overwhelming sense that disclosure would negatively affect the care they received (Bradford & Ryan, 1987; Dardick & Grady, 1980; Johnson et al., 1981; Johnson & Palmero, 1984; Smith et al., 1985; Stevens & Hall, 1988). In the study by Johnson et al. (1981) 40% of respondents thought that their health care would be adversely affected if their physician knew they were homosexual. Only 18% had told their physician their sexual preference.

When questions have been asked in previous studies about whether sexual orientation should be recorded on health history or medical charts very little support has been granted (Lucas, 1993); more did not want it recorded (50%) than those who did (28%). This refusal to have the information noted on a health chart was common even where the same women indicated a preference for sexual orientation to be asked in a health history (Lucas, 1993). Lesbians reported that they would be much less likely to disclose if their sexual orientation was being recorded on a health history (Dardick & Grady, 1980; Rose & Platzer, 1993). Record keeping raises issues regarding the privacy of health notes (James, Harding & Corbett, 1994).

The consequences of disclosure of lesbian sexual orientation have, not surprisingly, been the focus of a great deal of attention. There is a lot of fear associated with anticipated responses, and these fears have often been borne out by the negative reactions of health providers informed of a patients lesbian sexuality (James et al, 1994; Rose & Platzer, 1993).

Stevens and Hall (1990) write:

> Seventy two percent of the participants reported experiencing negative reactions from health care providers when their sexual orientation was known. They described ostracism, invasive questioning, shock, embarrassment, unfriendliness, expressions of pity, condescension, and fear. They spoke of instances in which nurses did not respond to their requests and physicians stopped talking to them after learning that they were lesbians. They reported that partners were mistreated and confidentiality about their cases was breached. Some said they had been improperly referred to mental health services. They also reported being handled roughly and subjected to derogatory comments. Several had been forced to disclose their sexual orientation as the result of verbal harassment by health care providers (p. 24).

Smith et al. (1985) report responses from health professionals ranging from a 'cool' response to 'overt rejection' and 'voyeurism'.

Service use and preference for services

> Lesbians and gay men are well aware of the attitudes held by the public in general and by health and mental health professionals in particular ... Surveys of lesbians and gay men indicate that they use caution when seeking therapy or health care (Rothblum, 1994, p. 214)

The reported effect of anticipated or experienced negative health experiences has been shown to have a significant impact on the health care encounter. Termination of the health care interaction, not returning to the health care provider, and general avoidance of routine health care are consequences cited in research (Robertson, 1993; Stevens & Hall, 1988).

Research regarding lesbian health indicates that one of the most significant health problems for lesbian women is that they "avoid seeking needed and routine care" (Peteros & Miller, 1988, p. 132; see also Horsley & Tremellen, 1993; Trippet & Bain, 1993a). Gynaecological health care, in particular, is most often sought only when there is a problem (Smith et al., 1985). Lesbian women avoid health care significantly as a result of experiences which reflected ignorance and antipathy towards lesbians by health care providers, and because of fears about the consequences of disclosure of sexual orientation (see Stevens, 1993 for a review). As a result of the barriers that lesbians must overcome at all levels of the screening process, "lesbian women are under-represented in screening programmes, have cancer detected at a later stage, and receive less adequate care" (Horsley & Tremellen, 1992, p. 9; see also Stevens, 1993).

It is shown in the research that lesbian women delay using health care services, and do not consistently seek medical help when they need it (Trippet & Bain, 1993a). It was found that lesbians are very likely to use a health provider only where there is a problem (Dardick & Grady, 1980; Trippet & Bain, 1993a). The level of health service use has been compared to other groups such as bisexual women. Bisexual women are more likely to seek care on a regular basis (Dardick & Grady, 1980).

Preferences in service use have been explored with attention to factors influencing those choices. Research indicates an overwhelming preference for a lesbian or woman health

care provider (Lucas, 1993; Smith et al., 1985). Some services are used considerably more than others, for example, two studies indicated that cervical and breast cancer screening services were the highest priority services indicated for use by lesbian women (Bradford & Ryan, 1987; Lucas, 1993).

Beyond this, the most common reason for not going to health professionals was economic; many lesbian women experience financial barriers to care (Ryan & Bradford, 1988; Peterson & Bricker-Jenkins, 1996). Other reasons given for not seeking health care included a lack of low cost alternatives, lack of holistic care, little preventative care and education, lack of communication and respect, and few women managed clinics (Trippet & Bain, 1993a). Trippet and Bain (1993a) note that:

> underlying all five reasons for lesbians failing to seek traditional health care was fear of discrimination or the actual experience of discrimination from health providers (p. 61).

For some it was just not worth the effort, and may be more trouble than it was worth to find a non-homophobic health provider to discuss potentially embarrassing issues such as non-orgasmic or painful coitus (Trippet & Bain, 1993a).

Sources of health care termed "alternative" are an important part of the discussions about preferences and options for health care. Studies have shown that lesbians may prefer alternative prevention and care (Robertson, 1993; Stevens & Hall, 1988; Trippet & Bain, 1993b). Alternative health care includes herbalism, homeopathy, naturopathy, massage, tai chi, and a range of non-Western medical and health practices.

While almost entirely empirical in nature, research into lesbian health care experiences has developed over the past few years. It has progressed from being almost entirely quantitative and survey-orientated in nature, to being reviewed extensively and distributed through a range of disciplines, to current work, which has employed more qualitative and critical research methods. Morag Robertson (1993) interviewed lesbian women about their health care experiences, being one of the first in the lesbian health area to use a grounded theory approach to interpret the data from her interviews. She identified four key themes with respect to experiences of health care: i) the assumption of heterosexuality, ii) coming out or disclosure, iii) expectations about health care

providers regarding sensitivity to lesbians, and iv) issues around the lack of routine care. In a more recent study, Patricia Stevens (1996) considered lesbian health care encounters. The study is important because of its rare use of qualitative and interpretative approaches. Stevens "describes lesbians' experiences of power relations in health care encounters and offers a typology of doctor's uses of power" (p. 37). She draws attention to identities as clients or patients in a health system, and ethnicity, rather than as (only) being lesbian. Stevens (1996) attention to body sculpting, reproductive regulation, bodily transgression had not been part of lesbian health research and its theorising to this point.

PHYSICAL HEALTH

Identifying physical and mental health concerns is an important area of lesbian health research, yet research focused on the incidence of specific health issues in lesbian populations is limited. In the published research, there are many contradictions and conflicts about what the physical health risks for lesbian women may be.

The earliest research on lesbian physical health was on sexually transmitted diseases (Deevey, 1995). Though very little research on lesbian gynaecology is published in traditional medical journals, sexually transmitted diseases and gynaecology continue to draw significant research attention compared to other physical health issues (O'Donnell, 1978). Much of the knowledge about lesbian gynaecology is anecdotal (Deevey, 1995). O'Donnell (1978) suggests that "considerably more is known [by women's health practitioners] about lesbian gynaecological health than is available in written form" (p. 10), but does concede that what is known far from complete.

Susan Trippet and Joyce Bain (1993b) surveyed over five hundred lesbians and bisexual women at a women's music festival event in the United States. The lesbian women had experienced a wide range of gynaecological and related physical health problems, including dysmenorrhea, irregular periods, STDs, uterine infections, pelvic pain, fibrocystic breasts, and breast cancer. Trippet and Bain found that menstrual problems, STDs (mainly vaginal infections) and reproductive system problems (e.g. pelvic pain, uterine infections) were the most common health problems for which lesbians sought health care. Bladder and kidney problems and breast problems were next most common. But the rates of health care utilisation were not high. As many women did not seek any

health care intervention for their health concerns as those who did, with the exception of menstrual problems where two times as many did not seek treatment for painful periods. While respondents did not seek assistance for painful periods, they did seek assistance for irregular ones. Respondents felt their breast cancer risk was no different from heterosexual women.

Bradford and Ryan (1987) also found that menstrual problems rated highly. The most common concerns for lesbian women were painful periods, as well as heavy menstrual bleeding, irregular periods and premenstrual syndrome. Again, most were *not* receiving care for gynaecological problems. Other issues raised included breast examination, and cervical smears, birth control and menopause. In this study, 30% of the women had been pregnant in the past (only 16% were currently mothers). Birth control issues reflected tensions between health professionals, with 11% reporting birth control had been "forced upon them" (Bradford & Ryan, 1987, p.*ix*). These studies, and others on gynaecological health (Smith et al., 1985) have reported a similar order in the health concerns expressed by populations of lesbian women.

This area of lesbian gynaecology and sexual health draws attention to several characteristics of lesbian health writing which are explored in depth in later chapters but briefly introduced here. The research of both Trippet and Bain (1993b) and Smith et al. (1985) included and compared findings with populations of bisexual women. This feature is predominant in writing on gynaecological health and sexually transmitted disease. Comparisons are also made with heterosexuals, bisexual, even gay men, and are often reported as a risk comparison (less, more or same risk) for specific issues. Another key feature is the identification of lesbian risk by counting rates of past (and in recent work, current) heterosexual intercourse. As many as "80% of women who identify themselves as lesbian have had heterosexual intercourse in the past" (Johnson & Palermo, 1984, p. 725).

Sexually transmitted diseases

Lesbians, the research suggests, have low incidences of sexually transmitted diseases (STDs) (Bradford & Ryan, 1987; Johnson et al., 1981; White & Levinson, 1995). Incidence of STD symptoms was reported by four to eight percent of lesbian

respondents in the Bradford and Ryan study (1987); at the time of study half were being treated, with only 25% having experienced STD symptoms at one stage in their life.

However, the findings are not consistent. Sexually transmitted diseases reported in lesbian populations in one study include incidences of gonorrhoea, herpes, and hepatitis B (Trippet & Bain, 1993b); and another study reports abnormal pap smears, vaginitis, trichomonas, dysmenorrhea, and endometriosis, but *no* incidence of herpes, gonorrhoea, or syphilis in the women "while engaged in only homosexual activity" (Johnson et al., 1981, p. 22).

Some STDs are shown to have a higher incidence than others. Syphilis, gonorrhoea, chlamydia, herpes, and HPV are found in low rates in lesbian populations, but bacterial vaginoses, trichomonas, and monilial vaginitis are common (Berger, Kolton, Zenilman, Cummings, Feldman, & McCormack, 1995; Roberts & Sorensen, 1995), or at rates equal to a general population of women (Berger, 1983a; Johnson & Palermo, 1984). This, it is argued, is because the presence of "STD" caused by yeast or bacteria is not necessarily due to sexual transmission. There is further contradiction; another study comparing rates of STDs for a group of lesbians to rates for heterosexual women, found even the rates for vaginal infections were less than for heterosexual women (Barnett, 1985).

The finding that lesbians are low risk is accompanied by a sense that lesbians seem virtually invincible with respect to sexual health problems. This sense of invincibility was discussed in Bradford and Ryan's (1987) study where less than one quarter of respondents felt concerned about getting STDs. Berger (1983a) supports this view:

> One result of choosing a lesbian lifestyle is relative freedom from worry about health care problems, which are more common among gay men, as well as heterosexual men and women (pp. 63-64).

Berger (1983a) adds that this freedom is the result of what she conservatively defines as lesbian sexual practices. But the descriptions of lesbian sexual practice, as with heterosexual sex, are contentious. Discussions about sexual practice are now less conservative, raising the spectre of lesbian unsafe sexual behaviour (refer section on HIV/AIDS) (White & Levinson, 1995).

It is a commonly held view that the incidence of STDs in lesbians (particularly syphilis, gonorrhoea, vaginitis, herpes) is related to heterosexual intercourse (Berger, 1983a; Berger et al., 1995; White & Levinson, 1995). Risks are said to be greater for lesbians who have had or are currently having sex with men (Council on Scientific Affairs, 1996; O'Donnell, 1978). Yet it is not known whether STDs transmitted through heterosexual intercourse may be transmitted through woman-to-woman sexual activity (Johnson & Palermo, 1984). The link between heterosexual intercourse and lesbians contracting STDs is questioned (Burns, 1992).

This health issue has engendered substantial comment about the lack of research in the area (O'Sullivan & Parmar, 1992). There have been potentially misleading conclusions about which STDs are transmissible, through which activities, and what care is appropriate (Barnett, 1985; Dardick & Grady, 1980; Johnson & Palermo, 1984; O'Sullivan & Parmar, 1992; Peteros & Miller, 1988; Rankow, 1995). Certainly, the research and writing in the area of lesbian sexual health is contradictory about transmissibility, risk, and appropriate safe sex practice for women who have sex with women. As Johnson and Palmero (1984) state that "the scientific information is lacking" (p. 725).

Bacterial vaginosis is a key example of a common sexual health problem which has been reported both as not being related to sexual contact (Williamson, 1986), *and* as being transmissible in sexual contact between women (O'Donnell, 1978; Peteros & Miller, 1988). Certainly the fact that bacterial infections can be caused by contraceptive pills and stress has likely confounded the issue, but verification that bacterial vaginosis (BV) is transmissible through sexual activity between women was provided only recently in a study with lesbian women (Berger et al., 1995). It was found that the likelihood of a lesbian having BV is 19.7 times greater if their female partner had BV. However, the researchers were not primarily concerned with exploring lesbian transmission, rather with use of a lesbian 'control' group to explore sexual transmission in heterosexually active women. "Because no male counterpart for BV has been found, a population of lesbians is an ideal one in which to test the hypothesis that BV is sexually transmitted" (p. 1402).

It is thought that other STDs such as Hepatitis A and B may be sexually transmissible, depending on the sexual behaviour engaged in between women, and that syphilis and

gonorrhoea are not easily transmitted between women (O'Donnell, 1978; Williamson, 1986).

Human Immunodeficiency Virus (HIV), and Acquired Immuno Deficiency Syndrome (AIDS)

> The most common attitude seems to be that AIDS is not a lesbian problem. In the dominant media we are consistently portrayed as the "lowest risk group", leading many people to believe that lesbians just don't get AIDS ... On the other hand, there seems to be a great deal of confusion among lesbians as to how we are at risk and what precautions we should take (Leonard, 1990, p. 113).

HIV and AIDS feature strongly in writing about lesbian health, particularly work published after the mid 1980s. Articles in this area are relatively easy to locate. My access to writing on lesbians and HIV and AIDS was significantly aided by the gay-positive organisation, the New Zealand AIDS Foundation, who actively search for and hold updated material.

There is very little research into rates and transmission of HIV during sexual activity between women (Leonard, 1990); while it is clear that HIV can be transmitted between heterosexual, and gay male sexual partners, it has not been clear whether HIV can be transmitted between women during sex. At the time of writing there have been a small number of cases of woman-to-woman transmission of HIV reported in the mainstream medical literature, with most research reviews reporting about four cases of woman to woman transmission (Hepburn, 1988; Kwasnieswska, 1995; O'Sullivan & Parmar, 1992; Roberts & Sorensen, 1995; Solomon, 1992; White & Levinson, 1995). Monzon and Capellan (1987), for example, in a letter to the editor of *Lancet,* notify one case of (to use their term) female to female transmission of HIV which occurred without heterosexual contact, intravenous drug use, or blood transfusion. Reports of woman-to-woman transmission are considered contentious by some researchers who argue that not much is know about other possible routes of transmission, and comment that a significant uncertainty exists in the form of unexamined risk behaviours (Hepburn, 1988; Solomon, 1992). Some research studies have populations of HIV positive lesbians and bisexuals who are considered to have HIV through means of transmission other than woman-to-woman transmission (Bevier, Chiasson, Hefferman, & Castro, 1995; Lemp, Jones, Kellogg, Nieri, Anderson, Withum, & Katz, 1995).

Articles written by lesbian community workers and AIDS activists differ from mainstream medical writers; the former group reference a body of research findings which are virtually invisible elsewhere. Solomon (1992) cites an "observational data base" study carried out by the Centre for Disease Control (the US agency which studies and tracks AIDS) which shows 287 woman who have HIV, seven of which could be the result of woman-to-woman transmission. Solomon (1992) discusses two further reports:

> A report by Denise Ribble of the Community Health Project in New York contended that two of thirty-one lesbians with HIV she had worked with had no risk factor aside from lesbian sex. San Francisco's Susan Foster of Lyon-Martin Women's Health Services reported the same for five of thirty-five lesbians who have attended her lesbians with HIV support group (p. 9).

What is clear is that there are lesbians with HIV and AIDS (Brumby, 1988). The Lesbian Aids Project (LAP) in New York had contact with 200 HIV lesbians in 1994 (Vasquez, 1994); the CDC in 1989 acknowledged 79 cases of lesbians with AIDS and 103 of bisexual women (cited in Cole & Cooper, 1991). There were an additional 1242 women whose sexual orientation was unspecified (and this category is significantly higher for women than men). Lemp et al. (1995) found 1.2% of lesbians and bisexual women in their survey had HIV - a rate higher than that found in general, population-based, household surveys of women. The comment has been made that most women's AIDS organisations, large AIDS service providers, and long-time HIV counsellors have seen cases in which female to female transmission has occurred (Cole & Cooper, 1991).

Part of the debate surrounding HIV transmission from a woman (to a woman) focuses on the presence of the virus in saliva, vaginal secretions, and menstrual blood. Research has shown it is low in saliva and vaginal secretions in comparison to levels found in blood and semen, with transmission between women likely to be "inefficient" (O'Sullivan & Parmar, 1992; Vasquez, 1994). It is considered that HIV in lesbians is most likely the result of traumatic bleeding or exposure to menstrual blood. Critiques argue that this research does not go far enough. While rates are low, the risks of a lesbian woman passing the virus to a lover cannot be dismissed (Solomon, 1992). One study has cultured HIV "from cervical and vaginal secretions and cervical biopsy specimens taken throughout the menstrual cycle" (Cohen, Sande, & Volberding, 1990, cited in White & Levinson, 1995, p. 464). Very little research has been done on the course of HIV illness in women, which is thought to be evidenced by pelvic inflammatory disease, or rapidly

developing cervical cancers, and is quite different from that clearly documented in the progression of HIV illness in men (Chiaramonte, 1988). Given this, it is possible that many more women are dying from AIDs related-illnesses than are diagnosed as such.

It is important at this point to indicate that critiques directed at the advocates of a "low risk" factor for female-to-female transmission, stem in part from dissatisfaction with how lesbian HIV/AIDS data is collected by the CDC. The CDC in the United States defined a lesbian as someone who has not had sex with a man since 1977 (Vasquez, 1994). This would exclude most lesbian women I know, either by the length of time they have been out, or by the fact that heterosexual socialisation has meant that a significant number of lesbians have had sexual relations with men. More than half of the self-identified lesbians in Einhorn & Polgar's (1994) study had had sexual experience with men since 1978.

The CDC constructed a hierarchy of possible exposure categories to the virus which does not include female-to-female transmission (Califia, 1992). In addition, disparities exist in the categorisation of risk. Cole and Cooper (1991) explain:

> If a woman has more than one possible exposure she will be categorised by the highest risk only. If a man has had more than one possible exposure from, say, drug use and sexual contact, he will be listed in an exposure category such as IV drug use (heterosexual) or male homosexual, and IV drug use (p. 18).

That is, if she has had risky sex with other women and shared needles, she would be listed only as an intravenous drug user. It is noteworthy that cases of female-to-female transmission are classified in a 'no identified risk' category. The percentage of 'no identified risk' is twice that for women than men.

One of the key issues in lesbian HIV and AIDS writing is the myth that lesbians' sexual behaviours do not put themselves at risk from AIDS (Gale & Short, 1995; Leonard, 1990; Livingston, 1989; Vasquez, 1994). An 'at-risk' groups approach in response to AIDS is due to a decision by the CDC early in the AIDS epidemic to categorise risk according to group rather than behaviour (Solomon, 1992). AIDS activists are clear about the significant detrimental effect of this categorisation on HIV for lesbians, creating a mythology around the fact that 'real' lesbians do not get HIV and setting up a separation of the 'bad' women from the 'good' women (Ristov, 1992).

Lesbian women and health professionals often hold the view that lesbian sex is safe sex and that lesbians are only at risk through certain rough acts or sex with certain groups (Braine 1994; Kwasnieswska, 1995; Morrison, 1994; O'Sullivan & Parmar, 1992; Ristov, 1997; Short & Gale, 1995). However, lesbian women do engage in unsafe sexual activity. A number of studies indicate that lesbians are more likely to engage in high risk behaviours than heterosexual women are (Bevier et al., 1995; Einhorn & Polgar, 1994; Lemp et al., 1995). These studies indicate high levels of injection drug use in lesbian and bisexual women. They also show high reports of unsafe sexual practices with male and female partners (such as unprotected sex), and low rates of safer sex practice with women (i.e. not using latex barriers).

Einhorn and Polgar (1994) found that lesbians who engaged in high risk sex translated their sexual health concerns into a high rate of testing for STDs, rather than safer sex (which they rarely practised). 'Monogamous relationships' were commonly (but inappropriately) viewed as safer, as was reduced sexual activity, or not having sex with 'at risk women', rather than using lesbian safe sex 'gear' such as dental dams or gloves (Califia, 1992). This is despite the fact that lesbians see themselves at some risk from HIV and AIDS (Califia, 1992). Of 2,500 women surveyed by *The Advocate* (Lever, 1995), over half of the unpartnered women and one quarter of the partnered women said they were worried about being infected with HIV, but only nine percent had practised safer sex using a protective barrier during the previous year. Yet lesbian safe sex needs are not being met (Leonard, 1990). Whereas condoms (for sex toys) are widely available, at low cost and on prescription, dental dams are only available in New Zealand through mailorder and some sex shops (particularly those which supply prostitutes with safe sex gear), and come at a high cost.

The literature about HIV/AIDS and lesbians appears to have two strands. The medical view considers lesbians at low or no risk from HIV. Workers in the HIV/AIDS field and health activists comment that 'low risk does not mean no risk'. It is suggested that there needs to be a focus on at risk behaviours rather than at risk groups (Chiaramonte, 1988; Solomon, 1992). Activists supporting the need for lesbian women to practice safer sex emphasise that the focus should be redirected towards unsafe sexual behaviours (Lampon, 1995). Safer sex education concerned what woman *do* rather than *who with* might limit the marginalisation of groups seen to be at risk. Such groups include

injecting drug users, bisexual woman, and lesbians who have had, or do have, sex with men. This may also aid the prevention of other STDs (Patton & Kelly, 1987). What is important is that information about HIV and AIDS changes rapidly, and could well be out of date at the time of this being read (Hepburn, 1988; Kwasnieswska, 1995).

Racism has been a dominant issue in the HIV/AIDS arena. AIDS has been constructed both as a gay male problem and as an African (heterosexual) problem. In New Zealand Peter Mawai's ethnicity is thought to have played a significant part in his conviction for having unprotected sex with Pakeha women while he knew himself to be HIV positive (Worth, 1997). Furthermore, a great deal of the information which is produced, relating to the progression of Kaposci's Sarcoma (an indicator of the virus), assumes white skin (O'Sullivan & Parmar, 1992). Solomon (1992) notes that in the US, HIV is concentrated amongst women of colour, poor women, bisexuals and injection drug users. While health statistics pointing to overrepresentation in 'marginalised' groups cannot be read uncritically, these communities are also traditionally marginalised by 'mainstream' lesbian communities (Braine, 1994).

Many further points can be made surrounding HIV/AIDS and lesbian women. They include the following: lesbians are diagnosed later than men; women are often not seen as at risk from HIV so their symptoms are often not taken seriously; opportunistic illnesses for women are not identified in the list of HIV opportunistic diseases, and are very different from that listed for men; a higher proportion of women are diagnosed at a later stage in the disease than men; women not included in clinical drug trials for experimental AIDS treatments; AIDS services are not geared for women with HIV; self insemination is not listed as a risk activity but has relevance for some lesbian women wishing to conceive; medical guidelines for safe sex rarely address lesbian sex; AIDS councils and gay men have been notoriously poor in addressing the situation for lesbian, heterosexual, and bisexual women; differing perspectives on what lesbians do sexually affects the construction of HIV 'data' and information (Barnett, 1985; Cole & Cooper, 1991; Danzig, 1990; Hepburn, 1988; Leonard, 1990; Livingston, 1989; Morrison, 1994; O'Sullivan & Parmar, 1992; Ristov, 1992; Shew, Say, Ellis-Pegler & Thomas, 1993; Short & Gale, 1995)

Cervical screening

Cervical smears provide information about the status of cells in the cervix, and changes that can be indicators of cervical cancer. As a largely preventable disease linked to sexual activity, the question over whether lesbian women are at risk for cervical cancer has been an important one in the lesbian heath literature.

Uncertainty around the need to recommend cervical screening for lesbians is matched by the variation in findings on rates of cervical abnormalities for lesbian women. Early research indicated low rates: Johnson & Palermo (1984) found only one lesbian woman out of 117 with significant cervical dysplsia. Robertson & Schacter (1981, cited in Wray, 1992) found 2.7% with cervical dysplasia. But over 30% of the lesbians attending a sexual health clinic had abnormal cytology (Conway & Humphries, 1994), with rates for abnormal smear results found in 12% of lesbians in another study (Barnes, 1994).

Recommendations for lesbians have suggested that women not engaging in heterosexual intercourse did not need cervical smear tests (Wray, 1992; Nye, 1994). Cervical screening in recent times in New Zealand was only recommended for heterosexual or lesbian women who had had sexual intercourse (Ministry of Health, 1996). Knowledge about the risks of cervical abnormalities for lesbians was initially drawn from research that did not include lesbians. A study in the 1930s conducted with nuns found them to be at extremely low risk from cervical cancer and was erroneously extrapolated to lesbians (Saffron, 1988; Nye, 1994).

As cervical cancer is thought to be linked to the transmission of certain viruses during heterosexual intercourse, data about the number of lesbians who have had sex with men has been used to confirm that lesbians may be at risk from cervical abnormalities (Conway & Humphries, 1994). Yet, questions about whether viral transmission of the human papilloma virus (HPV) during woman-to-woman sex is possible are important. Recent research has confirmed a link between human papilloma virus (HPV) and cervical abnormalities (World Health Organisation, 1996), and as there is evidence of HPV transmission in lesbians, the opportunity for lesbian women to be at risk from cervical abnormalities is confirmed.

One impact of the poor information about cervical screening needs for lesbians, is that cervical abnormalities in lesbian populations have been found to remain undetected until a later stage (Johnson, Smith, & Guenther, 1987 cited in Burns, 1992; Lucas, 1993). Lesbian women have also been shown to have low rates of regular screening, even for those lesbian women who have had heterosexual sex in the past (Lever, 1995; Rankow, 1995). Lesbians have also reported being dissuaded from regular cervical smear tests by their health care providers (Council on Scientific Affairs, 1996; Rankow, 1995).

The discussion about lesbians and cervical screening again strongly focuses on the invisibility of lesbians in research about women's health, and on the lack of research with lesbians (Burns, 1992; White & Levinson, 1995). Sexual health clinics, established solely for lesbians, have been important in including clients in new research on rates of cervical abnormalities (Conway & Humphries, 1994; Nelson, 1992). Recommendations based on this research (which includes the finding that lesbians have the same rate of cervical abnormalities than heterosexual women) have been made which encourage all sexually active lesbians to have regular cervical smears (Barnes, 1994; Conway & Humphries, 1994; Freedom, 1993; Nelson, 1992; OutSkirts, 1997). However, a number of writers take an agnostic position and suggest that health providers need to make individual assessments for their lesbian clients based on an assessment of risk factors (Johnson & Palermo, 1984; Rankow, 1995; White & Levinson, 1995)

Breast cancer

It has also been suggested that lesbians may have a higher than average risk for some health problems not directly related to their sexual practices. Lesbians are thought to have a greater incidence of endometriosis and breast cancer, in part because they are considered to have high rates of nulliparity (Barnett, 1985; Berger, 1983a; Williamson, 1986).

> Because most remain childless, they are among the never-pregnant category of females who have a higher than average incidence of mammary and endometrial cancer (Williamson, 1986, p. 288).

Yet the actual risk of breast cancer among lesbian women is not known (Rankow, 1995). Breast cancer discussions are focused on politics not supported by research. There is frequent comment on the overshadowing of the higher number of women's deaths from

breast cancer by the much more prominent but lower rate of overall deaths from AIDS and HIV (Brownworth, 1994; Winnow, 1992).

One researcher whose work is unpublished features prominently in discussions about breast cancer. Susan Haynes, using existing data from breast cancer research and lesbian health studies, came up with a risk factor for lesbians which suggested a two to three times greater risk than for heterosexual women (cited in Brownworth, 1994; Horsley & Tremellen, 1993). Haynes combined suggested risk factors for lesbians which included nulliparity, poorer access to health care, higher levels of body fat, alcohol and cigarette use, in her calculations. These figures purporting higher risks for lesbians gained press attention, but are heavily criticised by Horsley and Tremellen (1993) who were concerned about combining statistical data about lesbians, without any actual research being carried out (see also Peterson & Bricker-Jenkins, 1996).

Key issues raised in the breast cancer debate return again to the underuse of health services. Bradford and Ryan (1987) reported that of the seven percent of lesbians in their study who reported breast lumps, only four percent were receiving treatment.

Pregnancy and childbirth

Parenting and having children is an issue for lesbian health (Levy, 1996). Lesbian mothers either have children from an earlier heterosexual relationship, or through a decision (while lesbian) to become pregnant (Shaw, 1989). It is estimated that a third of lesbians are parents or have been pregnant (Deevey, 1995; Hall, 1978, cited in Kenney & Tash, 1993; Johnson, et al., 1981).

Physical health and other issues raised by pregnancy and childbirth, conception and sexual health are obvious ones raised in the literature (Kenney & Tash, 1993; Levy, 1996). They include the risks of conceiving using artificial insemination (AI), or unknown donors, outside of a fertility clinic. HIV in particular is discussed as a risk, given that a considerable number of lesbians consider gay men as potential donors (so a greater risk is assumed, than from a heterosexual donor). However, access to fertility clinics is not assured in New Zealand, and costs are high. Health issues also include service issues and responses to lesbians in delivery situations, and the invisibility of lesbians as parents and birth mothers in gynaecological care situations.

To summarise, gynaecological health issues dominate accounts of physical health issues. Explorations into the kinds of gynaecological health problems encountered by lesbians appear to reflect a number of different positions. Firstly, lesbian women are compared to heterosexual women. Secondly, lesbian women are perceived to have lower risks of gynaecological and sexual health problems than heterosexual women, but the same risks as heterosexual women if they have engaged in heterosexual intercourse and/or have had children (Johnson, Smith, & Guenther, 1987 as cited in Trippet & Bain, 1993b). Indeed, a study into gynaecological and obstetric problems of lesbians indicated that "vaginal infections, cystitis, and herpes were associated with prior heterosexual intercourse" (Johnson, Smith, & Guenther, 1987 as cited in Trippet & Bain, 1993b, p. 60). Third, lesbian women are viewed as having a similar risk for gynaecological problems as heterosexual women (Johnson & Palermo, 1984). Finally, lesbian women are seen to have no specific gynaecological problems associated with being lesbian (Trippet & Bain, 1993b). A noteworthy comment raised in the literature is that lesbians and health professionals believe that lesbians are more healthy (or more immune) than heterosexual women (Peterson & Bricker-Jenkins, 1996).

MENTAL HEALTH

This section on mental health represents only a small portion of the work available that discusses lesbians. The topic of mental health is usually considered separately from physical health and constitutes a large body of work. Key material is presented here which outlines the current context of mental health research.[28] Mental health and illness in the literature on lesbian mental health are broadly defined, and are not limited to or by diagnostic definitions of mental ill health (such as DSM categories).

The leap that must be made here is from historical research focusing on lesbianism as a mental illness to recent work which actually deals with mental health problems experienced by lesbians as a group (Bradford, Ryan, & Rothblum, 1994). The maintenance of stigmatised views of lesbians has occurred despite an increasing research focus in the past two decades on issues in the lives of lesbians and gay men, such as the

[28] For a comprehensive review of lesbian mental health research, see Welch (1995).

coming-out process, ageing, relationships, social interaction, and parenting (see Rothblum, 1994).

Welch (1995) looked comprehensively at mental health and lesbians, and noted that:

> Of the literature discovered (after 1985), much relates only indirectly to mental health issues of lesbians ... The material can be divided into a number of themes: origins of sexuality; stigma and general mental health; coming out theories; youth; drugs and alcohol; and lesbians and health professionals (Welch, 1995, p. 11).

There is focus on social issues for lesbian mental health rather than a focus on psychopathology (Rothblum, 1994). Of hundreds of studies on women and depression contained in a report by the Women and Depression Task Force of the American Psychological Association (1990, cited in Rothblum, 1994), not one focused on lesbians and depression. Rothblum (1994) reiterates:

> Despite a growing body of knowledge about assessment, aetiology, and the intervention of psychopathology in heterosexual men and women, virtually no research has focused on lesbians and gay men in these areas (Rothblum, 1994, p. 213).

The limited research that has been carried out in the area of lesbian mental health is described as "theoretical in nature ... and small in scale" (Bradford et al., 1994, p. 228). A major exception to this is the area of lesbians and alcohol, discussed below.

No intrinsic relationship exists between sexual orientation and psychopathology (see Rothblum, 1994). This means that there is no difference in the homosexual and heterosexual populations in terms of the range of psychological adjustment to be found (Platzer, 1993). However, lesbian women may still be diagnosed with 'illnesses' such as borderline personality disorder to account for their lesbianism (American Psychological Association, 1987, p. 346, cited in Deevey, 1995). Prevalence, assessment, aetiology, and intervention in mental health concerns are controversial, and yet the lack of research implies that the experiences of mental illness are the same for lesbians as for heterosexuals.

Another question debated in this field is whether being lesbian or gay places someone at higher or less risk from mental health illness. This is difficult to quantify due to methodological problems of researching lesbians, but risk assessments for lesbian mental illness often compare risks or rates of mental illness to populations of married women, or

more generalised populations of heterosexual women. Sarah Welch's (1995) research is one example of this as she compares her lesbian sample to other surveys of New Zealand women. Rothblum (1994) concludes that "the experiences of lesbians may place them at increased risk for some mental health problems and may protect them from other mental health problems" (p. 213). Sarah Welch's (1995) work concludes in a similar manner.

Lesbians are frequently presented as those individuals likely to be over-stressed and more vulnerable to mental and physical health problems (Burns, 1992). The coming out process is likely to be an anxiety laden process, and as such, might "result in the expression of behaviours or feelings that may resemble symptoms of severe psychopathology" (Gonsiorek, 1982 cited in Greene, 1994, p. 249). He goes on to say that caution must be exercised in the diagnosis of lesbians with psychiatric disorder.

Theories about 'poor' lesbian mental health form part of the body of mental health research. Recent perspectives focus on lesbians living as a stigmatised group (Rothblum, 1994); having extra pressures and stresses due to the effects of homophobia and prejudice, and dealing with the effects of internalised homophobia, leading to self hatred and low self esteem (Platzer, 1993).

Two larger scale studies of lesbian mental health illustrate approaches that have been made towards researching mental health concerns. The first of these is the Lesbian Mental Health Study (LMHS) which was carried out in New Zealand (Welch, 1995), and the second is the National Lesbian Health Care Survey (NLHCS) (Bradford & Ryan, 1987; Bradford et al., 1994). These studies confirm a high rate of mental health service use, and report homophobic experiences of treatment from mental health services. Notably, psychiatrists, hospitals, psychiatric hospitals and drug and alcohol services are recounted as being significantly more homophobic than other mental health services. With respect to past serious mental illnesses, Welch (1995) found similar rates to a general population of New Zealand women. Both surveys found lesbians to have high rates of suicide, attempted suicide, cigarette use, and drug abuse (these are discussed in the sections below). Alcohol use was found at high rates in the NLHCS, but this was not confirmed in the LMHS. The respondents of both surveys indicated high rates of sexual abuse, incest, and rape. The most commonly identified problem in Bradford and Ryan's study (1987) was financial concerns, followed by concerns about family, job, illness,

responsibility, and lover. In the Bradford and Ryan study, 37% reported being harshly beaten or physically abused at some time in their adulthood and, or childhood. Twenty-one percent had been raped or sexually attacked as children, 15% as adults. Only one third of these women had ever sought help. Bradford et al. (1994), in a further article on mental health responses from the NLHCS, note high rates of verbal abuse and discrimination for being gay, high rates of loss or separation from families; as well as similar rates of depression and eating disorders when compared to general populations of women. Other areas raised in these studies include outness, social and community support networks, and stigma, which are seen to be key issues in lesbian mental health (Bradford & Ryan, 1987; Welch, 1995).

An important concern is the historical relationship between lesbians and mental health, which has a significant impact on lesbian mental health. The importance of, and the need for more 'gay-positive' approaches to mental health, has been suggested (Gonsiorek, 1991; Greene, 1994). Celia Kitzinger (1987) provides a critique of this position (see Chapter Five). In summary, perspectives offered by research include i) lesbianism being viewed as a mental illness, ii) lesbian mental ill health being the result of society's (negative, stereotyped) view of lesbians, iii) that there is nothing intrinsically wrong with being lesbian but features of diagnostic categories may mean being lesbian involves some risk for being diagnosed as having a mental illness, iv) being lesbian has a protective impact on mental health. This latter view is found in the perspective that lesbians are healthier than heterosexual women and men.

Suicide and serious depression

Suicide, attempted suicide, and suicide ideation have been shown at distressingly high rates for lesbian women. The proportion of lesbians who had thought about suicide, sometimes or often was 21% (Bradford & Ryan, 1987). In the NLHCS, the proportion of lesbians who had attempted suicide was 18%, and 20.3% in the LMHS (see also Greenwood, 1996). Deevey (1995) notes that there is some suggestion that suicide and depression are two to seven times greater in lesbians than heterosexual women. This situation is considered to be particularly high for lesbian (and gay) youth (Platzer, 1993).

Serious depression has also been focused on as having a significant risk for lesbian women. Ryan and Bradford (1988) found that 37% of their respondents had suffered

serious depression. Sarah Welch (1995) found 20% had suffered depression in her New Zealand sample. In New Zealand, we have the highest suicide rate for women in the 'developed' world. Notably, the position for women did not rate as significant until New Zealand males also reached the highest in the world. Since this time there has been a great deal of media attention to the issue of suicide (see Greenwood, 1996).

Suicide, attempted suicide, and depression are raised as specific concerns for lesbian and gay youth because of the difficulties for teenagers in coming to terms with their sexuality in a positive manner. Deevey (1995) notes that lesbians who have come out as teenagers (in the past) have suffered isolation, harassment, possible suicide, and harsh treatments. As Platzer (1993) adds "there is a higher rate of suicide, attempted suicide, unwanted pregnancy, homelessness, and drug abuse in lesbian and gay teenagers" (p. 36).

Alcohol and drugs

Bradford et al. (1994) argue that the exception to the lack of research on lesbian mental health has been in the area of alcohol abuse. Other researchers who maintain that alcohol abuse has not been systematically studied and perspectives may be based on unfounded assertions, contest this view (Burns, 1992; Nardi, 1982; Ratner, 1988; Williamson, 1986).

Research attempting to determine prevalence of alcohol problems in lesbian communities suggests that alcohol problems affect 30% of lesbians as compared to 10% of the general population (Ryan & Bradford, 1988; see also Anderson, 1996; Hall, 1993b; Ratner, 1988 for a review of prevalence studies). Johnson and Palermo (1984) state that the incidence of alcoholism among lesbians is thus five to seven times that of heterosexual women (in the United States). Due to variable and contested definitions of lesbian and alcohol abuse and misuse, and because of the 'hidden nature' of the lesbian community, the accuracy of these alcohol abuse statistics are questioned (Anderson & Henderson, 1985; Deevey & Wall, 1993; Ratner, 1988). In the New Zealand study, Welch (1995) found that the drinking patterns of lesbian women were not any different from those reported by a general population of women.

The relationship between lesbianism and alcohol abuse is so well established that the controversy over its factuality is hard to unravel. The link between lesbian and alcohol is

not coincidental (Hall, 1993b). The psychoanalytic perspective viewed lesbianism as a co-pathology to alcoholism, and thus reciprocal with being lesbian. Hall writes:

> Both were considered severe mental disturbances arising from oral fixation, oedipal conflicts, and incestuous drives...both were said to breed malignant jealousy, sadomasochism, criminality, suicidality, and violence (1993b, p. 111).

The liquor industry has also utilised its niche marketing practices and capitalised upon the historical and contemporary attention given to homosexuality and alcohol (Ewing, 1995). Some of the biggest commercial sponsors of the lesbian, gay, and bisexual communities are the alcohol companies. In New Zealand, Absolut Vodka and Dominion Breweries (DB) have sponsored events such as the Hero parade and gay television. In 1994, the value of liquor industry sponsorship for the Gay and Lesbian Hero Festival was worth about $NZ 40,000 (Ewing, 1995). In fact, the largest and highest funded health campaign on a lesbian health issue in New Zealand is from the Alcohol Liquor Advisory Council (ALAC).

The literature on lesbians and alcohol accepts, and discusses theories and explanations for this relationship, as well as treatment approaches. The explanations are broad, often conflictual and inconsistent, and are outlined briefly below (see Hall, 1993b; Nardi, 1982, for critical reviews).

Theories that exist about lesbian alcohol abuse range from the mainstream view of alcoholism as uncontrolled drinking, to ideas about it being the result of internalised homophobia, societal oppression, and bar culture - lesbians drink because bars were the only social environments available (Anderson, 1996; Anderson & Henderson, 1985; Deevey, 1995; Hall, 1993b; Johnson & Palmero 1984; Peteros & Miller, 1988). Explanations of high alcohol use also include the isolation and stress of being lesbian, and being a minority or part of an 'alternative' lifestyle (Anderson & Henderson, 1985; Burns, 1992; Council on Scientific Affairs, 1996). Responses to heterosexism (Anderson, 1996); sex-role conflicts (Anderson, 1996; Hall, 1993b); 'latent homosexuality' or inhibiting unacceptable sexual drives so allowing lesbians to perform sexually with men (Hall, 1993b; Nardi, 1982), and alternatively disinhibition leading to the explosion of repressed homosexual desires (Hall, 1993b) are amongst other individual, social, and cultural explanations posited in the extensive discussion on alcoholism and lesbianism (see also Hall, 1993a).

Treatment and service issues are attended to in the literature with some of the same factors outlined above believed to contribute to the lack of responsiveness of alcohol abuse treatment agencies (Berger, 1983a; Johnson & Palmero 1984; MacEwan, 1994; MacEwan & Kinder, 1991). Of particular concern is a balance in treatment, which is responsive to the needs to lesbians and yet does not focus on sexuality as the problem (Burns, 1992; Diamond & Wilsnack, 1978; MacEwan, 1994; Peteros & Miller, 1988). Calls are being made for contemporary treatment perspectives for lesbians "which reflect changes in both the treatment of addictive behaviours and in the sociology of homosexuality" (MacEwan, 1994, p. 58). The efficacy and effectiveness of lesbian treatment agencies are also discussed (Anderson, 1996).

Other substance abuse issues have been overshadowed by a focus on alcohol, but the rates are also high. Both the NLHCS and the LMHS surveys found about a third of lesbians smoked one or more cigarettes a day. Twenty-six percent, in the NLHCS, were concerned about their personal levels of use. In the New Zealand study at least a third had used cannabis in the last year. Use of tranquillisers, and cocaine was reported, and while injecting drug use was much less common, it was present in the sample (4.1% had injected at least once) (see also Bradford & Ryan, 1987; Welch, 1995). Theories linking alcohol abuse to lesbianism are also found in the substance abuse literature; the result of current trends to treat all substances together (including alcohol). Currently, links are being made with unsafe sexual practices (with AIDS being a common example) and substance abuse, where substance abuse is seen as a risk factor for sexually transmitted diseases (Faltz, 1988).

Violence

Violence is discussed in two forms. Firstly, there are hate crimes against lesbians and gays, usually committed by those who are not gay. The second is the issue of partner abuse to same sex lovers.

Physical and verbal attacks against lesbians and gay women do occur. While a number are reported in the queer media, certainly many more occur than are reported to the media or to police. A report completed by the New Zealand University Students' Association (1994) found 60% of respondents had experienced harassment on the basis of sexual orientation. Of this group 55% had experienced verbal abuse, 42% had been

threatened with violence and 12% had been physically attacked. Despite high rates of reported verbal and physical harassment against queer students and staff, 70% had not taken any action against it. Of the remaining 30% who had acted against harassment, only 60% were satisfied with the outcome. Not many of these cases appear to go to the police. Further discussion with staff and students indicates there are many more instances which are not brought to attention (anonymous communication, 1997)

Gregory Herek (1990) writes of hate crimes against lesbians and gay men as an "extension of the heterosexism that pervades American society" (p. 316). "Cultural ideologies of sexuality and gender foster heterosexism[29] and, ultimately, anti-gay violence" (Herek, 1990, p. 317). While heterosexism and hate crimes against lesbians and gay men - and the experience or anticipation of these - influence significantly issues of emotional and physical health, the impact of heterosexism and homophobia[30] also "leads us to perceive that lesbian battering is nonexistent or minimal" (Benowitz, 1986, p. 198).

While the societal focus on 'domestic' violence is increasing, there still remains a great deal of silence on the issue of lesbian partner abuse (Renzetti, 1988). Some writing and discussion has appeared in the form of journal articles and other academic writing (Hammond, 1989; Lie, Schilit, Bush, Montagne, & Reyes, 1991; Renzetti, 1988), yet commentary on lesbian partner violence appears limited to lesbian and feminist newsletters and magazines (Glover, 1993). Kerry Lobel (1986), editor of an anthology published by the National Coalition Against Domestic Violence Lesbian Task Force, discusses the invisibility of lesbian battering in both lesbian and straight media. Lesbian battering is an issue that some lesbians do not want discussed outside their communities, as it is likely to support anti-lesbian views (Renzetti, 1988). Mindy Benowitz (1986) argues that this is due to risks of shattering the myth of lesbian utopia, the misperception that lesbian relationships are 'above' the power issues of heterosexual relationships - a response, by some lesbians, to both societal and internalised homophobia which fears

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[29] Herek (1990) defines heterosexism as "an ideological system that denies, denigrates, and stigmatizes any nonheterosexual form of behaviour, identity, relationship, or community ... (it) is manifested both in societal customs and institutions, such as religion and the legal system...and in individual attitudes and behaviours" (pp. 316-317).

[30] Homophobia is defined by Benowitz (1986) as "a fear or hatred of lesbians and gay men, and it is also a fear of getting close to someone of your own gender" (p. 198). Homophobia is said to be internalised when expressed by lesbians and gay men. "Members of oppressed groups grow up hearing negative myths about themselves and are treated in a prejudicial manner. They come to believe that somehow they deserve the oppression they have received, and that the myths must be true" (p. 199).

exposing these issues to ourselves and an already prejudiced heterosexual community (Bell, 1989; Gentry, 1993). In addition, the effects of emotional abuse from a lesbian partner are often not believed or treated seriously.

> Many people believe that women are not capable of doing serious physical harm to others. When this fallacy is applied to the case of battered lesbians, a profound misunderstanding and minimisation of the impact of battering and other abuse occurs (Hammond, 1989, p. 91).

It has been suggested that it is much more difficult to distinguish the perpetrator in lesbian relationships compared to heterosexual relationships (Moeke-Pickering, 1993). Lie et al. (1991) who looked at the frequency of aggressive past woman-woman relationships, indicated what they felt to be a significantly high relationship between being a user of violence in a relationship, and a victim of violence in the same relationship. Lie et al. (1991) considered both past relationships with women and familial relationships, as indicators of past abuse. Over half had at least one previous relationship with a female partner that was aggressive, with 73% overall having experienced aggressive acts. Their finding supports the view that lesbian partner violence differs from what is currently known about partner violence, based as it is on heterosexual couples.

Taima Moeke-Pickering (1993) writes on lesbian violence, and in particular violence amongst Maori lesbians. She notes that the experiences of lesbian women in New Zealand reflect inadequacies and gaps in dealing with partner violence. She includes a case where police, not being able to identify a male perpetrator took both women to a safe house (Women's Refuge) so that both the batterer and victim ended up in the same refuge. She discusses alternative options for intervention, namely whakama (or shaming of an individual), as successful in small Maori or Pakeha communities.

The social sciences literature liberally proposes that violence in lesbian relationships is, in part, the result of "daily living in a homophobic and heterosexist environment (which) negatively affects lesbian's self-concepts and the quality of their intimate relationships" (Renzetti, 1988, p. 382). Thus 'conflict' results from the balance of power and issues such as dependency versus autonomy (with perpetrators being more dependant) (Renzetti, 1988).

Some of the discussion around lesbian violence has focused on education and resources (Leeder, 1988; Lobel, 1986; Walber, 1988), on power and control models (Glover, 1993; Walber, 1988), and other models (Morrow & Hawxhurst, 1989), rates of and comparisons to heterosexuals (Brand & Kidd, 1986; Lie et al., 1991), lesbian community responses (Hammond, 1989), and possible interventions (Moeke-Pickering, 1993).

Counselling

Lesbians are reported as having high rates of use of mental health services. The studies carried out by both Bradford and Ryan (1987) and Welch (1995) support this. Lesbian women in Bradford and Ryan's (1987) survey were shown to have a high use of counselling services, either currently seeing or having seen counsellors in the past. Seventy-three percent of the NLHCS sample:

> were in counselling or had received some form of mental health support from a professional mental health counsellor at some time in the past ... In addition, slightly more than a third had received help with mental health problems from non-professionals, such as friends, support groups, and peer counsellors (Bradford & Ryan, 1987, p. 52).

Counselling issues considered by the survey also included reasons for going to counsellors. Relationships and depression were most common reasons for using counsellors. Twenty-one percent had sought help for problems associated with being gay. The survey also considered reasons for not going to counselling despite thinking of going, the length of time in counselling, and preferred attributes of a counsellor.

Ageing

Ageing and the concerns of seniors in western society have become increasing visible. Yet, while this has been occurring, the status of senior lesbians remains invisible and a silent issue in lesbian communities. POLLY (Proud Older Lesbians Like Yourselves), a name taken by informal support and social groups, was established and running in communities throughout New Zealand during the mid to late 1990s.

Many of those who "came out" in the 'gay' and feminist movements of the sixties and seventies, and those who remain in closeted relationships, are faced with Western societies responses to the "elderly", to unmarried older women, and to the conflicts that emerge between perspectives of lesbian as sexual, and aged as asexual (Kehoe, 1988). Notably, ageism exists within lesbian communities (Hepburn, 1988).

In a study by Monika Kehoe (1988) the majority of the sixty-plus lesbians who took part rated themselves in good or excellent physical health, despite pervasive views that a primary concern of ageing is the deterioration of health, and the restriction of activities. Kehoe (1988) argues that physical deterioration is the most difficult aspect for those women who were very active (such as the lesbian 'sportsdykes' and 'tomboys' of this generation). Many of the women interviewed by Kehoe had suffered as a result of abusive experiences with health system where it was common to enforce treatment for sexual orientation.

Ill health and dependency were further issues of concern. Kehoe (1988) found that one third of respondents did not know who would care for them in the event of serious illness and disability, the remainder opting for a partner, friend, neighbour, health professional or possibly a family member. Family members, however, were rarely considered as an option for support. Hepburn (1988) notes that many lesbians become isolated from their families of origin because of their sexual orientation. Other health issues associated with ageing and mid to older life including issues such as menopause and osteoporosis (Hepburn, 1988; McClure & Vespry, 1994). Notably, lesbian women are invisible in discussions of women's health and ageing.

Other mental health issues

This final section briefly looks at relationships, parenting, youth, and disability. These issues are often raised in conjunction with other concerns such as the suicide rates for youth, legal issues for parents, and violence in relationships.

Relationships are an important feature of lesbian health (Bradford & Ryan, 1987). Lesbian relationships have been researched along the dimensions of perceived egalitarianism, closeness and merger, non-monogamy, debunking stereotypes about lesbian relationships, sexual intimacy and frequency of sex within relationships, sexual dysfunction, and sadomasochism (Johnson & Palermo, 1984; Kassoff & Hunt, 1988; Nichols, 1988; Pearlman, 1989; Peplau, 1991).

Parenting and families is an issue for lesbian relationships and lesbian health (Levy, 1996). Parenting discussions address the invisibility and discrimination that exists against lesbian parents. The lesbian as a poor or bad parent, and the lesbian 'environment' as an

unsuitable environment for raising children, is a strong discourse of those opposed to 'gay' parents. Research has considered heterosexist assumptions in interactions with child health care workers, as well as custody and other legal concerns that influence the emotional and mental health of lesbian parents. Lesbian community reaction and support of children and parents (including boy children), gender-roles of parents and children, and importantly co-parenting issues form part of the wider discussion on lesbian parenting (for a review see also Green & Bozett, 1991; Kenney & Tash, 1993; Levy, 1996).

A number of studies have focused on comparisons of lesbians to heterosexual women with the intent of addressing the misrepresentations of and discrimination against lesbians as parents. This has been fuel for custody battles for children of lesbian or gay parents. Studies have compared lesbian to heterosexual mothers on behaviour, expectations of the child's gender-role, maternal attitude, self concept, and child development, finding 'no significant' differences between the two groups and nor any pathology related to lesbian parenting (Green & Bozett, 1991; Peplau, 1991).

There is also increasing attention to women who have children outside of heterosexual relationships, and/or within lesbian relationships. The reproductive technologies may be simple, such as self-insemination, or via a fertility clinic. At the time of review, the most prominent discussion pertained to women choosing sperm donors, and especially where the donors were gay men, advised rigorous monitoring of the HIV status of the donor.

Health issues for lesbian youth are raised in discussions and concerns surrounding the processes of adolescence and coming out - a combination which is often highly stressful for the individual (Browning, 1987; Coleman & Remafedi, 1989; Council on Scientific Affairs, 1996; Morrow, 1993). Questions about identity, and health problems associated with the potential stresses of questioning family and societal values are, critical for this group (Browning, 1987; Morrow, 1993). Remafedi (1988) comments:

> Young people who are struggling with the issue of homosexuality are not miniature lesbian and gay adults. Often, these youths are unfamiliar with the homosexual community; they vacillate between various stages of self acceptance; they may avoid identification with a community; they may even want to change their sexual orientation (p. 87).

Access to services for youth are limited in our society (MacBride-Stewart & Greenwood, 1993) but services for lesbian or gay youth are even more limited and uninformed. While some may take the view that coming out is easier to do in this modern society it is important to note that current health issues for lesbian youth include suicide, alcohol and drugs, harassment and violence, and often serious isolation (Council on Scientific Affairs, 1996; Morrow, 1993; Taylor, 1989; White & Levinson, 1995). Some research on lesbian youth has been carried out in New Zealand but it is mainly limited to the areas of education (Stapp, 1991), and suicide (Greenwood, 1996; Taylor, 1989).

Possibly one of the most invisible areas of health concerns in lesbian health is that of disability. In the New Zealand context people with disability and lesbians share a political landscape in the form of the Human Rights Legislation in which shared agenda building is actively encouraged by members of both disability and gay rights groups. Yet, invisibility remains a significant issue. Burns (1992) comments that lesbian women who are disabled face oppression for their disability and their lesbianism.

Lesbians as a population have large numbers with chronic fatigue syndrome (Winnow, 1992), but disability is mentioned in few other places in the lesbian health literature. There is still almost nothing on the subject of lesbian sex and disability (Zwerner, 1982 cited in Hepburn, 1988), although some lesbian writing does broach it (Loulan, 1984).

CONCLUSION

This chapter explored current writing and discussion about lesbian health. Compiling such a body of literature is significant, because lesbian research in both published and unpublished formats is often difficult to access. Compiling this review so that the findings appear as a coherent account of health issues required considerable effort, as there were frequent gaps resulting from inconsistencies and repetition in the collected studies.

To reflect a traditional approach to a literature review, this chapter could have commented more fully on the style of the research, definitions, and possibly focus on some contextual features. For example, I would have more clearly defined the terms: 'lesbian', 'health', and 'medicine', and reflected on the primacy of medicine (care,

diagnosis, treatment) in the lives of people within Western culture. Yet, as definitions are considered part of the process for making meaning rather than as a point at which ideas are fixed, these explanations occur throughout the thesis.

This literature review characterises a number of features of lesbian health research. Lesbian health as body of work attempts to describe or contribute to the status of lesbian health in a positive way. The frameworks for determining health concerns were very similar. The major physical health concerns raised, for example, were ones for which biomedical tests can be devised (e.g. cervical screening). Yet, biomedical research, which would appear to have the most currency in medicine, was overwhelmingly absent. Very few medical studies were targeted at lesbians or include lesbian as a category.

Empirical research on lesbian health is often elaborated on by comparing findings with other populations. In addition, comparisons between heterosexual and lesbian women appear to dominate assessments about which lesbian health issues are relevant or important. The context of heterosexual intercourse is particular important here. Yet, there are differences between heterosexual and lesbian women in the types of medical problems they are likely to develop. Berger (1983a) gives the example of intrauterine devices, which are not used by lesbians but which can increase susceptibility to pelvic inflammatory disease and vaginitis. Not addressing the differences between lesbian and heterosexual women can misrepresent lesbian health concerns.

Research credibility comes from its potential to transfer easily into policy and education, and its ability to influence the actions of health professionals. Many studies concluded that the status of lesbian health would be improved by promoting the visibility of lesbians, and proposed changing medical interview techniques so they no longer assume heterosexuality. However, as the following examples suggest, promoting lesbian visibility has potential risks, and education has the potential to work against a positive health status for lesbians. For example, a lesbian health study released to the media by Saphira and Glover (1999) appeared in newspapers throughout New Zealand with the headline "lesbians are sicker". In addition, before any research into cervical cancer included sexual activity between women, lesbian visibility led to the recommendation that lesbians did not require cervical screening. This misinformation was shown earlier in the chapter, to have been corrected only after epidemiological study determined that all women

regardless of their sexual partner should be advised to have regular smear tests. Promoting lesbian visibility therefore is a complex issue, and appears to rely on currently held views about lesbians, and on the influence and status of research carried out.

Lesbian health appeared to be a burgeoning field of study with many of its contributors suggesting the need for more research to add weight to lesbian claims about health concerns. Yet, given the limited availability and amount of research, the preponderance of review articles, and the many similarities in the research methods, topics, and suggestions for future development, I assessed this body of work as reflecting a significant reproduction of ideas. It gave the appearance of repetition and coherence while being unable to offer many answers as to what lesbian health concerns may be. This reproduction occurred despite the research material being widely sourced.

Given that much of the research appeared to be marginalised by its research matter and methods[31] it is important that it had been published at all. However, research that is predominately representative of student or community projects and not a mainstream issue or underfunded, is often limited by time, space, or resources. These constraints may influence the ability to offer original ideas or expand on findings except in very limited ways. Therefore, the available research material must be evaluated in light of these issues.

[31] This view of lesbian health research as marginalised will be critiqued in later parts of this thesis by the suggestion that the research still reflected predominately mainstream approaches.

CHAPTER III

THEORY: EXAMINING APPROACHES TO SEXUALITY AND SICKNESS

INTRODUCTION: SHIFTING PARADIGMS

This chapter has two functions. The first, in the traditional sense of a theoretical chapter, operates to locate the epistemological approaches and essential arguments of this project. The second is to outline the shifts in theoretical perspectives of the project, which progressed from modernism towards the implementation of a social constructionist and then a critical analysis of corporeality.[32] These shifts developed during the research process, including after the interview data had been collected. In this way, method and theory are not regarded as distinct. This chapter also explains a process in which theoretical possibilities for examining intersections between the lived experiences of 'being' or 'acting as' 'lesbian' in 'health' settings, and representations of lesbian health, are explored.

Notably, the impetus for attempting to revise the initial approach of this thesis towards examining the discourses and corporealities of health and sexuality rather than the question of 'what are lesbian health concerns?' is a consequence of dissatisfaction with the material in the literature review. Therefore, my engagement with lesbian health literature and policy has raised questions more fundamental to the thesis project than those that ask, "how healthy, or sick, are lesbians?" and "how can their health be maintained or improved?" I am concerned with the assumptions that inform the theory and practice of health.

The shifts in my conceptualisation of lesbian health are discussed in three sections. The first section discusses feminist conceptualisations of identity and (lesbian) sexuality that were relevant to the initiation of this project. 'Lesbian health' has been retained in the

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[32] Modernism can be explained as an approach encompassing the genre of gay-positive research. Modernist approaches in the social sciences can take into account complex social structures and values, and can realise concerns about crisis, fragmentation, and introversion. In this thesis, modernism describes positivist approaches that link social sciences' concerns about social laws, attempting to do this by modelling a scientific approach (Marshall, 1998). The more substantial explanations of social constructionism and corporeality occur in the context of this chapter.

title of this thesis and the relevance of identity politics to the constitution of sexuality and gender is examined. Lesbian is not assumed to operate as a subcategory of gender, and so this section goes on to examine the relationships between gender and lesbian identity, again drawing on feminist theorising on identities. This section indirectly assesses how liberal humanist approaches, in the context of the analysis of social issues for underrepresented or oppressed groups, might influence claims to identity.

Conceptualisations about 'homosexuality' are overwhelmingly constructed in western philosophy as part of a binary and hierarchical relationship, in this case with heterosexuality. In order to make sense of 'homosexuality', the hegemony of heterosexuality must be understood. Similarly, the second section is engaged in a deconstruction of health and medicine and an examination of the hegemony of medicine, including a brief discussion of the history of medicine. Contemporary understandings of health and illness and their relationship to sexuality and gender are explored. The work of these two sections is prefaced on the assumption that much of the lesbian health research, described as gay-positive, is similar in its epistemological underpinnings to work (modernist, liberal humanist[33]) carried out in the social sciences in general, and social psychology in particular. The intention is to make explicit how traditional concerns about identity, power, and language are reformulated in the context of this project. The third section introduces queer theory in the context of corporealities, by drawing on work of theorists such as Elizabeth Grosz and Judith Butler who can be categorised as both. The intersections of theorists and queer and critical approaches to corporeality highlight a juncture for the previous shifts in the theoretical work.

A Lesbian Looking Glass? Sexuality, Gender, and Identity

Lesbian identity is a starting point for my analysis. Lesbian health is prefaced upon the belief that lesbian as an identity makes meaning of health, in particular ways (and vice versa). Yet readers may question why lesbian identity is relevant or important to understandings of health, despite concerns raised in the literature review that lesbians did

[33] The particular pairing of liberal and humanist refers here to ideology underpinning ideas which relates to rationality, or the belief in free choice and the progression towards the rights of humans. Humanism is described as a "set of philosophies that have as their core the belief that human interests and dignity should be of primary importance" (Marshall, 1998, p. 289), and liberalism is viewed as a dominant ideology of western philosophies regarded as the opposition to many forms of authoritarian demands.

not seek health care or received poorer care. This can range from the statement 'but health is just the same for everyone' and accusations of agenda-pushing, to more critical postmodern questions which explore the limits of identity notions. To approach these questions it is helpful to explore the ways in which lesbians have been defined and named, including who is, can be, or what constitutes lesbian. However, I am interested in the ways in which identity is constructed, and its presence or silence in the context of health, rather than in deconstructing it to leave potentially no salient identity per se.[34]

The analysis of *sexual* identity has an extensive history. Jeffery Weeks (1987) comments that although the idea of sexual identity is ambiguous, it has value because it refers to a sense of belonging, politics, or 'self'.

> The very idea of a *sexual* identity is an ambiguous one. For many in the modern world - especially the sexually marginal - it is an absolutely fundamental concept, offering a sense of personal unity, social location, and even at times a political commitment. Not many, perhaps, say 'I am a heterosexual' because it is the taken-for-granted norm ... But to say 'I am gay', 'I am lesbian' ... is to make a statement about belonging and about a specific stance in relationship to dominant sexual codes (Weeks, 1987, p. 31).

Judith Butler's (1990) theoretical work is a disordering of the notions of sex, gender, and identity as fundamental concepts of self (explored in the final section), yet even she appears to make claims about the relevance of the category 'lesbian'. Allen (1997) notes of Butler, it is not that she does not want to appear under a lesbian identification (or in Butler's words, 'sign'), but that she wants the identification to "take part of and contribute to lesbian culture in different and variable contexts" (Allen, 1997, p. 29). Butler may not entirely agree with this interpretation of her claims. However, this thesis makes the assumption that 'lesbian' is a relevant starting point from which understandings about identity and subjectivity can be articulated.

Weeks (1987) makes a further claim, which regards identities as caught in a paradox between belonging to an essential nature, or an historical and cultural flux. In this state of social change "we constantly strive to fix it, stabilize it, say who we are by telling of our sex" (Weeks, 1987, p. 31). The paradox outlined by Weeks is of major importance to

[34] A critique of constructionism is that it is responsible for fragmenting or disintegrating identity, making work with a liberatory politics appear difficult (Wilton, 1995a).

the theoretical development of this project, which examines distinctions and links between the essentialist view of sexuality (often ascribed to medicine) and its position as a social discourse. It is in the negotiation between essentialist and constructionist positions that debates over what constitutes homosexuality can be understood (Jagose, 1996). The debate over identity as natural, fixed and innate versus understandings of identity as "fluid, the effect of social conditioning and available cultural models of oneself" (Jagose, 1996, p. 1) often is the first dilemma articulated in discussions of sexual identity (Jagose, 1996; Ussher, 1997a; Weeks, 1987; Wilton, 1995a). Developments in the conceptualisation of sexuality as represented by queer theorists such as Butler (1990) are elucidated in the third and last section of this chapter.

Material sexualities

When sexuality is described in terms of its material sensibilities, lesbians are defined in terms of physical acts. As the (Western) story commonly goes, a lesbian is a woman who has sex with other women. Same-sex sexual activity here is viewed as the sole and fundamental means of conceptualising homosexuality. In addition, material claims to lesbian sexuality are found in discussions over how lesbianism comes about, and in the treatment and or punishment of homosexuality.

Jane Ussher (1997a) outlines two perspectives that examine the regulation of sexuality defined in terms of physical acts. The first relates to the discussion of homosexuality in medico-legal contexts. The intent here is to determine what constitutes same-sex sex, and to consider the consequences of defining lesbian in terms of sex between two women in the regulation or legislation against homosexuality. Notably, sex acts between women in many western countries (including New Zealand) did not come under the legal definition of homosexuality. Sex acts between women being regarded as benign and materially immaterial. However, while the assumption that Queen Victoria's alleged comment that 'women just did not do that sort of thing' excluded lesbian sex acts from the criminalisation of homosexuality per se, the same acts at times have constituted an offence under other sections of the British (and hence New Zealand) law. Ussher (1997a) gives examples of the challenges to lesbians under family law as legally fit parents, and the rare charge (for a woman) of indecent assault for dressing as a man and having (questionably) non-consensual sex with her girlfriends. She adds that if lesbian sex is presumed to constitute penetrative acts that are not penis-vagina sex, in law it

becomes defined with homosexual acts (sex acts between men) and regarded as deviant (Ussher, 1997a).

The second perspective in the management of sexuality relates to the extensive field of sexology. The theoretical roots of accounts that refer to natural processes as underlying all social effects of sexual identity are often attributed to sexologists such as Kraft-Ebing and Karl Ulrichs[35] (Ussher, 1997a; Weeks, 1987). Sexology produces a distinction between 'being gay' and 'acting on it', but with sex acts determining what kind of person you were. This became reflected in the medico-legal accounts. As Ussher (1997a) notes, it was the early sexologists:

> who moved the focus from the physical act of same sex sex onto the analysis (and regulation) of sexual identity or regulation, through their discovery of the homosexual and lesbian person... so 'homosexuality' became a categorisation for a type of person, rather than simply a physical act (p. 138)

As the psychiatric accounts of lesbianism attest to, the discovery of the 'homosexual person' located homosexuality as an internal psychological disorder, where the motivation for same-sex acts was a pre-existing but damaging force within an individual (Weeks, 1987). Diane Richardson (1984) notes that sexual desire was and is viewed by some as an 'innate' or 'instinctual' force. Consequently, this gives rise to the view that lesbian is a relatively fixed orientation because desire and behaviour are often linked in the definition of 'lesbian' (Richardson, 1984).

The reduction to traits or essential features of lesbian identity is part of the discussion about the material foundations of 'homosexuality'. This has included references to an underlying maleness, described in such terms as a deep voice, large clitoris and other supposed bodily manifestations. Such research is not historical. Simon Le Vay's (1996) *Queer Science* is a contemporary account by a gay researcher whose research (often criticised for its unreliable methods) into homosexuality focuses on the primary importance of biological causes of homosexuality, including genetic. He carefully acknowledges that while there are social and multiple causes of homosexuality there is

[35] The work of the German sexologists Kraft-Ebing and Ulrichs (also Hirschfeld) is implicated in attempts to argue that homosexuality is a natural phenomena. Their work was an attempt to challenge anti-gay policies in Germany (paragraph 175) which preceded the Third Reich. However, the enforcement of such policies by the Third Reich, led to persecution and extermination of gays during the holocaust. Controversially this work is sometimes implicated in the reification of these anti-gay policies.

"strong evidence that genetic factors underlie influence sexual orientation" (Le Vay, 1996, p. 274).

The essentialising of lesbian identity additionally locates lesbians as objects of research. Meaningful information about health conditions or concerns of lesbians (rigidly categorised by same-sex sex, for example), can be collated and used either to provide a measure of health status as a stand-alone group or in comparison with the categories 'women', 'the general population' or 'gay males'. Health research studies may specifically ask for self-identified lesbians as research subjects. Yet, there are implications for lesbians as the objects of research when assumptions are made, for example, about what constitutes lesbian sexual practices in a study on sexual health. As the literature review revealed, lesbians were excluded from some counts because the nature of sexual practices or histories were misunderstood or misrepresented. This has lead to erroneous portrayals of lesbian health concerns. For example, poor assumptions meant that lesbians were not considered to be at risk from the wart virus, although it was known to be transmitted between sexual partners during 'sexual activity'. It is understood that woman to woman sex should now be part of this definition of sexual activity.

One impact of these accounts of the material constitution of sexual identity is that they are more than simply descriptive. Rather, as Weeks (1987) argues, they are prescriptive in telling people what they ought to be like. Within accounts that discuss the emergence of a true and essential 'lesbian' identity, there is a peculiar sense of what is regarded as normal plus an homogenising effect of identity that obscures a diversity of sexualities.

Sexuality and social construction

> Essentialists assume that homosexuality exists across time as a universal phenomenon which has a marginalised but continuous and coherent history of its own. Constructionists, by contrast, assume that because same-sex sex acts have different cultural meanings in different historical contexts, they are not identical across time and space (Jagose, 1996, p. 9)

Essential categories of sexuality that attempt to define 'lesbian' solely in terms of sexual activity and desire make it difficult to explain a diversity of lesbian experience. For example, lesbians who may be celibate or have not yet 'made love' with a woman, or who sleep with men, raise questions about whether desire and behaviour are always linked, if they are distinguishable, or whether desire alone is a significant condition for 'being

lesbian'? Can a person 'choose' to be lesbian? That is, are social and apparently changeable aspects more important in determining sexual identity (Richardson, 1984). Additionally, how can we account for same-sex relationships or romantic friendships in antiquity? Can Vita Sackville-West be categorised as lesbian or bisexual given that she does not describe herself as such in her own biography?

Social constructionist or poststructuralist[36] perspectives enable understandings about sexuality that vary historically and evolve under certain social and cultural conditions. Foucault (1976) is primarily recognised for such work. Notably the work of Mary McIntosh and Margaret Mead is cited as having also made claims for sexuality as a social role by considering cultural influences on behaviour. Rather than concluding that civilisation simply and unequivocally repressed sexuality as Freud had done, or that the sexologists work lead to the invention of homosexuality (see Jagose, 1996), Foucault (1976) was concerned with how such historical movements lead to current understandings of sexuality. He argued that the activities of sexologists were a response to social conditions, supported by an increasing significance of medicine and science (as explored in the following section).

The attention to homosexuality in these historical analyses has often focused on males. As already demonstrated, women do not appear to occupy the same position historically as men do. Consequently, Foucault (1976) has been somewhat relieved of current criticism over the maintenance of this absence in his work. Faderman (1991), who examined historical documentation about lesbianism, mapping women's friendships before they were no longer socially sanctioned, retains the perspective that sexuality was present but repressed. The medical profession, she indicates, had a role in discouraging women's friendships. Faderman's (1991) is a useful account discussing the social forces that lead to historical shifts in meanings about lesbianism. Despite a concern that she essentialises women's friendships, assuming a direct progression to lesbianism, Faderman (like Kitzinger, 1987, in Britain) demonstrates the conditions for the emergence of a new lesbian identity in the context of twentieth century America. As Tamsin Wilton (1995a) comments:

[36] I have not distinguished between the two here as I regard them, in this context, as not easily distinguishable.

> Sexual identity is a reflexive self-narrative profoundly dependant on cultural, economic and social factors - such as the availability of the notion of 'sex' or 'identity' - all of which are subject to quite dramatic shifts, sometimes over remarkably short intervals. Scrutinising social history makes clear the contingent and constructed nature of all sexualities (pp. 3-4).

Perspectives on sexuality are also culturally specific. "Whilst Western discourses on sexuality concentrate on sexual acts, Polynesian discourses do not separate things into such a concept as sexuality, nor label individuals according to sexual acts" (Wille, 1994, p. 3). Wille (1994) writes that central to Polynesian discourses is the family, within which individual identity is constituted. Western discourses, in comparison, place the individual as primary in relation to a person's identity. She describes a cosmology within Maori and many Polynesian and Melanesian cultures where gods and goddesses straddle both male and female divinity, and may "whilst not in itself approving of forms of homosexual behaviour, provide a more neutral basis for different [from western perspectives] aspects of sexual behaviour and gender roles" (Wille, 1994, p. 3, brackets additional). She adds too, that discourses on sexual and gender matters differ between iwi ('tribe') for Maori.

Sex acts only become relevant to a lesbian identity because they constitute our understandings about sexuality and are more useful for the possibilities of learning and description. In a constructionist perspective, identity is not the goal but rather it is the site of struggle. The account of sexuality as a social role suggests that sexuality is about how you currently live your life, although "identity does not follow on unproblematically from experience" (Lather, 1990, p. 76). Identity is viewed as changeable, evolving under certain social conditions, and taking on different meanings in different contexts where it has importance and relevance to these contexts (Halperin, 1995; Weeks, 1987). The shift in perspective is away from a focus on flesh to one of discourse and power (Ussher, 1997a). However, that sexuality may have different meanings in different contexts can make it the source of controversy even in 'gay' communities. For example, public gay and lesbian parades, such as the annual New Zealand Hero parade highlight a diversity of floats representing gay, lesbian, bisexual, transgendered and takataapui in images ranging from sadomasochism, bondage and discipline, to sex workers, lesbian and gay parents, HIV, and youth. In the various contexts of promoting a health issue, a community event, and a gay spectacle, these representations offer legitimate but potentially contradictory images (Brickell, 2000; Johnston, 1998).

A further account, derived from lesbian feminism, is the understanding that women may not have a "uniquely 'homosexual' sexual life" (Ussher, 1997, p. 145a), but that they may have chosen to live this lifestyle. Identity is characterised as a personal choice and a personal responsibility. It distinguishes itself from male homosexuality to recount a profoundly female experience (Kemp & Squires, 1997). Reflected in the motif of 'personal is political', behaviour is not regarded as separate from identity. Both Faderman (1991) and Rich (1980/1997) indicate that this personal choice perspective avoids defining sexual identity primarily by sexual practice, or the suggestion that being lesbian is wholly about sex (Wilton, 1995b). As Rich (1980/1997) writes of the continuum of lesbian experience

> I mean the term *lesbian continuum* to include a range - through each women's life and throughout history - of women-identified experience; not simply the fact that a woman has had or consciously desired genital sexual experience with another woman. If we expand it to embrace many more forms of primary intensity between and among women ... we begin to grasp the breadths of female history and psychology which have been out of reach as a consequence of limited, mostly clinical, definitions of 'lesbianism' (Rich, 1980/1997, p. 323).

Similarly, Colleen Lamos (1991) states "lesbianism refers to the sexual orientation of a minority group of persons and a universal possibility for every woman" (p. 278). While this approach attempts to reflect a broader experience than that of sex acts, it places emphasis on a fundamental shared female belonging and oppression, or victimisation. As Dolan (1993) argues, the lesbian lifestyle reflected in the personal is political slogan "has limited efficacy in a culture in which lifestyles are so easily assimilated, commodified, and neutralized by dominant ideology" (p. 192).

Social constructionism is often regarded as a counter discourse to essentialism (Ussher, 1997a). Yet, Jagose (1996) suggests that rather than acting in opposition, many aspects of the two perspectives coincide, and social constructionism and essentialism may be more complexly related. Constructionism is understood as being both resistant to, as well as producing understandings about the limitations of the essentialist view. Weeks (1987) suggests that Freud recognised this complexity in his view of identity as a struggle and an accommodation between conflicting drives and desires, not easily assisted by the limits of available language. Weeks (1987) adds that while sexology sought to regulate homosexuality, "it also provided the springboard for self-definition and individual and collective resistance" (p. 38). It is the relationship between essentialist and

constructionist perspectives on sexuality, which begins to reflect the many ways in which sexuality has been broadly conceptualised and understood. So with the exception of Faderman, constructionism reflects a demonstrable shift from a focus on sexual acts to identities as ways of being or living. The theoretical shifts examined here have reflected a changing focus on how people live their lives, to what they do (in terms of sex acts), and back to how they live their lives, as making sense of contemporary understandings about sexuality. In the particular context of biomedical and contemporary health accounts of sexual health there has been a reverse trend with the focus shifting from identities to acts (also explored in the following section).

It is important to mention at this point, Celia Kitzinger's (1987) work in *The Social Construction of Lesbianism.* From a perspective of social constructionism, Kitzinger (1987) provides a critique of the liberal humanist traditions of social science, including gay-positive research. Liberal humanist research, she argues, is not as distinct from traditional and positivist science as might initially be understood, as gay-affirmative research is as poorly constructed and 'motivated' as the psychological and scientific work it seeks to critique. The distinctions between these areas of research are diminished to the extent that they appear the same or very similar, and she argues that liberal humanist theories allow lesbians to be 'added in' to its theoretical position only in individualistic terms. "The shift from 'pathological' to 'gay affirmative' models," she adds, "merely substitutes one depolticised construction of the lesbian with another" (Kitzinger, 1987, p. vii), the cost of which is argued to be systematic undermining of radical feminist theories of lesbianism. Specifically, Kitzinger (1987) suggests that gay affirmative research, whether it is located in positivist or social constructionist approaches, suffers from liberal assumptions which have offered new kinds of oppression for lesbians. She argues that:

> By shifting its emphasis ... from 'affliction' to affirmation, and by replacing the heterosexual with the homosexual expert, psychology and psychiatry have gained or retained the allegiance of lesbians to its individualised and depoliticized models" (Kitzinger, 1987, p. 179).

Kitzinger (1987) claims that a liberal humanist approach evokes "everyday social constructions of lesbianism" (p. vii). Her work is important because of the links she makes to constructions of lesbian identity and theoretical frameworks for their analysis and production. However, her work can be criticised for its assumptions about radical

feminism, ignoring as it does the essentialised nature of these perspectives, and concerns that she overgeneralises the ability of the 'Q'[37] sort methodology she employs to assess attitudes (Paulin, 1992). In particular, she considers assessments can be made without a priori assumptions that some attitudes may be favourable or unfavourable.

Identity fragments?

Social constructionism can be challenged for fragmenting or disintegrating identity. Many writers have indicated that attempts to "define lesbian" are "fraught with difficulty" (Wilton, 1995a, p. 29), "controversial" (Gonsiorek & Weinrich, 1991, p. 1), reflect "theoretical inconsistencies" (Lamos, 1991, p. 278), are problematic (Berger, 1983b), and contain stereotypes (Gartrell, 1981). Tamsin Wilton (1995a) points out that lesbians have been constructed variously "relative to gender, the erotic, the pathological and the political" (p. 3). They have become the "protean shape-shifter ... so multiform so as to become, ironically, slippery and invisible" (p. 3). "Sexual identity is a reflexive self-narrative profoundly dependent on cultural, economic and social factors - such as availability of the notion of 'sex' or 'identity' - all of which are subject to quite dramatic shifts, sometimes over remarkably short periods" (pp. 3-4). Additionally, 'lesbian' is regarded as a performance (a perspective more fully examined in the last section):

> (Lesbian) is variously understood and positioned within a multiplicity of paradigms: the moral, the mystical/religious, the juridical, the scientific, the medical, the political and the social. 'Lesbianism' can mean immoral behaviour, a sin, a crime, a sexual perversion, a site of metaphor for resistance, a form of deviance or a social role/lifestyle (Wilton, 1995a, p. 29).

'Lesbian' is therefore not coherent. Identities are continually placed and displaced (Lather, 1990). The individual "organises and reorganises competing discourses as they fight for supremacy" (Dolan, 1993, p. 88). The concept of identity can no longer be contained within its own parameters as a coherent or monolithic sense of 'being'. Identity therefore has changed and continues to change over various cultural and historical contexts making sense of multiple understandings of sexuality now.

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[37] Q sort employs a factor analysis approach to qualitative data which argues that "persons rather than tests, are treated as variables" (Kitzinger, 1987, p. 77). Kitzinger (1987) suggests it can be used to research subjectivity (or subjective*ness*).

Identity is usurped in this discussion by conceptualisations of subjectivity. This is not a straightforward replacement or an insertion of one term over another. Subjectivity involves unconscious thoughts and processes. It refers to "the conscious and unconscious thoughts and emotions of the individual, her sense of self and her ways of understanding her relation to the world" (Weedon, 1987, p. 32). Viewing identity as a "dynamic aspect of social relationships...forged and reproduced through the agency/structure dyad" (Bhavanani & Phoenix, 1994, p. 9), subjectivity is understood as constantly renegotiable, and inscribed with unequal power relationships.

Conceptualisations of identity are recognised as having limits. While in principle it might be conceived that all forms of subjectivity (provided by different discourses) are available to an individual, access is verily governed by historically specific social factors and by the power relations at work in the society.

> According to poststructuralism, subjectivity is never monolithic or fixed, but decentered and constantly thrown into process by the very competing discourses through which identity might be claimed (Dolan, 1993, p. 87).

As each situation or context offers "a place from which an individual can express multiple and often contradictory aspects of ourselves" (Bhavanani & Phoenix, 1994, p. 9), this recognises that lesbian may be only one of a number of identities relevant to a person in a health context, so that variously ethnicity, ill-ness or well-ness, gender, health status (i.e. occupation as a health professional) may be relevant (more or less) within a health setting. This conceptualisation of subjectivity as multiple, further destabilises the ability to fix or predict when 'lesbian' may be relevant to a person, their audience (who they are with) and context (where they are). As one writer puts it:

> If I could take all parts with me when I go somewhere and not have to say to one of them, 'No you stay home tonight, you won't be welcome', because I'm going to an all-white party where I can be gay, but not Black. Or I'm going to a Black poetry reading, and half the poets are anti-homosexual, or thousands of situations where something of what I am cannot come with me (Parker, 1978, cited in Wilton, 1995a, p. 84).

Often there are attempts to fix this increasing hyphenation of identity and claim multiple speaking positions, for example, "lesbian feminist post-structuralist psychologist". As Mandy Morgan (1995) reminds poststructuralists, each of us produce such multiple positionings differently, and she cannot hope to speak as a representative, so remains wary of presuming that she knows her place.

Lesbian, as a position, rather than a person, may allow for a space or a strategy for the reading of texts. However, the notion of subjectivities also means doing 'lesbian' differently. Social constructionism can allow for the development of a "politics which draws upon the strengths of the fragmentary and diverse meanings of 'lesbian' rather than the otiose and enervating compulsion to police the one true, politically correct identity" (Wilton, 1995a, p. 84). While a focus on 'lesbian' has been retained in this thesis, its management reflects the incoherence of sexual identity. Yet, Wilton (1995a) notes the risks of deconstructing 'lesbian':

> Any attempt to stake out intellectual territory for lesbian studies must engage with the problematic nature of a liberatory politics predicated upon its status as stigmatised 'other' within the discursive regime of heteropatriachy. By refusing the ideological imperative by which we are defined and cast out of the body politic, by deconstructing 'lesbian' as a disciplinary sign instrumental in the social control of women and sexuality, we render the subject and object of lesbian studies both archaic and politically contaminated (p. 3).

Relations between gender and sexuality

Sexuality and gender have historically been intertwined in both theory, and feminist political movements. Theorising on gender is often discussed in terms of a sex-gender binary. Similarly to sexuality, gender has been broadly conceptualised in terms of essentialist and constructionist positions where gender is variously regarded as reducible to sex organs and traits, or conversely, is regarded as a cultural construct distinct from the essential categories of male and female 'sex'. Gender and sexuality have also been theorised in terms of difference, but this will be examined later. Yet, it cannot be assumed that gender and sexuality are produced via these debates in the same way for the same effects. While it is understood that a person may choose to be gay, and it is understood that a person can change their gender, conceptualisations about gender appear to rely more heavily on the biological and material imperative of sexual organs. Sexuality may be seen as more variable, or less constrained by material aspects of bodies.

The production of understandings or contestations of gender are linked strongly to feminist political projects, which have historically debated whether sexuality is a central tenet of women's oppression.[38] Wittig (1992) argues that sexuality here more correctly

[38] For an overview of feminist theorising on gender and (hetero-)sexuality, see the Oxford reader, *Feminisms* (Kemp & Squires, 1997)

refers to *hetero*sexuality. Furthermore, it is suggested that opposing attitudes to sexuality produced feminism's first major rifts and questions about unity in its nature, direction, and goals (Kemp & Squires, 1997). Radical feminist approaches have had some of the most controversial things to say about gender and sexuality. Sexual pleasures that did not involve men (including lesbian sex, and the absence/removal of 'sex-industries' such as pornography) were regarded as revealing of women's essential sexuality, and the primary means of challenging patriarchy (Kemp & Squires, 1997). Notably, feminist perspectives regarding gendered subjectivities cannot readily be divided into essentialist or constructivist, as most reflect both (Kemp & Squires, 1997).

Two accounts of 'gay' sexuality and gender intersections, which produce conceptualisations of 'homosexuality', are briefly examined here. These particular accounts of gender deconstruct a homo/hetero binary, and are related to a conceptualisation of otherness. The first regards gender as distinct from sexuality. In her account of *One is Not Born a Woman*[39] (in which sex and gender categories, woman and man, are viewed as constructed), Wittig (1992) argues that lesbian is not constituted in nature or definable in material terms. Therefore, lesbian is not-woman or man, but is *something other* than woman. In her now familiar text, she states: 'lesbian is the only concept I know of which is beyond the categories of sex (man and woman), because the designated subject (lesbian) is *not* a woman, either economically, or politically, or ideologically" (Wittig, 1992, p. 20). She proposes that lesbian is the third term replacing the man/woman binary. However, her argument that the refusal of heterosexuality is also the refusal to become a man or a woman, gives the appearance that sexuality can exist outside gender (a lesbian utopic) (Jagose, 1994). In order to produce an account with such radical possibilities, Wittig relies on and even reinforces gender notions. Jagose (1994) comments that "the category "lesbian" is neither subsumed by, nor unimplicated in, the category "woman" (p. 10). Therefore, rather than gender and sexuality being distinct, they may (in the second account) be linked. It must be noted again, as Jagose (1994) does, that the differences in the historical constructions of gender and sexuality are a consequence of 'woman' having been "naturalised as a thoroughly essential category, [yet] the category 'lesbian' is essentially indeterminate, not the least

[39] As Wittig (1981/1992) points out, it was of course Simone de Beauvoir in *The Second Sex*, who said 'One is not born, but becomes a woman'.

because sexuality has traditionally been constituted through categories of gender" (p. 10). She adds that 'lesbian' is always troublesome in relation to gender (Jagose, 1994).

Jagose (1996) elaborating on a schematisation proposed by Sedgwick (1990), suggests that the linking of gender and sexuality offers two possible but contradictory means by which a gendering of homo sex might be expressed in relation to same-sex desire.[40] The first is an account of the separatism of gender and sexuality, and the second is of their transitivity. Where gender is transitive, same-sex desire is regarded proceeding from the homosexual's liminal or borderline location between genders. There is a presumption that homo sex operates in the same way for men as for women. Jagose (1996) provides the example of AIDS, which despite being regarded in one sense as the lowest risk group for HIV, a persistent relationship with lesbians is retained. Conversely, in the separatist account, homosexuality is regarded as a subset, or even the epitome of gender. The sex/gender system is considered to lock into mutually exclusive heterosexual/homosexual and masculine and feminine roles. Thus, the sex/gender system is recognised not only for stabilising heterosexuality but also homosexuality. While sex and gender are *not* regarded as the same thing, they are viewed as constituting part of an interlocking system.

Notably, different understandings of homosexuality in relation to gender were mobilised in various public 'gay' movements (homophile movement, gay liberation, lesbian feminism, and queer theory; see Jagose, 1996, for a discussion). Changes in understandings about gender are understood as being the key to the shifts in these movements, such as the assumption of similar experiences of male and female oppression, and the political affinity with other movements. Lesbian feminist conceptualisations of lesbian sexuality influenced the initial conceptualisation of this project, which identified primarily with women rather than with gay male identity.

There has also been a shift to recognising local sites of struggle. This thesis concerns a small New Zealand city, in a nation on the edge of the Pacific. Continual colonisation by North American and British cultures influences New Zealand understandings of 'gay'. At the same time, globalisation has meant Europe is closely looked at for its, for example, policies on same sex marriage. New Zealand 'gay' communities incorporate the Pacific

[40] Same-sex desire refers specifically to a conceptualisation of sexuality distinguished from sex acts per se. Same-sex desire is addressed in more detail in the essentialism versus constructionism debate.

takataapui and fa'fa'fine as part of the cultural discussions (though always not consistently). The drag queens and kings (females performing males) of the larger cities are often Pacific Island peoples and Maori. They offer diverse understandings of relations between gender and sexuality in a New Zealand context.

It must also be realised that in some accounts of gender, 'woman' is also regarded as a non-entity or a non-being. As Teresa de Lauretis states:

> the nonbeing of *woman*: the paradox of a being that is at once captive and absent in discourse, constantly spoken of but itself inaudible or inexpressible, displayed as a spectacle and still unrepresented or unrepresentable, invisible yet constituted as the object and the guarantee of vision; a being whose existence and specificity are simultaneously asserted and denied, negated and controlled (de Lauretis, 1990, p. 115).

As this project has developed theoretically, it has employed queer epistemologies. In queer theory (more fully elaborated on in a later section) gender is often critiqued for being absent. The understanding of this project is that queer theory treats sexuality and gender as distinct, enmeshed, and existing in differences (rather than a binary of fixed and homogeneous difference). Nevertheless, it leads to a particular incoherence around homosexuality, as gender is never certain and constant but often referred back to. This conceptualisation of queer in relation to gender posits an ongoing relationship between Sedgwick's (1990) liminal and separatist notions of gender and homosex. This is in conjunction with a further tension between homosexuality as being relevant to only a minority (minoritising view), or to all (including heterosexual, universalising view). Sedgwick (1990) argues that all these notions continually operate to produce understandings about gendered sexualities.

Revisiting lesbian health?

If research on lesbian health is understood as having lesbians as the subject of study, and definitions of lesbian, then naming, and the politics of naming, are integral to discussions of lesbian health. Furthermore, a discussion of the incoherence of what constitutes 'lesbian' impacts on lesbian health on specific ways. This is because precisely who is lesbian and who is not lesbian raises questions regarding how such a health community (or communities) may be identified (refer Rothblum, 1994; White & Levinson, 1995). In the opening pages of this chapter, 'lesbian' is realised as unpredictable, heterogeneous,

and constituted by multiple gendered subjectivities that interweave with cultural and historical specificities. For lesbian women:

> the cultural meanings of illness and wellness are linked to lesbian identity ... [where health is] ... a multidimensional process involving the well-being of whole persons in the context of their psychosocial and cultural environment (Stevens & Hall, 1988, p. 69).

Liz Eckermann (1993) raises the question "why women's health?" in her own work. She notes that this question is continually asked in a range of contexts in the current political climate of policy development, human rights and EEO, and fiscally imposed limits in health. As noted in the introduction, *lesbian health research* has been used to paint a picture of *lesbian health.* Lesbian health is assumed as a positive, achievable, and essential quality of lesbian experience. Yet, the relationship between the health arena and lesbians can be regarded as a tenuous one. As Miller, Rosga and Satterthwaite (1995) comment, "it might be said that "lesbian health' is something of an oxymoron" (p. 431). 'Health' has often been a site of oppression for lesbians, because lesbian has often been viewed in terms of sickness and disease.

The shift in the thesis is towards considering lesbian health as a discourse. This relies on the notion of discourse which considers that there are multiple, competing and potentially contradictory ways of giving meaning to the world, which provide for and explain the various ways of constituting sexuality. Lesbian health is regarded as constituting and constituted by notions about 'lesbian' and 'health', and is discussed as belonging to distinct ('lesbian' and 'health') and interrelated (lesbian/health) discursive fields. 'Lesbian' and 'lesbian health', are considered a consequence of cultural and historical representations. Lesbian health is no longer understood as being implicated in an individual or inherently shared quality. The manner in which it is institutionalised is believed to have implications for the possibilities for 'health'. The analysis of sexuality identity as a cultural construct in the context of health, means moving away from presumptions that sexuality is natural, stable, and fixed. This may lead to the loss of a discourse of desire, while paradoxically the denaturalisation of sexuality may be impossible (Jagose, 1996).

> Medical discourse on homosexuality since the nineteenth century has structured a field of knowledge and practice which still influences our conception today (Lhomond, 1993, p. 64).

> Although medical discourse is currently the privileged discourse within which and by which notions of what is or what is not 'normal' human behaviour are legislated, its legitimacy is increasingly challenged by those who recognise and contest the ideological subtext of its discourse and practices (Wilton, 1995a, p. 68).

If 'lesbian' is linked to the constitution of health in specific ways, then the next stage of theoretical development is to examine the constitution of medical discourses (indicated by Lhomond, 1993, and Wilton, 1995a), and consider how 'homosexuality' is constructed in medicine. The hegemony of medicine[41] is suggested to be due to its immersion in, and reduction to the determinism of science. Dominant understandings of health are highlighted by the historical analysis of biomedicine, which is central to the scientific status of medicine. The contemporary social sciences provide other accounts relating to health desires, consumption, and individual responsibilities (for example, lifestyle claims), which function both as a challenge and a response to dominant representations of medicine. Relations of power, place constraints on definitions of lesbian health, and allow for particular perspectives of health and medicine to claim authenticity or be authoritative. An examination of the relationship between lesbians, legitimate health populations, and those who influence the production of health discourses, is useful here.

While inconsistencies in the constitution of 'lesbian' were mappable in the last section, definitions of health initially appear to be more consistent and impervious. That is, it appears obvious when we are sick (Petersen & Lupton, 1996). Understandings about medicine are discussed in this thesis as encompassing a set of practices (directed towards health, mortality, and social order), a theory of the body, and as well as in terms of "the reciprocal interdependence of medicine and the prevailing cultural structures"

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[41] The institution of medicine is taken here as encompassing medical science and knowledge, distinguished from, but including the practice of medicine, the health care system and its agents (doctors, surgeons, specialists, and nurses). I include in my account of medicine the contemporary notion of the Health System. In New Zealand 'The Health System,' 'The Health Funding Authority,' and 'The Health Research Council' are all exemplars of the use of this term referring to medical institutions. It is suggested that there is a linguistic effect of using the term health which positively shifts the attention of traditional medical institutions towards socio-cultural dimensions, including notions of care. However it is my belief that 'health' remains firmly located within the medical model, and cannot be so clearly distinguished from it. I do however distinguish the health system from the notion of health, which refers to ideas about the state of the body. 'Health' suggests an expectation of how the body should be. Note that while the body is not absent from medicine, it has indeed been argued as having been rendered silent.

(Komesaroff, 1995, p. 1). These understandings also extend to the lifeworld; the intimate and private realm of experience in which we live and construct realms of meaning and value (Komesaroff, 1995). Health care, often linked to notions of health, refers to a wide spectrum of health behaviours. These may include consultation with friends, caregivers, or health professionals; and may range from healthy living behaviours, to accessing a range of health care providers and professionals offering services from 'alternative' to 'mainstream' practices.

Historical accounts: Medicine as science

> Despite the enormous influence of poststructural thought on the humanities and social sciences, the fields of academic enquiry and practice that have traditionally focused on the health of the human body - medicine, nursing, and public health - have remained relatively impervious. This is due in no small part to the traditional exclusion from medicine, nursing, and public health of perspectives offered on embodiment, health and disease by the humanities and social sciences. These fields have tended to present themselves as scientific disciplines, built upon an objective knowledge base unsullied by questions of power (Petersen & Lupton, 1996, p. xi).

An historical account of the scientific status of medicine and its practice, is concerned with the overlapping and co-constituting moments and modes of inquiry which have contributed to the production and interpretation of current understandings (Rose, 1994). The institution and practice of medicine has been recorded as moving through a number of distinct stages, but it is recognised that there has been a discontinuous development of knowledges rather than a "wholesale replacement of one form of knowledge over another" (Redding, 1995, p. 90). The current status of 'lesbian health' must be viewed as dynamic, constantly responding to many simultaneous events and philosophies (for a more extensive review refer to Cooper et al, 1996; Turner, 1995).

> Biomedicine is fundamentally a triumph of positivist science. It explains the phenomena of health and ill-health in terms of cellular or molecular events (Atkinson, 1995, p. 26).

The dominant representation of Western medicine is that of a science. Biomedicine is like science in that it can be characterised as deterministic, reductionist, and mechanistic. Medicine is deterministic in that it is engaged in a process of explanation and implicated in notions of progress, and neutrality. As a progressive activity, medicine produces knowledge under certain rules of inquiry, which serve as the basis for further knowledge production in the achievement of health gains. This enquiry is centred upon a belief in

rationality and organisation to produce or achieve 'gains' in the fight against illness and disease (Petersen & Lupton, 1996). As Atkinson (1995) alludes to below, claims to neutrality and knowledge, which have constant and universal truths, are assumed its theory and practice.

> The designation of biomedicine in contemporary medical science is both descriptive and evaluative. The identification of its characteristic traits is always redolent of criticism and the search for alternatives (Atkinson, 1995, p. 25).

Medicine is regarded as reductionist as health gains are determined to be numerically measurable, dependent upon scientific methods of objectivity, goal, and objective setting, as well as the measurement of outcomes and efficacy (Petersen & Lupton, 1996, p. 6). Pathology is reduced to a biochemical or cellular level. The application of scientific method is often regarded as absent of social, cultural, or historical, psychological or behavioural influences (Cooper et al., 1996). The reduction of humans to their biological organs can be understood in medicine as, for example, the reducibility of women in health to a gynaecological perspective, or their difference (to men) in brain function. Similarly, the reduction of health to the functions of the body is understood in terms of disease as having a determinable cause or effect on the body.

Consequently, when a person is ill they become a problem to be solved mechanistically.[42] By its treatment of the body as a machine, modern medicine regards illness and disease as malfunctions of the body's mechanisms (Martin, 1994; Turner, 1995). "All 'real' diseases have specific causal mechanisms which can be ultimately identified and treated" (Turner, 1995, p. 206).

So, the claims of medical science (as naturalism or science) involve a disengagement from the world by objectifying it and regarding it as a neutral place. Such claims provide a constancy where western medicine is viewed as "the universal against which other medical systems were mapped" (Gordon, 1988, p. 19). This ideology of medical care treats disease as a problem of the individual (Geist & Dreyer, 1993). In the process of determining disease, a patient is abstracted, so that they become an external fact to what

[42] What this chapter does not do is to fully explore the systems of religion and law which are crucial in the development of modern medicine, the professional medic, the clinic and hospital institution.

they are suffering (Foucault, 1973). This may give rise to the claim that lesbians who are sick, are only relevant in terms of their sickness rather than 'being lesbian'.

The hegemonic status of medicine was secured with the "ascension of science over religion" (Cooper et al., 1996, p. 6). This development is reflected through the uptake of a mechanistic approach. Sixteenth century humoral notions, based on classical theories and practices from Greek medicine, had difficulty accounting for the plague and other widespread diseases such as syphilis (Cooper et al., 1996; Turner, 1995). By the seventeenth century there was an attempt to make rational the 'vagaries of nature' in medicine and healing (Petersen & Lupton, 1996). Philosophical approaches of the time, which regarded the universe as automated, lead to the belief that humans and even human nature could be viewed as mechanical. Using methods of scientific analysis that had aided explanations of the universe (Schultz & Schultz, 1987), the aims of medicine became important to physical and social bodies in the same way that the aims of science are important to the domination of nature (Hollway, 1989). The "rational, visible organism of modern science marks the end of the fantastic, imaginary representations of the alchemists and consequently empties the body of all its opacity and mystery" (Braidotti, 1994, p. 62, cited in Grace, 1997, p. 88).

Healing also reflected a conscious shift, towards a mechanistic uncovering of the dysfunctions of the workings of the body responsible for disease. The first medical schools (established in the nineteenth century) resulted in, and relied upon, unitary approaches in the training of practitioners' skills (Cooper et al., 1996). Medical evidence gathering shifted from a reliance on direct verbal communication between the patient and the physician, to a desire for reproducible and standardized information (Reiser, 1979). Physical examination of the body became a preferred method for medical evidence gathering. Machines meant there was less need for the physician to rely on verbal reports from patients. These were initially simple, but the interior of the body became subject to a variety of techniques (from traditional thermometers and stethoscopes to computer assisted (CAT) scanning apparatus and cameras to explore veins) that provided an increasingly visual picture of the interior (Fox, 1993). As the mechanisation in health care became woven with the mechanistic approach to the body, the practice of medicine relied on measured and measurable indicators. However, assertions about the validity of instruments, and emphasis of the importance of their objective nature must be treated cautiously (Reiser, 1979).

> Inventions appeared that converted subjective sensory events into numbers, graphs, and pictures whose immutability eliminated controversial evaluations of illness, by producing records that could be readily checked and trusted as means of change. Such numerical and visual depictions did not simply provide more precise, limited definitions of a medical fact - fundamentally they were agencies to dependably store information (Reiser, 1979, pp. 228-229).

Contemporary accounts: Lines of enquiry

> The postmodern position on health asks some questions which focus upon the creation of knowledgeability about illness and health. How do discourses on health and illness, be they medical, lay, or from other groupings, claim authenticity, how do they claim authority, and how is it that we are willing to accept their 'knowledge' of the character of health and illness? (Fox, 1993, p. 9).

Foucault (1972, in the *Birth of the Clinic*) considers the ways in which medical discourses organise themselves in relation to various political and social structures.[43] This organisation of medical knowledge is viewed as a "series of relative constructions which are dependant upon the socio-historical settings in which they occur and are constantly renegotiated" (Lupton, 1994, p. 11), to produce a more or less coherent sense of medical science. Contemporary discourses of medicine are understood as having been brought into existence, and given characteristics and saliency, through liaisons and tensions in historical and competing versions (Rose, 1994). This challenge to biomedicine "does not necessarily call into question the reality of disease or illness states, or bodily experiences, it merely emphasises that these states and experiences are known and interpreted via social activity and therefore should be examined via cultural and social analysis" (Lupton, 1994, p. 11).

The equation between scientific knowledge and power, argued by Hollway (1989), is important for understanding and conceptualising the ways in which lesbian subjectivities are medicalized and realised in medical contexts. Power relations are also an important aspect of identity. One approach considers the ways in which medical knowledge has given power to one group over another. Often those identities which are asserted, or which are the interrogative focus of scientific, psychiatric and other comment, belong to minorities, and have included, for example, a focus on lesbian, gay, bisexual and (more recently) transsexual people. Heterosexuality had remained virtually uninterrogated (and

[43] The work on *Birth of the Clinic* is an early text that precedes Foucault's later theories about power.

often assumed) until postmodernism made its impact (Kitzinger, Wilkinson, & Perkins, 1992). Similarly, Pakeha culture or identity in New Zealand has avoided scrutiny in the context of producing knowledge about Maori. Being white is said to act as a "silent signifier ... [which] ... serves to maintain, and obfuscate its privileged position" (Bhavanani & Phoenix, 1994, p. 13).

Medical knowledge is not regarded simply as an oppressive power but as dependant on context, including time and space (Lupton, 1994). While research can make lesbians visible, asserting their perspectives over other dominant and often pathological discourses, "readers have few opportunities to measure what they read against competing versions" (Greenwood, 1996, p. 31). Multiple and shifting subjectivities may also contribute to changing unequal power and social relationships. The analysis of medical power must attend to assumptions, including the assertion that it is "dangerous to assume that the inequities and power relations that pertain to those other dimensions of social situation will not play out also between women" (Kruks, 1995, p. 3). Lesbians can, and do, oppress other lesbians.

> To unravel and try to develop an understanding of the workings of power within the paradigm of Western medicine and how it works to discipline and create experiences of the body (in Foucauldian terms) is something that even Foucault himself (1973) claimed to be a daunting prospect (Grace, 1997, p. 95).

The analysis of power relations in medicine is acknowledged as a daunting task. Nikolas Rose (1994) suggests that to examine medicine, representing a Foucauldian approach but as 'historians of the present', would be to regard medicine as a "series of associations between events distributed along a number of different dimensions, with different histories, different conditions of possibility, different surfaces of emergence" (Rose, 1994, p. 50). Rose (1994) suggests five lines of enquiry through which such an analysis of medicine could proceed. Rose (1994) argues that medicine should be first considered in terms of the *dividing practices* in which it is constituted, and which distinguish for example, illness from sickness. Second, he notes that medicine is a set of *assemblages* or combinations of spaces, people and techniques in which it has been deployed (including the hospital, the clinic, the community and home), which constitute complex apparatuses for medicine's production and regulation. Medicine also has many diverse sites for the exercise of *expertise.* Rose (1994) argues that people and populations from areas of policy

and administration, to nursing and psychology, and their professional rivalries, should be examined. Fourth, he argues that *technologies* of health, understood as the 'technical forms' used to cure sickness or produce health which include broad activities from injunctions on behaviour, to procedures used by alternative practitioners and doctors, can be understood as locating subjects differently in relation to medicine dependent upon the technologies employed. Finally, he notes that medicine must be regarded as *strategic* and realised in particular ways including for example through campaigns, policies, staffing, funding, and reform. Each of these areas is inextricably linked and intertwined, and reveal the heterogeneity of medicine rather than a systematisation or delimiting of it. Rose's (1994) approach to the analysis of contemporary medicine recognises that discourse and meaning cannot be distinguished from power and domination, but that there are complex relations which locate people variously in medicine in particular relations of power (Rose, 1994).

Dividing practices: Disease, illness, and health

Dividing practices refers to the processes by which people or groups are produced as objects of medical attention and separated from other practices or institutions, including law, religion, and education. The divisions between disease, illness, and health are understood to produce particular relationships of power, which differently position people and practices in association to the other. In the first instance, these dividing practices reflect an historical Cartesian dualism, regarded as underlying, and ongoing separation between sick and healthy, and illness and disease.

The importance of binaries is in their understanding as a primary means for conceptualising and developing knowledge. In a Cartesian dualism, the human bodiless soul can be separated from a mechanistic body which is the site of biological disorder of the body (Kirmayer, 1988). The historical struggle between religious and esoteric accounts, and rational, scientific perspectives, reflects a period during which Cartesian dualism came to dominate. Yet, as scientific materialism gained importance, a monist view appeared to be favoured. It regarded the functions of the body (as machine) as always reducible to its biological functions, giving the appearance that there is no longer a binary since activity always occurs in one direction. However, both Cartesian dualism and monism can be regarded as privileging medicine, essentialism, and science over the cultural. It is suggested that in the monist view, the binary remains present. Yet, as the

body only appears to be of concern when it becomes diseased, the binary is often only obvious when disrupted as through sickness. Kirkmayer (1988) asserts that binaries still appear to operate in medicine in the "metaphoric descriptions of disease, the symbolic classification of diagnoses and the organisation of the health care system" (p. 59), and reflected in distinctions between direct observation and subjective awareness.

The notion of dividing practices is predicated on a concept of oppositions, acquiring meaning from their contrast or difference from each other "rather than from some inherent or pure antithesis" (Scott, 1988, p. 37). Good-bad, healthy-ill, identity-difference, male-female, heterosexual-homosexual are examples of such oppositions. Often binaries are regarded as immutable and fixed, and act to constrain the possible representations of a condition. A notion of internal consistency, supported by rational science, suggests that there is no overlap between the pairs (Atkinson, 1995). Additionally each aspect of a dichotomy (sickness or disease) has been regarded as being homogeneous. Illness and disease appear easily distinguishable between health discourses related to the medical profession, or lay responses. Fox (1993) comments:

> The sociology of health has been inclined to a distinction between discourses (predominantly biomedical) which concern themselves with 'disease' and others - lay or non-medical - which speak of 'illness' ... so that disease is defined through physiology, while illness is subjective or experiential, and 'sickness' is the social response which surrounds disease and illness (p. 4).

Disease is often represented as a physical or pathological change in the body (Jones, 1994; Radley, 1994). It is defined through physiology as "a deviation from measurable biological variables which represent 'normal' parameters in the healthy body" (Jones, 1994, p. 11), and reflects the practices and philosophies of biomedicine (Fox, 1993; Jones, 1994; Radley, 1994). Illness is seen to be based in nonmedical discourses (Fox, 1993). It is considered to be subjective as it is concerned with the experience of the individual and thus not able to be verified by scientific method (Radley, 1994). Jones (1994) adds that illness is "mediated through the individual" (p. 9), and represents 'feelings' about the bodily state.

Signs are also separated from symptoms (Atkinson, 1995). Signs are something determined by an observer (usually an expert, a doctor or physician) and interpreted in relation to models acquired through training and learning. The symptom is the body account of the client. Thus, disease reflects a "physicians biomedical interpretation of a

disorder", while illness represents the "patient's personal experience of distress" (Kirkmayer, 1988, p. 59). Matters of the social world or the mind (illness) appear to be considered separate from the physiology of the body and the world of nature (disease). The dichotomy is further consolidated because disease is relatively immutable, and contrasted with illness having a dimension of change through its relation to culture. These distinctions are hierarchical, with far greater attention to the production of disease. While disease is linked to the pathology of the body and illness to the social state, the prevalence of a monist view suggests that illness is more correctly the disease *plus* the social attribution (Atkinson, 1995). Illness can be viewed as "an unnatural state of the human body, causing both physical and social dysfunction" (Lupton, 1994, p. 6).

Outside of their formal definitions, the terms 'illness' and 'disease' are often used interchangeably. Radley (1993) suggests that:

> the mixing of these terms in everyday speech arises from the assumption that 'normally' the two occur together. Someone is 'ill' because he or she has a 'disease' but it is possible for a disease to be diagnosed on the basis of bodily signs that the person concerned has not perceived (p. 3).

Health is also discussed in a dichotomous relationship with disease, as 'the absence of disease', but not distinct from it. A person is viewed as being healthy when they can be diagnosed as such. Health is about the alleviation, as soon as possible, of a state of illness or disease. This definition of health reflects a negative view of health (Jones, 1994). Illness and disease have traditionally received significantly more attention by researchers in comparison to health, reflecting the unequal relationship between these concepts. Radley (1994) notes that health is usually only considered when one is ill, and is taken for granted until this point. The linguistic usage of health and illness is further suggested to reflect differences between the two terms; illness is the subordinate opposite to health. "Simply inverting findings about illness will not produce complementary results concerning health" (Radley, 1994, p. 6).

The conceptualisation of both health and illness as having social dimensions has been important to Parson's (1951, cited in Radley, 1994) notion of a sick role. To be sick is to actively remove oneself from the demands of the everyday world and to adopt a social role or status, or conversely to resist labels related to sickness. Inherent in this notion is a belief in authority of doctors to admit people to the 'sick role' by labelling and

legitimising illness (Radley, 1994). This highlights how disease is made more than *just* disease (Fox, 1993). Distinguishing sick from healthy does not occur passively, but rather medical knowledge can be productive and or oppressive (Lupton, 1994). As Turner (1995) adds:

> The manner in which disease is conceptualised will be an effect of the prevailing cultural system and the power structure associated with dominant discourses. The way in which we are sick is culturally defined (pp. 82-83).

Critical to a discussion of lesbian health is the view that through these meaning systems (or discourses about sickness and health), people are positioned within them and subjectivities are generated. Individuals become both constituted and governed through the exercise of power within these discourses (Weedon, 1987). For example, perspectives of 'lesbian' as a pathology meant that once women 'sought help' from a physician, their existence outside societal expectations was legitimized and they were no longer regarded as 'deviant' (Lupton, 1994).

As suggested, understandings about sickness and health (and other objects) are produced through their relation, particularly their difference from each other, rather than their essence. This draws on Derrida's notion of '*différance*'. Power is inherent in difference, and in the structuring of relations between subjects across or within discourses. In a particular discursive field there will be competing discourses, some dominant, others marginal. This notion offers an explanation of the indeterminability of health concepts given "the fundamental *undecidability* which resides in language and its continual *deferral* of meaning, [and] the slippage of meaning which occurs as soon as one tries to pin a concept down" (Fox, 1993, p. 7, emphasis in original). As Radley (1994) explains of medical terminology:

> one of the initial stumbling blocks to a social scientific understanding of health and illness is that as members of Western societies we experience our ailments (and our body in general) in medical terms ... the fact that we experience our illnesses (if not our health) using medical terminology means that these terms carry significance and meaning for us (p. 7).

Wellness is an example of a contemporary notion of health, which attempts to rectify divisions between illness, and disease, by incorporating influences from a broad range of social parameters including lay definitions (Jones, 1994). A notion of wellness is represented in the WHO definition of health which states that "health is not merely the

absence of disease, but a state of complete, physical, mental, spiritual, and social wellbeing" (World Health Organisation, 1974, cited in Jones, 1994, p. 5). The ability of the individual to modify their lifestyles, overcome, and balance environmental and social 'conditions' in pursuit of health goals is seen to be crucial to this perspective (Martin, 1994). This includes diet, exercise, stress reduction, self-affirmation, and the like. In relation to dividing practices, the discussion of wellness still occurs in a dichotomous relationship with biomedicine. There exists a common denominator of giving people control and a sense of self-determination over their lives, and their health (Neubauer & Pratt, 1981). However, unless this individualism is placed in a context of social responsibility, the blame for illness becomes focused on 'guilty' individuals having indulged in risky activities or an immoral lifestyle (an example is HIV and AIDS). Thus, medicine (its practices and knowledge) is constituted through dividing practices, and defines certain people, groups, and locations as appropriate to the concerns of medicine while excluding others.

Assemblages: Lay and clinic

Rose (1994) describes medicine as a set of assemblages, or combination of spaces, people, and techniques in which it is deployed. Spaces for the deployment of medicine may include the hospital and medical centre, but also involve the home, the community and other physical and social spheres (Rose, 1994). The people that produce and are produced by these spaces include medical professionals, and health workers, as well as patients, clients, or 'lay' people. Techniques are not limited to medical interventions (therapies, drugs, behaviours) but may also include those generated by and through 'lay' approaches. The intent is to characterise "the complex and heterogeneous apparatuses - which Foucault termed *dispositifs*[44]- in which activity has been problematised and acted upon in the name of health" (Rose, 1994, p. 51). Different interactions between these aspects of space lead to diversity in the practices and concerns of medicine. A discussion of specifically lay perspectives (in this section) illustrates how clinic space, lay people and techniques produce particular understandings about health. Lay perspectives are particularly relevant to lesbian health given the development of this field of study in predominately non-medical arenas. While dividing practices identify the separation of

[44] Rose (1994) names five *dispositifs* including a medio-administrative apparatus for regulating social space, transformation of home and family into a hygienic machine, medical staffing of population through general practitioners and other medical agents, varieties of hospital, and the apparatus of security which transforms fate into risk.

the space of the hospital from what it is not, and arrange bodies, spaces and gazes in particular ways to produce particular truths (such as the expert), assemblages refer to the opening up of 'new' spaces. As the following discussion highlights, the increasing importance of social discourses and the separation of medicine from the social has made new spaces available for lay or non medical discourses.

'Lay' refers to patients or clients of a health system. It also refers to the space (both physical and social) in which nonmedical gazes, practices, and concerns have significance. It is used extensively in the sociology of health and defined both in terms of epistemology and practice (Lupton, 1994). Here, the concept is often used to express the interaction between patient and doctor (or health professional), in reference to a lay versus medical binary. This apparently 'logical' distinction between health professional and lay person was a starting point for my thesis, in the proposal that lesbian women's conceptualisation of lesbian health differs to the medical profession's conceptualisation of lesbian health. That is, between lesbians as lay people (patients) and medical doctors (and other health providers), the practice, experience, knowledge, and agenda of health and health care operate in opposition or differently.

The doctor-patient interaction may be characterised by differing agendas of the doctor (to perform their professional duties) and patient (to alleviate suffering or pain). 'Lay' is often characterised by an unequal power relationship (Lupton, 1994), in which understandings about it are produced in relation to the concept of doctor or expert. Alternately, the patient-doctor relationship is portrayed as a consensual one, with both doctors and patients responding in ways to maintain social harmony. The doctor is seen as "socially beneficent" (Lupton 1994, p. 7), a perspective which may be criticised for assuming a type of utopia. The activities of medicine are often regarded as impacting beyond the physical walls of the clinic or hospital. Medical views of health and illness arguably dominate public as well as private discourse (Lupton, 1994). 'Lay' may more correctly reflect "the transformation of expert into everyday knowledge" (Burman, 1997, p. 135).

'Lay' experience has been viewed as secondary to scientific knowledge about the body (Stacey, 1994). Lay perspectives of the causes (and treatments) of illness have been termed 'folk' health beliefs or referred to as 'alternative practices', and characterised as

superstition. Folk health beliefs often refer to household remedies, such as chicken soup for colds, or other understandings derived from common-sense notions and beliefs that fall outside of 'orthodox' medical perspectives. 'Alternative health' now describes a more formal set of practices for healing and health maintenance, including the arenas of homeopathy, herbalism, massage, and the like. The boundaries between orthodox medical practices and alternative practices and beliefs are constantly shifting. The recommendations of many general practitioners for the use of St John's Wort for depression, previously categorised as a natural remedy, provides an example of this. Notably its use, and that of other alternative remedies, has been legitimised following scientific analysis. Additionally, the status of an illness may influence the acceptance of lay remedies in the mainstream, as "the more common and less serious the illness, the more likely it is that lay theories of causation and treatment draw upon traditional folk-methods of treating illness" (Lupton, 1994, p. 101).

In the particular dispositif of the medico-administrative apparatus, health and lay experiences have been understood in particular ways. In the context of hospital and medical experiences, a consideration of lay perspectives refers to the experiences of patients or clients or the sick in these settings. Hospitals and health clinics are regarded as regulated, controlled, and managed by health professionals on behalf of and for the benefit of patients. Foucault's notion of disciplinary power is important here. Disciplinary power is described as operating independently of the intentions of individuals (Parker, 1989), although it does seek to monitor and normalise. It is best explained through a penal model of surveillance - the Panoticipan model - featuring a guard tower from which it is possible to view all of the activities of the prisoners. It does not require a guard to be present but ensures a condition or belief by the prisoners, of permanent surveillance. This model is said to "illustrate the placing of power-subjects in relation to authority in such a way that power is not reducible to any intentions to exert power" (Parker, 1989, p. 63). It also explains the conditions through which subjects come to regulate their own behaviour, "thus becoming their own jailors" (Gavey, 1990, p. 145). This is particularly important in discussions of identity groups such as lesbian, who become adept at regulating the behaviour of their own group to protect against small transgressions which make the community immediately susceptible to increased surveillance from the outside. This regulation is exercised in hospitals through patients being told when they can eat, what to wear, as well as having movement around the

hospital limited. Individuals (including outpatients) are often required to expose on demand, be amenable to requests from student doctors to survey and study their body, and participate in procedures for body explorations and other treatments. Many western hospitals have nurses' stations that act as surveillance points in wards, as do other people in multiple bed "suites". For lesbian women and gay men particularly, hospitals also dictate the social environment, laying 'policy' regarding *appropriate* visitors (immediate family and spouse) through often inappropriate heterosexual norms. Docile bodies are produced through this disciplinary power (Gavey, 1990).

The study of lay perspectives has also focused on how communication in a medical setting uses expert language and often refuses colloquial terminology ('vomiting' rather than 'spewing'; 'haematoma' rather than 'bruise'). From a patient's point of view, this may hinder information sharing between patient and doctor (Radley, 1994). Hospital experiences (compared to general practitioner visits) are indicated by patients to be the most disempowering of medical encounters because of the surveillance and control placed upon people in this environment.

As discussed previously, Samuel Delaney (1991) examines academic (straight) and colloquial (street) discourses surrounding HIV/AIDS information in relation to gay men, and also lesbians. He discusses how HIV risk messages take on a variety of forms depending on the context in which they are examined, whether it is the rhetoric of 'straight' medical articles and literature, or in the 'street' during sexual activity in a public 'cruising' place. In his account not only are expert accounts diffused through the social, but the social (as synonymous with lay discourse) is also available to 'professionals'. In this way, social and lay discourses can be obfuscating or disempowering when used to interpenetrate medical discourse (Fox, 1993). Women may be diagnosed as having higher rates of depression than men, since 'depression' includes discourses about women, work, and the nuclear family. There is a need to be wary about falsely separating medical and social discourses or of privileging either medical or social and lay discourses (Fox, 1993). Each discourse is equally valid, situated, and rational.

Here, 'lay' has been conceptualised as an assemblage of persons, spaces (hospital and clinic) and techniques (folk and alternative), which produce particular discourses about health and sickness. The production of 'lay' knowledge reflects the operation of power

through a multiplicity of force relations and processes, the support force relations gain from each other, and the strategies and institutional apparatuses in which they take effect (Weedon, 1987).

Expertise: Psychology

Many types of people and groups have made health and illness their business. These include, as well as medical and nursing staff, particular areas of religion, law, and psychology. Rose (1994) suggests examining the involvement - rivalries, divisions of labour and legitimacy - that different types of expertise have been accorded or given. Here, the realm of psychology is examined as an area of expertise involved in the production of health discourses.

Medicine has often been distinguished from the realm of psychological function, concerning the care of the mind and social relations. This characterisation of a split between the bodily concerns of medicine and the mental concerns of psychology, is an historical one. Schultz and Schultz (1987) suggest that psychiatry (as the scientific investigation of the causes of mental illness) had two main schools of thought in the early nineteenth century. This is between the physical causes of abnormalities in behaviour (somatic), or emotional stresses (psychic). They argue that the former dominated psychiatry, whereas psychology was dominated by the later. The emphasis on memory, fixed ideas, unconscious forces, and the cure of emotional disturbances through the mind rather than the body is reflected in the development of the field of psychoanalysis. Psychoanalysis both developed as a distinct field and influenced the later and slower development of clinical psychology, concerned with the assessment, testing and treatment of abnormal behaviour.

The delimitation of psychology from medicine is not consistent. As a discipline, psychology contains similarities to lay perspectives (and resists medical notions), but has similar standings to medicine in areas such as mental health diagnoses. Social psychology[45] is one of the diverse areas of the discipline that appears less closely aligned

[45] "With a few exceptions, social psychologists regard their discipline as an attempt to understand and explain how the thought, feeling, and behaviour of individuals is influenced by the actual , imagined or implied presence of others. The term "implied presence" refers to the many activities that individual carries out because of his position (role) in a complex social structure and because of his membership in a cultural group" (Allport, 1954/1968, p. 3, cited in McGarty & Haslam, 1997, p. 6).

with biomedical approaches. Yet it offers a useful characterisation of the underlying tensions within psychology. The first conflict discussed earlier is to do with whether psychology locates itself in the pure sciences or social sciences. Orthodox psychology considers itself a science. The emergence of psychology as a discipline was aided by its separation from its philosophical roots and its use of the tools of science (Hollway, 1989; Schultz & Schultz, 1987). Whether it be behavioural, cognitive, or social psychology, the perspectives, methods and reason of science dominate as they do in medicine. Social psychology locates itself closely to other social sciences. The social sciences and arts have radically questioned the critical rationalism and hegemony of science, so aspects of the social psychological tradition exist in tension with these disciplines. Psychology's other ongoing tension is between the importance of the individual mind (and behaviour) or the broader social context as a subject of study (McGarty & Haslam, 1997). Individual behaviour is more likely fodder for scientific or 'psychological scientific' investigation; the social context being the domain of the 'social' sciences, which may include social psychology.

A discussion of homosexuality recognises that it is through the areas of psychiatry, clinical psychology, and sexology in which homosexuality not only came to be known, but was also the subject of study. Contemporary medicine, in the context of this project, is argued to need more than being understood in a social context, but rather it is regarded as "constitutively social", or bound up with the ways that "the very idea of *society* has been brought into existence" (Rose, 1994, p. 54). In a similar way, psychology is argued as using "a disease terminology to characterise socially and politically deviant behaviour functions" (Kitzinger, 1987, p. 32). This is argued to operate as a powerful form of social control of oppressed and minoritized groups who are overwhelmingly represented in psychiatric discourses. Kitzinger (1987) comments that the representation of homosexuality as a disease has been criticised because in its history, psychology has acted to diagnose mental illness in populations who pose a threat to the dominant social order. "The label of mental illness serves, then, to invalidate and depoliticize incipient challenges to the dominant version of reality, explaining them in terms of individual weakness and pathology" (Kitzinger, 1987, p. 33). Notably, as 'positivist' and 'behaviourist' approaches in psychology also rely on notions of individual pathology, the social distinctions between areas of psychology are diminished.

> Contemporary psychology and psychiatry have moved out of the asylum and into the family, the school, the workplace, and the community. The terminology and interpretative schema of psychology, psychiatry and psychoanalysis has invaded everyday speech and forms part of the commonplace, taken-for-granted understandings of the world (Kitzinger, 1987, p. 38).

Medicine and psychology are both bound up in government, rather than being limited to the identification of mental or psychological phenomena. Governmentality is the "political authorities in alliance with experts" (Rose, 1994, p. 54) that administer activities, divisions and locales (spaces and places) to restore or produce health. Rather than arguing that medicine is less important (than psychology) for determining the emotional disturbances of homosexuality, for example, the rivalries between psychology and medicine offer legitimacy in particular contexts. This explains why an apparently psychological perspective has not been taken up in this thesis. Populations of homosexuals are problematized within a matrix of psychological and medical discourses, made available for analysis, and managed through the competing disciplines. The movement of psychological discourses away from the pathologisation of lesbian has the consequence of lesbian being rendered politically innocuous. Psychology has not sought to get rid of, but rather control the political implications of homosexuality.

Technologies: Health campaigns

The technologies of health are described as "technical forms within which one seeks to enact the business of curing sickness or promoting health" (Rose, 1994, p. 52). Health promotion was introduced in the first chapter as a practice that seeks to educate health populations about health behaviour, and bring about lifestyle 'change' to maintain or develop health (and includes participation in health checks). The responsibilities on people to maintain, take responsibility, and make decisions about their health in the context of health promotion differ from other contexts such as the hospital ward. Health promotion is part of public health, which is primarily concerned with disease prevention and the achievement of human wellbeing and potential (Winett, King & Altman, 1989). The goals of health promotion and public health – prevention, improvement of health status, targeted education – are technologies through which political objectives, individual desires and responsibilities are brought together to secure health.

By examining the features of health promotion, this section focuses on the forms it takes achieve its intent. In a structural sense, health promotion has established guidelines for practice and philosophy such as the Ottawa Charter, and Alma Ata Declaration. Contemporary health promotion charters, such as Alma Ata charter, appear to pertain to a community and holistic approach and be more directed towards environmental and social issues (including environmental health, poverty, housing, employment, and food supplies). Postmodern researchers heavily critique such charters (Kelly & Charlton, 1995; MacDonald & Bunton, 1992). This is because the methods and assumptions regarding health and community still appear to rely on modernist theory and positivist research methods (including epidemiological approaches for 'counting' health concerns).

Health promotion relies on a coherent, discernible population. It uses a notion of 'target populations' but in reality, it is directed towards changing the behaviour of the individual. That is, it directs groups - their lifestyles and behaviour - towards health. In this way health promotion constitutes appropriate behaviours (and subjectivities). Public health, however, not only defines the limits of acceptable behaviour, but health promotion in its practice requires self-surveillance. Self surveillance is not limited to groups identified through public health as requiring attention, but is also so for groups such as 'lesbians' who may bring themselves to the attention of public health. The view of health promotion as engaged in the control of individual behaviour and lifestyle maintenance additionally has strong links to discourses surrounding the body as a commodity (Burrows, Nettleton & Bunton, 1995). 'Lifestyles' can be sold to consumer groups - the individual can purchase or adopt different types of lifestyles depending on their purchasing power.

Health education messages have also been directed at 'the community'. Yet these often make assumptions about who the members of that community might be. Daykin and Naidoo (1995) comment, "whilst many health issues (such as coronary heart disease, strokes and cancers) face women, the targets are constructed around male health patterns" (1995, p. 65). Research, they note, often ignores health conditions for women. AIDS symptomatology is a good example of this. Many women receive AIDS diagnoses at a considerably later stage of the disease than men, because the symptoms that women present with (such as high incidence of thrush, and vaginal infections) are not recorded as symptoms of AIDS. In addition, Daykin and Norman (1995) note that health

promotion has relied upon stereotypical taken-for-granted roles and behaviours for women, such as the encouragement of women to be responsible for the health of her children and family. The consequence has been the medicalization of family and home. She adds, "campaigns sought to make the family into a quintessentially 'private space', yet ensured it accepted its responsibilities for securing the 'public' objectives or the social health" (Rose, 1994, p. 66).

Health promotion can be viewed as a disciplining body. In contemporary discourses, the maintenance of 'health' is understood to be occurring in the context of its uncertainty and the potential of the environment for causing chaos. The environment is understood both in terms of the internal (immune) system, and the external (from the body) environment (Martin, 1994). Here, the body is viewed as having the potential to lose control. Public health is regarded by some as an approach directed towards the social control of bodies. In current discourses the perspective of the body as a flexible system has superseded the view of it as chaotic (Martin, 1994). This values the individual's ability to adapt to changes in environment, which may not be distinguishable from a requirement to adapt. Notably, 'ill health' in both these perspectives is regarded as 'deviant'. While the assumption that public health can create 'risk-free' environments is critiqued (Kelly & Charlton, 1995), health is increasingly being viewed as a right for all.

Strategic: Health rights

> In most Western societies, access to medical care is widely regarded as a social good and the inalienable right of every person ... There is a set of expectations surrounding health and the body prevailing in western societies: we expect to feel well, without pain or disability, long after middle-age, we expect all children to survive birth and infancy, all women to give birth with no complications, all surgery and medical treatment to be successful (Lupton, 1994, p. 1).

The strategic dimension of medicine regards "the particular ways in which medical thought and medical activity have sought to realise themselves ... [and considers] the different ways in which political tasks have been problematized and political objectives have been specified" (Rose, 1994, p. 52). The perspective that medicine is strategic means that the relationship it poses between people and activities is no longer a passive or non-partisan one. Various aspects already touched on in the discussion of contemporary accounts of health are brought together here, by the suggestion that

people in western society consider health, and health care, as a normal state and an inalienable right (Lupton, 1994).

The expectation of a right to health is a belief held by the citizens of western society. This expectation is also about living long lives, with few ailments. Health is viewed as a positive value, something to acquire, and aspire to. The 'good' in 'good health' is not a redundant term. It distinguishes from poor health, and reflects values of progress and status. The expectations that citizens of western society hold about health *rights* are inextricably linked to their reliance on biomedicine, viewed as being able to save and sustain life. This presumes and relies on medical advances, such as the achievement not only of organ transplants but also of organ growth. The perspective of 'health rights' is posed against another conservative and value-based argument that proposes that all medical interventions can be funded and death is inevitable.

If health is considered a right, then laypersons are viewed as entering into medical systems willingly, and as such, cannot be viewed as passive. However, 'lay' are often regarded as carrying a moral weight and responsibility for their illness. This conceptualisation draws on the idea of a 'sick role', and appears integral to the view of illness as deviant. Illness, as a potential state of social deviance, is suggestive of "an unnatural state of the body causing both physical and social dysfunction ... a state which must be alleviated as soon as possible" (Lupton, 1994, p. 6). The medical profession has a role in organising people who are viewed as acting (deviant or normal) to maintain harmony and order, and it operates to control the disruptive nature of illness, returning people to their non-deviant, non-sick role. This is supported by the notion of an omnipotent health practitioner. When health is viewed as failing to deliver on these expectations, it has increasingly led to disappointment, disillusionment and, in litigious countries, to legal action against doctors. Patients are regarded as actively and willingly placing themselves 'in expert hands' in the case of illness, as they often wish to be absolved of the responsibility of health decisions.

Baer, Singer and Johnsen (1986, cited in Lupton, 1994) highlight a particularly relevant commentary on contemporary medical practice. Drawing on a political economy perspective with roots in Marxist philosophy, they suggest that good health is identifiable in "political terms ... not only as a state of physical or emotional wellbeing, but as access

to and control over the basic material and nonmaterial resources that sustain and promote life at a high level of satisfaction" (Baer et al., 1986, cited in Lupton, 1994, p. 8). Health therefore becomes inextricably related to human rights and economics. This considers - and importantly for this thesis - the perspective of marginalised groups. In the Marxist approach, the restricted access to health care services and poorer health as a result, reflects how marginalised groups are positioned as not being able to contribute to the equal production and consumption of commodities. Therefore, medicine is seen to perpetuate inequalities. The role of medicine in ensuring that individuals can contribute to society means that medicine can define normality. This approach acknowledges power not as benefactory (as in a functionalist perspective) but as damaging to marginalised groups. Despite some views of biomedicine as politically neutral and good, and seeking to provide more and better services to the underprivileged, its strategic role in social control is iterated.

This framework provided by Nikolas Rose (1994) for a Foucauldian analysis of health, alerts one to the complex interrelation between dividing practices, assemblages, areas of expertise, health technologies and strategies. Through examples provided by the divisions between illness and disease, lay practices and ideologies, psychological expertise, health promotion and the perspective of health as a right, this framework reflects a heterogeneous complex of health relations and practices. The initial discussion of the progression of medicine to its current form has been further problematised by an emphasis on the complexity of relations examined here. The conventional view of the historical progression of medicine is signalled as a narrative of simplicity rather than fact. The moral and ethical imperatives that are diffused throughout the discussion of medicine reflect the operation and management of relations of power. Medical sites, people, activities and thought, have a governmental form through which relations between each are managed and produce health knowledge. This position on power does not quantify power, or prescribe certain forms of power that take precedence in certain social contexts. Instead, power is not certain in any situation and cannot be assumed in advance (Weedon, 1987).

In the second stage of the development of theoretical ideas in this project, there was a deconstruction of medicine as a dominant epistemology. A deconstruction of medicine

or sexuality provides valuable knowledge into the interactions between subjects and objects. Yet a more important goal of the project is to attempt to offer possibilities in which this new complexity of relations can be realised. As the focus of this section has been a critique of predominantly biomedical approaches, it must be noted that alternative models to the biomedical model have been proposed, such as biopsychosocial model, for example. To briefly elaborate, the biopsychosocial model evolved out of dissatisfaction with the biomedical model's lack of attendance to the psychological and social effects of health and illness (Cooper et al., 1996). Posed as an holistic approach to health it is described as having a diverse application and interpretation. It underlies practice models of nursing and social work, and aspects have been developed for application in public health and health promotion. It reflects "the emergent complexity and multiplicity of understandings of health and illness through the inclusion of biological *and* psychological *and* social factors" (Cooper et al., 1996, p. 2. *emphasis in original*). However, even such an alternative is criticised for its parallels with biomedicine despite its attempts to extend itself and to differentiate itself from it (for an extensive discussion see Cooper at al., 1996). In the context of the current project, I considered the exploration of corporeality an important step for further investigating 'lesbian health'.

QUEER THEORY: QUEERING HEALTH

This section explores queer and critical approaches to corporeality. Queer and critical theory builds on the Foucauldian analysis presented in the previous section. This is in keeping with Rose's (1994) assertion that neither his nor Foucault's approach was ever intended to be a crystallised method, and should be a starting place only. The current section introduces queer theory and discusses its characterisation through notions of transgression and performativity. In particular, queer is characterised as attending to corporeality in ways that constitute bodies and sexuality as material and discursive. The contribution of psychoanalytic theories to this analysis is outlined briefly. Finally, the chapter offers a critique of postmodernism.

Queer is part of the language of sexualities. Its meaning and practice change over a number of different contexts, and its theoretical and popular uses both overlap and have distinct understandings. In a New Zealand context, 'queer' is used in reference to theory ('Queer Theory') and has a popular use in relation to the techno-cultures of the late

nineties and early millennium amongst younger gay, lesbian and bisexual communities. Particularly in New Zealand city areas, queer sometimes serves as a replacement for the increasing proliferation of labels and terms, making alliances between gay men, lesbian, bisexual, transgendered and takataapui, with the possibilities of new alliances. For some, it is a response to the frustrations of earlier lesbian, feminist and gay movements, simultaneously contested by the fear of a new queer nationalism. However, its popular use cannot be presumed to be the same as overarching notions of gay identity. Included below is a range of interpretations related to the notion of 'queer'.

> It is a strategy, an attitude, a reference to other identities and a new self-understanding...Both in culture and politics, queer articulates a radical questioning of social and cultural norms, notions of gender, reproductive sexuality and the family (Smyth, 1992, p. 20).
>
> Queer is a form of resistance, a refusal of labels, pathologies, moralities. It is defined more by what it is against than what it is for (McIntosh, 1993/1997, p. 65).
>
> Queer theory provides a critique of the heterosexual assumptions of some feminist theory (McIntosh, 1993/1997, p. 68).
>
> Queer, then, is an identity category that has no interest in consolidating or even stabilising itself ... having no stake in its own hegemony, queer is less an identity than a *critique* of identity. But it is in no position to imagine itself outside of the circuit of problems energised by identity politics ... Queer is always an identity under construction, a permanent site of becoming ... it is more accurate to represent [and theorise queer] as ceaselessly interrogating both the preconditions of identity and its effects (Jagose, 1996, pp. 131-132, italics in original).
>
> Those who knowingly occupy such a marginal location, who assume a de-essentialized identity that is purely positional in character, are properly speaking not gay but *queer*. As the very word implies, "queer" does not name some natural kind or refer to some determinate object; it acquires its meaning from its oppositional relation to the norm ... It is an identity without essence ... not a positivity but a positionality ... it describes a horizon of possibility whose precise extent and heterogeneous scope cannot in principle be delimited in advance (Halperin, 1995, p. 62).

Queer, then, is defined in relation to identities (gay and heterosexual), and is a refusal of these. Queer is understood in relation to these movements. Queer reflects both activism and theory, and it is a new strategy. It is identified as a resistance and a critique, an informed or knowledgeable marginalisation, and a continuous becoming. As Jagose

(1996) suggests, queer marks both continuity and a break with previous gay liberation and lesbian feminism.

> [Queer] is meaningful only in the context of its historical development ... Queer is a product of specific cultural and theoretical pressures which increasingly structured debates (both within and outside the academy) about questions of lesbian and gay identity ... The delegitimation of liberal, liberationist, ethnic, and even separatist notions of identity generated the cultural space necessary for the emergence of the term 'queer'; its non-specificity guarantees it against recent criticisms made of the exclusionist tendencies of 'lesbian' and 'gay' as identity categories. Although there is no agreement on the exact definition of queer, the interdependent spheres of activism that constitute its necessary context have undergone various shifts (Jagose, 1996, pp. 75-76).

As a theoretical position, queer, is suggested by David Halperin (1996), to be a critical approach. This analysis offers the most useful discussion for developing understandings about the application of queer theory and practice in this project. Appropriately, this quote appeared in a student gay and lesbian special issue of a student magazine at the University of New South Wales, where Halperin was teaching at the time.

> 'Queer Theory' designates the branch of lesbian and gay studies that conducts its work in a register of critical theory. In practice, it refers specifically to work that concentrates on the analysis of sexual discourse and that explores such topics as the production and circulation of sexual meanings in society, the operation of sexual norms (homophobia), and the construction of subjectivity. Queer theory often deals with popular media, such as film or video, or social institutions, such as science and law, or cultural practices, such as dance parties and parenting ... it draws upon psychoanalysis, post-colonial theory, feminism, deconstruction, and the uncategorisable work of French philosopher and historian Michel Foucault (Halperin, 1996, p. 18).

Jagose (1996) charts an ideological trajectory for queer theory through the work of Althusser, Freud, Lacan, and Saussure as providing a poststructuralist context through which queer emerges (see Halperin, 1996; Jagose, 1996). Importantly, queer was first coined in relation to theory by de Lauretis; "the coinage was intended to be mischievous as well as scandalously offensive" (Halperin, 1996, p. 18). Jagose (1996) describes Teresa de Lauretis and others such as Eve Sedgwick, Diana Fuss, and Judith Butler as a handful of the queer researchers who are "undoubtedly feminist" (p. 119) and who intentionally attend to gendered sexualities. The work of queer theorists Elizabeth Grosz and Judith Butler is primarily relied upon in this project.

Queer also informs gender. Its relationship to gender, however, is understood in many different forms. As 'queer' (as a theory and as activism) is sometimes regarded as having developed from feminist and lesbian and gay movements, and because its earlier work was often discussed in light of AIDS, queer is regarded as activating a gender neutrality due to its alliance-making, or as presuming a white, male hegemony (Allen, 1997). I would argue that the view that 'queer' hides gender is too simplistic an analysis, and misses its radical potential. Queer is an "unfixed site of engagement and contestation" (Jagose, 1996, p. 129) for the mobilisation of any identity category. Notably, de Lauretis and Halperin both no longer use 'queer' (Halperin, 1996; Jagose, 1996). This is due to a lack of distinction from gay, lesbian, and feminist movements, with the analysis of gender, for example, occurring from within the category lesbian and gay. Halperin (1996) comments on the commodification of queer:

> The 'queer' in 'queer theory' produces a *frisson* of sexual transgression, but at the same time produces a merciful exemption from the inescapably referential terms 'lesbian' and 'gay' (not to mention 'bisexual' and 'transgender'). In this way 'queer theory' can be sexually despecified, purged of its homosexual referents (p. 18).

The impact on identity politics is the notion that it is a cultural fantasy to regard 'queer' as a coherent and permanent sense of self. Attention is therefore towards the *differences* within subjects rather than just the difference between subjects. As Smyth (1992) adds:

> If queer develops into an anti-straight polemic, it will have betrayed its potential for radical pluralism. Nor can you simply substitute 'queer' for 'gay' and masquerade reactionary politics under a radical new guise (Smyth, 1992, p. 25).

However, the potential and intent of 'queer theory' is its offer of a constantly unfolding analysis which constantly also destabilises itself (for an extensive critique of queer see also Allen, 1997; Jagose, 1996; Smyth, 1992). Notably, due to the deployment of queer, there is an absence of discourses of multiple identities in this thesis, for example a bisexual discourse or a discourse of lesbian parents are not specifically claimed here. Nevertheless, the term lesbian is retained. Rather lesbian must be read as no longer a constrained sign. It must be read in queer terms.

The implications of 'queer' theorising relate to whether it is transgressive, and can contribute to social 'progress'. In the previous discussion on health, a Foucauldian approach asserts that sexuality is not simply an object of culture but is the effect of

power (Jagose, 1996). Power is not only viewed as repressive but also as productive, because it offers the possibility of resistance. This is important in the reconceptualisation of sexuality, offering potentially new cultural forms and possibilities. Resistance is seen to be essential to social change. The most controversial of these concerns is the implication that 'queer' refers to a reclaiming of aspects commonly referred under the broadly diverse rubric of 'perversion', including sex between adults and children as legitimate sexual acts, sadomasochism, and so on. Queer is implicated here because in its theory there is concern about the slippage from ethics to aesthetics (Smyth, 1992). While lesbians were already starting to explore themselves as sexual subjects and already engaging in transgressive sexual politics, it was understood that desire, fantasies and sexual politics needed to be discussed without 'policing' (Smyth, 1992). Further to this, and with connections to queer politics, is the notion that lesbians can engage in sexual acts with men, or engage in sex with 'phallus-like' objects and retain their lesbian identity claiming "certain sexual practices as transgressive and politically radical" (Wilton, 1995a, p. 33). Is queer transgression for transgression's sake or does it radically question the moral imperatives that make homosexuality and sexual abuse, for example, appear as if they were the same thing? As Jagose (1996) notes, some of the criticisms against queer question the possibility of social transformation, and argue that it is neither absolute nor incontestable. Additionally, some queer theorising can seem as if all transgression happens on a sexual level. It must be recognised that this is only one area of difference.

> Whether 'queer theory' ultimately turns out to be a reactionary or progressive development will be determined by how the concept is made to work in practice. At its best, 'queer theory' can transform our understanding of the politics of discourse and can revolutionise lesbian/gay thought and action. At its worst, the term can license new forms of academic closetry and heterosexual presumption (Halperin, 1996, p. 18).

Queer theory offers perspectives that have the potential to transform understandings of sexuality and gender. The notion of performativity, attributable one of the most influential and persistently cited queer theorist, Judith Butler[46] (1990, 1993) is key (Jagose, 1996). Butler (1990) calls into question whether gender and sexuality have any ontological or material status other than what is produced on the surface of the body.

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[46] Louise Allen (1997) argues that Butler cannot be regarded as a queer theorist because of the way that Butler mis- (sic) utilises the work of Eve Sedgwick.

The suggestion is that "reality is fabricated as an interior essence" (Butler, 1990, p. 136). These fabrications are, she argues, sustained and produced through public and social discourses. This assertion is about a so-called denaturalisation of gender and sexuality and the category sex, where these are regarded instead as performance. The implications of performativity mean that many of the ideas of sexuality and gender introduced at the beginning of this section, including the notion of the integrity of a gender core (i.e. sex), are disrupted. Butler (1990) explains it in this way:

> If the "cause" of desire, gesture, and act can be localised within the "self" of the actor, then the political regulations and disciplinary practices that produce an ostensibly coherent gender are effectively displaced from view ... If the inner truth of gender is a fabrication and if a true gender is a fantasy instituted and inscribed on the surface of bodies, then it seems that genders can be neither true nor false, but are only produced as the truth effects of a discourse of primary and stable identity (p. 136).

There are some important implications from Butler's analysis. Heterosexuality is widely understood to be a stable and natural quality. Butler (1990), however, regards heterosexuality as effect of a production of discourse, specifically, of the system of dividing sex and gender. She utilises *drag*, or cross-dressing to further highlight anatomical sex as dissonant from sex and performance *and* sex and gender, and gender and performance. "*In imitating gender, drag implicitly reveals the imitative structure of gender itself - as well as its contingency*" (Butler, 1990. p. 137 italics in original).

The queer theories described here, and the work Judith Butler (1990) regarding sexuality and gender, contrasts with the work of social constructionists elaborated on at the beginning of the chapter (Grosz, 1994). In the context of Butler's work, she explicitly elaborates on the body as an important site for understanding sexuality and gender. The very brief discussion of her work here is in sharp relief to the earlier focus in this chapter on gender and sexuality. Relevant to the current project are queries that ask why the meaning of the cervix changes depending on whether the subject realises her body as lesbian or something else, as well as being influenced by the context she is in. If the meaning ascribed to the cervix changes, then the cervix must not be just a biological body part. As the construction and constitution of 'lesbian health care' relies in part on the certainty of a biological body, these realisations about 'the cervix' or 'cervical screening' will have consequences for lesbian health care.

The body

> The human body, in either explicit or latent ways, is ultimately the subject of all research and scholarship directed towards analysing the social dimension of medicine, health and illness (Lupton, 1994, p. 20).

Any exploration of medicine and sexuality must encounter the body. The previous sections have already engaged in discussions that regard the body as the object of health intervention and uncontrollable sexual desire. The body has been presented as material or as social (body politic). Yet, this section needs to address a number of elements concerning these representations of the body.

The first is that the obviousness of the body in positivist social science research on sexuality and health is contradicted by the absence of any real attention to it. It is often absent or ignored. Grosz (1995) reminds us that the body's status as an object appears unquestioned. There is often the presumption that it is fixed and passive, never active, but acted on (for example, by motivations that lead to physical signs of sexual arousal, or as recipient of a virus). In the second, the body is represented in social constructionist and other work influenced by Foucault as a body politic. Here the body is regarded as a product of social, historical and cultural features, and is understood through a dualistic split distinguishing it from the mind. In the final note, the attention paid by feminist theory to problematising binary distinctions like sex and gender re-activates many previously passive aspects of the body, so that it is regarded as productive and active (Haraway, 1991). The potential consequences include a reconceptualisation of understandings about biological determinism (see Haraway, 1991).

In response to the first two points, the body may not have been missing, but there has existed "a conceptual blind spot in both mainstream Western philosophical thought and contemporary feminist theory" (Grosz, 1994, p. 3). This is considered a consequence of dualistic organising in which the body is regarded as 'Other' to the 'Self'. This Self/Other "weaves with other binaries such as masculine/feminine, mind/body" (Johnston, 1996, p. 327), such that the body is present in these texts as 'Other'. As described earlier, the body that translates with ease into medicine is a mechanistic, mechanical object, but frail. It is associated with nature, object, passion, irrationality, femininity, and non-

consciousness. In contrast, the mind is conceived in positive terms, such as culture, subject, reason, rationality, masculinity, and consciousness.

Where the focus is on the social aspects, the body is conceived of "as a surface on which social law, morality, and values are inscribed" (Grosz, 1995, p. 33). The implication is that the body can be understood simply as 'raw material' (Johnston, 1996) on which the subject or an interiority is 'marked'. This is a process engaging various regimes and institutions of power and discourse. Even aspects of morality and memory that are the concern of traditional realms of psychology, are not viewed as inherent features of humans, but are etched on or constructed (Grosz, 1995). In this way, the subjectivities (or bodily interiors) are decipherable by reading the apparently expressive body surface such that the body is conceived as "an exterior upon which the mind or soul forges a public face" (Fox, 1993, p. 23). No longer able to be considered to be a given reality, the body is produced via the ways in which it is controlled and its activities are regulated (Lupton, 1994). The kinds of knowledge that the body is a product of are always subject to change.

This discursive body or 'body as a surface of inscription' provides a range of accounts of the body. A discourse, which regards the sociopolitical body as representative of and constituting an economic system, does not presume that the body itself is laden with value but rather that civilisation reflects processes in contemporary western society of its increasing commodification and prizing. Value is given to those bodies that represent work, through grooming, exercise, surgical augmentation, or removal. In this way, bodies that are disabled, aged, or unfit, have less value placed on them (Lupton, 1994). In the New Zealand medical system, the commodification of the body was strikingly represented in the Core Services proposal (Ministry of Health, 1996). This proposal sought to suggest a prioritisation of health care for those individuals whose lifestyles represented the most value. That is, in the core services definition the most eligible for health care were those not engaging in 'health-risk' behaviour such as smoking and high alcohol use, and or who had a valued social role, a parent for example.

Any disturbance to the economic or social system is described here by Turner (1995):

> The dominant metaphor of social, political and medical disturbance is the body and its equilibrium. The threat of an epidemic for the social body was conceptualized within the framework of disturbances to the

> body politic; there was a close parallel between the notion of conflict within the human body from a medical perspective and the larger political vision of authority, legitimacy and power for the society as a whole (p. 83).

As a discipline, medicine seeks to control bodies and "literally discipline" them (Fox, 1993, p. 24). The normalisation of bodies occurs through surveillance, control and regulation already evident in the accounts of homosexuality, and the kinds of intense medical scrutiny, from craniology to genetics, to which homosexual body has been subjected (Lhomond, 1993; Wilton, 1995a). Lupton (1994) argues that attempts to identify the homosexual body reflect attempts to control this body, so that it functions mainly through "external regulation, supervision, and constraint" (Grosz, 1995, p. 2). The body is therefore conceived of as a series of relative constructions and practices that control and represent it (Fox, 1993; Lupton, 1994). In public health and medicine, sexuality raises not only the debates around competing discourses such as biological determinism versus social, but remains "a constant reminder that humans are embodied" (Lupton, 1994, p. 24).

Medicine constitutes just one of a number of contexts in which the body becomes marked and territorialised. The physical body is regarded as a map for the social body (Douglas, 1966). Other contexts of the civic and the public further identify processes by which bodies and identities become understood through geography. Mohanram (1999), for example, discusses the nationalisation of bodies, which are reflected in concepts of the citizen, or 'queer nation' and 'lesbian nation'. These discursive and social bodies are explored in later sections of the thesis.

Lived bodies, sexed bodies

As the work of Robyn Longhurst (1996) on pregnant embodiment attests, not only are bodies always interpreted through history and culture (such as the constitution of 'appropriate' behaviours for pregnant women), but also the ever-present physicality and materiality of the body in its changing shape and activities cannot be denied. These bodies are also gendered, as the cultural, historical and social aspects on which meanings about the body have been premised, have assumed a rational or masculinist, able-bodied, white body.

There are a number aspects of this approach that distinguish it from social constructionist approaches. Former analyses left the raw material body intact and the centrality of the mind and the ontological status of the body apparently unchallenged in the mind body dualism. The body had been conceived of in very limited terms. However, the regard for the lived body changes the centrality of the mind through a reconfiguration of subjectivity via the body (Grosz, 1994). The proposal is suggestive of the body having all the explanatory effects of the mind. The body is not regarded as active or passive, but as constituting systems of meaning and signification (Grosz, 1994). The body must not be considered as 'raw material', nor should it be conceived of a purely discursive, but as both in a continually rearranging relationship. What is critical is the sense that rather than dismissing mind or body, permeability is key. These aspects leak into each other. Mind and body are neither distinct nor indistinct. As Grosz (1994) suggests, the body is a cultural interweaving and production of nature but also:

> there is a commitment to the notion of fundamental and irreducible differences between sexes (which does not amount to essentialism, for there is a whole hearted acknowledgement, even valorisation of differences between members of the same sex rather than an uncritical acceptance of universalist essences or categories) (p. 17).

In this view, the inscribed surface of the body is not neutral, but rather based in differences. This is of course distinguishable from the notion of male and female difference. Differences refers to the domination of one particular mode of representing the body (as male, white) as achieved through and bound up in multiplicity of processes of desire, signification, contestation, and struggles over knowledge, economics and politics (Grosz, 1994). Grosz (1995) agrees with Butler that sex is the terrain of the production of sexual differences, and against Foucault who regards it as the marking of two sexes in their difference. Differences must be based in notions of alterity or sameness and otherness, but these differences are multiple, and constantly contested (Grosz, 1995).

The concern with lived, sexed bodies is the consideration that 'natural' processes such as pregnancy, or considerations of health or sickness are "socially required, produced and regulated" (Grosz, 1995, p. 36; Longhurst, 1996). Because of the social and cultural production of bodies, 'lesbian bodies' are also possible. These bodies become interfaces between politics and nature, mind and matter. They are already material, imbued with constructions and particularised meanings. Bodies here "become sites of struggle and

resistance, actively inscribing themselves on social practices" (Grosz, 1995, p. 36), and engaged in the production of gendered, sexualised and medicalised subjectivities. The intention is not to deny that there is sickness nor deny that lesbians exist, but rather to explore these as representations that quite literally constitute bodies and are constituted by them.

The consequence is the realisation that bodies are never 'just' their biology. Bodies have material limits (i.e. we cannot fly and we do die), but through culture and technologies, bodies are continually remade. In health and fitness, this is reflected in the marketing slogans to 'become some body'. Also in health concepts such as wellness (defined as a balance in mind and body) there is a recognition that one can be unwell even without determinable physical or mental diagnosis (as sometimes discussed in accounts for example of tapanui flu or ME).[47] This is a concept of subjectivity in which sexuality and health are no longer end products, but processes of becoming. Their effects are explained in Chapters Five, Six, Seven, and Eight.

Grosz (1994) suggests a number of strategies for an analysis of embodied subjectivities and corporeality. Already mentioned is the avoidance of mind body dualism, and no longer associating corporeality with one sex as reducible and containable within a set of sex characteristics. She also comments that there is a need to refuse all models (including monist) based on the perspective that there is only one kind of body. She concludes her points about the avoidance of essentialism, and a dis/articulation of the relationship between mind and body and interiority and exteriority, with the suggestion that the body must be regarded as a threshold between binary pairs.

> The body can be regarded as a kind of *hinge* or threshold; it is placed between a psychic or lived interiority and a more sociopolitical exteriority that produces interiority through the *inscription* of the body's outer surface (Grosz, 1995, p. 33, italics in original).

As a final comment, Weiss (1999) explains that there are constraints in viewing 'the body' in this lived way because of the continuing use of the definite article. In the discussions about 'the' body throughout the thesis, I ask the reader to regard the body as a lived

[47] This is not to suggest that wellness reflects a lived body approach. In fact, the concept of 'wellness' is often criticised for its reliance on a stable, material body. However, it is used here as an example of its explanatory potential in the understanding the processes of becoming and representing health.

phenomenon, and not, as Weiss (1999) comments, to continue to read it as fixed and neutral.

> The danger of viewing the body as a singular entity is that we may lose sight of the fact that the body is never isolated in its activity but always already engaged with the world ... also to use the definite article suggests that the body and body image are themselves neutral phenomena, unaffected by the gender, race, age, and changing abilities of the body. Put simply, there is no such thing as "the" body (p. 1).

Psychoanalytic bearings

I have included psychoanalysis in this section about queer theory since key queer theorists like Grosz (1994, 1995) and Butler (1990, 1993) rely heavily on psychoanalytic theory in their analyses. Liz Grosz is a philosopher who draws on and has written extensively on Kristeva, Irigaray, and Le Doeuff (see also Grosz, 1989). There are, of course, many traditions of psychoanalytic theory. The main approach attempted in this thesis is not a psychoanalytic one, but it draws strongly on work by Kristeva and Irigaray, and on Butler and Grosz's interpretations of their work.

French psychoanalytic and deconstructivist feminists such as Kristeva and Irigaray[48] have taken psychoanalysis as an object of investigation, as phallocentric knowledge (Grosz, 1995). Grosz (1994) describes Kristeva and Irigaray as difference feminists. This is the result of their attention to women's autonomy, sexual specificity, and femininity in order to challenge patriarchal preordained positions that locate women only in relation to men (Grosz, 1989). Their perspectives developed in response to earlier work by Freud and Lacan (see Brooks, 1997). Grosz highlights, for example, three significant contributions from the work of Freud, refined by Lacan. These are "his (Freud's) notions of the ego, his conception of sexual drives, and his accounts of psychical topography" (Grosz, 1994, p. 27). Kristeva's work, in particular, seeks to link the work of Saussure on language and signs, to the work of Freud in his development of a theory of the unconscious and of human sexuality (Grosz, 1989, p. 194).

Irigaray's central thesis is that "language and systems of representation cannot express female desire" (Brooks, 1997, p. 78). Kristeva's work, however, takes into account the

[48] Kelly Oliver (1993) addresses Anglo and American audiences noting that these theorists have a more complex relationship to the title "French Feminists" than may be represented by it: as a country of origin, neither were born there, and the (European) French language is not their first nor their mother-tongue.

presymbolic realm (Brooks, 1997) or the "preoedipal processes of drive organisation in which the figure of the mother structures affect, as opposed to oedipal episode structured by the lawgiving father" (Young, 1990, p. 143).

> Both the semiotic and Symbolic are necessary for the continuing functioning of the three orders of human existence Kristeva is concerned to link: the psychical functioning of the individual; the ordered and ordering structure of social institutions and ensembles; and the coherent meaningful functioning of discourses and texts (Grosz, 1989, pp. 194-195).[49]

What remains is the undisputed notion that psychoanalysis has contributed to understandings of the body as a biological entity and as a psychical, lived relation. This is particularly so, as argued by Grosz, in relation to the ways in which "the psyche is a projection of the body's form" (Grosz, 1994, p. 27). In her advertising-like slogan Grosz notes that "psychoanalysis is uncontestably the great science of sexuality as drive" (Grosz, 1994, p. viii). Psychoanalysis conceptualises the body outside of a mind/body dualism, and remains a challenge to Cartesian thinking in the space commonly referred to as Western philosophy. Thus psychoanalytic theorists have been characterised as contributing significantly to understandings surrounding subjectivity, desires/drives, and the unconscious (Grosz, 1989). In particular, the development of these ideas by feminist theorists towards gendered notions has been critical (Brooks, 1997).

Reliance on the interpretations of Grosz and Butler over psychoanalytic theory holds the risk of oversimplifying psychoanalysis, or appropriating its use by avoiding it on its own terms. This is a recognised tension. It is often difficult in the arena of queer theory to distinguish psychoanalytic theories within feminist and critical approaches to the body, as theorists located in the latter two have taken psychoanalysis as an object of study and/or critique. In psychology and discursive psychology I would suggest that psychoanalytic theories are likely to be viewed as just a tool. That is, psychoanalysis is posited as a binary opposite (and with seemingly less importance) to discourse approaches. It is a risky project at once deconstructing and reconstructing a binary between the two positions. I would be critical of the appropriation of psychoanalysis in this way and have attempted in this thesis to not posit it in direct opposition to discourse analysis.

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[49] Kristeva distinguishes Freud's Symbolic from what she terms the semiotic. The latter refers to a pre-oedipal sexuality which is the pre-signifying, or unspoken and unrepresented conditions of signification. Symbolic on the other hand refers to "the order of social and signifying relations, of law, language, and exchange" (Grosz, 1989, p. 194).

When the inscriptive surface is black not white

The location of this work in New Zealand holds particular understandings related to cultural difference and colonisation. The particular context for this discussion reflects Maori and Pakeha in a discussion of the presumptions about corporeality and sexuality, and ontological assumptions about health. The intention of this section holds a number of competing themes, which will be introduced here but not resolved.

As suggested in Chapter Two, much of the enquiry related to lesbian health suggests that attention is needed because lesbians are invisible and assumed to be heterosexual in the context of health, with (often presumed) significant health consequences. Yet, this perspective suggests that the kinds of experiences related to lesbian health care can be distinguished from those of heterosexual women. The broad area of research which considers health consequences for 'women of colour', Maori, Aboriginal, or indigenous peoples is overwhelmingly absent. Sexuality and ethnicity have been regarded as constituting discrete bodies. In the first instance, Weiss (1999) explains that the continuing use of the definite article appears to places constraints on viewing 'the body' as lived. The desire to work from notions of corporeality must not presume that 'the' body is monolithic.

This is not to say that accounts by or of Maori gay or lesbian are completely absent from the New Zealand frame. Ngahuia Te Awakotuku's narrative and essays *Mana Wahine Maori*, Witi Ihimaera's (1995) novel *Nights in the Garden of Spain*, and Georgina Beyer's presence in popular media as transsexual member of parliament are a few examples. However, Maori corporeality is constituted predominately in relation to nationhood. The corporeal relationships of Maori gay and lesbian reflect differences from Pakeha (particularly of European heritage) who may be more generally represented in terms of the perspectives presented above.

This relationship of Maori to nationhood has been explored in Radhika Mohanram's text *Black Body* (1999). There are a number of important elements to her discussion. The first is that in New Zealand, the location of Maori in relation to corporeality is present in Maori practices. By referring to the Maori practice of burying the whenua (placenta) in the whenua (land) she evokes a familiar discourse of 'native' as having a strong affiliation

to 'the land'. Maori concepts about land and family (whanau), hapu, and iwi[50] are integral to health. Health[51] is the responsibility of the whanau, iwi and hapu. Land is inextricably linked with health to the spiritual past, and to the present and future as a standing place and nurturing place for growth from one generation to the next. Mason Durie (1994) describes the whare tapa wha model of Maori health, which is well known, and reflects the perspective of health as constructed in a number of interacting 'variables'. The whare tapa wha model "compared health to the four walls of a house ... taha wairua (the spiritual side), taha hinengaro (thoughts and feelings), taha tinana (the physical side), taha whanau (family)" (Durie, 1994, p. 70). A later model, nga pou mana, described four supports, which were pre-requisites for health and well-being.

> The four supports - family (whanaungatanga), cultural heritage (taonga tuku iho), the physical environment (te ao turoa), and an indisputable land base (turangawaewae) - brought together social, cultural, and economic dimensions (Durie, 1994, p. 76).

By not simplifying the relationship of Maori health concepts to land, family, and spirituality, Mohanram addresses the multiple meanings that the practice of burying whenua has in the context of the confiscation of Maori lands in breaches of the Treaty of Waitangi and in the context of the dispossession of Maori by Pakeha from their lands. The potency of land is that it works to assign an individual identity as well as indicate places amongst ancestors and kin (Mohanram, 1999). Identities in relation to the land are highlighted, maintained and resistant to breaches of a Treaty, the original intent of which was to make New Zealand a state and part of the British Empire.

The consequences and relationships of this activity also are reflected in the use of such notions as biculturalism, and the activism of Maori in sovereignty, nationalism, and feminist endeavours. Mohanram (1999) argues that "the centrality of land rights to indigenous Maori ... allows Maori to demand the definition of the state as bicultural or multicultural" (p. 94). Biculturalism signals a distinct notion of identity for Maori and

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[50] Hapu refers to kin-groups or sub-tribe; iwi refers to tribe

[51] Maori health perspectives have often been denied, and 'health' has been controlled and defined by western systems. Maori have been indicated as having poorer health than Pakeha on the majority of health indicators, and Maori have been made responsible for this through the perspectives of deviance and individual responsibility for health. Maori health problems are stigmatised (Durie, 1994). In the current health system, Maori have to compete with all other groups for funding. Where Maori health initiatives are supported they are significantly underfunded (Erihe & Herewini, 1988), or comparable Pakeha services employ Maori health workers under the guise of 'health for all'.

Pakeha in a postcolonial context, and reflects the relationships that are expected to occur in lesbian and gay communities.

Again, the importance of Maori nationality, and biculturalism offer re-evaluations of corporealities. Historically, the Tohunga[52] Suppression Act 1907 recognises other health approaches were regarded so threatening to society that they were legislated against (Durie, 1994). The accounts of new diseases brought by colonisers recognises that diseases serve as a regulatory process, that because the histories of management lay with the colonisers, this also served to reinforce the sense that western knowledges related to health and its care were superior to those of Maori.

Concerns of Maori women cannot necessarily be considered separately from issues in Maori health. Pakeha feminists have been criticised for separating out concerns for Maori women, and linking these to feminist debates rather than issues of racism for which Pakeha feminists are not exempt from being culpable. Maori women, however, have considered issues of women's health for themselves (Murchie, 1984) and noted concerns about poor health.

Maori have particular cultural, historical, and social locations in relation to health, which have been articulated in public health settings. The history of ethnicity in gay and lesbian movements has meant that many Maori and Pacific Islands peoples were disenfranchised from these movements, or had other pressing concerns, before any queer developments. In New Zealand, Maori have often worked together in communities in ways that are not obvious to the ethnocentrism of Pakeha-based movements.

Critiques of postmodernism

Concerns raised about postmodern theory in relation to political action must be considered since "if research is not carefully theorized it *may contribute as much to the problem it seeks to solve* as it does to a politically sensitive situation" (Gavey, 1990, p. 17, italics in original). An example of these concerns is raised in the issue of difference. Difference is

[52] Tohunga refers to an expert or priest (Melbourne, 1995). In *Whaiora*, Durie (1994) also refers to tohunga as healers, who were forced underground as a result of the Act, and whose skills in areas such as "rongoā (traditional Maori treatments) and karakia (rituals such as prayer)" (p. 46) lost value during this time and even after the Act's repeal in 1964.

considered as having the potential to depoliticise feminism, particularly where it "may become a substitute rather than a starting point for resistance" (Burman, 1996, p. 214). The suggestion is that sexuality may simply become an issue of difference rather than the point at which the constructions of difference or equity are considered. It must be noted that postmodern theory relies on "our privileges as academics to give voice to what Foucault terms 'subjugated knowledges'" (Lather, 1990, p. 72). The question of how we deconstruct the ways our own desires shape the texts we research is crucial (Lather, 1990). The responsibility of careful theory for successful political action must be considered.

Postmodernist augmenting of a position that values fragmentation and multiple voices or truths, rather than vocality (Fox, 1993), is charged with creating a schizoid subject (Lather, 1990) which also paralyses political motivation (Burman, 1996). Postmodernism, it is suggested, will launch us into anarchy and nihilism that in the context of social justice may produce a sense that there is no hope or change. It is clear that as researchers we are involved in discursive production in an attempt to produce some coherence and consistency; however questions are raised about what accounts for predictability or repeated positioning in discourses (Hollway, 1989). Burman (1996) advises that we will lose the material and historical basis of oppression by forgetting to treat the discursive as a *purely* symbolic relation.

Whether the use of postmodernism with marginalised subjects is responsible remains in question. Fox (1993) compares the postmodern responsibility to otherness, to a modernist responsibility to act. Many would argue that the responsibility to act is paramount. Yet, histories of colonisation may highlight that action, without a responsibility to competence or safety, might not be a good thing. It is important to note that research is not innocent of the will to power or the desire to understand and change (Lather, 1990). Research is indelibly political (Gavey, 1990). While postmodern theory does not adequately answer for some researchers contentions about language, elitism, and effectiveness as a tool for social and community action, it is able to be used by the powerful (that is, who may speak and whose discourses are legitimately heard) to deconstruct their own praxis. The risk in deconstructing our own practice, is that it may lead to "our own work having less political impact than texts which stay within traditional authoritative modes" (Gavey, 1990, p. 21).

Nicholas Fox (1993) suggests that postmodernism generates a requirement for a different attitude towards politics and ethics in terms of how one uses some of the contested questions of social theory (subjectivity, knowledge, power and the social itself) to engage practically with the world. He argues that:

> what postmodernism and poststructuralism have disclosed is not their own lack of political and ethical allegiances, but the failure of modernism to generate a morality which does not reflect partial, political interests (Fox, 1993, p. 121).

CONCLUSION

This chapter makes several assumptions about heath and lesbian sexuality. Lesbian health appeared at first glance as an area of study and research, important for the wellbeing and advancement of the status of lesbians. While the previous chapter drew attention to limitations in lesbian health research, the premise for researching health needs retains the assumption that lesbians have the potential to become 'ill' with specific conditions, and that health holds status, has lived importance, and raises legitimate concerns for lesbians. Concurrently, this chapter has focused on making sense of the trajectories of this thesis, including its developments following data collection. It has outlined epistemological approaches that have guided understandings about sexuality and health in either a discursive and or a material sense. It has sought to explore how 'lesbian health' could benefit as a field of study, a lived embodiment, a set of practices, and subject positions by addressing assumptions in gay-positive research, and utilising analyses offered by discursive, deconstructive and critical and queer approaches.

Writing about medicine as the cornerstone of work about health and the body has a risk of reinstating medicine as being wholly dominant in this area. Making explicit the perspectives and assumptions that underlie 'health', and asserting that it is not an unmediated knowledge but is based in subjective understandings of the world, is important in the process of changing and unsettling 'medicine'. It is also suggested that opening out historical and social analyses of discourses can explain how power and resistance are produced, leading to new discursive positions. Attention to the multiplicity of power relations and corporealities in discourses about sexuality and health is important to this thesis, acknowledging that health research has often been "blind to the range of points of resistance inherent in the network of power relations, a blindness which impedes political resistance" (Weedon, 1987, p. 124).

CHAPTER IV

HANGING OUT THE RESEARCHER'S SHINGLE: [53] METHOD/OLOGY

OUTLINING METHOD

> While the debate [on qualitative enquiry] has advanced, qualitative work continues to bump into ethically messy territory. Listening to qualitative data requires that researchers be willing to change hunches or hypotheses. We may be surprised, perhaps embarrassed. We will look naïve (Kidder & Fine, 1997, pp. 46-47).

Miles and Huberman (1994) open their book on *Qualitative Data Analysis* with the statement: "qualitative data are sexy" (p. 1). My high school physics teacher who used to declare that "quantum mechanics is *beautiful*" might well disagree, particularly with their assertion that it is words, not numbers, that provide rich and deep material. I would add that if 'being sexy' incorporates a considerable sense of a faltering, uncertain body as indicated by Kidder and Fine (1997), then I too might tout qualitative method/ology as sexually and sensually embodied.

It is not uncommon for researchers in the social sciences to still have to promote or defend the use of qualitative method/ologies, often in the context of debates surrounding postmodernism and positivism. Qualitative method/ologies are sometimes misconstrued as no longer belonging to positivism. There are many forms of qualitative work. I employ a critical approach in this thesis (influenced by feminist, postmodern and poststructural approaches) which, as argued by Kidder and Fine (1997), is not necessarily "co-terminous" with or automatically yielded by qualitative methods. Where method in the tradition of modernist psychology is separated from theory (Hollway, 1989), in a postmodern and critical theory approach the conventional distinction between ontology and epistemology disappears (McDowell, 1992). This thesis will therefore begin to reflect some structural differences from traditional research projects in psychology.

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[53] Hanging out one's shingle is an expression of a professional act of being - one has a plate or shingle to advertise one's place of work. Psychologists enter the debates about professionalism in many ways: i) in New Zealand by being able to use the title 'psychologist' without being a member of a professional body, and contrastingly ii) by developing research practices monitored by 'guidelines', from the American Psychological Association (APA). I use this phrase deliberately to unsettle and as an allusion/illusion to professional practice, as the research 'practices' described here do not fit with established APA guidelines.

Kidder and Fine (1997) suggest that there are particular features of qualitative work which facilitate critical analysis. These are: i) assuming an open-ended stance where research questions are necessarily revised; ii) reflecting on subjectivity and bias, including that of the researcher; iii) worrying about relationships, with respondents and communities; and iv) analysing open-ended questions and writing kaleidoscopic interpretations. These features are all explored in detail throughout the chapter. However, I want to comment that this 'strategy' forms a platform for further conversation rather than reifying the approach undertaken.

This chapter is divided into three main sections. The first section outlines the method of the current thesis project.[54] It is a description of the snowballing, participant selection and interviewing processes used. Interview was the method of choice, focusing on meaning questions (phenomenology), and descriptive questions about experiences, values, beliefs, and practices (Morse, 1994). The invisibility of lesbians makes it obvious why, for example, an alternative ethnographic approach observing lesbian women in health care environments would not work easily and was not undertaken. The second section describes the analysis of data. There are two approaches referenced here - discourse analysis (Burman & Parker, 1993; Potter & Wetherell, 1987; 1994) and critical theory on corporeality (Grosz, 1995). The third section comments on the epistemological assumptions that underlie the method focusing on issues of representation, positionality, and reflexivity.

In undertaking this project, I continually reassessed the methods employed. While the discussion of the participant selection, interview methods and discourse analysis are written as two separate sections, this is for the purposes of clarity. This chapter produces an embodied account of the research process, resisting hegemonic constructions of knowledge as objective (Johnston, 1998). The actual process of this project represented a number of shifts in my thinking which do not necessarily reflect an ad hoc approach to method, but can be considered part of the dynamic approach where research processes are engaged in and developed as they occur (Stanley & Wise, 1993). For example, the development of interviews was considered a process where subsequent interviews could build on the previous one (Morse, 1994). This is, as Kidder and Fine write (1987, cited

[54] This research project was approved by the Human Ethics Committee, Department of Psychology, University of Waikato, which is guided by the Code of Ethics of the New Zealand Psychological Society.

in Kidder & Fine 1997), an approach that does *not* require each participant to be asked the same questions. Rather the research and interview questions changed as the research progressed.

Preliminary workshop

I began the process of collecting data by running a workshop at the Lesbian Studies Conference (Victoria University, Wellington) in October 1993. The workshop was intended to facilitate discussion around a set of questions related to lesbian health. I informed those attending that I was developing this into work for my thesis. The workshop was an opportunity to explore some preliminary questions and areas for discussion. These included relating experiences about i) identifying as lesbian in relation to health care, ii) current health concerns, iii) health information sources, and iv) options for health services. To prepare, I categorised key studies on lesbian health into subject areas (similar to a three-page version of the literature review in chapter two), and presented this to the group prior to discussion. The workshop therefore engaged in information exchange. The workshop participants were all women who had chosen to attend a lesbian conference.

I used my impressions from the workshop to develop my theoretical and interview questions further. The workshop was an attempt to 'get a sense of' the possibilities of the research without foreclosing. The specific thesis developments that resulted from the workshop were mostly about expansion of all areas explored. For example, I had initially intended to research lesbian women in a specific age group only (20 to 30 years old). However I consequently realised that this could have provided repetitive textual material that was not sufficiently rich for analysis. I did not carry out any further preliminary interviews. I felt confident with the development of the method at this stage.

Snowballing participants

Women who identified as lesbian were invited to participate in the research. I employed a modified snowball approach, which utilised informal lesbian networks, to solicit participants. Snowballing is described as a helpful technique to access people in "sensitive" or "hidden" populations (Watters & Biernacki, 1989). It has been used extensively in previous studies with lesbian communities (Hitchcock & Wilson, 1992).

Snowballing asks participants to nominate other people to the researcher. New participants are invited to the research in a chain of referrals (Heckathorn, 1997; Welch, 1975). Thus it is also called the referral or chain referral method (Watters & Biernacki, 1989; Welch 1975). Privacy (and legislative[55]) considerations meant that participants were asked to seek agreement with the potential interviewees before any details were passed to me.

I considered the snowball method to be a pragmatic approach to accessing participants in Hamilton, New Zealand. Hamilton is New Zealand's fourth largest city, traditionally represented as a rural city. At the time of planning and data collection (July 1994 to February 1996) there were limited local, formal 'lesbian' or 'gay' community networks, with no publicly accessible newsletters or mailing lists. Dances were organised occasionally for lesbians (one to six a year), and there was (and remains) one local gay bar which caters predominately to men.

My criteria for participation in the study were broad. I used age-based criteria to establish initial contacts with participants. It was around age that most people appeared to be grouped in Hamilton and this was reflected in informal social groups, which met occasionally. These included Queers on Campus - a Waikato University based 'club' which was run by and for students predominately aged 16 to 25; and POLLY (Proud Older Lesbians Like Yourself) - established for lesbian women aged 40 years and over. I approached women in the twenty to thirty age group using my own informal lesbian networks, and contacted other women to help me approach women in the below twenty, thirty to forty, and forty and above age groups, respectively. I have termed them *linkpeople.*[56] There was at least one linkperson per age grouping. As POLLY provided me with a place to contact lesbian women aged forty and above, I retained this age grouping for the purposes of this project, although none of the participants were at any time confirmed to be members of any of the social groups mentioned.

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[55] The New Zealand Privacy Act (New Zealand Government, 1993) requires that in certain institutional settings personal details about individuals are not passed on to a third party without consent.

[56] The dictionary term linkman is defined as "a person providing continuity in a broadcast programme" (Tulloch, 1997, p.889). It is also a player description in football. I have used this term in preference to 'targets'.

Therefore there were two main ways in which participants were invited to the research - via interviewees, or via linkpeople. The linkpeople were invited to be interviewed but fulfilled a more formal role in identifying and asking potential participants than the interviewees. The linkpeople effectively widened initial contact areas for snowballing, as described above. The linkpeople were given copies of the research introduction (Appendix One), research information (Appendix Two), and consent forms (Appendix Three) so they were informed about the research. I spoke with each linkperson indicating that I was interested in interviewing a range of women with a range of experiences - the examples I gave included family, occupation and/or major activities, health, and participation in lesbian communities. The linkpeople were asked to keep these in mind as they approached people about the research. In all cases participants agreed to be contacted by me, and receive printed information about the research (see Appendices One to Three).

The decision to use linkpeople, and the identification of broad features for participation in the project, marks a stage of expansion occurring shortly after the first four interviews were completed. A discussion of the specific issues surrounding this mid-thesis expansion is considered here with a critical look at the snowball method.

Considering my interest in the deconstruction of deviance, the snowball method is, ironically, recommended for research in communities where "membership involves stigmatised or illegal behavior" (Heckathorn, 1997, p. 174). Retrospectively, I engaged a method that is often used to access 'other' populations, with the advantage that it relies upon an understanding that traditional sampling methods have limited access to these groups. Surveillance and appropriation mean that lesbian and gay communities are more likely to be involved in an event or activity (including research) if - as discussed in the lesbian health literature - it is 'gay-friendly'. There is a greater perceived sense that gay or 'friendly' people will understand the cultural ethics of lesbian/gay/queer communities. Snowballing allows for additional information and verification (including 'friendliness') by potential participants, because it contains a sense of the word-of-mouth or personal approach. Aspects surrounding the advantages of this method must be understood as assumptions also - including the belief that if you have access to informal networks, you have an understanding of the cultural ethics.

Kate Paulin, a colleague and peer at Auckland University was undertaking a PhD in the area of lesbian/bisexual politics at the same time. Kate also used a snowball approach, and encountered a similar need to expand the method. She writes:

> because I chose the pragmatic strategy of a snowballing technique for contacting participants, beginning with women I knew, most of my participants were Pakeha (and university educated)...(*there was*) a homogeneity in age, education and ethnicity created by my snowballing techniques...I began organising to gather narratives from a much more diverse set of participants: working-class, non-university educated and Maori (Paulin, 1996, p. 205).

The homogeneity of the participant group had been highlighted as a potential problem throughout the lesbian health literature and I did not want to replicate this in the current study. I sought to collect an increasing rather than a decreasing array of interview material, selecting for diversity rather than replication. Homogeneity in this study now refers to the interview or textual material rather than a set of so called 'demographic characteristics'. While a demographic description of the participants is outlined in a later section, the characteristics described here are redundant in their traditional roles of 'ensuring a population mix'. It was not my intention to gain a representative sample of a population. Yet, there is longstanding concern in the empirical literature on research methods that snowballing results in 'sampling biases', and prominence is given to the resolution of "bias" (Heckathorn, 1997; Watters & Biernacki, 1989; Welch, 1975). The emphasis on 'bias' caused me to reflect on my use of a method, which had come heavily recommended in the lesbian health literature, but which I translated for use in an epistemologically different environment. I use the term linkperson, for example, in preference to "targets" because targeted sampling is described as a:

> response to the deficiencies of chain-referral models. Researchers recruit a pre-specified number of subjects at sites identified by ethnographic mapping, ensuring that subjects from different areas and sub-groups will appear in the final sample (Heckathorn, 1997, p. 175).

The term linkperson distinguishes the approach used in this study from these erroneous empirical concerns related to targets and sample populations in research informed by positivism.

Participation

As I noted earlier, I spoke to each of the women who were interested in participating in the research (including those women I had initially contacted through my own networks).

I arranged to deliver to them the research introduction, research information and consent forms so that they would have an opportunity to consider the research. I arranged to telephone each of the women a week later so there was an opportunity for them to raise questions, or talk with me further, before deciding if they would participate in the research. At this point, if the woman agreed to be interviewed, I arranged a suitable interview time and location. The consent forms were signed preceding the interview (see Appendix Three).

No predetermined number of interviews had been established, but a total of fourteen interviews with sixteen participants were carried out. Kvale (1987) argues against having too many interviewees, and a consequently inflated volume of textual material to interpret. The number of interviews cannot be decided from the beginning but requires attention be paid to the ways in which the data will be analysed. While I had a sense that less than ten interviews might not provide sufficient information and the high twenties would produce voluminous amounts of material to analyse, I selected participants until I was confident that there was a diversity of material appearing in the interviews. However I stopped selecting for additional participants when the interviews were no longer producing new results, but rather were elaborating only on existing themes. Using this method I approached eighteen women, and invited them to be interviewed. Sixteen women agreed to be participants in the research. The women were aged from 20 to 59 years of age. The two women who declined to be interviewed were aged 17 and 18 years respectively.

I respected the decision of the younger women not to participate and so did not question them further about it. However, I perceived the reluctance of these women to be part of the research as resulting from a combination of factors. Both of the younger women still lived at home, and were either not out to their families, or in a position where raising their lesbian identity could be disruptive to their living environment. As the research process involved contact with the women, the women may have felt that there could be risks to the custody that they have over that environment. This would have been a perceived cost no matter what safeguards I established. It is common, too, for parents to maintain some control over their daughter's health while she is still living at home, thus limiting their independent experience of health care as a lesbian. As these younger women were less likely to have control over their own health care, they may have felt

they had little of their own experience to share. Comments from some of the women who were interviewed indicated that they initially thought they would have little to say about lesbian health.

Interviews

Each of the participants and I discussed where they would like the interview to be carried out, with a number of options available. These included the possibility of being interviewed in their own home, at an independent location (such as a room at the university or at a local community centre), or in my home (when my partner was at work). I arranged to bring light refreshments to each interview, so the interviews were often carried out in a lounge area or at a kitchen table with biscuits and hot/cold drinks. I discussed with the women the idea that interviews were intended to be relatively informal, while also indicating the areas we might cover. I was cognisant of the potential for the interviews to touch on personal areas and wanted to fully inform the women so they were best able to negotiate an appropriate time and space for the interview.

Of the sixteen women who agreed to be interviewed, three were couples. Two of these couples were living together at the time of the interview. The remaining couple had moved in with each other during the time interval that elapsed between interviewing each partner. Another two participants were flatmates. Thirteen women requested to be interviewed in their own homes. I interviewed one woman in her office at her place of work. The remaining two women were interviewed in my home.

There were fourteen interviews in total. I discussed separately, with each partner of the two couples living together at the time of the interview, whether they wished to be interviewed independently (one by one), or together. Both couples requested that they be interviewed with their partners. Eleven of the interviews were carried out with only the participant and myself, as interviewer, present. For the remaining interview, the participant had a friend who sat with us throughout the interview, but who listened and did not speak, as per the request of the participant.

Each of the interviews was tape-recorded with the women's permission. Two of the interviews had to be carried out twice, one as a result of irreparable loss of a tape and the other because the tape was inaudible due to equipment failure during recording. The lost

tape was in listening equipment (used to transcribe the interview) stolen from my home during a burglary. I alerted the participant involved immediately. We reviewed the interview and I checked out her sense of safety. She indicated she did not feel unsafe. I asked if she still wanted to be a participant in the research and she offered to be re-interviewed. I know that if I read this account in other researchers' work I would consider them remiss. As a cautionary note, I had not perceived the storage of my interview tapes and scripts to be in jeopardy. I now ensure that all material is locked away twice each time I am not at my desk, including for short breaks. I am also reminded of the more limited opportunities offered to students for safe storage of research material - often in the absence of offices, secure storage facilities, or limited finances to own locked filing cabinets.

Each interview lasted approximately one and a half hours in length. I used a semi-structured interview format, using a set of interview questions that I had developed as a guide to the areas that I hoped to cover (refer Appendix Four). The semi-structured format allowed the interviews to be guided by the women's accounts, while following basic themes. This approach was most appropriate for the interviews as some areas of interest and concern proved to be of more importance and relevance to some women than to others. I encouraged the telling of stories, anecdotes, and conversations that they had had, as well as the relating of experiences. If the participant asked specific questions while discussing health issues, for example, whether lesbians need cervical screening, I endeavoured to facilitate a discussion around what she thought or had experienced and exchanged what I knew after this.

The topics areas for discussion during the interviews were as follows:

i) personal health (health problems, health strategies)
ii) knowledge of lesbian health issues
iii) sources of health information, including difficulties in accessing information
iv) experiences of health services, including health-provider relationships
v) coming out to health professional/service provider.

My formulation of the theme areas were informed by three processes: i) reading the literature currently available in the area of lesbian health, ii) extensive discussions with

lesbian women throughout the research process about areas they identified as important, and, iii) my own health experiences.

The interviews began with a set of questions focused on 'demographic' information. I also talked with the women about how they represented their own sexuality identity, and health. In particular I asked questions about how they described and understood their sexual orientation. I also asked them what 'health care', 'being healthy' or 'well', 'being ill' or 'sick' meant to them, and indeed if they used these at all or some other notion.

I concluded the interviews with a format using statements, rather than open-ended questions. The statements were intended to focus the discussion about lesbian health in another way. I asked the women to comment on the quotation: "Lesbians are healthier than heterosexual women", and to complete and/or comment on the opening phrase: "A healthy lesbian is...". These excerpts were common in contemporary lesbian health literature. They were also local. A lesbian health group I was part of at the time used a version of the latter statement in its incommensurable mission philosophy to promote 'happy healthy lesbians'.

The recorded interviews were transcribed in full with information likely to identify the participants removed. A copy of her transcript was delivered to each participant. I asked each woman to assess the transcript in terms of anonymity and content, and to add, remove, or alter any information that she wished. Each woman was asked to choose a pseudonym to represent herself. None of the women requested the use of their own name.

Participant profile

A profile of participants was put together from the demographic questions. The intention here is to provide a sense of the women who participated in the research. Of these sixteen women who agreed to be interviewed, fifteen identified as lesbian. One woman identified, if asked to label herself, as bisexual. Fourteen of the women identified as European Pakeha. Of the Pakeha women, two strongly identified with their European identities, and a remaining one identified strongly with her Australian identity. One woman identified as Maori, was supported in her identity by her iwi, hapu and whanau. Another woman identified herself as New Zealander with Maori and Pakeha parents.

Six of the women were aged 20 to 29 years of age. Four were aged 30 to 39, and a further four fell between the ages of 40 to 49 years. The remaining two participants were aged 50 to 59 years of age.

Ten of the women had been to university and five had attended polytechnic for tertiary study. At the time of the interview, six were still completing either an undergraduate or a postgraduate degree at university. Four of the women were supporting themselves and their family on the Domestic Purposes Benefit. One woman was currently on a Sickness Benefit attempting to be accepted for the Invalid's Benefit. Four women were in full-time employment. Four of the women had part-time employment, two of whom were involved in the production and sales of their own products. Three of the women in part-time employment were also students at university.

The women represented a wide range of experience. Their collective current employment at the time of interview was as follows; teaching and tutoring (tertiary institutions and schools), counselling, trades and technical, parenting, nursing care, sales and purchasing, domestic and hospitality positions, craft and arts. Their combined community experience and involvement included; sports (both team and individual pursuits), volunteer work (in predominantly feminist community organisations), and the organisation of and involvement in the running of lesbian community events. They held creative, sporting, leisure and community based interests.

The women had been 'out' for eleven months to twenty-five years. Being out meant different things for each of the respondents. This is discussed in more detail later in the thesis.

INTERVIEW ANALYSIS - A CRITICAL READING OF DATA

Miles and Huberman (1994) provide a view of qualitative data analysis, which they see as "consisting of three concurrent flows of activity: data reduction, data display, and conclusion drawing/verification" (p. 10). Longhurst (1996) uses this to describe the method of her doctoral project *Geographies that Matter: Pregnant Bodies in Public Places.* I concur, as I also find this a useful place to start. Yet, given the relatively short and particular history of psychology related to qualitative research and its 'turn to language',

the discussion on discourse analysis might be expected to be focused in a specific way (Burman & Parker, 1993). Discourse analysis was not the only approach considered for analysis. The materialist-discursive approach used (Grosz, 1995; Ussher, 1997b) enables this section to explore relatively new territory. I am concerned in particular, with not dismissing the epistemological roots of discourse analysis. I continue this discussion in the section on conclusion drawing and verification.

Data reduction

> *Data reduction* refers to the process of selecting, focusing, simplifying, abstracting, and transforming the data that appear in written-up field notes or transcriptions (Miles & Huberman, 1994, p. 10).

Miles and Huberman (1994) make the point that data reduction occurs throughout the research project. It starts before the interviews have happened, is anticipatory, and continues throughout the writing of one's project. The intention is to not foreclose a final analysis of the data. Most importantly, rather than being separate from it, data reduction "is *part* of analysis" (Miles & Huberman, 1994, p. 11 italics in original). 'Reduction' refers here to a process of ongoing clarification of areas such as the theoretical and methodological approaches, and research questions (Miles & Huberman, 1994).

Data reduction occurred as a result of the preliminary workshop described at the start of this chapter. I determined that I would only interview women who were resident in Hamilton, New Zealand. Miles and Huberman's (1994) notion of data reduction - as clarification - is used liberally here, allowing it to account for the impact of the preliminary workshop which lead to a broadening of age and a focus on only one locality. I had been initially concerned that the Hamilton community would be too small to accommodate a snowball study. The workshop highlighted the distinct differences between communities throughout New Zealand - with which I was familiar as I had lived and identified as 'lesbian' in two other New Zealand cities, Dunedin and Auckland. To explore a variety of localities *and* communities I felt would be a substantial project in its own right. I realised that wanted to carry out the research in the Hamilton community because it is often characterised a 'transitional' place. I realised that the locality offered good access to people who had lived in cities and rural environments.

I transcribed the interviews in full myself. I was interested in retaining a full copy of the interviews to return to, and felt that the discussions had stayed relatively 'on topic'. I did not reduce the data at this point other than using a modified conversational analysis transcription schema from Button and Lee (1987, refer next section) since details relating to timing and intonation were not crucial to the research questions.

I had spent a great deal of time in the early stages collecting articles published about lesbian health, on both general and specific topics. Again, I presented the first stages of this at the preliminary workshop. In arranging this material around specific health topics I was aware that the list was potentially endless and that some issues could provide a valuable focus. After the interviews and transcription I decided to highlight two specific issues - cancer/screening of the cervix and breast, and HIV/AIDS. Each characterised particular issues in the 'field' of lesbian health research that could be explored for further analysis.

In addition, I collected magazine and newspaper articles, community newsletters, health columns, and health pamphlets, about lesbian health. Cartoons were commonly found in these media, and I paid particular attention to assembling these. The cartoons functioned something like vignettes (Longhurst, 1996; Miles & Huberman, 1994), as they are emblematic of a case, are characteristically brief, have a storyflow and bounded space. Cartoons function to portray characters, events, and contexts. They played a role in data reduction by succinctly and pictorially representing particularly meaningful pockets of data in a way that was skilful and often humorous.

I decided to turn the focus of my attention away from mental health. I considered that lesbian health discussions appear to be dominated by mental health issues and professions, for example: i) there is large volume of literature about lesbian mental health; ii) a national study on *Lesbian Mental Health* was completed by Sarah Welch in 1995; and iii) events such as the first national gay/lesbian/ bisexual/takataapui/intersex Pink Health conference in 1995 were funded by the mental health group ALAC (Alcohol Advisory Council of New Zealand). The decision to focus the analysis on physical health concerns was made after the interviews, and was neither to be at the exclusion of mental or 'alternative' health nor re-impose a binary between mental and physical health. In clarifying the boundaries of the project to explore predominately 'physical health' in

contexts with doctors, nurses, specialists, and health promoters and promotions, I had an opportunity to apply new theoretical frames.

Denzin (1994) describes processes similar to data reduction. He identifies a phase that he refers to as *sense making*. Denzin's (1994) phases are also cyclic. Sense making is described as a movement between field notes and actual writing where decisions are made about "what will be written about, what will be included, and how it will be represented, and so on" (p. 503). So throughout the research I was engaged in processes which sought to "sharpen, sort, focus, discard and organise the data" (Miles & Huberman, p. 11), and in an ongoing manner determine how it would be represented in the final analysis.

Data display

Miles and Huberman (1994) describe a *display* "as an organized, compressed assembly of information that permits conclusion drawing and action" (Miles & Huberman, 1994, p. 11). The goal of displaying data is to break the material into manageable chunks. There is a sense of 'trying out' various presentations of the data (Miles & Huberman, 1994, p. 91). In the early stages of the research, I did a broad sweep of the lesbian health material. I roughly sorted material into areas. I labelled these with archetypal names - the 'sick lesbian', the 'alcoholic' lesbian, the 'contagious' lesbian, the 'homosexual' lesbian and so forth. These archetypes appear briefly in the final analysis, as they were critical in moving the analysis from a description of health topics to an analysis of discourses (see Chapter Five).

Miles and Huberman (1994) indicate that data displays most commonly take the form of an extended length of text. They can include the transcription of the interviews into text documents. Potter and Wetherell (1987) agree that the process of transcribing is part of the process of analysis, and suggest that it can be helpful in forcing a close reading of a text.

The interview tapes were transcribed with some attention paid to writing down what was said in full. The transcription symbols used are a modified and significantly reduced version of Button and Lee's (1987) codes. I employed this system because I was familiar

with it, having been employed in the past to transcribe (up to six-track) tape-recorded conversations for psycholinguistic study. The symbols are described as follows:

italics	represents the respondent's own emphasis on a word or words.
-	a dash. Indicates a brief pause usually reflecting a small but discernible pause in speech.
example-	a dash found directly at the end of a word. Indicates an abrupt break in the speech.
(example)	brackets around a word or words. The speech was not clear. The words given inside the brackets are a best approximation.
[.....]	empty brackets. The words were not able to be distinguished.
[Example]	square brackets. Actual words, such as place names have been removed for confidentiality.

The interviews were transcribed in a way that retains features of the conversational style of the speakers. Extracts from the interview transcripts, which appear in chapters five to nine, include mid-sentence breaks, repetitions, 'grammatical errors', and other features which have been preserved to limit interpretation by the researcher at this early stage of analysis. The transcripts were checked through for accuracy (in terms of the features discussed here). The transcripts from the interviews amounted to 260 pages of text. Each line was numbered for easy reference. They were stored in separate computer files and printed copies were sorted into a folder together. Then the processes of reading, and rereading began (Potter & Wetherell, 1987).

Conclusion drawing/verification

> From the start of the analysis the qualitative analyst is beginning to decide what things mean - is noting regularities, patterns, explanations, possible configurations, casual flows, and propositions (Miles & Huberman, 1994, p. 11).

This section describes the process of conclusion drawing that developed as verifications were sought. Verification is described as being anything from checking back to notes, to lengthy argument and looking to other theorists for discussion. Verification, in this project, was not about a positivist measure of *validity*. It was about looking to (postmodern) theories about the body, sexuality, and institutions to come to a form of final analysis. I looked to notions about things that 'made sense' and to those I resisted, both as sites for considering and exploring ideas further. This is a notion central to deconstruction, or the "problematising of logocentric discourses" which is described by Grosz as emanating from Lacan and Derrida where the close reading of texts "signal(s) blindspots, and points of unrecognised vulnerability" (Grosz, 1989, p. 28).

I was interested in looking for discourses. I employed in the first instance Potter and Wetherell's (1987) ten stage approach to analysing discourse. After transcribing the first half the interviews, I carried out an initial rudimentary coding of the interview texts. This initial sweep of the texts drew out a range of discursive themes that were concerned with the ways in which lesbian health, and lesbians in relation to their health, were present and absent in the texts. When I had transcribed all of the interviews, I carried out a second sweep that extended this initial and rudimentary coding. Using word processor cut and paste commands, I collected together references to the themes I had formulated, using as broad criteria as possible. This meant that each of the themes became a fairly exhaustive list, including even oblique references of a few lines to a number of pages of text for each reference. These themes included: invisibility and visibility of lesbian health; how lesbian health was constructed as a relation (particularly to women's health and gay male health); and references to a lesbian 'lifestyle' and health. These initially formed the basis of the discussion chapters.

The later stage of this analysis, using a discourse analytic process provided by Margaret Wetherell (1996), involved asking questions: do the themes and the references contained within them belong to broader discourses or chains of arguments related to 'health' and 'lesbian'?; what versions/accounts of actions do these references provide?; what subject positions do they provide?; what contradictory positions are apparent? (Wetherell, 1996). Throughout the analysis I was concerned with reading the detail, with looking for variation, contradiction and consistency, and for points of resistance (see Potter & Wetherell, 1994).

Potter and Wetherell's (1987) work however, is described as an 'analytic' (Burman, 1996a, p. 137) 'non-critical' approach to discourse analysis (Fairclough, 1992, p. 23), with a view towards a "sensitivity to language" (Burman, 1996a, p. 137). Burman (1996a) adds that in the context of discussions about 'discourse' in social psychology their approach seems to be "more accessible and acceptable than Parker's (1992) 'system of statements' that produces an object". Erica Burman (1996a) in her paper *The crisis in modern social psychology and how to find it* argues that "discourse analysis is the primary site through which postmodern ideas have entered and address Anglo-American psychology" (p. 135). She argues that it is 'methods' which are "a central pedagogic structure for the filtering of knowledge and the erasing of subjectivity in psychology" (p. 135).

Abandon my method? It is tempting certainly to discard any references to Potter and Wetherell (1987) because of the risks of casting my work into a place that repeats rather than transforms past methods and approaches. But the very point lies in leaving it here. This account is a careful rendering of my process, and it reflects the gaps that encouraged me to look towards other approaches.

In this way the method cycles back to theory. The approach closest to what I was theorising was a discourse approach from the *Changing the Subject* group (Henriques, Hollway, Urwin, Venn, & Walkerdine, 1984). This approach was preferable to that offered by Parker and Burman from the Manchester school, or by the early collaborative work of Potter and Wetherell in what has been characterised as the Loughborough school (Morgan, 1995; Nijkander, 1995). What I was interested in was how some discourses were more meaningful or had more impact than others. This engages a Foucauldian notion of power (discussed in Chapter Three) which is also supported by the work of Henriques et al. (1984) and the Manchester school. I began to use Derridean deconstruction, looking particularly (and critically) towards binary pairs. What became apparent in the discourses present in the literature material and interview texts, for example, that of the 'healthy' lesbian, were underlying notions of good/bad, healthy/sick, and mind/body, and so forth. It was important to provide a "more fluid and less coercive conceptual organisation of [these] terms" (Lather, 1989, p. 9; brackets added) than the binary might appear to represent. Lather (1989) refers to an early discussion by Liz Grosz (1989) who argued that the goal of deconstruction is neither "unitary wholeness nor dialectical resolution" (p. 9) but rather to displace or transcend these binaries by simultaneously being both or neither of the terms.

In the final stages however, I looked particularly to questions about the lived sexed body rather than the body as a surface of inscription (Grosz, 1995). Materialist discursive approaches in psychology still retain a discourse 'method' but claim to look for signifiers *and* material realities or lived experience (see Ussher, 1997b). With the data I explored references to the body, paying particular attention to discussions surrounding exteriority and interiority (Grosz, 1994).

It is important to note that by no means is this analysis exhaustive. As Hollway (1989) explains, the boundaries around the text are limitless, and yet (in contradiction) there are limits placed by the research for pragmatic reasons. It is conceived that there are no

limits on the respondent's knowledge, and that the researcher's knowledge is not exhaustive. There is no essential true meaning in a text and thus, numerous readings of a text are possible.

Tools for analysis

At a point in the research I had to decide what kind of computer software to assist in the storage, retrieval and analysis of material. Miles and Huberman (1994) consider that the functions of data packages to look for include: 1) coding, 2) memoing/annotation, 3) search and retrieval, 4) data display, 5) data linking, 6) conceptual/theory development, and 7) graphics editing. There were a number of reasons I decided to use the word processing programs *Word 5.1* for Macintosh, and *Word 95* for Windows. I consider that word processing systems can currently - if laboriously at times - be used to perform the basic functions of the first four activities listed by Miles and Huberman (1994). The roles not fulfilled are data linking, conceptual/theory development, and graphics editing. I chose to use word processing programs in preference to two code-and retrieve systems, such as *The Ethnograph* and *NUD*IST*, described below (Miles & Huberman, 1994). Note that the switch to an IBM compatible (and *Word 95*) was an economic choice made when I upgraded my system.

I had used *The Ethnograph* version 3.0 (for pc) extensively in the past for conversational analysis. It is suitable for long text segments, such as those obtained from extended, open-ended interviews, and it is relatively easy to use with some training (Weitzman & Miles, 1995). However, *The Ethnograph* functions that I wanted, I could achieve using Word without the outlay for the analysis package. Miles and Huberman (1994) recommend not to strip qualitative data from the context in which they occur. When sorting material for analysis (or 'display') using *The Ethnograph,* the maximum *hit* expansion allowed is ten lines. With the find commands on the word processor I was able to go directly go to the text and have no externally imposed limit on the *hit. The Ethnograph* numbers each line, a utility I was easily able to carry out with the word processor.

My other option for analysis was *NUD*IST.* It is similarly suited to long text segments (Thomas, 1996). *NUD*IST* however requires more training than *The Ethnograph.* I undertook an eight hour training workshop for students in the Psychology Department

at Waikato University. A staff member who was using *NUD*IST* herself and had trained with the program developers, ran the workshop. *NUD*IST* was available in the psychology department, but I thought that the projected time it took to get familiar with the package would not have balanced the anticipated benefits. The length of time it takes to become familiar with *NUD*IST* is widely commented on (Peace, 1997). However I also appreciated - having started a rudimentary coding of my data - that the main role of NUD*IST (and related computer packages) is to provide ways of arranging data. In particular it offers a hierarchical index or code system (Weitzman & Miles, 1995). This project has resisted a turn to hierarchising meaning systems, or at least to reproduce that through a data analysis package. It would also be a misnomer to assume that a package such as this can fulfil the role of conceptual/theory development (Miles & Huberman, 1994). This work still has to be done by the researcher regardless. Robin Peace (1997) - herself a *NUD*IST* user - reflects eloquently on its use. She states that in the context of postmodern impetus in qualitative research and the proliferation of heterodox technologies "systems such as *NUD*IST*, represent an impetus towards orthodoxy" and furthermore they "endorse orthodox approaches through the identification of patterns" (Peace, 1997, p. 382). It is this emphasis on patterns and generalities rather than supporting discrepancy and difference that motivated my decision to continue analysis with a word processing package.

ISSUES OF REPRESENTATION

Determining participants, and the politics of representation, have been sites for ongoing reflection throughout the process of this thesis. I am immersed in lesbian politics about identity and health. This engenders particular questions about relations of power in the research process, related to who the researchers and the researched are.

The conversation about being a lesbian researching lesbians begins here with a panel discussion which occurred at the second New Zealand Lesbian Studies Conference (May 1995). I was a member of this panel. In the approach taken by the panel, lesbian was overwhelmingly viewed as a marginalised identity. Based on an assumption about a shared lesbian identity and rooted in a politics of oppression, one effect is the belief that one can 'speak for' other lesbians. I have included key points from the panel discussion relevant to this project. These points form the heading titles for the following section:

invisibility; safety and confidentiality. The panel marked my initial approach to articulating issues about representation and method.

Invisibility

The history of lesbians in research has positioned them as pathological and as sick in some way. The marginalised status of lesbian women means that their perspectives are often invisible, with pathological discourses dominating over alternative accounts of lesbian experience. While research makes lesbians visible, its small volume means there is little opportunity for people to measure it against competing versions (Greenwood, 1996).

Sallie Greenwood (1996) argues that the invisibility of lesbians' experiences in research makes it difficult for the research to be accountable to the participants, and their wider communities. Lesbian researchers at the panel session talked about their processes to establish feedback and evaluation, as a way to address accountability issues in the context of invisibility. The conference discussion ranged from including research participants in the editing process to ensure the inclusion of participants' voices, to questions about participant ownership of the research, and having lesbian supervisors or advisors to advocate for and involve community perspectives.

The argument here is that having lesbians involved in the research process can ensure authentic and therefore accountable reports. This position is not difficult for feminists who advocate standpoint theory - claiming that "knowledge is supposed to be based on experience" (Harding, 1986/1997, p. 168). Since knowledge is gendered, standpoint theory acknowledges and validates the specificity of women's knowledge (McDowell, 1992). A version of standpoint theory - which challenges the presumed commonality of women's experience (Hill-Collins, 1991/1997) - has been used to develop the notion of a lesbian standpoint with consequences for feminism in the provision of "a fuller more adequate epistemology" (Kemp & Squires, 1997, p. 143). These understandings support the view that lesbians can provide specific readings on lesbian knowledges.

In my early drafts of this thesis, I listed the conferences at which I had presented my thesis, the lesbian community health projects I was involved with, and identified that

lesbians formally supervised the project.[57] I offered these as an indication (as other panel members did) of how I addressed concerns about invisibility and accountability. While these lists are relevant - they indicate the multiple environments where my work was open to scrutiny - I no longer offer them as an account for visibility. To do so is to assume that 'lesbian' perspectives *alone* can guarantee accountability. It presumes an uncertain homogeneity (for 'lesbian'), and that I did not resist any attempts, unconsciously or consciously, to have all critiques of my thesis included in this text. Engaging in a politics of representation is important to this thesis project (refer to Yeatman, 1993, who considers emancipatory movements). Yeatman (1993) argues for a notion of representation/re-presentation that acknowledges participants have potential contradictory positionings across multiple selves.

The panel discussants argued that the process of being accountable to lesbian communities requires that challenges be made to the unitary concept of lesbian. The attempt to address the heterogeneity of lesbian effects what Yeatman (1993) refers to as an internal politics of difference. Already comment has been made in this thesis that when research is presented about lesbians, it often does not reflect the experiences of *all* lesbian women. That is, the research focuses on 'mainstream' lesbian culture - white, middle class, university educated, young women aged 20 to 40 years, who are 'out' to a predominant number of family, friends and work colleagues (Stevens, 1993). Yeatman acknowledges:[58]

> A politics of difference *within* an emancipatory movement makes explicit the contradictory nature of emancipation itself...When an emancipatory movement develops an internal politics of difference, a chronic tension

[57] I have presented my research at the following conferences and seminars: National Lesbian Studies Conferences (Wellington, August, 1993, and Wellington, May, 1995); National Women's Health Conference (Rotorua, October, 1994); New Zealand Psychological Association Conferences (Hamilton, August, 1994; Auckland, August, 1995; Hamilton, August, 2000); Health Development and Policy Programme Conversation Series (University of Waikato, May, 1995); Spring Gayly into Health: a health weekend for Lesbians and Gay women (Hamilton, October, 1995; Pink Health Conferences (Wellington, September, 1995; Wellington, June, 1997); Public Health Association Conference (Hamilton, July, 1997); Postmodernism in Practice (Adelaide, February, 1998); International conference on Critical Psychology (Sydney, April, 1999). I have also been part of a lesbian health group in Hamilton (Lesbian Steering Committee) which organised a lesbian health weekend; been a member of a Pink Health – a national lesbian, gay, bisexual, transgendered, takataapui, and intersex health network; a member of Outskirts, producing a lesbian cervical screening pamphlet in conjunction with Health Waikato (which incorporated work from this research). There have been many other informal opportunities to discuss this research.

[58] Yeatman (1993) refers to a definition by Jacques Rancière, where emancipation is defined as "a set of practices guided by the supposition that everyone is equal and by the attempt to verify this supposition" (p. 234). The work of lesbians who were researching lesbians (and who were participating in the Lesbian Studies Conference), the research literature I was using, and my own approach at the time, would all be characterised as 'emancipatory' using this definition.

> and a degree of contestation attends all its work of self-representation, when this self is made to appear a categorical identity: 'women' as distinct from men (Yeatman, 1993, p. 229, italics in original).

Yeatman (1993) recognises that the dilemma of researching 'lesbians' and representing 'lesbian' reflects messy territory. Her commentary highlights why, when seeking to expand my research method and work with a heterogeneous notion of 'lesbian' (as discussed here and in a later section in this chapter), I encountered significant struggles.[59]

A particular concern about invisibility relates to the relationships between lesbian and straight communities. If knowledges about lesbians are constructed in both straight and lesbian communities, it is likely that invisibilities that exist in straight communities will have an impact on the absence of knowledge in lesbian communities - particularly in those areas (such as health) where straight communities control that knowledge. In the conference discussion this was highlighted by the paucity of models available to assist research with and/or by lesbians. In my research, this was signalled by interviewees' belief that they would have little to say, the sharing of available 'health' information during the interview, and my initial sense that 'lesbian health' overall was poorly conceptualised. In each of the interviews, I attempted to address the issue by encouraging multiple discussions of what lesbian health might be through a variety of questions. These questions did not assume that I knew how people used terms such as 'health', 'lesbian', 'sickness' or indeed if they used these words at all - for example I asked participants whether they used sexuality labels to describe themselves, and if so, how did they understand them. The approaches here reflect Kidder & Fine's (1997) idea that qualitative research methods attempt to address epistemological and ontological assumptions in the research process, and does not presume that analysis is neutral but rather it pre-empts interpretations of research material.

'Safety' and Confidentiality

Confidentiality is an issue that predominates in research. Research with a stigmatised group such as lesbians has additional concerns about the preservation of 'safety'.

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[59] Note that Yeatman (1993) also comments upon relationships (of power) between what she terms custodians, and the contestatory voices of those who represent the emancipatory movement. She acknowledges that "each group reduces the complexities of its quite different participation in an emancipatory politics to an interested, to indeed an identity, politics (where) the identity of the emancipatory subject is not only ontologized but retroactively established" (p. 237).

Hoagland (1990) states that safety is a central aspect of lesbian community - a move that has resulted from the need to preserve "the deepest parts of ourselves" which, under heteropatriarchy, have been subject to attack (Hoagland, 1990, p. 194). Research with lesbians includes maintaining the safety and anonymity of individual participants. It also extends to protecting against researcher appropriation of the participants' voices, or a minimisation of their diversity (Yeatman, 1993), and the protection of aspects of lesbian culture from outside scrutiny. As Yeatman (1993) argues, the strategies in which researchers (or custodians) are involved and which can foreclose movements towards equality may include:

> the simple re-assertion of established policy and a correlative refusal to listen to the contestatory voices of emancipation; or a more subtle version, the appropriation of the contestatory and emancipatory voice by the custodian subject voice (p. 235).

Concerns about the protection of lesbian culture come from the experience of having research findings and other lesbian writing interpreted in harmful ways. That is, being used by the reader in such a way that is contrary to the 'intent' of the researchers; to limit rather than open out new opportunities for understanding and/or action. This is an effect of research being translated through or about the additional barriers of homophobia, heterosexism, and sexism. One lesbian, during the panel session, cited a recent example from her own clinical practice. A male psychiatrist colleague had read the results of a recently completed study into lesbian mental health (see Welch, 1995) to support a position which fitted his previously conceived beliefs. The study reported that lesbians had similar 'rates' of mental illness to other samples of New Zealand women (except for attempted suicide, sexual abuse, and drug use). Lesbians were also reported as high users of mental health services. The concern was that this information was being used by the male colleague to argue against a planned targeted service for lesbians, because information about lesbian experiences of and delays in using mental health services were being ignored. While a researcher can not control the ways in which research may be read, the need to be doing research was still considered to be important, particularly where it can raise alternative accounts - in this case where a proactive approach towards lesbians and mental health was encouraged. The work by Foucault (1977) in *Discipline and Punish* suggests how writing, and research in particular, is a regulating institution that opens such things up to surveillance and control.

Confidentiality as a researcher meant that there was a need to safeguard information known about a participant. Throughout New Zealand's lesbian communities, there exists a large amount of shared information about individuals. Lesbian researchers are likely to meet research participants in a wide variety of settings. As a lesbian researching lesbians I had, and have, a particular demand to constantly monitor what information I hold about an individual from her interview, and what information is known through my social interaction with her, and keeping these separate. As a result of the amount of shared information within lesbian communities about 'members', it is also possible that other lesbian women could identify participants. An important part of the research process was to ensure that identifying information was removed from the transcripts. Identifying information was removed during the transcribing process, and was checked by the women when they read over their transcripts. To protect confidentiality, individual profiles have not been included and some stories have been altered slightly.

Difference and representing the other

The first part of the discussion in this section commented on research *within* a community. The second part focuses on the processes or methods for participant selection and interviews that were undertaken in this project. In particular, I comment here on the mid-thesis expansion, discussed earlier in the chapter. What I experienced at this point in the thesis process, are ongoing issues about conducting research which consider who participants of the research are, and issues of representation when a member of the community that one is researching. The effects of this are summarised below.

The first effect relates to the assumptions I made regarding the question of 'who' were the participants of this research. I had thought at the start of the research project that I was researching sameness (as discussed briefly in the opening of this section referring to 'lesbians researching lesbians'). What occurred was a developing awareness that my tenuous assumptions about my sameness to the research participants firmly positioned me in the practice (and not just the theory of) a politics of difference. Yeatman's (1993) work has been crucial to understandings of identity politics and a politics of difference (see also Burman, 1992, cited in Gill, 1995). As Yeatman writes:

> the hegemonic feminist intellectual thus plays out the same/difference game, in which these become mutually exclusive options: you are like us so we do not have to create space for your voice; you are like the other,

> so when we invite you to speak, please speak on behalf of all others, all minorities, all difference. What is avoided is the complexity of dialogue that arises between subjects who understand themselves to be complexly alike and different from each other (p. 241)

Michelle Fine writes "the Self and Other are knottily entangled" (1994, p. 70). To talk about the self is to be inscribed within a binary of self/other. Other theorists have written about how the 'self' is constituted through the process of constructing the 'other' (Hall, 1991 cited in Fine, 1994; also Mohanty, 1991/1997). In the very process of deciding to expand the research I realised I was already and previously positioned in a binary of same/other. However, this was not a fixed binary, as argued by these theorists, but one that reflected multiply contested sites and shifting places (Bhavnani & Phoenix, 1994).

The second effect of the mid-thesis expansion is closely related. Two of the women participating in this research identify as Maori. I did not consider how I would systematically incorporate ethnicity, race, or dis-ability into the research process. I had decided I would interview Pakeha women only, but was not consistent in identifying this to potential participants or linkpeople (see also Paulin, 1996 for a discussion of a similar event in her research with lesbians). Specifically I had assumed that the snowball method would not access Maori women, given my understandings of the networks in Hamilton, New Zealand. I did not want to interview Maori women specifically to provide 'alternative', or ethnically orientated accounts of lesbian and health, as such accounts could be used to aggregate mainstream discourses on 'lesbian' and 'health'.

There is a contradiction here. I did not discount the possibility that Maori women may wish to participate in the research; I considered that the appropriate process would be to establish networks and systems for feedback if this did arise. I also considered that I had established formal supervisory support that was appropriate to negotiating this.

Explaining this contradiction is not a simple process. There were several issues that lead to me to change my earlier - admittedly tenuous and uneven position to research Pakeha women only. In the Community Psychology postgraduate diploma I was undertaking at

the same time as my doctoral project, I was learning about cultural safety.[60] I was approached by one of the Maori women who asked to be a participant in the research. She felt that lesbian health research needed to also reflect the experiences for Maori lesbian women. I felt that because I was approached, I was considered an appropriate person to do this, and my complicity the result, in part, of my Pakeha liberalism.

Cultural safety, and other writings on researching Maori communities, take up a number of positions which can be referenced to theories about researching difference and the 'other'. Other aspects of cultural safety have been developed with specific reference to New Zealand's colonising history, and to (generalised and specific) protocols for visitors to Maori sites/engagement. The discussion following here briefly explores aspects related to managing the interview material. My position as a Pakeha researcher researching Maori has brought me closer to examining a multifarious politics of difference. I am not saying that I did not consider this with regard to class, sexuality (i.e. bisexuality) and dis-ability. However, I acknowledge that it is at the site of representation and ethnicity I have examined my assumptions most closely. Power relationships are central to these understandings about difference (Burman, 1992, cited in Gill, 1995).

Paulin (1996) characterises the main threads of Pakeha research on Maori. Specifically she notes that such research has been "implicated in the process of on-going colonisation" (Smith, 1992 cited in Paulin, 1996, p. 205). This is critical to understanding the perspectives taken up by Maori and tauiwi[61] researchers. Paulin (1996) identifies that research which is determined by Maori, conducted and disseminated by Maori, and carried out in a Maori context reflects the most significant drives towards autonomous and valuable research for Maori communities (see also, Spoonley, 1993). Three main perspectives on the relationship of Pakeha researchers to research with Maori is identified as: i) Pakeha should not research Maori but their own culture - specifically because Pakeha lack the cultural knowledge/ understandings and whakapapa[62] to be able to undertake this safely; ii) Pakeha may be 'sponsored' by Maori to undertake research,

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[60] Cultural Safety is a philosophy and practice originating in the training of nurses in Aotearoa/New Zealand. It refers to (usually Pakeha) practitioners identifying their own cultural values which operate in ethnocentric practices. The focus is predominately on bicultural practice, with recognition of the benefits of working with broader issues of diversity.

[61] Tauiwi is a Maori term that refers to foreigners. In context of Maori as tangata whenua, or the original inhabitants of New Zealand, this refers to settlers that arrived subsequently.

[62] Whakapapa refers to genealogy (Melbourne, 1995).

particularly where it has been shown that Pakeha can act in culturally appropriate ways; iii) that partnership models where negotiated resource sharing and expected processes are undertaken (Department of Psychology, Waikato University, 1997).

Like Paulin (1996), my initial decision to not research Maori was based on the first perspective, that Pakeha should not research Maori. The change in my thesis towards including Maori women in the research is based on the second assertion. It must be noted that there is considerable debate in the academe whether the third option is a real possibility given the requirements and constraints of university study to be individual rather than collaborative work.

Reflexivity

Epistemology raises questions in research about how a text claims to be legitimate, and how it claims its own authority (Denzin, 1994). The process of the research and analysis explained in the previous sections must be considered in light of these concerns. Lather (1990) iterates that a culture's epistemological codes are created in and acquired by language. "The ways we speak and write are held to influence our conceptual boundaries and to create areas of silence as language organises meaning in terms of pre-established boundaries" (p. 71).

Feminist research methods are often characterised by their attention to reflexivity. This is described by Gill (1995) as a position that "requires analysts to make explicit the position from which they are theorising, and to reflect critically upon their role" (p. 179). Reflexivity reflects the feminist researcher's turn to 'addressing *bias*' in a research methodology where researchers are themselves decentered and revealed within their texts or research processes.

Key questions raised by feminists focus on how to engender a relationship between the researcher and the texts produced by participants. Questions about whether we seek to represent women's, or in this case lesbian, voices are often the focus of discussion. Whether or not there is a 'feminist method', it is argued by some that there is an important need to situate our knowledges, in relation to the contexts elaborated by Hollway (1989):

> People's accounts are always contingent upon available time and discourses (the regimes of truth which govern the directions in which one's thinking can go); upon the relationships within which the accounts are produced and upon the context of events recounted; upon power and the defences in operation against formulating different versions because of their self threatening implications (p. 39).

It is often noted that any analysis is not separate from the situated positions held by a researcher; "my own embodied genealogy" (Braidotti, 1994, in Morgan, 1995, p. 1). As Patti Lather argues, the influence of feminist research on poststructuralism reflects the ways in which interpretation is considered such that "writers consider their own situated versions of the worlds studied" (Lather, 1993, cited in Denzin, 1994, p. 510). It is further argued that the knowledge of each person is only partial, and is a product of their particular location.

The view of reflexivity taken by feminist researchers such as Stanley (1996, see also Stanley & Wise, 1993) has it roots in the consciousness raising movement reflected in the work of people such as Paulo Friere (1992). However, this is closely aligned with a relativist position which can reduce reflexivity to a self-referential position only (Gill, 1995). Without an exploration of the epistemological understandings that lead to various representations (including of the researcher) the effect is that one's position in research is more protected and less open to scrutiny.

The account I gave of myself, in Chapter One, might be understood as an exercise in reflexivity, yet, it must be regarded in light of the critiques offered here. Gillian Rose (1997) identifies reflexivity as a strategy for situating knowledges and "as a means of avoiding the false neutrality and universality of so much academic knowledge" (p. 306) may be considered "less as a process of self-discovery than of self-construction" (p. 313). The problem, Rose argues, is that we can never entirely get away from power or relations of power, or from the dilemma of self-construction. Instead, researchers must view themselves in a landscape of power in which research is viewed "as a process of constitutive negotiation" (Rose, 1997, p. 316) constantly producing new discourses. The effect is that researchers can never simply situate knowledges through a transparent reflexivity. Research needs to be carefully considered and understood as always carrying unknown risks. It may be about addressing the uncertainties and contradictions in

research and interpretations, but it is also about "not assuming that the self and context are transparently knowable" (Rose, 1997, p. 318).

My discussion of representational issues in research has considered standpoints on researching lesbians and questioned my ability to 'give voice' - not to individuals - but to an emancipatory movement. These concerns were heightened by my active engagement with a politics of difference, and specifically considerations about researching Maori. The perspective on representation which I take up here, and for the purposes of this thesis, recognises that relationships of power are critical to understanding how and who we research (Stanley, 1996).

Yeatman's (1993) theoretical and considered discussion related to the complexity of issues where white/Pakeha women research Aboriginal women, is helpful. Yeatman (1993) argues that where a politics of identity meets intellectual representation, and where white/Pakeha women seek to represent Aboriginal women's experience, self-advocacy exists. The effect is that this "is revealed as the imperial voice, of others" (Yeatman, 1993, p. 242). I chose to include Maori women in the research - in response to my own and others involvement. I have chosen not to abandon these interviews. My suspicion is that such a decision would be unequivocally motivated by an unwillingness to not engage in the challenges presented by this thesis.

It may be clear to the reader that the discussion about researching 'lesbian' has been positioned in a self/other binary, directly opposite to researching Maori. I positioned 'self' and 'other' in opposition to each other in apparent contradiction to my intentions to represent lesbian as heterogeneous. To seek to represent the 'other' can reproduce unequal power relations, and as some feminist theorists argue, the very act of talking about the other reconstructs the binary relation (Hall, 1991, cited in Fine, 1994). The solution is not to only speak for ourselves, or to celebrate otherness, as this still carries risks of the exoticisation. Rather the focus on difference is understood here, as working to destabilise or interrupt otherness (Wilkinson & Kitzinger, 1996).

CONCLUSION

The epistemological and ontological assumptions of this project have been outlined in this and the previous chapter. They reflect the ideas that have influenced and encouraged the theoretical shifts of this project. They also reflect the ideas that provided coherency in working towards the aims of the project. This is in the search for new ways of making sense of 'lesbian health' that might potentially influence health practices and knowledges.

This chapter appears to be a clear elucidation of 'a thesis process', though much of what is written is contested and continually under review. The chapter raised a number of issues, which examined assumptions underlying the accounts of the method and analysis. I understand analysis as an ongoing and cyclic process. As a researcher, I have not assumed that I can take a neutral role in the process. I have also considered what it means to carry out research with women who identify as lesbian. The heterogeneity of this group can be questioned, and such a questioning has consequences for the participation and representation of lesbians in research. Reflexivity about my claims as a 'lesbian researching lesbians' highlights beliefs I held about my role from the early stages of the research. As this project is feminist and qualitative, attention to the thesis processes leads me to examine specific assumptions that underpin these methodologies. This is, at the very heart of feminist, critically discursive, and qualitative research.

SECTION II
ONE THING AND THE OTHER: DISCOURSING ABOUT LESBIAN HEALTH

Section Two examines the intersections between sexuality and health. More specifically, it explores the intersections between representations of lesbian sexuality within discourses of health and illness. 'Health' and 'sickness' emerged from the interview accounts as two dominant discourses of lesbian health. The analysis of the constructions of 'lesbians as sick' and 'lesbians as healthy' are presented in Chapter Five and Chapter Six, respectively. In Chapter Five, a brief discussion of the images or archetypes of both 'sick' and 'healthy' lesbians found in literature material prefaces the interview analysis.

A discursive rather than an epidemiological approach was described in Chapter Three as offering an understanding of how particular risks and the prevalence of specific health concerns become associated with lesbians. The advantages of a discursive approach are that it focuses on how and what knowledge is created and made available to selected audiences about health and illness; it provides a sense of what health concerns exist for lesbians; and more importantly how this character of illness and sickness becomes accepted. This section discusses how notions of health and illness, body and mind, heterosexual and homosexual, combine in the construction of discourses about sick and healthy lesbians. It examines how these notions are related to underlying dichotomous discourses, such as nature/culture, individual/social, in their explanations of the aetiology and solutions to health issues as well as representations of sexuality and illness.

Discussions about health 'issues' have been traditionally divided into three substantive areas, reflected in Chapter Two: mental health, physical health and health care issues. These are often regarded as 'common sense' divisions. In this section those common sense divisions will be problematised, particularly those distinguishing physical and mental health. In Chapter Three, illness, health, and disease were identified in relation with each other, and to discourses about society and biology. Illness was identified as synonymous with social discourses, and either distinguished from notions of disease (represented in bodily or physical terms) or as making sense in relationship with each other. Health was presented as an absence of disease, taken into account only when a person is ill (Radley, 1994). Health and illness were also discussed as a binary in which

both are explained in terms of non-physical (social) aspects, with health often having meaning in times of sickness. However, the slippage between medical and nonmedical uses of the term illness, meant that illness could be explained in physical terms. The construction of social discourses about health, illness, and sickness, is important for understanding the production of lesbian subjectivities explored in this section of the thesis.

As lesbian health concerns appear to be limited by understandings of what constitutes 'lesbian', the production of lesbian subjectivities in the context of health and illness is important here. Attention to the work of Foucault in the *History of Sexuality Volume 1* (1976) requires discussing the way in which sex is "put into discourse" (Foucault, 1976, p. 11). The assertion made in the opening chapters is that lesbian health is an oxymoron. Yet, there is concern that scarcity and rarefaction arguments (over the amount of available lesbian health information) often characterise the ways in which sexuality has been discussed as repressed or invisible in health. Despite an increasing body of literature, the argument that producing more health information should improve the status of lesbian health does not yet appear convincing. The search is instead for instances of the discursive production of sexuality and health. Attention is directed towards the administering of silences via these moments of production, particularly in the production of power and continuation of knowledge, and therefore, to understand how lesbian health is limited or enabled by the discourses that constitute it.

CHAPTER V

SICK LESBIANS AND LESBIAN SICKNESS: STILL CRAZY AFTER ALL THESE YEARS?

ARCHETYPES OF LESBIAN HEALTH AND SICKNESS

In this chapter, images of 'sick lesbians' and 'healthy lesbians' drawn from a preliminary analysis of the literature reviewed in Chapter Two are outlined. These archetypes (which in this context I use to describe a cultural construction rather than the psychoanalytically loaded term) were drawn from gay positive researchers' own work and their commentaries on other pathologising accounts. These archetypes introduce a discussion about representations of 'lesbians as sick' or 'healthy', and reflect a range of expert accounts from pathologising to gay positive descriptions. Interview accounts are more fully explored in the second part of this chapter. Each of these archetypes may be linked, and in contradictory ways. They reflect the multiple ways in which lesbian sickness and health have been constructed, and are displayed in contemporary accounts. These archetypes or images do not attempt to distinguish discussions or constructions of sexuality from those of health 'concerns'.

The following archetypes will be briefly explored: the sick lesbian, the contagious lesbian, the lesbian alcoholic, the immature lesbian, the oppositionally defiant lesbian, the homosexual (pseudo-male) lesbian, the 'other' woman, the sexual lesbian, the lesbian victim, the pink dollar lesbian, and the super healthy lesbian. A discussion of lesbians as sick was introduced in Chapter Two. The archetypes are dominated by representations of 'lesbians as sick'. This emphasis reflects the overwhelming attention of published research to health *concerns* and the desire of published research to improve health status, which may also be an artefact of the analysis. These archetypes offer just one perspective of a range of possible representations of this material.

The 'sick' lesbian is the first of the archetypes discussed here. There is a historical (and contemporary) discourse of lesbian pathology which, by constructing a notion of lesbians as pathological (whether physiologically or psychologically) emphasises lesbians as sick in some way. Lesbianism could be seen as an illness for which there is an aetiology (nature), a diagnosis and a cure (Stevens & Hall, 1990). Doyle (1967) writes:

> From this description of what a homosexual is, what sexual activities he [sic] performs, and why he [sic] is sick, we might ask what we, as professional people, can do to help these troubled individuals (p. 40).

The archetype of *the contagious lesbian* progresses from this discourse of sickness. Literally described in terms of 'lesbianism as contagious', contagion discourses of lesbian sickness are strongly influenced by the notion that homosexuals harbour contagious diseases as well. The most familiar intersections here are HIV and AIDS. This contagion discourse is imbued with notions of risk about both sexuality and health. Lesbian women were included in the tide of naming of high-risk groups because AIDS was first constructed as a gay epidemic (see Miller et al., 1995). This includes the false presumption that lesbians were at high risk from HIV, AIDS and other STDs, and therefore are potential infectors, or vectors.

Additional to this is the belief that 'gay' is somehow transmitted, caught, or infected. An article from *Out* magazine in 1999 described a study that mooted homosexuality to be a virus which alters genetic codes (Crain, 1999). This sub-discourse can also be found in the current debates in the education system over curriculum content and teaching about lesbian and gay sexualities. This is most evident in Section 28 of the Local Government Act 1988 debate in Britain in which teachers are banned from mentioning homosexuality. The key parts of the text are that local authorities shall not "intentionally promote homosexuality" or "promote the teaching in any maintained school of the acceptability of homosexuality as a pretended family relationship" (Wilton, 1995a, p. 192). The reference to 'intentions to promote homosexuality' reflects concerns that this may 'persuade' young women to pursue a lesbian 'lifestyle', through the combined recruitment behaviours of lesbian and gay communities and the presumed vulnerabilities of youth.

The archetype of *the lesbian alcoholic* draws on material related to addictions presented in Chapter Two. This literature suggests that lesbians are not only seen as being 'sick', but also as having a condition to which a wide variety of health problems can be attributed (Stevens & Hall, 1990). The particular construction of alcoholism as a co-disorder to lesbianism, provides the evidence for this (Nardi, 1982). As Nardi (1982) states, "rather than studying alcoholism among homosexual populations, researchers tended to look for homosexuality among alcoholics" (p. 15). In a sense, this archetype also provides an account of and for all the diverse 'sickness' archetypes offered here.

The archetype of *the immature lesbian* reflects that lesbians have a historical legacy in which they are regarded as immature, or 'psychologically maladjusted' (Stevens, 1993). In the historical account, the adult lesbian was regarded as arrested in her development (towards adult heterosexuality) at an adolescent stage. However, the archetype refers to a contemporary view, which argues that lesbian immaturity is a consequence of an arrest in her development towards a stable *lesbian* identity. When homosexuality was removed from the DSM III, the notion of the well-adjusted lesbian was retained in the diagnostic category of "ego-dystonic homosexuality". This category refers to individuals who are disturbed by, in conflict with, or who wish to change their sexual orientation (Burns, 1992). Based in a liberal construction of a healthy lesbian as 'one who is well adjusted to society' (rather than vice versa) (Kitzinger, 1987), sickness is notified as the lack or absence in achieving such a state. The archetype of *the immature lesbian* relies on assumptions that lesbians are striving internally and psychologically to gain personal integration, and even that there may be various stages to be gone through to meet this adjustment (Burns, 1992). The focus of this view is on the individual - on the internal workings of the lesbian. As Burns (1992) states, "the lesbian may not be sick by virtue of her lesbianism but continues to require psychological services to help her reach developmental maturity" (p. 230). This archetype also includes a perspective of internalised homophobia (Kitzinger, 1987).

The archetype of *the oppositionally defiant lesbian* reflects concern that adolescents (in the United States in particular) are being inappropriately committed to psychiatric institutions for being 'gay'. While not explicitly stating that lesbianism is the pathology, it was indicated in a 1994 article in the *10 Percent* magazine that there is sufficient evidence of adolescent lesbians currently being committed to psychiatric institutions labelled as having an "oppositional deviant disorder" or "gender identity disorder" under the current Diagnostic and Statistical Manual categorisation (Mirken, 1994). What is important about this portrayal of sickness is that it is argued that the kinds of behaviours that constitute these diagnostic categories can also be regarded as the very behaviours that may reflect a process of coming out as an adolescent. This is particularly the experience of finding one's orientation at odds with the expectations of surrounding environments.

The archetype of *the homosexual (pseudo-male) lesbian* reflects two perspectives. Lesbians appear in both as being the same as or not distinguishable from men. The first has

already been alluded to in the discussions about HIV and AIDS, with the presumption that lesbians are 'homosexuals' and therefore become subsumed into the category 'men'. Here, sexual orientation is discussed apart from gender, with gender being ignored. Miller et al. (1995) assert that homosexual rights, and gay and lesbian rights appear to focus on and are referenced to men, with the consequence that "lesbian has tended to disappear" (Miller, et al., 1995, p. 438). The second perspective reflects the view that lesbians are less like women and more like men, and constitute a type of pseudo-male. The construct of a pseudo male appears in an historical psychiatric discourse of sexuality related to inversion (Lhomond, 1993; Wilton, 1995a). Lesbians were labelled tomboys, suffering from (unresolved) penis envy. They were identified as 'masculine' with male bodily characteristics such as male hair growth; an elongated clitoris that 'resembles a small penis' (Barale, 1991, cited in Wilton, 1995a); as having male hormones (despite men and women having both 'male' and 'female' hormones); as having a deep voice; and displaying 'male' behaviours:

> They admit that, right from childhood, they had a passion for masculine games, dressing like a man, dancing with a woman, smoking strong cigars, getting drunk, riding horses, fighting; others began smoking at five years of age, liked masculine pastimes and had a loathing for needle work (Lombroso & Ferrero, 1896, cited in Lhomond, 1993, p. 66).

The construction of lesbian in relation to 'homosexual' and 'male' have been considered together in this archetype, in which the silencing of notions of femininity, womanhood, or women's bodies is highlighted. The constitution of lesbian in relation to men *and* homosexuality produces different discourses than when considered separately, and they are particularly present in contemporary writing.

Lesbian women have not only been constituted in relation to gay men, but also in relation to heterosexual women. In this archetype of *the 'other' woman*, gender is the focus and lesbian women are constructed as the 'other'. For example, lesbians are either not included in the women's health literature (see Oakley, 1993), or are included as a separate topic (see Burns, 1992). Further to this, an articulation of the health needs or rights of women has primarily focused on reproductive health. While reproductive health is relevant to lesbians, reproductive health has been linked strongly to heterosexual women's rights to control their own bodies. In this way, lesbians have been effectively excluded (see Miller et al., 1995), locally and internationally. This has the effect of homogenising the experiences of lesbians, ignoring the huge complexity and diversity of

lesbians, and presuming that the same issues predominate for all lesbian women. A similar thing happens for bisexual women who are assumed in the medical literature to have the same experiences as lesbian women.

In the archetype of *the sexual lesbian*, a broad range of discourses has been included, for example those regarding sexual freedom (which may involve a variety of sexual practices including sadomasochism, cutting, and sex with men). It may also involve discourses that suggest 'normal' sexual behaviour for lesbians, and discourses about asexuality and celibacy. The attention is predominately on notions that produce discourses around ill health but which focus on (presumed or suggested) sexual practices for lesbians. Note that the sexuality of lesbians can also be ignored by a discourse that appears to produce a notion of lesbian as 'the celibate heterosexual'. The cervical cancer research with nuns (Saffron, 1988; Nye, 1994), which inappropriately extrapolated the findings of a study carried out with them to lesbians, makes a similar presumption.

The representation in this archetype of *the sexual lesbian* draws on the epistemological assumptions outlined in Chapter Three that constitute lesbian subjectivity about sex and sexuality. Kinsey's description of lesbianism as a normal variant of sexual behaviour, is just one example (Burns, 1992), or lesbians can be regarded as having a more natural, totally erogenous sexuality (Marcuse, cited in Abbott & Love, 1978). In the latter case, lesbians are constructed in relation to sex, being regarded as too sexual and therefore morally dangerous. Even radical feminist notions of lesbianism, which attempt to argue that lesbian identity should not be constructed about relationships, sexuality, or sexual practices, have frequently placed intercourse as the central and universal expression of 'normal' sexuality.

A lesbian is often seen as being either a member of an oppressed or disadvantaged group having additional or more stressors than the heterosexual to cope with and likely poor mental health as a consequence (Burns, 1992). In this archetype of *the lesbian victim*, she may also be seen as a victim of poor parenting, chemical or hormonal imbalances, traumatic sexual experiences, and so on (Abbott & Love, 1978). Lesbians as repressed, or oppressed, suggest that the consequences and causes of sickness are out of the control of the individual.

The concept of the pink dollar is often used strategically to encourage the view that it is good business to support 'gays'. The archetype of the *pink dollar lesbian* draws on the notion that 'gays' can purchase health resources if unwell. Where health is regarded as a commodity, there is considered no need to target groups for fiscal reasons. 'Health' is regarded as purchasable by high earning groups. Yet, the pink dollar concept primarily refers to gay men. As gay men are less likely to have children and are higher wage earners, lesbian women are doubly economically disadvantaged by this concept. Lesbian lack of health may be viewed a consequence of not motivating resources that they have erroneously been assigned.

The final archetype of *the 'super healthy' lesbian* is a reverse discourse that contests those mentioned earlier. It includes research 'evidence' which attempted to show that lesbians were generally more healthy than heterosexual women. This ranged from stating that lesbians have fewer reproductive problems (Peteros & Miller, 1988), had better mental health (if a well-adjusted lesbian) (Burns, 1992), were more independent, resilient, self-sufficient and so on, than heterosexual women.

One of only a few books devoted entirely to the topic of lesbian health *Alive and Well* (Hepburn, 1988) opens with the suggestion that "lesbians are more healthy than heterosexual women" (p. 8). Hepburn (1988) refers to research regarding gynaecological health and mental health (Fredman, 1975, cited in Hepburn, 1988). Hepburn (1988) suggests that lesbian health is the result of positive self esteem about being lesbian, and that internalised homophobia still accounts for aspects of poor lesbian health.

The archetypes offer an introduction to various images of lesbians as sick or healthy that can be found in the lesbian health literature. Presenting lesbian health as a series of archetypes also reflects the ways in which this particular kind of health knowledge not only produces an epidemiological picture, but is engaged in the production of particular discourses which can be extracted from a brief overview of the material.

The archetypes surrounding notions of lesbian health are fewer than those about lesbian sickness - the perspective of lesbian as pathology has a long research history. There may be a much broader sense of what constitutes lesbian sickness, as discussions of lesbian health or wellness can be influenced by the need to be unequivocal in any assertions

about 'health'. For example, there remains a considerable level of uncertainty as to whether lesbians are less at risk from cervical cancer or HIV, but it is more important to assert that there may be some level of risk rather than none. But a greater level of sickness accounts may be an artefact of health being determined by sickness, as health is often not considered until there is sickness. Even contemporary accounts of wellness incorporate a discussion on 'sickness', because wellness refers to a notion of balance between illness and health.

The archetypes reflect some similarities to the 'ideological' accounts of lesbianism offered in Celia Kitzinger's (1987) work *The Social Construction of Lesbianism* described in Chapter Three. These archetypes are similar to the kinds of material produced in the first stage of Kitzinger's (1987) research. Whereas Kitzinger uses her material as evidence illustrating her concerns about gay positive research, the archetypes I have produced through a brief sweep of the collected literature provide a starting point for the deconstruction of binaries only. Kitzinger's clear assertions problematising gay positive research were influential in my own reading of the lesbian health literature review material, though importantly and unlike Kitzinger I do not regard radical feminism as a solution. The suggestion that gay positive models have produced new kinds of oppressions has motivated my analysis and search for alternative epistemological approaches. While the archetypes evoke what Kitzinger describes as liberal humanist accounts producing everyday constructions of lesbianism, they cannot be regarded as an exhaustive list. They offer a provisional analysis of accounts of lesbians as both sick and healthy.

LESBIAN SICKNESS AND SICK LESBIANS

A focus on lesbian sickness dominated the interview accounts, through the mutual construction of lesbian health concerns and discourses of 'lesbian as sick'. Discourses of lesbian sickness feature binary notions of individual and society, nature and culture, which underlie and interact to engage in the production of these accounts. By examining the ways in which interactions between sexuality and illness are distinguished, collude or are represented, it is suggested that construction of the 'sick lesbian' remains despite 'gay-friendly' accounts or historical changes. The four areas that will be examined are: the representations of lesbian health concerns as predominantly mental health concerns (particularly alcoholism), the causes of sickness, the representation of lesbian

communities as inherently unhealthy, and the production and verification of sickness through lay accounts. These four discourses are introduced here briefly, using quotes[63] from one of the participants.

Deb Mental health stuff's definitely an area, I think. That could be for some lesbians, gay women. And I think that will manifest in body stuff eventually. I suppose I think the safe sex issue is a major for lesbians because of the- the ramifications of bisexuality [...] You know, like they could be specific lesbian issues when it comes to the sexual- sexual side of it [...] I don't think it's been particularly sufficient in the amount of education around this. I mean it is generally said that lesbians are less likely to contract AIDS because they're lesbian [...] The other health issue for lesbians which is not specific to lesbians, but is a very major one, is the bloody domestic violence within lesbianism which really is a sore point with me, because as a group we haven't dealt with it at all well. [...] I don't know much about the drugs - I mean, there's alcohol stuff too - fuck. They are issues of lesbian health that are not - of course they're not peculiar to lesbians - but they are going to become areas that need education.

In the first instance, Deb overwhelmingly refers to issues that appear to produce 'poor' health. Deb's account reflects the main health concerns raised by participants in this project, which are in the broad areas of mental health, including violence, drugs and alcohol. The exceptions here are her comments about HIV and AIDS. Deb suggests that lesbians are less likely than heterosexual women to have sexually transmitted diseases, distinguishing between the apparently social issues of mental health and a bodily and *contracted* virus or illness.

Deb I actually don't know [if there are health issues for lesbians]. It depends what you call health issues? Are you saying there are particular illnesses or sicknesses that lesbians are going to get by being lesbian? I don't know. I haven't really thought too much about it [...] it seems to me there's a lot of issues that are by no means peculiar to lesbianism but are lesbian issues, because in fact we're not dealing with them as the heterosexuals have been dealing with them. [...refer quote above...] All those things are health issues that I think are going to become very specific lesbian health issues. And of course. This *new* one - of what constitutes a lesbian! Is a lesbian a woman born woman, or a lesbian born man converted to- had that medical - a transsexual. That's a whole mental health area that's going to come up. That's a whole health area in its own right.

[63] I remind the reader that the transcribed quotes retain features of the participants' speech including mid-sentence breaks, repetition, and non-standard forms of grammar, such as inconsistencies in tense.

Despite being uncertain whether there are lesbian health concerns, Deb discusses causes of 'lesbian sickness'. She identifies ill health as being produced in particular ways. She suggests that physical health concerns are the consequence of a manifestation of mental health on the body, or other social causes. Illness and sickness depend on, for example, a lack of education or poor management of health concerns, in ways that are different from heterosexuals. Deb has a concern over 'whether there are particular illnesses or sicknesses that lesbians are going to get by virtue of being lesbian'. Accounts of lesbian sickness enter various debates in which there is a tension, between asking whether it describes health concerns associated with lesbians or whether it is a more fixed and inherent nature of being lesbian.

The two remaining areas of lesbian sickness considered in this chapter refer to 'sickness' being produced and verified through lay accounts, and the representation of lesbian communities as inherently unhealthy. Deb notes, when she says it 'depends what you call health issues' that personal experience is authentic knowledge for deciding lesbian health concerns. She queries what definitions of lesbian can be used, and identifies that there may be multiple perspectives outside of traditional definitions. Interestingly, having diverse definitions or means of constituting lesbian not only causes difficulties but also gets reproduced as a mental health concern ('that's a whole mental health area'). To put her discussion in context, at the time of the interview there was a debate in lesbian community newsletters about excluding from some women-only and lesbian-only events, women who were not born women. Deb comments that lesbian communities have not addressed concerns over domestic violence, and so she implicates lesbians as a group as culpable in this health problem. This overview of the discourses of lesbian sickness introduces the more detailed examination that follows.

Personal accounts: Alcohol and drugs

The discourse of lesbian sickness examined here is verified through personal accounts, via representations of lesbians as heavy drinkers or alcoholics. The representation of 'lesbian as alcoholic' (lesbians viewed as having high levels of alcoholism or alcohol use) is a dominant feature of participants' discussions about lesbian health issues and 'sickness', but is not limited to discussions about alcoholism as it also encompasses incidences of (illicit) drug use and cigarette smoking. The discussion considers how the participants, through personal verification, make sense of research that suggests levels of

alcohol consumption are a concern for lesbians. It then examines participants' discussions about interactions, perceptions, and experience with addicts, in both the current and historical context, and the impact that these have on the constitution of lesbian subjectivities.

Ellen [...] I went on to one of the [focus group] health things that [a research team] organised [on lesbian and gay health]... The report was really good. Because I left [the focus group] being really fearful that - it sounded like they were going to concentrate on things that they'd always concentrated on - they always concentrate on drugs and alcohol.

In the extract above, Ellen refers to research studies focusing on drugs and alcohol. She claims that because lesbian research always appears to focus on 'addictions', the attention in itself presumes that alcohol and drugs are a *lesbian* concern. Morgan asserts that research findings also indicate that lesbians drink a lot of alcohol, do a lot of drugs and smoke lots. The apparently high rates of alcoholism discussed in the literature appear to imply that lesbians are not doing as well as they could be, or as well as heterosexual women are doing.

Morgan I think there's lesbian alcohol health issues - definitely. Yeah I did a bit of a survey on lesbians and alcohol...And I found all this information on pregnancy and alcohol, and then found more information about lesbians and alcohol. And there's just such a high rate of alcoholism amongst lesbian women. Much more than what there are in the heterosexuals per capita.

In the context of her discussion about lesbians and alcoholism, Morgan talks about pregnancy and alcoholism, and indicates she found additional, or more, information about lesbians and alcohol. Given the concern over the risks to prenatal development and the implied roles of women as primarily responsible for prenatal care, lesbian women, in this context, appear to be overemphasised as an area of concern.

In the following extract with Morgan, there is a conversation between us about the emergence of a potential overemphasis on lesbians, and alcohol. Morgan initially comments that having already done 'her own research around', her perceptions confirmed that 'this alcohol thing' is 'quite a big health issue for lesbians'. But in another New Zealand study of lesbian health, Welch (1995) suggests that lesbian women may have a higher perception of the 'problem' of alcohol and drug issues than actually exists.

When questioned about potential over-perception of alcohol as a problem Morgan claims that further research would be needed, and that verification with other lesbian women would be important. Given the overwhelming pathological attention of research and medico-scientific approaches, research has the potential to be regarded sceptically in the context of lesbian health. It appears that experience has the potential to provide research material with verification or not, and may serve as an attempt to deal with contradictions in research findings, or its intent.

Morgan [...] So I did my own little research around that, and came up with my own theory on it, and I think it's mostly social...So I think that's quite a big health issue for lesbians, is this alcohol thing.

Sara In some research into lesbians and mental health in New Zealand last year, it found alcohol use was quite low amongst lesbians, but the perception was high. What's your reaction to this?

Morgan May be it was just what I was reading. I don't even know. I probably didn't even really look to see who had written what I was reading. 'cause I mean, you're only reading someone else's work aren't you? Yeah I was quite surprised myself to find that. It will be interesting to look into that and see what it is. You can only get other people's information. Unless I went out and did a survey on all lesbian women.

It is her experience (not simply her perception, or perceived view) of witnessing 'unhealthy' behaviour, Hine suggests, that provides an authentic account of lesbians as heavy drug and alcohol users. Statistics are regarded as only being able to provide some measure of how often these unhealthy behaviours occurred. This type of research knowledge, Hine comments, is irrelevant because the existence of these health problems has already been confirmed.

Sara I'm interested in what we perceive as specific health issues, and you've mentioned from drugs and alcohol, to violence, relationship issues-

Hine I'm only speaking from what I've witnessed and experienced, so they're not my perception. But I can't perceive how much of it is. It's only from my experiences of being in those little groups. In terms of a national statistic, I wouldn't have a bloody faintest. But I do know from my own experiences, it was there.

Max similarly asserts that she knows of many lesbian women who are or have been alcoholics. She dismisses statistics and asserts that there were 'lots and lots of women that I knew'. Max uses heterosexual women as a comparison or norm to solidify her account of many more lesbians having drinking problems.

Max Heaps of lesbians I know were recovering alcoholics or are still alcoholics, or smoke a pack a day, or [there were] probably heaps less heterosexual women. I don't know statistically. All I know is that there were lots and lots of women that I knew who had drinking problems. And I'm not sure if I know many heterosexual woman who do.

So there appears to be a tension between research, which is seemingly dismissed for stating that lesbians have high rates of alcohol and drug use, and personal experience which asserts a similar perspective but that has a particular authenticity in the current context. Liz Bondi (1993) suggests that personal experience allows usually subordinated perspectives to be articulated. Personal accounts may have an important role in enabling concerns over alcohol to be raised in other frameworks than that of pathologisation. Attention then to the features of personal experience, engaged in the production of accounts of 'lesbian as alcoholic', becomes the focus here.

Personal interaction appears to be the principal way through which representations of lesbians as heavy drinkers (smokers and drug users) are verified. Jo supports Lee's comment that 'most lesbian women smoke' by directly referencing it to her own initiation into smoking, and (she later confirms) coming out.

Lee Smoking. Most lesbian women smoke.
Jo I started.
Lee And more than just the brown stuff too. Some of green. Yuck. Refuse that.

(she later adds)

Lee And not many heterosexuals do much rush either. I'll give them credit for that one. And you see a lot of that at the club. And it's not just the guys. I've mostly seen females using it.

Ellen reiterates that she knows women who use drugs and alcohol substantially, and adds unhealthy relationships to her list of lesbian health problems. She re-asserts that lesbians could do better in terms of mental health. Such representations, based on experiences of lesbian women in unhealthy relationships, and of heavy drug using and alcohol use, appear difficult to question. Criticism of such knowledge may appear as an attack on the person from whom this knowledge came.

Ellen I mean I'm concentrating pretty much on mental health and I think a lot of lesbian women - this is an area that there could be a lot more health I think. A lot of - I know personally a number of heavy drinking lesbian women. I know a number of fairly heavy drug using lesbian women. I know women in fairly unhealthy relationships.

Bondi (1993) supports the view that it is hard to question knowledge that comes from personal experience. As Bondi (1993) explains, in liberal feminist politics, knowledge is considered to flow directly from experience in turn ensuring the authenticity of knowledge. Claims to authenticity are not the same as claiming truth, but implies the following:

> rather than being constructed, experience has the quality of an irreducible essence, which resides in such characteristics as female-ness, middle-class-ness, white-ness and so on. It also invokes a kind of personal immunity in that to authenticate knowledge in terms of personal experience is to make one's ideas and one's being indistinguishable. Consequently, anyone who criticises knowledge produced in this way is liable to be accused of attacking the person from whom it originated (Bondi, 1993, p. 95).

While personal interaction offers the possibility of authenticated knowledge, it is also regarded as informing the ideas and actions of participants, and can change depending on the context. Therefore, it appears to offer greater flexibility than material verified through traditional research approaches. The following extracts from Ellen and Maggie suggest that any notion of alcohol or drug use being linked to a coherent identity can be questioned when comparisons made to earlier generations reveal possible changes in alcohol use. These changes in alcohol use reflect increasing abstinence or a reduced prevalence, and relate to environments perceived to be progressive. Lee has already commented on the differences she has noticed in starting to associate with different groups of women. However, these reflections are always comparative, and lesbian women still appear to have a 'greater' incidence of substance use.

Ellen The people that I mix with [...] some of those women have been through drinking. And some of those women have been through drugs. And some of them are still social drinkers, and social drug users. So they're not sort of extreme. [...] And some of the people I am involved with it has been in the past, and I don't know whether it is because they've grown up and realise that it was something they wanted to carry on for the rest of their lives. [...] I've just been to lesbian dances - and not so much recently I have to say. There tends to have been a little bit of a switch I think. Or maybe these women just aren't going to dances. And women just used to get absolutely *rotten.*

Maggie also makes the suggestion that alcohol abuse is not so prevalent now as it may have been, but that within her own (and mid-age) generation high use of alcohol has been obvious amongst her peers. So, personal interaction not only appears to authenticate knowledge, but it informs identity in such a way that it can reflect historical variability.

Maggie I don't know whether it's so prevalent now, but there has been a lot of alcohol abuse, and probably amongst our peers, or our generation - maybe that has been more of a thing than drugs?

In the next extract, Wyn initially suggests that it was not her experience that a lot of lesbian women used alcohol and drugs, and appears uncertain whether lesbians can be regarded as having high rates of alcohol use. However, she contradicts herself and asserts that 'it just seemed often'. Wyn's 'sheltered' life, in which she experiences few people who used alcohol and drugs, appears presumed upon norms of heterosexuality. Even stating in her interview that very few people know her to be lesbian and that she prefers to maintain it that way, Wyn appears to distinguish her 'sheltered' life from what a lesbian 'lifestyle' might be. However, mixing intimately with other lesbian women she does associate with heavy drinkers. In addition, she explains how much attention is paid to alcohol and drug issues at lesbian forum she has attended, and confirms this with her own experience of a woman partner who was alcoholic. It is in the difference between her sheltered life and her interactions with lesbians in social contexts that Wyn consequently affirms an account of 'lesbian as alcoholic'.

Sara Was it your experience that a lot of [lesbian] women used alcohol and drugs?

Wyn Well not a lot. But I mean, I saw enough to feel that - maybe it was just because I live a sheltered life before. Maybe it's not any different than anywhere else. But it just seemed quite often. It seemed to me- And of course [the woman] I was involved with turned out to be an addict...And a few of the conferences, and weekends and days that they had those things [addictions] always came up. People have slowly been more open about it, and prepared to talk about it.

Notably, a common aspect of accounts of lesbian as 'sick' is their production and verification in comparison to perceptions about heterosexual women or a heterosexual lifestyle. Heterosexuality acts as a norm against which the 'incidence' of alcohol, drug, and cigarette smoking concerns are made. Therefore, implicated in discourse of 'lesbians as sick' or unhealthy is a construction of lesbian sickness in relation to the heterosexual

woman. Jo's account of lesbians as no different to others in their alcohol use, also appears a legitimate account especially when her young age (early 20s) and experience of the gay and lesbian club are considered.

Jo I don't think they drink more alcohol than anybody else, but I do think they smoke lots. When you go to the club almost everybody smokes.

The perceptions Jo holds, while they differ from Wyn's and other accounts above, still appear to be authentic. This also confirms the difficulty of dismissing personal accounts, even when the discourse of 'lesbian as sick' appears shaky as a consequence. Personal experience appears both relevant and legitimated as the knowing discourse.

In these accounts, there is evidence of a discourse of 'lesbian as sick' which functions through suggestions that 'lesbians are alcoholics' (drug users and smokers). However, these discourses are already critiqued as historical and as pathologising. The ways in which 'lesbian sickness' has entered the discourse of 'lesbian as sick' and is constitutive of lesbian subjectivity, in the participants' accounts, is notable. Of particular interest is the verification of 'lesbian as alcoholic' through personal accounts and interactions that claim authenticity.

The participants' accounts reflected a desire to desist from pathologising research statistics, and despite similar findings and potential overrepresentation, to claim authenticity for personal experiences. It is implied by the gay-positive literature that the influence of such a dominating discourse of homosexuality 'as sick' could be usurped by the availability of other discourses. However, through their personal accounts lesbian women appear complicit in the production of a discourse of lesbian sickness. Personal verifications also appear to allow for flexibility, variability, and heterogeneity in the participants' accounts, giving sickness accounts authenticity, while contradictory and changing. This discourse of 'lesbian as sick' appeared to change between generations, when socialising with different groups of women, and as one participant suggested when she moved outside of her 'sheltered life' and into a more diverse or different social group.

Personal experiences are regarded synonymous with lay accounts. Lay speakers are not often considered to be experts, and negotiate their understandings of medical discourse

in a social sphere, which is presumed to be distinct from the medical one. However, the interview material shows that lesbians do manage and negotiate information from scientific discourses. In a perspective that attends to social aspects, health and illness "make sense in light of the lay person's cultural traditions and assumptions about reality" (Radley, 1994, p. 14).

> The cultural perspective poses biomedicine, not at a distance from lay beliefs, but as a set of ideas that connect events in the social world with mental and bodily feelings. As well as using medical knowledge to organise their own experiences of illness, individuals grasp the social significance of medicine through sharing in its cultural meanings (Radley, 1994, p. 15).

It could be suggested that social and cultural accounts were present simply because I focused on lay participants and did not interview doctors. However, doctors can be assumed to have come up with a similar set of accounts and interactions, which would have been locatable in their experiences in their practice, rather than in lesbian bars or social events. The ways in which this material is managed reflects how the discourse of lesbian as sick is socially constructed (Haraway, 1991).

The discourse of 'lesbians as sick' appears to be a consequence of some shared essential features of lesbian existence, since claims to the authenticity of experience relies, as Bondi (1993) states, on a notion of experience as having an irreducible and essential quality. However, cultural accounts dominate here, because this knowledge is produced and confirmed through social interactions which already have shown the possibility of change.

AETIOLOGIES OF SICKNESS

A discourse of 'lesbian sickness' appears to be produced in accounts about its causes or effects. The construction of the aetiology of illness (as medically and scientifically located) and illness solutions (or the production of health) can be considered to have consequences on lesbian subjectivities. This is particularly visible in the dispute over whether lesbianism can be regarded as the cause of sickness, in a material or social form. There is a dialectical relationship here, in which the constitution of lesbian health is regarded as producing a notion of sickness (or health), and accounts of lesbian 'sickness' produce discourses about 'lesbian health'. The following discussion focuses

predominantly on alcohol and drugs. Other mental health such as suicide, depression, and poor relationships are included.

Lesbian cause and consequence

The importance of the sickness discourse does not just lie in its existence, as it could easily be disregarded given the presumption that people get sick and experience mental health problems. The particular claims here refer to the suggested consequences to identity that sickness or illness constitutes. As Lupton (1994) asserts:

> The onset of illness, especially if severe, constitutes a threat to the integrity of the body and self-identity, and requires a status change from well person to patient (p. 79).

While presumed ill 'effects' of lesbianism are considered, they cannot be distinguished from questions which ask about aetiology of illness, since both potentially pose a threat to identity. These questions ask whether "lesbians are sick by virtue of their lesbianism?" or if "there are social factors surrounding lesbianism that make women sick?" The former argument is related to a discussion of the nature of 'lesbian', while the latter is focused on the social aspects. They are located in much longer-standing discussions about how health gains can be made if sickness precedes a lesbian identity, or is a consequence of it. Notably, in its historical construction as a co-disorder to lesbianism, alcoholism has been presented as both.

Lesbianism is regarded in the following as a cause of other sicknesses. Morgan comments how her psychiatrist appeared to treat lesbianism as a cause of her mental ill health. In the context of identifying as gay, she interpreted her sexuality, specifically her childhood and relationship to men, as the focus or cause of the 'problem'. However, she was uncertain whether she was treated differently because she was a lesbian, or whether this was his usual approach.

Morgan Just because I think that I was probably treated differently because I was lesbian other than just a woman. I think it became an issue that I was lesbian. [...] He just kept bringing everything back to men. Instead of how I am now, it was how were you in your childhood. But then that's psychiatrists too. So I couldn't really be sure whether he was just like that or not [...] because yeah they do tend to fob it off "oh well. Oh you're gay! What do you expect?", you know, "Oh that's the problem".

Kay also refers to occasions where lesbian was regarded or diagnosed as the cause of other (mental) health concerns. Her attention here is specifically on experiences she has heard recounted by women who have been in a psychiatric institution (Tokanui). What she suggests is that the notion that being lesbian is the cause of mental health problems is produced by those responsible for creating the problem, the mental health professionals. The causes of mental health issues she suggests, is not lesbianism, but rather the attitudes of the staff in the mental health field.

Kay [...] over time I've had some contact with lesbian women who have spent some time at Tokanui, and something that they are clear about is the attitude was that their lesbianism was probably contributing, or the factor, the reason for their problems. When in fact they the staff were creating the problem. But that attitude runs right through that kind of mental health field.

Participants' accounts reflected a tension over whether lesbian health concerns had any relation to notions of 'lesbians as sick'. Vita emphasises that to 'be' lesbian is not to be inherently sick or ill. Vita asserts that she is not sick because she is 'a dyke', she is just sick.

Vita [...] all the times I've been into see the doctor lately I've never had any reason to tell them I'm a dyke just because I'm sick so I just haven't, you know, it's not important. It's not just because I'm a dyke that I'm sick, it's because I'm sick.

Lee also raises questions about identity when she clarifies that while 'most lesbian women smoke', but 'I didn't start because I was confused about my orientation'. However, Jo does directly link being lesbian to her starting smoking. She notes that the social patterns and effects of smoking were useful to her during the time of stress as she came to identify as lesbian.

Lee Smoking. Most lesbian women smoke.
Jo I started.
Lee [...] The only thing I'd smoke is cigarettes, but then I smoke[d] that since I was eleven. But then I didn't start that because I was confused about my orientation. I started that because it was cool. And then I got addicted. [...]
Jo Well I started because I was quite stressed out [coming out]. And it was just relaxing. It was just a thing you used to do by yourself - go for a smoke outside, and think. And it is quite funny how a lot of lesbian women do smoke.

At this point of enquiry, discourses of lesbian sickness, authenticity and personal experience (mentioned earlier) merge or contest at the points when mental illness is understood as constituted through these notions of identity. There is a tension in the accounts between those apparently coming from health professionals and those of participants. Where health professionals identify sexuality as the cause of lesbian mental health problems, participants predominately see mental health problems as a consequence of the social conditions of 'being gay'. The following sections further examine accounts that regard lesbian sickness as a reflection of lesbians having insular lives, being isolated from society, and stresses imposed by these. In particular, interest is focused on asking whether 'accounts of mental ill health rely on invariant social categories, functions, and activities to which all lesbian women are assigned?' and is 'mental health part of a shared essential characteristic which must be able to be understood also in purely social terms?' (Grosz, 1995).

Bar culture

Isolation of lesbians is regarded as producing ill health. Isolation is discussed in general terms as 'not fitting in'. Isolation may be from the norms of family, society, heterosexuality, or incorporate a sense of being different, or as consequent on a lack of support. Some accounts of lesbian health rest upon a belief that lesbians are unhealthy because of the social environments that lesbians create (and interact in), and because they are isolated from society. Both cause and effect are implicated here.

Alcoholism in lesbians has long been regarded as an effect of the social environments that lesbians participate in. The gay bar or club culture has received a great deal of attention, both as an exotic and an unhealthy environment. This discussion refers to relationships between isolation and the particular or limited social environments in which lesbians can socialise.

Morgan and Hine support the perspective that there are few spaces for lesbians to socialise in and these appear to be limited to bars and clubs. They both refer particularly to social events, which occur around alcohol and food, and provide otherwise limited opportunities to meet other lesbians, lovers, or partners.

Morgan I [...] came up with my own theory on it [lesbians and alcohol], and I think it's mostly social. It's just because we're just so limited. In our social activities and where we can meet. And alcohol's a big part because, it's a big part in *life*!

Hine [...] because the world is so small for lesbians, we may meet them in a variety of settings, but the main setting is usually at a lesbian nightclub, or a lesbian party. You'd be lucky if you met them at a lesbian conference. And so, the majority of places that we meet each other is usually when we socialise, and that's usually around beer or food.

Vita indicates in her example of the lesbian club, the Midnight Club (open in Auckland in the 1980s and early 1990s) that 'everybody drank'. Her assertion appears 'common sense'. That is, she is stating that that was just the way it was.

Vita You go to Midnight Club and there's smoke everywhere [...] Everybody's drinking. You know, it's just the way it works!

The extracts above resonate with the proposal by Joanna Hall (1993b) that lesbian alcohol consumption is linked to communality. The following quote refers to Hall's second suggestion (discussed below) that alcohol is a response to the isolation of lesbian existence. Morgan confirms this second point in her extract that alcohol is part of lesbian life because 'being lesbian can be really lonely'.

Morgan And I think we all get really lonely. I think being lesbian can be really lonely. So I think that's how alcohol comes into it.

Hall (1993b) elaborates on these two themes about lesbian alcohol consumption being common in the context of lesbian bars. She comments that:

> (1) drinking alcohol and gathering in lesbian bars symbolizes positive self-expression and communality for lesbians, and (2) lesbian alcohol use represents societal repression, as does the virtual ghettoization of lesbians in bar environments. Thus alcohol use has paradoxical meanings for lesbians: self-affirmation and nonconformity to heterosexual expectations versus isolation, repression, and self-deprecation (Hall, 1993b, p. 114).

As the comments so far reflect, participants hold both positive and negative associations between alcohol and the shared spaces that lesbians mix and interact in. Hine, for example, proposed that the environment of the lesbian nightclub or bar, provides a place to meet, but that the lesbian club environment can produce 'poor' lesbian behaviour, for

example, socialising around alcohol, and or acceptably drinking and taking someone 'home'.

Hine [...] And I certainly noticed that at the [overseas] lesbian nightclub, where that - you drink a few, you dance, you drink a few, and next minute there's a 'click' and you've found somebody and you walk out the door.

Hine is commenting on an experience in which she and her friends spent an evening in a lesbian nightclub, having not been in one for some years.

Hine So I guess in my early days of being a lesbian, that's how we all met [at lesbian nightclub or party...]. I don't know whether it's the early stages of being a lesbian that you drink a lot, but I know it's certainly not in the later stages because I don't see it as much as I used to [...] No actually I'll take that back [...] a good friend of mine [...] I haven't seen her for years [...] and she still drinks about the same amount, so- it might be an individual thing too.

Whereas Hine accounts for the 'poor' behaviour of lesbians in terms of the social aspects of bars, in contrast the drinking of her friend (who 'still drinks the same amount') is portrayed as an individualised account more or less distinguished from lesbian culture. The implication is that while not all lesbians are alcoholics, the poor social environments establish precipitating factors.

Maggie It was the accepted legal thing to do [drink alcohol and smoke drugs]. I know in my case it was and it was around my sports - and then I walked away from it, but what say I hadn't.

Hine and Maggie both state that the socialising around alcohol may just be an 'early stage' of being lesbian when other interests or connections have not yet developed. Hine, however, locates her friend as individually responsible for not having moved beyond this, suggesting that alcoholism is a fixed state. In their accounts of lesbian culture however, the environment or 'lesbian' appears to be again something that can change, be acted upon, or is managed.

Ariah suggests that the ways in which she was supported through a coming out group, was that group members socialised together at clubs and other activities. She refers to

the club environment as intimidating, to someone going up on their own, without having any social contacts. Again, the environment for socialising is clubs.

Ariah I did a coming out group to start off with, which was quite good. [...] We did a lot of stuff together, as in like going to clubs and stuff, which was good, to find- because that's one of the worst things up there to go to a club by yourself, if you didn't know anyone.

Bars appear as spaces in which lesbians can socialise and meet. In a dialectical relationship between poor health and alcohol, bars as lesbian social environments appear to be producing isolation and a focus on social drinking, as well being a consequence of isolation. Bars have positive and negative social aspects related to communality. However, the determination of lesbian ill health as produced through social accounts, is readily distinguished from an inference that 'lesbians' might 'be' alcoholics. The social environments, which may produce poor alcohol-related behaviour, can change. This is unlike accounts of individual alcoholics, which the participants, did not link to inherent aspects of lesbian subjectivities but linked to the individual.

Not fitting in

The discourse of isolation further suggests that lesbians exist outside mainstream environments. 'Not fitting in' is a discourse that reflects that the social environments lesbians exist in are different from those of heterosexuals. The following account by Angela offers examples of the environments in which differences in concerns between heterosexual and lesbian women might be realised, including families, work places, and relationships. Angela suggests that lesbians will have 'different issues' or difficulties that heterosexuals will not encounter, which include being excluded from their families because of their sexuality.

Angela [...] I think there are different issues for women, for lesbians, in relationships, because you're seen in a different light. [...] so there's still going to be a lot of pressure to conform and a lot from families that don't accept you and things like that, so yes, I think there are a lot of mental health issues for lesbians definitely [...] from a mental point of view there are other difficulties that straight women won't encounter [...] Yes, I think just the stress of being different. Yes. Yup. Of still not being accepted particularly by family with some people. The stress still in some work places.

The pressures of coming out are identified as being factors in ill health for lesbians. Coming out can be discussed as a metaphor of transition or process in which subjectivities and the recognition of being different from heterosexuals must be negotiated. Coming out can be further regarded in this context as a metaphor for isolation - it signals the differences between heterosexuality and 'gay' sexuality.

In the following extract by Ellen, she talks about what it was like for her in the process of coming out. Vividly describing her experience, she communicates her distress over her realisation that she 'didn't fit' in the heterosexual environment in which she lived. She also discusses a sense of the fear of being lesbian. The isolation that Ellen describes includes going through a process of years before she could access any external or formal support.

Ellen I can remember what it was like for me. It was really really hard. It was - what do I do? Where do I go? [...] I chickened out. I rung [an organisation where I thought there would be lesbians], and they gave me this number to ring and I never rung. So I waited another couple of years until I met up with some. But I remember that feeling really well - of a really wet, rainy, Friday night, being really distraught living in this heterosexual household. And knowing that I didn't particularly fit. (laughs).

In the continuing discussion, Ellen comments on the notion that society makes coming out or identifying as a lesbian difficult and hard. She specifically notes that 'being lesbian' is something women might not wish to be, and that they will resist it by 'turning to drink' and 'unsafe stuff'. She infers that this sense of being different occurs in the absence of affirmation, as a lack of encouragement or positive support from people external to those coming out.

Ellen I think it's about- I think there's a lot of lesbian women out there who don't feel good about themselves. I think there's a lot of women out there who have been - have had negative experiences who perhaps see being a lesbian as something that they don't want to be. Fighting it. And turning to things like drink, and really unsafe stuff. Maybe, I see a lot of lesbian women as needing real sort of affirming stuff. [...]

As Ellen's excerpt proceeds, there is the suggestion that isolation appears an inevitable consequence of 'being' lesbian. Ellen notes that isolation is at the very base of mental ill

health. She again emphasises the importance of and the need for women to come out into an environment where there is support.

Ellen So maybe my - sort of mental health focus area is on going right back to the base level, root level, in helping women come out. Or just - somehow letting women know that there are places you can go. There are people that you can talk to. That it's not something - it's not a sort of "Oh my god I'm a lesbian. I'm going to have to kill myself" type thing. I mean I've been doing some reading recently on suicide - and one of the highest, or they suspect that one of the reasons that young men in New Zealand kill themselves is because they suspect they're homosexual. And that shouldn't happen.

Ellen has suggested here that the experience of coming out may not be a transitory but a potentially unchanging state, which, in keeping with its definition, leaves some people suspended in the potential fears of what being gay or lesbian may bring about. In this being 'outside life' (to which a social death might be akin), suicide appears as a real option, even an inevitable one. Where suicide may be conceptualised as a giving up, Ellen offers an alternative perspective from her understanding of her experiences of isolation and realising her lesbian sexuality.

Toni's extract represents the process of coming out as a period in which women are increasingly isolated from societal expectations, but without yet having other knowledges or beliefs. It is this lack, absence or otherwise isolation and transition that Toni proposes can have significant consequences on women which can include those that 'stay locked away' and abuse drugs and alcohol.

Toni [...] Like the coming out process is very hard on any woman. And so then there's so much you've got to do in yourself. That transition because you're actually doing a lot of grieving and giving up society's expectation. I think we do look at a lot at ourselves. And also there is the other side. There's the one, the person that stays locked away inside and uses drug or alcohol abuse to keep the secret, so there is two camps.

Other aspects of coming out that may make coming out difficult and contribute to poor health, will be discussed later in this and the next chapter. These include the mythology of lesbian communities as supportive places, and the misrepresentation or romanticisation of these communities as sharing similar values between community 'members'. The societal constructs of lesbian as pathological, deviant or 'not normal' can

make coming out a stressful period particularly in the absence of supports and or affirmation.

Lack of formal support

Lack of formal support or access to what support is available, is also regarded as producing lesbian ill health. The participants' accounts indicated that a lack of support occurred because of two reasons. The first is limited resources, partly a consequence of the lack of lesbian and gay visibility. The second was that available resources were distributed to the most visible gay and lesbians, and were not evenly distributed within gay and lesbian communities.

Ariah comments that in contrast to gay men there are very few resources and information available for women; and those resources are more available to those located in a university environment. Universities have traditionally been regarded as liberal places. It is perceived that universities have a culture of access to and availability of a diversity of social resources, the ingress to which is limited to those who are at or have contacts at a university.

Ariah Well there's not much here [in Hamilton] is there? You want to come out - there's stuff for men - but there's not really for women. And the only stuff that there is around for women is through university, and unless you know someone from university or you go to university yourself, how are you supposed to get involved with that?

Jade elaborates further on the lack of professional support. She suggests that a lack of formal assistance for issues facing lesbians may increase the sense of isolation that someone coming out experiences. She is referring to the familiar kinds of assistance or understanding provided by medical care, including the accessibility and volume of knowledge. In our discussion we raise the idea of a 'coming out doctor' which Jade describes as akin to 'the ear, nose and throat specialist' for a sore throat. The notion of a coming out doctor was raised a number of times in the interviews. Coming out is described here as a crisis and as something that a person is struggling with.

Jade The [mental health] issues around, for lesbians coming out and not being sure of their identity and 'am I a lesbian, am I not?', and going through a whole personal identity crisis, and then not having some professional to turn to. [...] Medical knowledge identifies certain areas and so today if I wake up and I'm feeling sick with a sore throat I know I can go and talk

about this because there's a whole issue, that there are books and books written on this - so if I wake up one day and say 'oh I think I'm a lesbian today', or [...] a woman starts questioning her identity - there is nothing like that she can immediately think 'oh I'll go and talk to the lesbian um, you know, I'll consult that lesbian doctor about this' - like you go to the ear, nose and throat specialist. (laughs) You can't go to the-

Sara -lesbian coming out-

Jade -doctor [...]

Vita also suggests a 'coming out' counsellor as a means of easily identifiable and formal support. She suggests that the focus should be on an improved awareness of issues, which could assist people who are having 'big problems' having 'just come out'. The assertion here is that current support is not adequate and is lacking in information about rights, needs, and even sensitivity, and the implication is that the gaps are contributing to the struggles of coming out.

Vita [...] I just think people should just be a little bit more sensitive, and the people who are helping *everyone*, you know, the counsellors, the doctors and all that should be a hell of a lot more educated on what our rights and our needs and all that should be. *I think there should be a coming out counsellor* in every town! You should just have a thing in the phone book. You can ring them up and say 'hey look I've just come out. I'm having real big problems. Please help me!' But other than that I don't think anybody should really have to go to courses or be specialised in lesbians. I think they should just get to know a little bit more about it.

Sara You are the second person who has said there should be a coming out counsellor.

Vita There should be! There just should be! I mean I would have rung one up. And I wouldn't have known anyone in [Hamilton] if I hadn't thought to ring Lifeline.[64] [italics added]

In Jade and Vita's comments over 'coming out' support, there appears to be a distinction between lesbian ill health as related to mental health concerns, and as a physical bodily concern. Vita's suggestion of a coming out *counsellor* focuses on the mental health concern. In Jade's comment however, the bodily concerns of physical health, a cold for example, in which you can go to a medical doctor, are distinguished from the apparently lesbian health concern of coming out. She particularly regards coming out as a medicalised event, as if one could visit a doctor. In both cases, the focus is on support for the individual.

[64] Lifeline is a form of a counselling service, which provides listening, support and referral via a nation-wide, free-calling telephone number.

Vita also indicates that the stress and pressure that lesbians have to manage can come from a lack of support from a person's family. She comments that the lack of familial concern influences the need for formal services and offers as explanation that she has not needed to talk to anyone (we can assume) professionally as her own coming out was easy. This appears to contradict her earlier statement about ringing Lifeline which she qualified at the time saying "I didn't ring Lifeline because I had problems, I rung Lifeline to specifically ask if there was anyone that was a lesbian I could talk to, to get to know". However, the participants' commonly expected coming out to be difficult. Their own difficulties in coming out, particularly in relation to the loss of family, was often portrayed as relative to other peoples experiences - most women knew someone who had had more extreme reactions from family, friends, and colleagues.

Vita [...] Maybe 'cause there's a lot more pressure, and all that. And a lot more stress. It just depends on the individual. If you've had a really good coming out process and all that, like I've had. I've had a pretty good one. It's been pretty cruisy- you know you're pretty sweet. But then there's a hell of a lot of people who their parents have disowned them bla bla bla. and they probably tend to need a little bit more help where that's concerned, but I don't really know that much about the mental health side of things. I haven't really ever had to talk to anyone about anything.

The following extract, again from Vita, brings together a number of threads present in this discussion. That is, a relationship between poor mental health, not being positive about being lesbian, and the lack of support. Isolation and a lack of support were repeated accounts in Vita's interview. Vita discusses support as a complex issue. She states that people think they need to go to mental health professionals rather than actually going. Additionally, people are often not certain if concerns over coming out are real, or they may be people who do not talk to others in formal settings, and or they may talk only to close friends. Even where someone did seek formal support the theme that the counsellor might not understand returns here, and that a lesbian counsellor (who may be presumed to have some awareness) might be impossible to find.

Vita I think the main thing that I've talked with *my* lesbian friends, is, mental health, I think. Not exactly people going to counsellors but people who think they need to because they think the coming out process has just been so bloody hard. And all the problems they're having, and the health issues we don't really talk about them much [...] A few of my friends have been completely stressed about stuff like that, and they just

really need some help. And my old flatmate had some really big problems with her mum. She didn't know whether to tell her mum she was coming out or not. She wasn't exactly positive about herself being lesbian, she just wanted someone to talk to, and she just didn't know who to go and talk to. She couldn't talk to an ordinary counsellor, cause she didn't think they'd understand. She wanted to go and talk to a lesbian counsellor, and she didn't know where to find one.

Wyn also adds that invisibility may precede the issue of having resources available. A lack of attention to or knowledge about a particular issue constituting a health concern is important. It means that health issues needing to be resourced may themselves be unknown. Isolation is thus complexly related to resource provision. It is useful to add that in relation to both Ariah and Wyn's comments the men's sexuality resources they refer to are predominately in the arena of HIV and AIDS.

Wyn Yeah the issue of depression and sexuality I guess is just as much in lesbians as it is among gay men, although we seem to hear more about that. Which is interesting isn't it? It's that invisibility again. It's as if nobody takes it seriously. And I guess that could go with a lot of lesbian health issues. It's not often taken seriously.

The suggestion here is that mental health concerns are often regarded as the consequence of social or cultural factors, but are managed through individuals seeking support. In this account, mental ill health is produced through a continuing exclusion or invisibility of lesbian concerns, or limited access, which reimposes another form of isolation on individuals. Ill health effects and consequences are thus important at all levels from geographical, professional, lesbian community, as well as not having access to mainstream.

Stress of being different

Another discourse which attempts to describe an aetiology for lesbian sickness, is the stress that 'being lesbian' causes. In his cultural model, Radley (1994) proposes that women's poorer health compared with men's can be accounted for because women's lives and their roles give rise to more stress. While predominately basing his assertions on the effects of marriage, the participants in this study suggested that lesbian lives were also stressful and productive of poor health.

Hine talks about society not agreeing with you and that health cannot exist where society does not agree with you. She locates this in a context of shared oppressions of sexuality and ethnicity, referring to the ways in which Maori conceptualise oppressions. Hine relates experience to ideological, cultural and political controls imposed by hegemonic and centrist societies.

Hine I don't know if you can be a healthy lesbian can you? And it's because, from a thing that I first started off with, if society doesn't agree with you, how can that be healthy? The same as, how can you be a healthy Maori - if the world is putting you down - physically, spiritually, mentally, and all those sort of things?

Max notes that lesbian women experience greater stresses than heterosexual women, reflecting a continuous daily struggle. Constantly managing an awareness of being different or being perceived differently, including in relation to stereotypes about lesbian relationships adds, as Max notes, 'a lot of stress to the average lesbian'. However, Max also describes an ability to 'pass', or to not appear 'as if' she is lesbian. While Max suggests that passing may be a requirement towards appearing 'normal' her comments contradict Hine's. Hine, in relating aspects of Maori and lesbian experience, does not contemplate the possibility of 'passing'.

Max [...] what sort of problems differ between heterosexual and lesbian women? Besides a lot more stress mentally. I would say that lesbians would have a lot more stress mentally than heterosexual. I believe we would. I think we do [...] 'Cause every day is a struggle [...] I go out with [my partner] and people look at me, and they look at her, and they look at me, and look at her, and they try to figure out who the man is, you know [...] So like, that sort of stuff, adds a lot of stress on to the average lesbian, I think. Passing, you know. Passing in society as just a normal woman. I get stared at a lot, like I'm in a fishbowl or something. [...] But I just think that causes- that sort of stuff causes a lot more stress than heterosexual woman go through. I don't know.

An effect of appearing different in terms of health is that of dislike of oneself as 'gay', or internal homophobia. Here, pathological concepts of lesbian have been and are being replaced by concepts of homophobia as pathological. These notions are literally turned inside out with the notions of internalised homophobia, which refers to homosexuals being phobic of the homosexual in them.

Max [...] what I got [when I came out was] was 'Oh you can't walk outside with your girlfriend hand in hand 'cause like we're going to jeer at ya. And you can't tell your parents because they're going to hate you. And

you can't, you know, go to dinner and kiss because people are going to stare at you'. All this stuff, and it all adds up. It all adds up to internal homophobia which I think is the worst possible thing that lesbians can have, (very unhealthy).

Wyn suggests that relationships between women are regarded so differently that there is a lot of additional work that these partnerships need to do. In order to cope with and manage the stresses, lesbians engage in destructive and unhealthy behaviours. These behaviours also represent a kind of resistance. Wyn describes such destructive behaviours as 'kicking back at the world'. In this way, the pressures of being different produced what she suggests were extreme behaviours (positive and negative) in people she had otherwise thought were 'all right'.

Wyn There's all the whole issue about relationships and being accepted into society, and you kind of start from even before square one. You've got to work through to [...] how you feel about yourself, and what your self esteem is. And I think *all that's* got to do with health! [...] I think that's a major issue of lesbians. Because when I was in [city] I'd see so many people who you'd think they were all right, and then I suddenly saw them break out with the high number of lesbians that drink excessively. Smoke. And into drugs of some kind to cope with living. I felt several that I met were actually being self-destructive. Seemed to be the way they operated. Kicking back at the world.

Again Wyn individualises the stress of being different which is constituted in her attention to self esteem. Self esteem appears therefore to be a factor in what makes these women unhappy and isolated. Self esteem produces an internal locus of responsibility, and the concept can be used to ignore or minimise social or cultural effects. This effect is also seen in the latter part of Wyn's discussion. Doing things differently can be perceived as causing stress for lesbian women.

Toni [...] the dynamics of women getting together, and the difference in those things. That's something that is quite apparent. And often the unfinished business from the heterosexual world that still emerges, and probably even more so in their first relationship - lesbian relationship. That can be quite devastating.

Toni [...] And issues around more and more women that are actually moving into the lesbian family, and they have family. And so we've got these blended families, and how do deal with that [...] I felt quite isolated and alone last year, as I struggled with issues around that. And about my position - what is my position? [...] And tried to find things - and there's just been nothing there.

Toni discusses the challenge of doing things differently with the example of co-parenting in lesbian relationships. While struggling with co-parenting and blended families, doing this as a lesbian family was significant, and because of the expectations of the heterosexual world, potentially destructive. Not only do individuals struggle and have to manage the stresses of being different, but so also do families. We can just as well assume that this applies not only to families with lesbian parents, but to families with children that come out.

Sara Are there any health issues you think are of specific concern to lesbians?
Wyn There's all the whole issue about relationships and being accepted into society, and you kind of start from even before square one. You've got to work through to positions and how you feel about yourself, and what your self esteem is. And I think *all that's* got to do with health!

Self-esteem is a particularly individualistic concept developed by psychologists wanting to locate an internal locus of responsibility. Therefore, to suggest that self-esteem is the locus is a valiant attempt to ignore cultural or social constructs.

While comparative analyses between lesbians and heterosexual women are common in the broad research arena, and particularly in mental health, the possibilities for non-heterosexual sexualities are usually absent. Such comparisons must be regarded as problematic as social, cultural, and historical concerns are often ignored. In the construction of a discourse of 'lesbian as sick', heterosexual women appear to be the comparative norms against which the majority of these assessments were made by the women participants of this study.

Ellen I think [mental health] it's a major health issue. [...] I think that for lesbian women though, where it's different is that it's not as easy to be a depressed heterosexual woman or nonlesbian woman, because the areas that we get depressed around are relationship breakups, and you're really not in a proper relationship anyway because you were in a relationship with another woman. [...] So I think may be with lesbians is they tend to deal with it a lot more themselves than with their biological things.

Ellen suggests that stress of being different is about the stress of being different from heterosexual women, which is also about different expectations of feminine behaviour. Women are assumed to be emotionally invested in sexual relationships, yet this trope of femininity appears valued or supported only in the context of heterosexual relationships. As Ellen comments, lesbians are perceived as 'not in a proper relationship anyway'. This

perspective is reductionist since it locates explanations of lesbian problems in terms of their essential makeup, as the only way to reduce stress would be a switch of role from lesbian to heterosexual.

Physical health concerns

Mental health concerns dominated accounts of 'lesbian as sick'. In the participants accounts there was only one substantial argument relating to a physical health concern in which lesbians were represented as being less healthy than heterosexual women. Breast cancer is a health issue around which lesbians are represented as having a higher risk compared to heterosexual women. Although brief mention was made of sexually transmitted diseases, these are more commonly related to a view of lesbians 'as healthy' (discussed in the next section).

Jo The only time I've ever really heard about it is when she was talking the other night - she was talking about STDs or whatever. And she said '*lesbian women definitely can catch them. Trust me*!'

It is important to note that breast cancer is a lived reality for many lesbian women, and I do not want to dismiss its importance. The attention here is on how constructs of identity in the context of health limit the information actually produced about issues for lesbians. Because breast cancer 'protections' are linked to pregnancy and lactation, lesbians have been assumed to be high risk on the (false) basis that they do not have children. Also of interest is the new theorising on the environmental causes of breast cancer, which have developed links between straight women and lesbians based upon a belief in the essentiality of female experience.

Ellen [...] I guess also breast cancer. Generally speaking - most lesbians don't have children, so our chances are probably slightly higher than heterosexual women who have had children. So those issues exist

The suggested high incidence of breast cancer for lesbians is linked to the powerful discourse that exists in cancer accounts which cites stress as a significant 'cause' for the disease. This discourse has been reproduced in lesbian discussions and places the cause for stress, and thus cancer, at the door of discriminatory practice.

Max As a cancer risk, yeah. We have more stressful lives. Yeah. Statistically, probably, lesbians get more breast cancer than heterosexual women, would you think? Percentage wise?

Toni's extract makes a link to both cancer discourses that suggest that cancer is a consequence of the lives that people lead (a lifestyle account), and the stresses of the existence of being lesbian. Both discourses offer a social account of illness. However, lifestyle accounts have been blamed for making people who have cancer appear responsible for their illness. Toni and the woman whose experience she is relating, believe that the struggle for identity and isolation from family and everyday community, is responsible for the stress.

Toni [...] one of those partners died of cancer, and they *know*, both of them before she died, knew it was because of the struggle they'd had to maintain their relationship and their identity in those years. She would have died in '87, '88 [...] And she just died from the pressure. She'd been totally outcast from the family, cut-off, same kind of stuff that you're having. But now there's more support in the community. *Then* you could lose everything and they did. And she knew that was why she was dying. There was part of it - all that pain and stuff was still inside her body.

To summarise, the discourses of 'lesbian as sick' in this section are primarily about mental health. Accounts of lesbian sickness are somewhat although not totally discordant from accounts of what it is to be sick. The accounts of 'lesbian as sick' appeared constructed about social effects, in which isolation and the stress of being different were regarded as cause and consequence of sickness. In the participants' accounts, bar culture appeared in account of 'lesbian sickness' as producing isolation (represented in accounts of 'lesbian as alcoholic'), as well as being a consequence of the isolation of lesbians. A lack of formal or professional supports (as well as family support), the stress of being different from heterosexuals, and 'not fitting in' to the 'mainstream', were also implicated as producing isolation. This was particularly reflected in ideas about coming out as a period producing poor health, in which participants' experiences of isolation as a consequence of being lesbian were highlighted. The following quote from Deb summarises the accounts provided about 'lesbian as sick', drawing attention to both isolation and the stress of being lesbian.

Sara You mentioned mental health issues. Are there specific issues, or do you mean broadly?

Deb Off the top of my tongue, particular issues about isolation, about discrimination. Invisibility in some ways too. It can be. It's about being out or not out. It's about all those things that go with being discriminated against. It's about where a lesbian will - a woman, girl,

> whatever - sits with being a lesbian or not. Whether they can handle their sexual orientation may not be actually of the general population - that fits into the norm!

A discourse of lesbian sickness as produced through social and cultural factors dominated the participants' interviews. Deb locates her account of mental health issues in the individual, which is in her own words, an effect of where a lesbian 'sits' with societal oppression and where she 'sits' with being lesbian. However, the attention to social effects ('isolation', 'discrimination') in Deb's account, as in the other accounts by participants in this section, appears to disavow or avoid the idea that lesbians 'are sick' due to some inherent and material feature of being lesbian. The avoidance is possibly due to concerns about reducing 'lesbian sickness' to a discourse of pathologisation. In Deb's account, the individual has to struggle with the societal pressures of existing outside of the 'norm'.

It was in the archetypes and the literature material from which they were drawn that discourses about 'lesbian sickness' appeared to locate causes of 'sickness' in 'lesbianism'. Participants appeared to reject a pathologising discourse of 'lesbian as sick'. The participants discussed individuals long-term illnesses such as cancer and alcoholism, distinguishing between inherent causes in the individual which were not related to identity as a lesbian, and accounts in which lesbians were regarded as having physical manifestations of sickness due to social and cultural factors related to 'being' lesbian. That is, there is a split between individual causes of 'lesbian as sick', and those resulting from the stresses imposed by a homophobic society, and or the response of society to difference. Mental health concerns in general were also overwhelmingly represented as belonging to the latter. Lesbian bar culture, for example, was examined as appearing to produce lesbian drinking and isolation, as well existing as a consequence of isolation. Accounts of physical or bodily sickness, in general, were also attributed by the participants to a manifestation in and on the body of cultural pressures. Participants' distinctions between 'lesbian sickness' as due to social causes or some form of inherent features of 'being' lesbian, reflected an awareness on behalf of the participants of the consequences of the production of this discourse on the constitution of lesbian subjectivities.

COMMUNITY IDENTIFICATIONS, COMMUNITY 'SICKNESS'

This next section extends the analysis of the discourse 'lesbians as sick' to representations of lesbian communities as unhealthy. The discourse of 'lesbian communities as sick' can be read as the production of sickness accounts in which lesbians are regarded as members of a community that shares inherent features. As a cautionary note, Grosz (1994) points out that claims over women's current social roles and positions as the effects of nature, essence, biology or universal social position renders those roles and positions as if they are immovable and necessary (Grosz, 1995). Thus the contemporary production of 'lesbian sickness' as a feature of a lesbian community is an account that is likely to universalise 'lesbian' into the appearance of a coherent selfhood and presumed upon a liberal humanistic notion in which essentialism, and potentially naturalism, underlie claims for truth. It could be argued that the uptake of medico-scientific discourses in the context of health promotion relies on the elision of social discourses with notions of essentialism, biologism, naturalism, and universalism.

Phelan (1989) argued that lesbian communities serve particular functions. In this thesis, the lesbian community is represented as sharing common goals particularly relating to support. In the following discussions, participants appear to represent the 'lesbian community' as 'unhealthy'. That is, it is large and tightly networked but represents a sense of regulation, control, pain, unmet expectations, and lack of support.

Max describes lesbian communities as pained communities, located in a societal and heterosexual fabric that is cruel, particularly to lesbian women. She suggests that lesbians realise what a hard or unfair place the world can be, which is highlighted through their differences from society. The reason that lesbians are a pained community, she adds, is related to a lack of support.

Max Yeah. I came out. Fuck when I came out, like, I discovered so many things about this world. We are so isolated our little, fucken, insular, heterosexual world. And you come out man, 'cause you're alternative you just discover all these horrible things about the world. And how fucked over people are, and how fucked over lesbians are, by everything. And I've met so many women who have been hurt in some way, by somebody or something, and like I just couldn't believe how many people were walking around with that sort of shit in their heads, you know. There was like, it's such a- such a

painful community. It's such a pained community. And I find it's really sad there's not enough support for them.

The lack of health that constitutes lesbian communities in the following accounts is more locatable in the community itself rather than in its differences from society. Vita's 'gays of our lives' encapsulates for her the difficulties she experiences as a part of a lesbian community. In contrast with the usual presumption that coming out is 'healthy', she implies that the being out as opposed to coming out produces health problems. She refers particularly to relationship endings being aggravated by the involvement of the lesbian community.

Vita It's not just coming out. It's being out and having problems. [...] It's bloody hard, breaking up. I wouldn't say it's harder than any other relationship. Any straight relationship or anything, but it's still really really hard. And the lesbian community it's bloody bitchy. If you tell one person, the thing that's bound to happen is that everybody else is bound to know within the next three or four weeks.[...] I think that the reason that it's so hard to break up sometimes in lesbian community is that it all ends up turning into a big drama. [...] Everybody's just drama orientated. It's just like 'gays of our lives'.

Cinderella argues that the community is a group with common goals. Yet, her expectation of a common goal of care was not met when she developed a disabling condition. Support from the 'lesbian community' was not forthcoming in the way that she had expected or anticipated. Her disability individualised her and isolated her from community, and though 'the lesbian community' was not supportive, her straight friends were. This lack of support is in contrast to Vita's experience of the over-involvement of the lesbian community in her life.

Cinderella What I find really interesting with regards to the so called lesbian community, since I've been laid off, so to speak, like it's thirteen months now - the support I got from the lesbian community [over my physical disability], it makes me weep. [...] I got feedback that I put myself in an isolated place. [...] And I took that on board for a short time, and then thought 'excuse me'. My physical disability isolated me from the social scene, but how dare you use *my* physical situation as an excuse for your own laziness. [...] It's finally put in place some *things* for me. As in - for me, I'm a lesbian. I have this expectation that I'm going to have something in common *more*, so to speak with the lesbian community. At the end of the day all we have in common is that fact that we have a sexuality in common.

Cinderella argues that all that lesbian communities have in common is sexuality. Though she anticipated that she had *more* in common with a lesbian community than a straight one, she reassesses this because of her experience. However, the presumption that sexuality is a shared experience, which can be isolated from social and moral objectives, returns her account to a deterministic one.

Ariah comments that communities can be unsupportive places, both personally destructive and as reproducing problems. In the following extract, she discusses an issue which arose in another city over allegations of sexual harassment and rape, and which precipitated deep divisions in the community. The issue in question foregrounded discussions both at the level of personal relationships and ongoing theoretical notions about sexual relationships.

Ariah [...] And everyone had just sort of picked sides without actually listening to what the other person had to say. [...] I just stood back and freaked out a bit actually. 'Cause they were making it such an issue but the way they were doing it they were causing the community to split into two instead of communicating - communing and becoming one, and actually sorting out the problem. Like as much as they were sorting out the problem, they were making out the problem was a new problem. It's not a new problem, it's been around for years.

Violence in relationships, including lesbian relationships, is viewed as part of lesbian poor health. As discussed here, violence between women affects a wide number of acquaintances and friends. Ariah's assertion that the community could be split 'in two', implies a tightly inter-linked and relatively coherent community.

Toni [...] And if of course we don't have the openness, and to acknowledge this exists - also a thing that has been sadly neglected - in fact almost fought that we do not address it, is our own violence within our relationships.

Lesbian communities are not regarded by Toni to be 'open places', suggesting that they are bounded and rational entities. Toni comments that openness needs to be achieved on a community level in order to ensure issues, such as violence in relationships, are addressed and not silenced. She locates relationship violence, and solutions, as a shared issue of concern for lesbian communities.

Ariah [...] It's always been an issue with lesbians - safeness when it comes to violence - verbal or physical - I've gotten to know a few women, and they're quite violent to each other. It's quite freaky. Either verbally violent or physically violent. They probably wouldn't even think twice about hitting their mother. So why would they think twice about hitting their lover? It's the same concept. [...] they get themselves into situations where they get involved with women and they still want them as friends but they don't know how to break out of the relationship role to friendship [...] It's just weird because the community is so small that you *can't* do that. You know? If you're losing one person, by chance their ex - your ex's ex - might be someone, who could be your future lover.

Ariah's reason for addressing relationship violence is that it signifies societal breakdown. That is, that an entire community is implicated by the exposure of a failure in health in one part. The discourse that health problems reflect societal breakdown is a familiar and contemporary one that seeks to encourage individual members of society to take 'responsibility' for a range of behaviours that surround a health concern, for example, Ariah relates relationship violence to difficulties in ending relationships and the uptake of future ones. Sometimes, the utility of this discourse as a social change mechanism can be overrated. It can be moralistic, and regulatory. That is, behaviours become patrolled and under surveillance, rather than enabling a focus on broader societal or cultural institutions or even productive mechanisms of power.

Lee's and Jo's accounts focus on sexual health risks and promiscuity. They reflect on how members might negotiate their activities given that knowledge about infidelities and who people are having sex with can be well-known in lesbian communities. Interestingly, it is the tightly networked nature of lesbian communities that is seen to be 'unhealthy' in the context of sexual activity, because future, current, and ex-lovers may all form part of a social group. Sexual health concerns are focused on social interactions (who people 'sleep' with) rather than what they do.

Lee They're not totally immune to everything. It's an issue for those that sleep around. For those in relationships it's not so much of an issue just general health checks. For those who sleep with each others' girlfriends and on the off-chance have a night out and go and sleep with someone else's girlfriend. And find out that their girlfriend, someone else is sleeping with - Oh god I get so confused - I can't believe it sometimes. But for them it's obviously a separate issue, and they should be a lot more careful.

Jo If you're a newcomer to that group though and you didn't know their histories, it would be an issue.

Lee And so when I came up, I mean there was a few people I looked at. I didn't do anything really. I just- I didn't sleep- But you find out afterwards their histories and I'm really glad that I just stood aside and looked at it for a while because otherwise I'm pretty sure I would have got stuck in something I didn't want to. It's probably the closest I've ever come to making the biggest mistake ever.

Jo and Lee continue to discuss lesbian communities in much the same way that a person entering a small rural town might. Communities that are closely interlinked are often not familiar to people who live in cities. In the latter context, the closeness of friends and other relationships may be regarded as inappropriate for sexual partnerships. Management of such closely linked lesbian communities is achieved through regulation. The following extract reflects discussions over perceived promiscuity and the determination of 'appropriate' sexual relationships and groups.

Jo I guess you - what was it [a friend] said the other day. She came up with this profound thought the other day that every time you go to the club you're probably mixing with-

Lee You're sleeping with everybody because everybody's slept with everybody. I mean I've only been here up in Hamilton for a year, and I know the life history of someone's new girlfriend went out with their ex. And it's so amazing that-

Jo That's just one small group of chicks though.

Lee Oh yeah I'm not saying it's everyone. There's actually - if you look a little bit carefully there's two groups. Those that sleep with everybody, and those that have got a partner. And it seems that everybody stays in those groups. And it seems that those that haven't got one don't seem to be able to find that person.

Jo Or just out for a good time and don't care.

In the following account, Cinderella represents lesbian communities as imbued with power and control issues. Following from her earlier extract, she explains how her unmet expectations of support provided her with insight into the community's inherent unhealthiness. She suggests that lesbian communities are crisis orientated. Cinderella particularly regards lesbian communities as unable to manage diversity and her refusal to accept this homogenising, accounts for many years of her (and others) personal struggle for acceptance.

Cinderella [...] Another fairly interesting thing to be part of the lesbian community, is to be a victim. Yeah - there's so many power and control issues. It's mind blowing. [...] I guess I've been trying to be part of it [the lesbian community] for- [about fourteen years]. So I've been part of a lot of different circles. [...] And it would be the year before last [I]

said to her "well you know, it's not a scene that- it's not giving me what I thought was there". There's like this fallacy, this fantasy about being part of the lesbian community. [tape stopped briefly]. There seems to be this need to have a crisis. [...] And for me I'm a diverse person. I take up a lot of room. [...] I had this expectation - because I'm lesbian - that they talk about all groups that I've mixed in, about being supportive and da da da. It's all talk! It's fucken all talk. And I've had more disappointments in support from the lesbian women than I have had from the heterosexual women.

Max describes in her account a sense that lesbian communities were, and are, managed internally to present a coherent image of lesbian identity - clothes, relationships (including with gay men and heterosexuals), hair styles, and accessories were all regarded as part of this. Max, of course, is describing the regulation of the behaviour of community members through mechanisms of surveillance (Foucault, 1977). She refers particularly to the 'dyke police', a colloquial expression familiar to lesbian communities, though the term is less common amongst queer communities now. It has developed from both experience, and urban myth.

Max [...] I learnt my lesson. I learnt that, you know, there's a lot of division in the community. And like, the dyke police, I find out about the dyke police. Like this certain group that monitored what dykes could wear and what they couldn't, and who we could talk to and who we couldn't. And that, that sort of stuff ties in with health for me. It's- it's unhealthy, in your mind. To come into a community that you're quite fragile, and you're finally finally discovering yourself. You come into this community in quite a naive state 'Oh wow', and then they turn around and do all this shit to you. The dyke police, you can't wear a skirt, you can't have long hair. All these fucken rules. Like, no way. I'll do what I want, and I don't care who I lose as a friend.

Max alludes to the notion that lesbian communities offered a common identity for internal and external consumption. "Dyke police" and ideas about regulating lesbian appearance and behaviour were more common with women who identified with lesbianism at a time when separatist discourses were being more widely challenged and queer labels were being taken up. In apparent contrast, Ariah comments that the lesbian communities she is part of are large and made of individuals who 'want to be themselves' and 'enjoy their own company (and) friends'.

Ariah This [lesbian] community [in Hamilton] is big. People don't realise how big it is. There's a lot of women who just don't come out anymore. They don't support anything. They just want to be themselves, enjoy

their own company, enjoy their own friends, and that's as far as it goes. So you don't get to see them until there's like a major event or something that's *so* different that they'll come out for it.

Ariah reinforces, in this account, the sense that the women she is describing *should* be participating, active, and attending (at least) major events. Activity and support appear appropriate to her expectations of belonging to lesbian community. However, there are particular concerns for people just coming out, or younger members. In the following extract, Ariah suggests that it can be hard for someone to make contact with support groups or otherwise with the lesbian community. She appears to be saying this is due to more than the challenge of realising that one is lesbian. Rather she infers that lesbian invisibility and public mythology about lifestyles and social networks, makes the experiences of coming out difficult because a person has not "been in the situation of being around lesbians".

Ariah It takes a lot for them to even get the courage to ring places like that [a support group]. You know the means of doing it, but it still takes a lot to get the confidence up to do that because either - one, you haven't been in the situation of being around lesbians or whatever, so you've lost that- lack of confidence, so it will take you a lot of effort to get the courage up to ring women's-line, to get lesbian-line phone number, to ring lesbian-line to find out about social groups, support groups or whatever. And then by the time you get round to actually ringing those - might be a few months down the track - and after that - a few months down the track to actually get enough courage to go to it. Then to get that type of woman there, who are going to turn you away. It's like, it's just defeating what it is. It's [support group] not there for the woman anymore, it's there for the members

In the first instance Ariah's implication there is a group or body that one can make contact with, is suggestive of a relatively coherent community. Yet, she notes that the community of lesbians one might make contact with may not be supportive or caring, which may have a negative impact. In a discourse of sickness, these things do not assist women's development or health as lesbians.

Cinderella distinguishes herself from a community of younger women over their physical and sexual health behaviours, using another variation of the discourse of lesbian sickness. She argues that the younger community is 'careless' and 'lax'. Their poor sexual health is regarded as an effect of poor uptake rather than a lack of material information or sexual health risks.

Cinderella [...] I actually find it really difficult the lax attitude with the younger ones on their sexual safety. In that regard. I know more lesbian women than I do heterosexual women. [...] So in my experience - it's almost like we have all this education. We have all these avenues for finding out how to take care of us health wise, but with the young women's community, I just find them shockingly careless. When it come to mental and emotional issues, I sometimes think that lesbians women have more opportunities than heterosexual women.

What is particularly interesting in her account, and the earlier one from Ariah, is that younger women are thought by the older women to be behaving badly, leading to poor health. This argument relies upon social determinist discourses, viewing adulthood as a progression towards a seemingly natural state, whereas youth represents a stage of immaturity featuring 'bad' or 'juvenile behaviour'. As Blaxter (1983, p. 69 cited in Radley, 1994) argues:

> People have to inhabit their bodies, and their physical identity is part of themselves. Particularly as they grow older, they have a need to account for this identity, to draw together all that they have experienced. This body is their inheritance, it is the result of the events of their life, and it is their constraint (p. 122).

Relying on social determinism in the discussion about unhealthy lesbian communities betrays a view that regards lesbians, in much the same way, as having to progress towards a full identity.

Ariah Yeah - that when you come out as a lesbian you sort of pick up on and you adapt to what's being said around you with the community, and you're taking on this lesbian identity that might not be yours, it's the community's. When you first come out, you're vulnerable to that and you can pick up on it, and maybe adapt that to your life, that becomes your life, that's your views. Unless you're actually strong enough to take on your own views you can actually lose a lot of yourself. So when it comes to smears they think 'okay I've heard that being a lesbian's the safest thing'. They forget that a) they are a lesbian now, but have they been heterosexual in the past or whatever.

Ariah confirms a similar presumption about a social determinism when she states that women, when they come out, 'take up' a community identity which determines their health risks. In this way, the community appears to be responsible for producing lesbian sickness. What is noticeable from this account and has become highlighted throughout this part of the chapter, is that health problems are continually linked to social and cultural factors, and as Ariah suggests, this includes the relative importance given to person's identity in relation to their family or sexuality. Yet, there is a constant attempt

not to locate poor health in inherent features of lesbians. Lesbian health is based on the production of a shared representation of poor health, which is not constructed about biological features. On the other hand, family histories presume that genetic and biological codes are responsible for ill health. Biology and genetics importantly still remain the overwhelming way in which families are constituted in western societies.

In these accounts then, lesbian communities are constituted as unhealthy, as well as providing support and alleviating isolation. The sense that community, like identity, can be inherently oppressive and constrained by what others say you can be (Kitzinger, 1989) was also reflected in the participants' views. In this discourse of communities with shared features, the lesbian community appears relatively monolithic. Accounts of lesbian as 'unhealthy' are conceptualised in terms of the naturalistic, essential and homogenising qualities of communities (Grosz, 1995). The important feature of this discourse appears an attempt to avoid an account of lesbians as sick which relies upon pathologising discourse. Notably, this discourse of lesbian communities as unhealthy represents the consequences of the failures of communities when they did not meet participants expectations of its potential shared features. On close reflection, what can be presumed to be at stake is the maintenance of discourses of lesbian as sick.

Two valuable but contradictory elements in a postmodern perspective on community and identity are relevant here. The first is the view that community and identity (in modern terms) are potentially impossible (Rosenau, 1994). Given that the 'self' is constituted and reconstituted relationally as part of an historically situated context, the ability to 'belong' to a community can become fragmented and fraught. The second view suggests the following possibilities for a postmodern community:

> It must be based in a community without unity, a community that does not constrain the individual ... Post-modern community may belong to people with very different points of view ... but they agree to work together temporarily until their interest in the common issue wanes, the issue is resolved, or they conclude that further efforts are fruitless (Rosenau, 1994, p. 312).

Participants wanted to belong to some form of 'lesbian' community, and recognised that communities might be important to 'health'. They wanted to view self and community as a coherent whole with explicit and shared understandings, yet, because communities may

not share common features, or members may not be able to achieve support, the lesbian community is implicated as inherently unhealthy.

CONCLUSION

Archetypes of lesbian sickness drawn from the literature overwhelmingly focused on images of lesbians as unhealthy or sick. Sources used included gay positive accounts, which incorporate responses to research that pathologises lesbians. These archetypes pre-empt a discussion that suggests that health discourses both produce and are produced by images of sexuality and health.

This chapter examined the production and maintenance of a discourse in which lesbians were regarded as sick or unhealthy. It appears that in the context of a discourse of lesbian sickness, there is an overwhelming focus on mental health. Isolation and differences from heterosexuals were two aspects through which this discourse was constructed. Here poor health is constituted through absences in social systems of support, resources, information, and community. Represented as causes and as consequences of lesbian sickness, isolation and difference also were constituted by accounts of 'lesbian as sick'. In this way, 'lesbian as sick' was often barely distinguishable from 'lesbian sickness'. This discourse was affirmed and given validity through personal experiences. Particular issues that identify lesbians as having 'poor health' relate to ways in which being lesbian in society has been constructed, that is, through discrimination, invisibility, homophobia and heterosexism. Lesbians are regarded predominantly as being unwell as a result of the influence, impact and consequence of culture, as well as producing and establishing poor environments and other artefacts of a social nature as apparent 'consequences' of being lesbian.

The production of a discourse of 'lesbians as sick' must pay attention to the notion of community, which includes the sharing of some similar values. The interview material produced a discourse in which lesbian communities were regarded as inherently unhealthy, and having a double disadvantage. These communities are unhealthy because they are both external to 'society' and because they do not fulfil the expectations of their supposed functions. The production of a discourse of 'lesbian communities as

unhealthy' represented a failure in a perspective of commonality in which lesbians were expected to share common values, desires, and experiences.

The failure of expectations around shared features of community in the context of a discourse of lesbian sickness may be read as an avoidance of the suggestion that lesbians are sick *because* they share natural qualities. In the interview accounts this is supported by the realisation that there is an avoidance of lesbian 'physical' illnesses, mention of the biology, and even biological illness and an overwhelming concern about the social environment and mental health. However, those discourses that compare the lack of health of 'younger' to 'older' lesbians may be predicated on the view that 'being sick' is due to failure in achieving the expression of a full, healthy, and presumably stable sexuality, and related to the idea that lesbian health is constituted in an individual's essential makeup. Not allowing for the expression of lesbian sexuality results in sickness because repressed feelings and desires will have a negative effect on the individual. However, the accounts offered in the interview material appeared more constructed around a sense of regulating the behaviour of the 'younger women'. That is, lesbian social spaces are important as long as they lead to 'healthy' behaviours around sex and relationships, rather than alcoholism, violence, and sexual 'promiscuity'. So the apparent claiming of discourse of 'community as sick' appears to recognise the importance of community and also functions strategically for the regulation of lesbian communities by its members.

Notions about community, slip in an epistemological sense, between the view that a community shares features, and that the consequence of 'lesbians sickness' produced by these communities can be reduced to essential and inherent qualities of members of these communities. This returns us to Rosenau's (1994) view that a postmodern 'community' itself might be strategic, and, it might be argued that there is a strategic use of a discourse of lesbian sickness. The risks of stating in a discourse of lesbian sickness that lesbians do share features might be too risky or familiar given the long history of pathologising discourses about lesbians and poor health. While the discourse of lesbian communities is strongly predicated upon the desire for and belief about a shared experience, lesbians are highly invested in not locating this in a discourse of nature in which lesbian has been historically pathologised.

CHAPTER VI

SICK NO MORE? CONTESTING DISCOURSES OF HEALTHY LESBIANS

> They wanted to know if I knew what 'gay' meant. I said sure - happy, fun, jolly (Hoffman, 1958, cited in Zimet, 1999, p. 51).

This chapter focuses on accounts of healthy lesbians. Lesbian health is made sense of through the evaluation of accounts of both sickness (examined in the previous chapter) and health. Hoffman's (1958) reflection on 'gay', quoted above highlights what has become a missing discourse in the landscape of the current project, that is, that 'gay' was also laden with the same positive meanings usually associated with health.

In the analysis of lesbian sickness it was suggested that health could be achieved by overcoming the socio-cultural factors imposed on 'being gay', represented as the cause of poor health in lesbians. The production of a lesbian 'health' discourse in the context of this project and this chapter is primarily a reverse and even resistant discourse to that of lesbian as sick, reframing 'gay' in ways other than as perverse or unhealthy. These speculations about a discourse of lesbian 'health' draw attention to binaries constituting the arena of lesbian health. In the sickness accounts, physical health concerns were virtually absent, and the focus was on mental health concerns. If lesbian health is resistant to and a reversal of the discourse of lesbian sickness, it is suggested that physical concerns might dominate this discourse.

PRODUCING HEALTH

Coming out and staying out

'Coming out' is often associated with the strategy of telling friends, family, acquaintances, workmates, or peers that one is 'gay'. The concept of coming out featured in the discussion of 'lesbian sickness', appearing as a potentially difficult time of transition in which a person realises that they exist outside of heterosexuality, or as something other than heterosexual. Coming out is also commonly discussed as a process of producing health, in which a person develops strategies for self management and management of the public world after having 'come out'. The processes associated with constituting

health via coming out include coming to terms with lesbian sexuality ('becoming' a well adjusted lesbian), seeking supports, and geographical relocation. As Angela comments, coming out did not change her physical health, but it did and has improved her mental health.

Angela From my point of view, 'No'. I've always been a healthy person. I'm no more or less healthy physically than I was before, but mentally, I think I'm more healthy than I was before.

Angela I think there was a long period of my life where I put on a very bold face, and everybody thought I was the happiest person under the sun, and I wasn't a bit at all. And I convinced myself I was too. But I wasn't. [...] So I actually think that knowing who I am, and acknowledging who I am was a major breakthrough mentally for me.

Angela describes coming to 'knowing who she was' as a positive change, productive of good health. In contrast, she suggests that isolation from her own 'sense of herself' had lead her to present an act, or inauthentic self, for many years. This affected her 'mentally' because she thought she knew what happiness was until she came out, realising retrospectively that she had been unhappy. The positive aspects of health and happiness were discussed, in the interviews, as if they are the same.

As Toni notes, coming out can be associated with transition, and with grief and loss (of family and of societal expectations). These losses can be regarded as positive, in that they assist people to develop and grow.

Toni Like the coming out process is very hard on any women. And so then there's so much you've got to do in yourself. That transition because you're actually doing a lot of grieving and giving up society's expectation. I think we do look at a lot at ourselves. [...] But I think, my observation is that a lot of people grow within there and do more work on themselves than the rest of the community.

Many women discussed moving away from families and from familiar environments, as a part of a process of coming out and again associated this with a positive action to enable health. The geographical shifts either precipitated a coming out (as in Angela's comment below), or were considered a move to assist coming out. There is an unspoken assumption here that while they remained in these environments each of these women was unable to come out. As Angela mentions, she did not move to come out, but moving meant many changes occurred or were possible.

Angela Well it didn't-[my move to Hamilton] It wasn't as a result of coming out. But it just precipitated it. I was going to retire [from my job] anyway, but I would probably have stayed in my home town. Whereas coming out meant that I shifted and did something different and I went to university and all kinds of things. So actually coming out opened a new life for me. Whereas I would have probably just been playing golf three times a week, and maybe earning a little bit [...] part-time.

In her discussion, Maggie refers to how moving geographically provided an option for coming into a community where there may be more lesbians or support, so that coming out became easier. In this way, moving assisted her to come out. However, she still had many fears surrounding her sexuality, so her moving was not a straightforward decision to come out. She acknowledges coming out as a long process, alluding also to the variability of people's experiences.

Maggie I knew that I would have to start to deal with the question of my sexuality - that was before I even left my marriage. A friend said to me at the time I was leaving and preparing to leave [...] told me that Hamilton had a really good women's community, [...] and if she'd said there was a really good lesbian community there that might have scared me off. But I was drawn to the idea of the women's community and the university, because I knew I wanted to go to university. So I guess, at least since that time - but even before that time. Like, I think back even in the early years of my marriage I was really attracted to it, and even as a thirteen year old, but I wouldn't have said I identified as lesbian way back then it was just the beginning of the knowledge and the thinking about it.

Reflecting on her own move, Ariah suggested that it was a clearer and certain more decision. She comments that she moved cities in order to take part in a more visible and accessible gay and lesbian community, which also meant relinquishing friends who were still at school. Access to other gay and lesbians was discussed as a feature of the places where participants moved to, and was relative to where they were originally located. Lee moved from a rural or isolated place ('wopp-woppy') to the city that Ariah moved away from. Moving to the city with a visible gay and lesbian community and support was, as Lee states, 'her starting point' for coming out.

Ariah I mainly came out in [another city which I moved to...] Mainly because there was nothing here in Hamilton. All my friends at the time were still at school, and I wasn't! And so I thought 'okay. There wasn't much of a community that I knew of here, and no way of finding out one'. And I thought 'If I could go to another town I could probably find it a lot easier'.

Lee There's more, seems to be, well up in Hamilton anyway there seems to be more publicity over gay stuff. Like most people that come from a wopp-woppy place like [...], come to a varsity, and there's a GLB[65]! And- well that's your starting point. You know, you don't have to look for anything. And then you gradually find more things as you go along.

Seeking supports may be relative to a person's environment in other ways. Support can refer to places where gay and lesbian resources are accessible, or to the 'mainstream' and 'visible' 'community' (out, young, and university educated, able-bodied and Pakeha). Universities are presumed to be places where visible lesbian contacts may be found. At the time of the interviews, gay and lesbian communities were much more visible on the university campus in Hamilton than currently. As Lee mentions, the student association, to which all students were enrolled, had gay, lesbian and bisexual in executive positions and in additional there were gay, lesbian and bisexual (GLB) elected representatives on the student union body, and a visible presence on the university campus.

Seeking supports, in a formal and an informal sense, was regarded in the interviews as productive of health because it was a way of managing ongoing isolation from society. It is the 'out' lesbian, who represents health and who is enabled to seek support, in terms of professional or expert advice. Having community support is also regarded as important to the production of health and the management of exclusions from heterosexual society, as Toni comments.

Toni And I think a big thing [for lesbian health] is about the community - having a good peer group. And people that you can go and talk to. I think that has been - there has been many issues where I know I've been knocked about in the heterosexual community, even challenged by people who think they understand homosexuality, and they think that I shouldn't have my homophobia, and I've had to go back and put in those support systems again and get support from my own community, to keep moving ahead. I think that's really important. It has been important for me.

Toni claims that having good community support can enable lesbians to manage misunderstandings and 'knock backs', from heterosexual colleagues and friends.

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[65] These GLB representative positions on the student body at Waikato University were disestablished following the time of the interviews under the premise that such positions were discriminatory to other students and that all elected members of a student union or council should be eligible to represent all students.

Moreover, the lesbian community enabled her re-establish supports in the straight community after these 'knock backs'.

Toni I think it is important, that it is made public. The more we're public, the less stigma. See, for Maggie and I having that support's been important. Having that support for our relationship, because that actually makes Maggie's side of things with her family a lot easier to handle because they are so against the relationship. Well, not the relationship, anything to do with homosexuality. In a - it's fullness. You can be a lesbian but don't live it-

Toni, indicating that people are 'in the closet' because they have limited other supports for their sexuality, associates the public aspect of coming out with health. She suggests that 'the more we're public, the less stigma', and that being public within her own family can ease the difficulties she and her partner encounter over their relationship.

Wyn [A healthy lesbian is] someone's who's come to terms with their own sexuality, and feels comfortable with that. And then follows through with anybody else within society with being aware of what they need to do to look after themselves, and take care of themselves. In *all* aspects of health. So the most important thing is to come to terms with where they're at and to feel comfortable with that.

Here, coming out is represented as a sense of completion, and as a process with an achievable goal and end, in which the production of a well-adjusted lesbian is seen as both possible and desirable. As Wyn comments, an important aspect of achieving 'health' is for a person to come to terms with "where they're at and to feel comfortable with that". This she views as enabling a person to take care of future health demands and associated societal pressures, the implication being that if one has not come to terms with one's self (as lesbian), then one is also unable to access resources and achieve self care.

Max Emotional health. I think that lesbians are better off in a way, because we have to go out of our way to discover avenues to help ourselves, whereas het. women are like, you know, *duh*, really complacent (laughing). 'Oh, my husband will provide', or 'Don't argue, just accept the het. role and don't question it.'

Max suggests set expectations for heterosexual roles make life simpler for them. These include the expectation that men will provide. Stereotypical role divisions assume males in heterosexual relationships contribute practical and mechanical help, and women give

emotional support and care. The inference here is that lesbians are 'healthier' because they have to do both, more than is usually expected for (heterosexual) women. As Max has noted, lesbians' ongoing struggle is productive, making them resourceful and enabling them to exist more easily in society.

Max All of us are like, sorting it out for themselves- for ourselves in any way possible that makes them healthier. [...] Or, just, lesbians are so incredible. They're such incredible women, we're such incredible women. To face such horrible odds in this world and come up- come out on top, and be able to smile.

Toni comments, that lesbians 'have had to work on themselves' to find a stable and solid identity, and be viewed by heterosexual women as healthier, freer, more aware, and strong. In contemporary accounts, 'health' is considered to be the achievement of an internal and individual stability for managing any tensions that arise from one's identity.

Toni Yes - they [lesbians] can be [healthier]. Psychologically I would say that. They're [lesbians] a lot freer [...] I think women, lesbian women have to do a lot of work on themselves to live in the community, and so I think in that way we are a lot healthier and more aware of ourselves. And I think a lot of heterosexual women can actually lay back and not have to do anything, they're supported by the community, by society at large [...] I've often had women - heterosexual women say that they find lesbian women very strong, very sure of themselves, and we've had to do it to exist in that community!

The emphasis on pride in 'being lesbian' is represented as a sense of health and as being engaged in health production, is in contrast to earlier discussions where women talked about not wanting to be lesbian. Max represents pride as lesbians being strong, taking enjoyment, and pleasure in being lesbian. Overcoming the negativity or aversion of others produces a sense of health and wellbeing, not just in individuals but also in the community.

Max You know someone said to me a long time ago 'lesbians are so happy. I always see them, they're so fucken happy. They're always smiling. They're just so- proud, and loud. And I thought 'Yeah! Yeah. Well that's all we've got' -to be proud of something that everybody else finds repulsive, or is frightened of. That's what gets us through. That's what gets us through life. We take pride in the fact that we're lesbian and- It makes for a healthier community.

Angela confirms that health is constituted through a sense of pride.

Angela A healthy lesbian is one who knows who she is. Who not only accepts who she is, but actually revels in it. Who seeks expert advice when necessary. Otherwise lives as healthy lives as necessary.

Deb focuses on the representation of a healthy lesbian as one who is 'strong in her lesbianism' or 'orientation', as a result of being determined, clear, and assertive, and out. 'Strength' includes a realisation that the meanings and claims to 'lesbian' can shift and change, and in this way, her interpretation of 'health' contrasts with the notion of a coherent sense of self. Deb, then, incorporates a postmodern perspective in which the emphasis is not on a rigid identity, with health being constituted through its fluidity, and changeability.

Deb Feels strong, I think, actually strong in her lesbianism too. I think it's really important. Yeah. A healthy lesbian has to feel strong in her sexual orientation. Really strong, and feels - not necessarily clear that they're always going to be lesbian - but clear and strong and okay that at this particular point in time; 'I am a lesbian and I am a happy lesbian, and I will do all the other things that every person has to about maintaining that place, balance', whatever.

The representation of coming out as a difficult time in which one might lose family, a sense of society, contacts and support appeared to be important to the constitution of 'health'. Coming out and the processes constructed as facilitating and maintaining it - moving away from home, finding contacts, dealing with grief at loss of families or making peace with them - were presented as productive. The difficulties of coming out are not dismissed, but positively overcome. Despite the importance of community, it still appears the responsibility of the individual to access structures and support, to manage transition of coming out and to maintain being out.

Sexual health

A further discourse of lesbian health focuses on sexual health, a physical rather than a mental health concern. The discussion of lesbians as 'sexually healthy' is constructed around lesbians as 'not heterosexual'. Absence or invisibility is examined in the construction of this discourse, and in particular, the constitution of lesbians 'as healthier than heterosexual women'.

In the context of violence, Kay distinguishes between lesbian and heterosexual women's relationships. Characterising lesbian relationships as an absence of men, she views

lesbian relationships, though a little doubtfully, as healthier because they appear to not have to put up with the 'crap that het[erosexual] women do'.

Kay I used to think that [lesbians are more healthy than heterosexual women] for a long time, but I don't- I'd like to say 'yes'. And I'd like to say that - as lesbian women we don't have to put up with the crap that het. women do, whether they believe they do or not - that in general lesbians aren't. At the same time I don't want to deny the stuff that goes on within lesbian relationships. So I would say 'yes' [lesbians are more healthy], but I think it's a huge, hard question really.

The discourse of an absence of men as constituting notions about 'safer' lesbian sexual health, is evident in Ellen's statement. Lesbians are regarded as healthier because of the implication that men are the cause or carriers of sexual health diseases. Her account distinguishes lesbians as healthier than both heterosexual women and gay men.

Ellen And I still, I think, have a belief, that having sex with women is safer than having sex with men.

This discourse of lesbians as 'sexually healthy' appears particularly because heterosexual sex is not regarded as safe sex. As Ariah suggests, attitudes in heterosexual 'culture' towards safer sex (including condom use) reflect a lack of thinking or concern, and this places women who have sex with men, at risk. However, because lesbians are not assumed to be part of this culture, then they are not similarly 'at risk'.

Ariah Heterosexual women in Hamilton - they're one of the most unsafest in New Zealand when it comes to not using condoms. So bisexuals seem to get that flack as well. In a heterosexual environment they don't think. With a heterosexual people one of their past times, you know, drink as much as you can and get laid if that's what happens. If they don't - if all their friends don't think about using condoms then how - they're one of the most unsafest. Therefore it makes it more important for you to ask safe sex questions before you get involved. Cause if they've just come out as bisexual possibly they have lived the typical heterosexual lifestyle.

In Lee and Jo's discussion below, Jo comments that although lesbians are as promiscuous as heterosexual women, they are not as at risk because same-sex sexual activity does carry the chance of pregnancy. In contrast to Ariah, Lee suggests that since her straight friends are on the pill they are engaged in practising healthy behaviours. It is not heterosexual culture putting heterosexual women at greater risk than lesbians, rather pregnancy is considered to be the (the most) substantial 'sexual health' risk. The risks of pregnancy for heterosexual women are seen as a trigger for managing sexual ill health.

Lee I think that- Well I've got more straight mates. They're on the pill. They use condoms. You see the odd bottle of all-sorts hanging around. They care about themselves, and they're looking after themselves because they've got a risk of getting pregnant and catching something. And I think that because lesbians don't have a chance of getting pregnant they seem to think that's where the thing ends.

Jo Yeah that's true.

Sara What do you think Jo?

Jo I think that's a tough one because there are heterosexual women that are just as promiscuous as lesbian women, but they still take precautions, whereas lesbian women that are likewise - they don't! Because you could get pregnant that's like a life a threat - I mean, that's going to alter your whole life-

Ariah suggests that there is no reason why heterosexual women should be '*more* unsafe', arguing that they 'risk' their health despite greater access to health care and receive additional resources related to pregnancy and contraception.

Ariah Because heterosexuals are probably *more* unsafe. They know that it's more available for them to be safe, but they don't! Not in Hamilton anyway. Hence the high pregnancy rate, but you know, it's safer to ask. It's your life that you're dealing with, and if you want to play russian roulette then just dive in don't ask - but it's better to be safe.

Any lesbians who have had a 'heterosexual past' are implicated as sexually unhealthy or unsafe, and are often dismissed by lesbians as 'bisexual'. Deb determines 'the ramifications of bisexuality' as including the length of time a woman has been out, and time since her last heterosexual partner. 'Lesbianism' is viewed as providing women with a sexual safety net - they have less sexual health risks '*because* they're lesbian' - with bisexuality constituted as damaging to sexual health of lesbian communities.

Deb I suppose I think the safe sex issue is a major for lesbians because of the- the ramifications of bisexuality, of how long a woman's been out and away from maybe heterosexual partners, of needles. You know, like they could be specific lesbian issues when it comes to the sexual- sexual side of it. I do think it needs to be dealt with. I don't think it's been particularly sufficient in the amount of education around this. I mean it is generally said that lesbians are less likely to contract AIDS because they're lesbian.

The hiding of heterosexual pasts can make lesbians appear safer. This includes, as Ariah comments, the processes of identifying with a lesbian community which can ignore family histories of illness. This is not surprising given that 'lesbian' is often defined in terms of its distinction or exclusion from heterosexuality.

Ariah So when it comes to smears they think 'okay I've heard that being a lesbian's the safest thing' They forget that a. they are a lesbian now, but have they been heterosexual in the past or whatever. With my family I know that there's a background and even though I have not been with a man I know that it is very high priority to me to make sure that I'm okay because it's part of my family history. If I listened to the community and "I've never been with a man, so I'm one of the safest when it comes to it" but with my family history, I'm not. I've got to remember things like that. There's a lot of women out there who - they're coming out so much younger nowadays - you get adapted into a community that is *telling* you so much. You want to listen, you want to *be* part of the community so you're adapting on their views and you forget who you are. What your family history's like

Women who have sex with men are represented in the accounts as 'at risk' from unsafe sex due to pregnancy, or attitudes from male sexual partners. Because lesbians are distinguished from women who sleep with men, they appear to be 'more sexually healthy', and this is generalised to the belief that sex with women is safer than sex with men.

Jade Well, when I taught [...] we had some health care worker come in to talk to our students about HIV- catching HIV, becoming HIV positive, and we talked about the different categorizations of sexuality on the spectrum of, you know, how you can get it - gay, heterosexual, lesbian, and I think I asked the question 'well how far along the spectrum is everyone?' - and she said lesbians might be the lowest to get - catch HIV- to become HIV positive, but it doesn't mean like they're at the other end, it's just that they're, you know, further way from the highest highest risk - whatever that means.

Jade notes that the view that lesbians are the lowest risk, does not mean that lesbians are 'no risk'. This is an example of the 'healthy' lesbian being an account produced through its relation to heterosexual women. Lee expands on this in her extract.

Lee Because where there's a form that we had to fill out for their health- it's private and confidential - for AIDS and stuff like that, 'what do you identify yourself as most?'- 'ah stuff it, small town gossip. She won't say anything will she?', and filled it out. So my dentist knows. And then I did that, if, you know, for my safety in the long run, to make me feel better that I'm not putting - I'm making her feel- If she found out later that she was in danger -of doing anything - even though there's not much chance as there is with someone else who identifies as heterosexual but has AIDS or something.

Sara Which is interesting because you said before that you see lesbians as a low risk.

Lee Yeah. But I mean I still put it because everybody's a risk. Lesbians are a lower risk, but everyone's a risk.

Lee appears to resist this hierarchy of risk related to HIV and AIDS, although she knows that lesbians are lowest risk for HIV and AIDS. However, because no distinction has been made on the form at the dentist's clinic between 'female 'and 'male' homosexuals, she responds to the questions as if she was a gay male, and therefore indicates to her health professional that she is a 'high risk' patient. This highlights how the construction of lesbian as distinct from those who have sex with men, rather than in relation to any particular 'truth' about lesbian health, might be significant to the constitution of lesbians 'as healthy'. It must be added that the dentist's question itself is inappropriate given that they should have asked about HIV risks, rather than sexuality.

There is a need to recognise the multiplicity of identities in which an individual might be located. Often these multiple locations are rendered invisible or a multiplicity of lesbian experience is ignored. Jade notes that if a woman is working class, or an intravenous drug user, she potentially becomes defined 'at risk' from HIV and AIDS under this category rather than lesbian. Therefore, because of the exclusion of these groups from any construction of lesbian identity, lesbian as a category appears healthier.

Jade Hepatitis. HIV. That's one of the things at my mother's work, is the medical history - do you have any tattoos? If they do they are automatically given a hepatitis test, and I don't know about HIV. Constructing the body- working class body or the, you know, the not the middle class body as being diseased, or possibly picking up those nasty diseases that we pure white ones don't get. I imagine lesbians who have SM sex might have some medical problems depending how far they go and what they do, into body mutilation. That could be something you don't want to go to a doctor about.

The contention that lesbian 'health' is produced through distinctions between lesbians and 'others' is reflected in further discussion of lesbians as lowest on an HIV/AIDS hierarchy of risk. Where lesbians are viewed as lowest risk they are recognised as different from gay men, and this distinction has the potential to challenge the generalised discourse of 'homosexuals as sick' discourse. However, there has been an emerging and newer sex acts discourse, which is resistant to the construction of lesbian as low or no risk. It suggests that lesbians do engage in risky sexual behaviours. The consequences, for Ellen (below), are that she viewed herself as previously ignorant of her sexual health

risks, but in the context of attempting to understand (new) HIV risks, had felt that the safest possibility was having no sex.

Ellen I've got to the stage when I think the safer sex is to have no sex at all. Or not with another person. Or to be really aware that my partner was HIV negative. And I still I think, have a belief, that having sex with women is safer than having sex with men. And how wrong that is. But in terms of sexual practices I'm pretty ignorant so- I'll leave that one out.

So the smaller the distinctions between lesbians and others, the 'more risky' and 'unhealthy' lesbian sexual activities seem to be. Lesbian health has been outlined in this research as an apparently constrictive landscape in which lesbians are continually engaged in resisting or overcoming societal constructs. Thus, the production of a discourse of 'lesbian as sexually healthier' may also be important for enabling the expression of lesbian sexual desire.

Lesbians are constituted as being a low or no sexual health risk because of exclusion from research or writing on sexual health. Invisibility is important here because it has produced a discourse about lesbians as healthier than heterosexual women. Because lesbians do not figure in discussions about health checks, sexual or gynaecological health, there is a presumption that they are 'healthier'. As Card (1992) explains, the invisibility of, or ignorance about, lesbian and gay experience "is not, strictly speaking, absence of knowledge: it is absence of attention" (Hewson, 1993, p. 16), a sentiment confirmed by both Lee and Vita.

Lee I mean, you don't really know what problems people [lesbians] do have anyway. That's specifically to the issue. I've never heard of them.

Vita Well yeah. I never even thought about it until I'm talking to you now, and *now* I figure out that I don't actually know as much as I thought I did, and it's quite horrendous how little information there is around. 'Cause if there was, I would have read about it and I would have been able to talk about it.

This issue relates to the relationships between lesbian and straight communities. If knowledge about lesbian is constructed in both straight and lesbian communities, it is likely that the invisibility of lesbians in straight communities will also effect the absence of knowledge in lesbian communities. This is particularly so in those areas where

straight communities control health knowledge. As Kay implies, there is information for some groups, but not for lesbians.

Kay [...] like with [a friend] who worked with family planning, and she'd come back at night and thump her fists on the table and say 'I go out and teach this stuff in the schools, and there is nothing there for young women, and nothing for lesbians'.

As Patton (1995) adds:

> Claims about invisibility are complex, suggesting both a lack of specific images, but also a lack of interpretative practices [...] as well as control over interpretation of the images they have chosen to present about themselves (Patton, 1995, pp. 23-24).

To summarise, the production of a discourse of 'lesbian as healthy' appears constituted in the distinctions between lesbians and others that sleep with men. Lesbians are viewed as sexually healthy because they do not engage in, or are absent from health concerns over heterosexual sex. The appearance of newer sex acts discourses, focused on lesbians having 'some' sexual health risks, and reduced the distinctions between lesbians and those who had sex with men. Kitzinger (1987) comments that the minimisation of the differences between homosexual and heterosexual, is an effect of liberal humanist approaches which assert "that homosexuality is as natural, normal and healthy as heterosexuality" (Kitzinger, 1987, p. 45). The dialectical relationship between heterosexual and homosexual accounts for the fragility and ongoing contestation of lesbian 'health'.

WHAT LIES BENEATH? LESBIAN HEALTH, HETEROSEXUAL WOMEN

The constitution of lesbian 'health' in relation to heterosexual women is considered further here. It has been reflected as producing two accounts in which lesbian 'health' was either constructed as the same, or as better than, heterosexual women. While this section draws on discussions occurring earlier it brings into focus the idea that comparisons between heterosexual and lesbian women are reflected in divisions between social and bodily concerns. That is, the consequences of lesbians and heterosexual women as represented as having the same body are considered.

Participants responses to direct statements about 'lesbian as healthy' or as 'healthier than heterosexual women', introduced after the first interviews, were considered. The participants were asked to respond to the following questions: "Given this statement, tell me what you think of it? *Lesbians are more healthy than heterosexual women*", and "*A healthy lesbian is? Comment on or complete this sentence*". As reflected in Morgan's statement below, when participants had the opportunity to respond to direct claims about lesbian health, their reliance on divergent and contested discourses was quickly highlighted.

Sara If I use the start of a sentence, could you either finish it off, or tell me what you think of it? "A healthy lesbian is...?"

Morgan (laughs) Oohh. Can I do both? A healthy lesbian is someone who is comfortable and happy with themselves.
Why? Why ask it? What a healthy lesbian is..? It's irrelevant isn't it? What's it got to do with being lesbian? What's that got to do with a healthy person? But then- I don't know? A healthy lesbian? You're labelling somebody aren't you? It's really - before they're healthy they're lesbian. So it's stereotyping somebody I suppose. But then it could be quite a fair question. I don't know. It's a bit odd isn't it?

Morgan's comment is qualified by the concern over claiming 'lesbian as healthier'. The suggestion is that this poses the risk of stereotyping or labelling lesbians (but not, it appears, heterosexuals). In preparation for writing this section, I asked two friends the question 'Do you think lesbians are more healthy than heterosexual women?' They answered 'It depends on whether you are talking about physical health or mental health'. Their responses are typical of those analysed in this section.

Same body but no sex with men

The comparison between lesbian and heterosexual women is derived from a belief that heterosexuals only sleep with men, and that it is the arena of heterosex,[66] particularly pregnancy issues, which places heterosexual women at greater risk. But Ariah, suggests that lesbians tend to be healthier with (or possibly within) *ourselves*. The implication here is that lesbians have a better sense of self and person, usually associated with the mind and distinguished from the bodily matters of sex and sexually transmitted infections. Ariah contradicts herself when asked whether she regards lesbians as more healthy. She suggests that lesbians are 'exactly the same'. A close reading of her text suggests that

[66] Heterosex, refers to sex acts between male and female bodies in the context of heterosexual hegemony. For an extensive discussion, see Potts (2000).

despite having stated differences between lesbians and heterosexuals in physical and psychical terms, she regards them as having the same body. In other words, heterosexuals are viewed as less healthy only because they engage in different activities.

Ariah [...] heterosexual women have more pregnancy issues, as such, and know things like that, but where as *we* have a tendency to be more healthy with *ourselves* - on a different level.
Sara Lesbians are more healthy than heterosexual women. Your feelings on that statement.
Ariah No. Basically no. No! No! (laughing)
Sara So are they less?
Ariah No they're exactly the same, I think.

Deb confirms the suggestion that because lesbians are regarded as having the same body as heterosexuals they are no healthier than heterosexual women, but adds that lesbians are safer in terms of sexual health because they are not involved with men. Lesbian 'health' is viewed as a consequence of social interactions rather than at a physical level.

Sara What do you think of this statement. Lesbians are more healthy than heterosexual women?
Deb I think it's a load of crap! It doesn't fit at all. I mean, god! What's the difference? What makes lesbian health different to heterosexual, bisexual, or transsexual health? You know - I mean we all are built the same. Just because we have sex with someone else doesn't mean to say - I suppose we could put a little clause in there that males do cause a lot of sexual problems for women because they're the carriers for a lot of those STDs, generally. Nah. Pretty bland there.

Vita extends the sameness argument as far as suggesting that because lesbians are women too, there is nothing different 'except for our sexuality'. That is, physically, lesbian and heterosexual women are the same. She also qualifies her statement with the added comment that 'just because you haven't slept with a man doesn't mean you can't get cervical cancer'. Vita does not presume - as medical studies have - that the absence of sex with men is an absence of sex. She correctly regards sex between women as still putting lesbians at risk from cervical cancer. Therefore, she differs from Deb in her suggestion that lesbian physical health is still 'at risk' in the absence of men.

Vita I think those issues are exactly the same for lesbians as they are for straight women. You've got just as much risk of getting breast cancer as anyone else has. I think that should be pointed out because there's probably a lot of people like me who think that if you're a lesbian you're basically safe from all that sort of thing, and you're not realistically. And

I think that should be made known because cervical cancer and all that's a hell of a scary thing. And it's not just straight women that get it, it's everybody. I mean, we're women too. There's nothing different about us, except for our sexuality. I mean, just because you haven't slept with a man doesn't mean that you can't get cervical cancer. It doesn't mean that you can't get anything else to do with anything like that.

The idea of lesbian sexual risk was present in the first part of this chapter. Yet Vita is asserting that there are no inherent or material features associated with the 'healthiness' of 'being lesbian'. The absence or presence of the material penis does not produce sexual health risks. She appears to be arguing that sexuality is distinguishable from the materiality of sickness, so that sickness bears no relation to sexuality or associated activities. Somewhat differently, Deb and Ariah imply that sexuality is relevant to illness, and by maintaining their absence from men (and as we saw in the earlier discussion, presumably from bisexual women too) lesbians have an ability to keep sexually safe.

Sara What do you think of the statement - lesbians are more healthy than heterosexual women?

Morgan I think it's an assumption. I think that it's as bad as saying heterosexual women are healthier than lesbian women. It's real. I don't think it should be an issue about whether you are het or lesbian, as to whether you are healthy. It's as bad as the other. And as a lesbian I don't think that I'm healthier than a heterosexual woman. I think everybody's just who and what they are, and there shouldn't be any assumptions made about who's better because of their sexual identity.

Morgan also resists claims that lesbians may be different in health terms than heterosexuals, and argues that sexuality is not relevant or pertinent to any discussion of health. She claims that any attempt to determine relative risks is associated with a value judgement. In this sense, she acknowledges that health and sexuality are constructed, and the similarities and differences between heterosexual and lesbians are minimised.

In summary, it is suggested here that physical health is viewed as determining how healthy lesbians or heterosexuals are. Heterosexuals are inherently risky, and have 'poorer' sexual health than lesbians. Participants appear to construct heterosexual sexual health as related to the physicality of women's bodies and the material contagion of male bodies (although not completely). But physical health, and in particular, sexual health for lesbians is focused on the importance of lesbian sexual 'inactivity' with men (in a material way). Lesbians therefore appear healthier than heterosexuals are. This is hinged on the

view that lesbians have the same bodies as heterosexual women, but differences in health are a consequence of differences in sexual partners.

Taking individual responsibility

When Wyn is asked in the following account how she regards the statement 'that lesbians are more healthy than heterosexual women' she is immediately concerned about generalising. Yet she does suggest that lesbians, as a 'minority', are regarded as having more stress, but this is something that is dealt with individually. The conclusion that Wyn makes, that 'we would all like to think we were healthy', readjusts any perception that she has contradicted herself.

Sara With this next text statement - tell me what you think of it- Lesbians are more healthy than heterosexual women?

Wyn That's such a generalisation, and I don't think you can have generalisations as much as that. I just - I don't think they are. But I do think there's the tendency to have- because you're working from being a minority, that can tend to be more stressful, so from that point of view, there may be. That coming to terms with yourself - there's that. But overall, I don't *think* so. And we would like to think we were all healthy wouldn't we? (laughs).

Ellen also asserts that she personally is healthier than heterosexual women, but also dislikes generalising. She suggests some reasons for lesbians' healthiness, including that they talk more about health, having strong friendships and community support, and have a positive attitude. However, she prevents herself from stating that this might be the result of lesbians generally having better health. She asserts that the people that she is with, 'just happen to be lesbian', reflecting on the apparent healthiness of individual lesbian women she is around, rather then on some inherent nature of the group.

Ellen I would have to say I'm healthier than most heterosexual women that I know. So I would be inclined to believe that statement, and reasons being - some of this stuff seems so generalised - a lot of the lesbian women I know have really strong friendships and communities whether they be big or small. So I think possibly we do a little bit more talking. And talking about real things. Talking about things like health, and what's going on in our heads, and letting I guess, the sort of yucky sides be known. And I think health is pretty much attitude. And I think lesbian women generally are - this is so generalised because there are a lot of women who don't-. I'll talk for myself. I live a healthier life because of the people that I'm with. And they just happen to be lesbians.

Embedded in the view that lesbians are personally healthier, but that to be constructed as healthier than heterosexual women may be overgeneralising, are two interrelated accounts that are also engaged in the constitution of lesbian subjectivities as healthy. They include the notion of agency[67] and the well-adjusted lesbian. Agency implies the possibility for willed or voluntary action, and the concept of the well-adjusted lesbian is part of the liberal humanist tradition which views lesbianism as a lifestyle choice, focusing on individual responsibility, personal development, and personal growth. Several of the accounts, including Angela's, have suggested that health is an agentic action in which self motivation and self management are key.

Angela Well the question that you asked me that I completed, I actually think you could just say 'what is woman?' I don't think being lesbian makes any difference to what I actually said there. I mean, you could have said 'a woman', 'Out' woman in there instead of lesbian, and I could have just answered in exactly the same 'she knows who she is'. Takes care of herself etcetera etcetera. Has common sense to do something about it if something happens. Hopefully not too frightened to do it.

Angela sees lesbians are healthier not because of a shared group identity but because a woman, who is lesbian, has on an individual basis been engaged in her own health production.

Toni Yeah! A healthy lesbian, I feel, is someone who's prepared to look at herself and work on the issues around that. On one part, protecting and taking care of herself but then again still being able to create space for herself, and an identity within that. Because I feel, personally for myself, if that is and has been for me shut down, then that shuts down who *I am*. So it is about creating the whole and continually working on myself and those issues can be around anything. And looking at myself and being honest, and trying, without pushing it on anyone else, carving my own identity in the heterosexual world. And if anything, getting stronger and stronger in being comfortable with that, being more and more out. And yeah, I feel I'm looking after myself then.

Toni notes that a healthy lesbian is one who is prepared to change. The emphasis here is that health 'as lesbian' is construed as an activity that one is personally engaged in, even

[67] Agency is often contrasted with structure. This concept is used here to refer to participants' regard for the possibility of willed or voluntary action. However, I consider it a problematic concept. I consider that 'will' must always be constrained through language, power and institutions, with the implications that a structure/agency dualism is also disrupted. This contradiction is implied throughout this thesis.

where the societal pressures of being lesbian are acknowledged. Health is regarded as productive, in contrast with the historical constitution of lesbians in health as repressive.

Maggie I think that just says it all really. I really like what you say in terms of carving your own identity. Because as we - none of us stays the same I guess, and I would say like a healthy lesbian is someone who is prepared to change and to grow and to take responsibility, and to seek help when necessary. So it's finding a balance. I often talk about balance - finding a balance between being assertive and being vulnerable, and creating, continually creating ourselves.

Maggie agrees with Toni. She states that a lesbian should recognise the possibility of change, but this change is viewed as agentic in that a healthy lesbian must be 'prepared to change, grow, and take responsibility, and seek help'. Lesbian health therefore is an activity and an achievement. The notion of balance raised here is constitutive of a wellness discourse, which incorporates a sense of physical and mental health, but it does not appear as a new or radical discourse rather it is another means of producing individual responsibility in health.

Deb reflects how a concept of wellness, which extends the usual definition of health beyond the limits of mental and physical concerns, has appropriated health into an individual activity.

Sara If I give you the first part of a statement, can you tell me what you think or it or finish it off? A healthy lesbian is...?

Deb Ha! A healthy lesbian is a woman who - do I want to finish it? A healthy lesbian is a woman who takes responsibility for all aspects of her health - mental, physical, sexual, spiritual, whatever. Takes responsibility. Actually seeks out information. Just like *any* person. Define it as lesbian. I mean, I don't like to actually- I have to think about this. I mean it's a healthy woman. A healthy woman wouldn't be with a man anyway. (laughs). Takes self-responsibility, and looks at the whole not the part.

Here, not having sex with men is only one part of lesbian health, and if this wellness model were applied, then there is no distinction between lesbians and heterosexual women. A lesbian woman, just like any woman, takes care of her own health. However, some of the participants' accounts raised the possibility of differences. Ariah suggests that lesbians have different approaches to health, although she still regards lesbians, as the same as but different to heterosexual women. She acknowledges a potentially

universal desire for health, but claims that there are different means by which to get there.

Ariah No they're [lesbians and heterosexual women] exactly the same, I think. 'Cause we've both got issues that are very important to us. We've got different approaches, we've got systems to go through, even though we're relying on the one system generally, but we do rely on other systems as well. Like we all rely on our GPs as such, but lesbians would go to a GP for a different reason, or whereas heterosexual women should go there for other reasons - it doesn't necessarily mean our issues are less important. Primarily we've got the same purpose and that's to be as healthy as we can be, so you can't just judge on any of the others.

Hine raises the possibility that the engagement with health is not part of an individual activity but part of a social movement.

Sara If I use a statement, can you tell me what you think about it? 'Lesbians are more healthy than heterosexual women'.

Hine I don't know. I don't really know the answer to that one. I sense they are. And I sense it is because the network is small, and we develop a lot of our own concoctions. And politically we tend to be politicised about the food that we eat, and getting exercise. Like I was the biggest Maori lesbian woman in Auckland - yeah, but being skinny doesn't mean to say you're being healthy. I sense strongly that they are, but I don't have enough backup information - statistics or whatever to back that up. Most of the groups that I've been with are.

Here, Hine suggests that health can be produced through attention to what one eats, knowledge of health cures and remedies, and other means of self-management, as well as the need to be political. Yet, the way in which Hine discusses politicisation seems to be another way of conceptualising agency. She suggests that while lesbians may be healthier, it is through politicisation and knowledge represented as a form of personal and individual responsibility, and wellness. Lesbians do not appear to share any consequences for health, but rather as individuals with knowledge, might be involved in seeking and gaining health.

In this discussion, the suggestion that the production of 'health' for lesbians is an agentic and individual activity is confirmed, and includes accounts in which wellness and individual activity are valued and encouraged. The healthiness of lesbians is either overgeneralised or produced through personal agency. Lesbians appear to be indistinguishable from heterosexual women in physical terms. While the limits of

heterosexual health appear to be represented in the limitations of the body, any similar suggestion for lesbians is ignored or resisted. The possibility that lesbian health may be constituted in bodily terms for lesbians appears to be avoided, along with the implication that to be healthy or healthier may be inherent. So in these accounts, while health is produced through the individual and is agentic, in response to societal and external pressures, it is not physically associated with 'being lesbian'.

CONCLUSION

'Health' is often only expressed in relation to sickness, when the body and its subjectivity are under threat. The particular effect of discussing lesbian 'health' included a reluctance to associate or constitute it as essential, material, or stable, and related to subjectivities of sexuality in any way. This is even though the participants did and do construct lesbians as healthy.

Lesbians were constituted as healthier through their sexual activities being represented in terms of the material absence of men. Sexual intercourse with men is regarded as 'contagious' and producing poor health for heterosexual women. Lesbians were constituted as 'healthier' than heterosexual women through personal will and individually overcoming the social exclusions and pressures of 'being lesbian'. A concern with overgeneralising accounts of lesbians as healthier was encompassed in this attention to individual action. The view of lesbians as healthier was suggested to be dependent upon the constitution of this discourse in relation to the body or the mind. As Angela comments, the constitution of lesbian health appears as a split between a healthy mind and body. Lesbians are represented as having a healthier mind, but not a healthier body, than heterosexual women.

Sara [...] 'that lesbians are often more healthier than heterosexual women' What are your thoughts on that statement?
Angela From my point of view, 'No.' I've always been a healthy person. I'm no more or less healthy physically than I was before, but mentally, I think I'm more healthy than I was before.

Overall, health in the context of lesbian health is represented as a more individualised construct in comparison to sickness. This adds complexity to theorising about health and illness, and some of these complexities are briefly highlighted here. Hine raises

some additional but critical questions about limitations in the production of a 'healthy lesbian'.

Hine And how can you be a healthy lesbian? You might be healthy physically, but there's all those other spiritual things that go on - mental stuff that goes on too. So a healthy lesbian is-? I don't really know. I've got to go back to the first statement that I made before. I'm only as healthy as my lesbian peers. I'm only as healthy as my Maori- That's sort of like, can you ever be healthy? In the wider sense. Physically - like personally - I think you can be. A healthy lesbian is a person that can personally be - physically spiritually, mentally - but in a politically or national perspective, no!, you can't be if the world still does not accept you.

Hine poses her questions in the context of her representation as Maori and through the constraints imposed by 'a world that does not accept you'. Her conceptualisation of health encompasses physical, spiritual and mental dimensions. Her account questions the limits of agentic action ('A healthy lesbian is a person that can personally be [...] but [...] no!, you can't be if the world still does not accept you') and relational assessments ('I'm only as healthy as my lesbian peers [...] as my Maori..'). Fundamentally, health is conceptualised as a continual struggle to overcome.

Finally, it has already been suggested that lesbian health may appear as a binary opposite to lesbian sickness, and that notions of the bad and sick lesbian have been merely replaced by conceptualisations of the good healthy lesbian. Reversing the 'sick pathology' of lesbians "merely substitutes one depolticised construction of the lesbian with another" (Kitzinger, 1987, p. vii). In this way, the production of a discourse of 'lesbian as healthy' does not in effect challenge the structures, apparatuses, institutions and binary relations that support the view of the "sick" lesbian. Attempting to understand the constitution of these discourses, however provides some insights that the reconstitution and reinsertion of lesbian subjectivities is related to the attention to the aspects of culture and mental health. The body, and the potential for a specifically lesbian body, appears to be ignored.

Section Three of this chapter considers the possibilities for the conceptualisation of 'lesbian health' in corporeal terms. This analysis must occur because the analyses of discourses of 'lesbian health' and 'sickness' have not been disembodied accounts. In fact, it is heterosexuality that is presented as a happy and healthy disembodied sexuality,

whereas 'lesbian' is sexually embodied and therefore sick. As has been claimed throughout this thesis, the lesbian body enters medicine at its inception, and is controllable through medicine and its discourses. In order to examine more explicitly the constitution of 'lesbian', 'health', and 'lesbian health', attention to the visibility of the lesbian body will be addressed.

SECTION III
INTERIORS AND EXTERIORS: RATIONAL SPACES AND LEAKY BODIES

Section Three considers the lived corporeality of lesbian bodies. The lesbian body is contentious. In the previous chapters a lesbian body emerged, constituted in relation to other bodies - women and gay men - and represented as 'healthy' or 'sick'. Healthy bodies were offered as an alternative to sick lesbian bodies, and because the binary relationship was not challenged they retained their relationship to the sick or pathological. This section develops the suggestion that lesbian bodies are figured and refigured in the particular contexts of sexual health promotion and care, in this case via cervical smears and dental dams. Both cervical screening and dental dams are preventive health strategies. Cervical smears monitor changes in the cervix which may lead to cervical cancer, enabling early treatment, and dental dams are safe sex devices for preventing sexually transmitted infections. These were health strategies that were a focus of discussion in the interviews.

This section is divided into three chapters. Chapter Seven introduces perspectives on bodies, making claims for a material but contentious lesbian body. Questions raised about the possibilities for a material lesbian body include asking: Can a lesbian body exist? Is its materiality always located in relation to women's bodies so that it is always and only a woman's body, or is it something else? These substantial questions have already been introduced, but the notion that a body can have meaning and is experienced as 'lesbian' in certain contexts, is developed here. Lesbian corporeality is placed in the context of discussions about lesbian (bodily) subjectivities and a consideration of theoretical perspectives on bodies, space, and gender. The spaces/places that bodies inhabit are argued to be constitutive of subjectivities produced through those places. The discursive and material 'features' of bodies are discussed in relation to concepts of the body as a space and as occupying space. Both are important considerations in this section, which focuses on lesbian bodies in the spaces of the clinic (as a heteronormative space) and the bedroom (as a private space).

It is recognised that in distinguishing expressly lesbian bodies, the material *borders* of the body are contentious. In the contexts of cervical screening (Chapter Eight) and dental

dams (Chapter Nine), I consider questions such as how lesbian bodies are understood and negotiated. Chapter Eight explores the idea that the borders or boundaries of the material, social and imaginary body may be represented as fixed or stable and considers the possibilities for, and consequences of, the representation of lesbian bodies as fluid and abject. The material, social, and imaginary are all of interest, and attention will be paid to each of them in a manner which is uneven, but consistent with their complex inter-actions and in relation to theorists drawn upon. In the first place, I draw on writing by Mary Douglas, Julia Kristeva, Elizabeth Grosz and Gail Weiss to begin an exploration of these questions. These writings, including the work by Liz Grosz, focused on women's bodies and for the most part ignored how the "*lesbian*" body is constituted and reconstituted as fluid and leaky.

The clinic in which cervical screening[68] occurs is regarded as a heteronormative space. Chapter Eight explores the consequences on 'lesbian' bodies if, as argued, it is recognised that heterosexual feminine bodies are expected, and supported by the technologies and processes of sexual health checks. Cervical screening permeates the body's boundaries literally, through the process of having a speculum 'in' the vagina so that cervical cells can be collected for further analysis. The particular aggregations of the permeation of body boundaries for lesbians, in cervical screening, in the clinic space, are explored. In particular, attempts to construct a rational and civilised 'lesbian' body in the space of the clinic are considered.

There are two main strands to the arguments posed in Chapter Eight and Chapter Nine. The first suggests that as fluid bodies, lesbian bodies 'are' the abject body of woman - that is, what is expelled or what is not taken up in the formation of representations of 'woman'. The idea suggested is that this abjection is resisted and yet is also consequential on the re-presentation of lesbian bodies as rational, and controlled in both the bedroom spaces of safer sex and the consultation/screening spaces of a health centre. The second strand explores the idea that the (potential) existence of lesbian bodies in certain health contexts (spaces of the clinic and 'home') can be viewed as threatening to the notion of fixed boundaries. In Chapter Nine, I ask what the implications are for the promotion of

[68] In New Zealand cervical smears may be carried out at a community women's health centre, hospital associated sexual health services, or more commonly a Family Planning Association service, marae health centre, general practitioner or medical centre service.

good health if, as suggested, the constitution of lesbian bodies in the context of dental dams as a safer sex practice reflects attempts to civilise the 'lesbian' body. Resistance to the use of dental dams as a safer sex tool is also considered here. Notably, dental dams reflect a public health message that challenges the boundaries between public and private space.

The bodies discussed in Section Three are the bodies of individuals, the participants in this research. These individual lesbian bodies are not discernible, knowing objects about which truths can be found, but rather lesbian bodies produced by and constitutive of discourses, and in particular, discourses which depict lesbian women's embodiment by means of spatial tropes. In this sense corporeality as lived bodily 'experience' is considered in terms of being located in 'different' spaces, and the discourses produced on the body are further considered as bodily metaphors for occupation in the spaces of health centres and health promotion. In this way there is a discussion of the physical boundaries of the body and the clinic, as the space in which the subject is located (Kirby, 1996).

CHAPTER VII
LESBIANS IN SPACE

A 'LESBIAN BODY'?

It has been suggested already that the existence of a lesbian body is contentious. The uncertainty in claiming a lesbian body was apparent in the discussions with women interviewed for this research. The participants were often suspicious about asserting a lesbian body in health contexts. Since the body is specifically engaged in numerous procedures in health and medicine, what is considered here is the existence and constitution of the lesbian body with regard to perspectives about lesbian (bodily) subjectivities and materiality.

Jagose outlines the major arguments that have been undertaken in 'figuring' lesbian, by the theorists Irigaray, Wittig, Kristeva, and Gallop. She asserts that lesbian has been figured both as "a subset of all women" (Gallop, 1987, p. 118, cited in Jagose, 1994, p. 9) and as "not women" (Wittig, 1981, cited in Jagose, 1994, p. 9). She adds "it is possible to argue that, considering their different historical constructions, the category "lesbian" is neither simply subsumed by, nor unimplicated in, the category "women" (Jagose, 1994, p. 10).

The discursive representations of 'lesbian' dominating the interviews were strategic, considering 'lesbian' as *no different* from 'heterosexual women' (as indicated in an earlier discussion about the claims made by participants about lesbian subjectivity), and or identified 'lesbian' as different, as *discrete yet continuous.* Importantly, neither strategy disavowed the embodiment of lesbian subjectivity, in which the body and lesbian subjectivity are simultaneously brought into being.[69] Even declarations of 'lesbians as no different' must be prefaced on claims which makes this relation between bodies and

[69] This is similar to the phenomenological approach adopted by theorists such as Merleau-Ponty. Locating subjectivity in the lived body is described by Young (1990) as jeopardising notions of dualistic oppositions. However the critique of these existential phenomenologists is that "to the extent that [they] preserve a distinction between subject and object, they do so at least partly because they assume the subject as a unity" (p.162). The current project attempts to work with the notion that one can not 'be' a unified self, but that this notion may be 'taken up' or one might represent oneself as such, where expedient, in order to function agentically.

subjectivities possible. In many ways this is a fractious birth that cannot deny the possibility that a birth has occurred.[70]

The lived experience of a lesbian body in health contexts may, in the first instance, be a contestation. The body (male or female) is either seen as a universal, with no difference between 'lesbian' and 'woman', or alternately, differences can be recognised between bodies which do not challenge the primacy of universal gendered bodies. Lesbian bodies can therefore be considered different from women's bodies, but not at a physical or 'bodily' level. The following statements by Hine and Vita reiterate these perspectives.

Hine No I think I talk more generally about health. Probably because I see the health as general - as universal. Like - there's no such thing as lesbian cancer or anything.

Vita Just because we're all the same. All have the same bodies and all the same working parts doesn't mean to say that we're the same.

The difficulty and unfamiliarity with making claims for a lesbian body are likewise highlighted in the following extract when Morgan is asked, 'do you think that there are any things that may be a health issue for you as a lesbian, or health issues for lesbians?' Morgan (like Max in an extract later in this section) initially relies on a version of "lesbians are all women", suggesting that health issues are the same for lesbians and heterosexuals.

Morgan [...] I think it more as woman health issues. I think it's, you know, all women. I don't think- I don't really know actually. I haven't really thought about it a lot. But even since reading the (interview material) I didn't even know how to start thinking about it (laughs). What are lesbian woman health issues? I guess it's an issue if you can't tell your doctor that you're gay... But I'm not really sure if there are any. Oh, I guess there are, but no I haven't really come across any problems that are just basically lesbian health problems or issues.

Morgan appears to shift her reply as she is presented with the possibility of lesbian health issues (in the context of receiving information about this research). Rather than reasserting her original position of no differences between lesbian and heterosexual women, she raises as a health issue for lesbians a concern about invisibility, of not being

[70] I discus later in the chapter the effects, in Kristeva's terms, of the separation of the two bodies - that is, separating the material body of 'woman' and 'lesbian'.

able to say to a doctor that one is gay. However, Morgan remains uncertain in her claims that there are health issues that are just about lesbians.

Throughout the interviews it is a familiar theme that a lack of any material 'sickness' or health attributable to 'being lesbian' was identified; yet many examples of lesbian 'poor health' or 'good health' were then immediately offered. This paradox highlights the constant but cautious emergence of a lesbian body in the context of health. This is a body that matters, and has matter, but the 'stuff' of a material lesbian body appears risky or tenuous, often being denied just as it is emerging.

Max articulates the second strategy, where lesbian bodies are viewed as discrete, and yet maintain a strong link to women's bodies.

> *Max* Health is crucial. Lesbian comes after woman. I'm a woman first. Women's health is more important to me than lesbian health. Lesbian health is really important, but women's health is more important because, like, all women have boobs. And like, this is not a lesbian boob, this is just a woman's boob. So stick the fuckin' needle in and tell me what you see. And I don't think if I have a breast lump it doesn't matter if I'm lesbian, heterosexual. It's a women's health problem.

As Max bluntly puts it, this is "not a lesbian boob, this is just a woman's boob". She prefaces this with the assertion that "lesbian comes after woman". So Max is arguing that the lesbian body is continuous with a woman's body, but she goes further than this. She asks the observer to tell her what they *see* - urging a consideration of the material cells of her breast (biopsy). Her breast is 'prickable' (in Max's words, 'stick ... the needle in') and 'pinchable' (Kirby, 1992, p. 6). In asserting the substance of her breasts in this context, she maintains that they could be either lesbian or heterosexual - she argues that it does not matter. There is a contradiction here. She declares the breast *both* as figured in terms of 'lesbian' and not relevant to it. Neither discounts the possibility of the breast being a lesbian breast. Inadvertently, Max makes flesh the lesbian body because whether distinguishable or indistinguishable from 'women's' bodies, the lesbian body begins to have matter, and to matter. Representing the lesbian body in this way appears to give it substance.

Many of those who write of lesbian bodies, including Barbara Creed's (1995) writing on representations of lesbians and Lynda Johnston's (1998) New Zealand work on gay pride

parades, do not deny 'lesbian' a certain materiality. Monique Wittig's (1975) writing in *The Lesbian Body* provides a particularly powerful account (also Butler, 1993, p. 72).

> The lesbian body the juice the spittle the saliva the snot the sweat the tears the wax the urine the faeces the excrements the blood the lymph the jelly the water the chyle the chyme the humours the secretions the pus the discharges the supurations the bile the juices the acids the fluids the fluxes the foam the sulphur the urea the milk the albumen the oxygen the flatulence the pouches the parietes the membranes the peritoneum, the omentum, the pleura the vagina the veins the arteries the vessels the nerves (Wittig, 1975, p. 28).

> The mouth the lips the jaws the ears the ridges of the eyebrows the temples the nose the cheeks the chin the forehead the eyelids the complexion the ankles the thighs the hams the calves the hips the vulva the back the chest the breasts the shoulder blades the buttocks the elbows the legs the toes the feet the heels the loins the nape the throat the head the insteps the groins the tongue the occiput the sine the flanks the navel the pubis the lesbian body (Wittig, 1975, p. 153).

In *The Lesbian Body*, Wittig (1975) skilfully evokes a materiality that cannot be denied. Her use of the language of medicine and science conjures a lesbian body about 'nature'. 'Lesbian' is the primary site of discussions about the body. Unlike the extracts from the above participants, *this* is the body that produces other bodies. This endeavour exposes notions of the body, offering contestations of heterosexuality and sexed bodies. The bodies that are produced are incoherent (Butler, 1990), but not unsurprisingly so. In Wittig's translated words, "*Le Corps Lesbien* attempts to achieve the affirmation of its reality" (1975, p. 10). *The Lesbian Body* deserves greater attention since its aims have been significant, including a desire to "overcome the split between materiality and representation" (Butler, 1990, p. 125).

The lesbian body and the articulation of it, is not denied but it *is* tenuous (and in Wittig's text, seen as producing incoherence), often being deliberated upon as it emerges. The lesbian body produced here is either superseded by a universal woman's body, or displayed as having a materiality that can be read as distinct or different (and yet continuous). This chapter goes on to argue that the contestatory nature of the lesbian body may be accounted for through recognition of the materiality of the body as neither fixed nor stable. What has emerged is that the corporeality of the lesbian body is a sexed one. Despite Vita's earlier assertion that we 'all' have the same bodies, these lesbian bodies do not assume similarities to the neutral or "hu-*man*" (Grosz, 1994, p. 188,

emphasis added), rather, their relationship is to women's bodies. Similarly, Wittig (1975) writes in *The Lesbian Body*; "The body of the text subsumes all the words of the female body" (p. 10). She further enacts this through the unconventional language use of the feminine subject. Wittig (1975) replaces *je* ('I') with *j/e* in an expressed attempt to reemphasise the feminine, so that the indifferent masculine is not assumed.

Annamarie Jagose (1994) writes in *Lesbian Utopics*:

> Gestures which indicate the fundamental uncertainty of the category "lesbian," which point out that category's resistance to definitional closure, are virtually de rigueur in current lesbian criticism and theory...However, there is a sense in which the very factors that result in the indeterminacy of "lesbian" destabilize the apparently unquestionable continuity of the category of "women" as well (p. 9).

Therefore I answer the query that is the heading for this section, 'A lesbian body?' in the following way. A 'lesbian body' both exists and does not exist. It must, however, be understood in terms of its material, discursive, and psychoanalytic dimensions. It also has to be understood in relation to the particular contexts that it inhabits (and that inhabit it). Critically, a 'lesbian body' is not distinct from its habitation in or habitation by the body of 'woman'. So just as these latter bodies are contested, so is the former. This is not to assume that the historical constructions of lesbian or women's bodies are the same (Jagose, 1994) but in relation to the other, and as distinct from the other, they are troublesome and problematic.

SPACES IN AND OF LESBIAN BODIES

Theorising about the body is tied up with a consideration of space - the space of the body and the spaces that the body inhabits. Space can be regarded in two ways - in the first instance as material and physical space, or *place*, and in the second as conceptual or *discursive space* (Kirby, 1996). It is argued that lesbian corporeality is constituted through these bodily spaces, rather than just in relation to the materiality of women's bodies. In this discussion, gender and sexuality are conceived as being intimately tied up with notions of space and place, and figured through binary relationships formed in the attempts to establish demarcations between spaces, such as distinctions between 'inside' and 'outside'. It is argued that the particular spaces in which lesbian bodies are considered in Section Three - the clinic and (family) home - operate as material spaces

and places in which heterosexuality and femininity is expected, inscribed, and produced. A discussion present in the interviews over the importance of women's and lesbian health centres is used to begin to illuminate how space can be regarded as both material and discursive.

To reiterate, in the first instance, the concept of space may refer to physical space. That is actual room/s, furniture, resources and decorations. Kirby (1996) notes that physical space commonly refers to the "three dimensional space that people occupy" (Kirby, 1996, p. 11). Often referred to as 'place', it is a description or quantification in traditional, geographical terms, from very small and local sites to much larger nations and continents.

An example of place is The Women's Room at the University of Waikato. The Women's Room (known as Women's Space in other universities) was the room I most feared entering on the university campus as undergraduate. Its door was cheerily painted (as has been my experience of other campus women's space) yet opening that door was one of the single most anxiety-provoking events I experienced in my early twenties. The Women's Room was the centre of a great deal of feminist, especially radical feminist organising and activity on campuses. It was the only place (apart from toilets) available to women only - a policy often translated as refusing and 'banning' men. But as a space, The Women's Room must be regarded as also discursive or conceptual. It is constitutive of subjectivities, since to enter The Women's Room was (and is still today) to be associated with feminists and feminism, and more substantially dykes and lesbianism. 'Woman' was marked as political, dyke, feminist, hag, men hating and separatist through the space of The Women's Room. My anxieties at entering The Women's Room are not surprising, as it defined a political becoming - as well as 'a coming to' coming out.

The reference to Woman's space is not incidental. In the interviews, the desire for the provision of *lesbian space*[71] in health settings in the form of lesbian health services or a specifically lesbian health centre was frequently expressed. Again, this must be read as both a desire for place, and as also having meanings inscribed through discourse which operate beyond the material.

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[71] Gill Valentine and Elspeth Probyn have also written extensively on 'lesbians' and 'space' (for example see Valentine (2000) and Probyn (1995)).

Morgan Yeah. *I'd like a lesbian health centre, for lesbians.* Not just for lesbian. I'd like a women's health centre. That had a real big focus on lesbian women [...] I'd like it to be public. I'd like to see a women's health centre. Maybe specialising in lesbian care or something. Something that people can see and identify with, rather than all these like, women's health centre, and then you're wondering, is that for lesbian women, is that for-? I know a lot of heterosexual women won't go there because they think it's for lesbian women.

Gill Valentine (1996) argues, the "production of 'authentic' lesbian and gay space is regulated to the 'ghetto' and the back street bar and preferably, the closeted and private space of the home" (pp. 146-147). Morgan's comment locates a lesbian health service as outside traditional and women's health centres, and the relationship between lesbians and heterosexual women in this space is a hierarchical and binary one. In this way, Morgan suggests that heterosexual women may not use a health service that is orientated to or inclusive of lesbian women because they may assume women's health services are 'lesbian' or for lesbians. Lesbians may claim the same services are 'not (for) lesbians', but view women's health services as adequate and not excluding lesbians. The suggestion is that women's bodies in a lesbian health centre are identified as external to cultural hegemony, and are potentially marked as feminist, lesbian, men hating or separatist through this space.

Max At a government funded level for ACC[72] payments, lump payments to lesbians, for shit lives. Thousands of dollars. At least fifty thousand to a hundred thousand. Maybe a big acre in the Coromandel for each lesbian. *Maybe a lesbian town.* I'd really appreciate that wouldn't you? On the Coromandel peninsula. I was being a bit silly.

Max's suggests that the government should fund a lesbian town. While she dismisses it saying she was being 'silly', her strategy of often using the ridiculous (or sublime) effectively begs a consideration of her remark. Can a lesbian town be 'silly' if it was only different from other places because of material differences? That is to say, to quantify such a place on material features only would make it no different from other towns, except that it 'is' 'lesbian'. Her comment betrays place as being operated upon

[72] ACC refers to the Accident Compensation Company. At the time the interviews were carried out it was entirely state owned, dealing with insurance for work related injuries. It also provided compensation to victims for things such as sexual abuse (including funding for counselling and historically lump sum payments). ACC was radically changed in 1999 by the then National government, when private insurers were included in the scheme. In 2000 the intention of the incumbent Labour government is to return to a version of the original and state organised scheme.

conceptually and discursively, such that "the organisation and management of space [...] has very serious political, social and cultural impact"[73] (Grosz, 1995, p. 120). To summarise at this point, space therefore can be considered as physical space or place; or it can refer to discursive (conceptual) spaces.[74]

Gendered spaces and spaces of gender

Best argues that "the question of space is bound up with the question of woman" (Best, 1995, p. 181) and 'woman' is overwhelmingly reflected in the notion of space as a bounded entity. Thus, the term *Women's Space* could be considered a tautology. Best (1995) iterates that the notion of woman and space are so thoroughly overlapping, that the invocation of 'woman' (or 'mother') in the description of space is both persistent and overwhelming. For example, countries, cities, and towns have been referred to by archaic names which personify women such as 'Britannia' or 'mother England', or more currently simply referred to by feminine articles such as 'she'. Best (1995) explains that it particularly infuses many geographical descriptions of space or place, and is extended to descriptions of houses as wombs or as the site of domesticity (Potts, 1999). The metaphor of woman as space is commonly reversed so that 'woman' is referred to in terms of spatial tropes - as vessels or containers, or as houses (for the womb).

Yet Best (1995) suggests that "the concept of space is not simply produced by the metaphor of woman, it is constituted through the body of woman" (p. 187). Thus cultural constructions of women correspond to notions of space (Potts, 1999). The relationship is reciprocal because both woman and space lie on the same side of an hierarchical organisation of oppositions. Irigaray asserts that 'woman' is the matter - the body matter for man - on which "he will ever and again return to plant his foot in order to spring further, leap higher" (Irigaray, 1985a, p. 134; see also Best, 1995). Subordinate feminine terms are associated with women because they are imprinted in the body-matter (which is not material and is malleable). Thus "one term of the pair - space/woman - cannot, as it were, 'move' without the other" (Best, 1995, p. 188).

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[73] Grosz (1995) also explicates a "constitutive and mutually defining relation between bodies and cities [where] the city is one of the crucial factors in the social production of sexed corporeality: the built environment provides the context and coordinates for contemporary forms of the body" (Grosz, 1995, p.104).

[74] Kirby includes a third space - psychic space (which includes the speaking of feelings coming from deep inside) - but I do not separate it here from a discursive space namely because I am concerned with psychoanalytic features in a discursive sense.

Irigaray's work leads to a recognition of "how concepts that ensnare and produce women, but also how conversely woman provides the matter for concepts" (Best, 1995, p. 188). There is a double action, in which the same movement leads to both the spatialisation of 'woman' and the feminisation of 'space'. A consideration of lesbians in the space of the clinic, in which lesbians are constituted, reveals two things. In the interviews the women referred to the practices of cervical screening as emphasising the interior space of their bodies, which is strongly associated with the feminine. They indicated also that the questions about sexual activity which usually precede a smear, highlight lesbians as outside or external to heteronormative sexual activities.

Space is demarcated and separated by boundaries. In a materialist perspective, items are brought into an existence through the marking of boundaries (Kirby, 1996). It is what separates them from other objects. A boundary may be conceptualised as "a line [which marks or differentiates objects] from other objects (or subjects)", or a "bring[ing] together [of] my edges, as an individual, with the edges of various socially defined groups" (Kirby, 1996, p. 32). Regardless, boundaries attempt to make a distinction between, and to separate inside from outside.

> We often think of our bodies as spaces composed of depth and surface, interior and exterior, with their contents properly contained within a skin, hermetically sealed and closed off from the environment (Kirby, 1996, p. 12).

In reference to the space of the body, a boundary may ostensibly be the skin - as the border that separates it from the outside, and containing the blood, muscle, and bone. Mary Douglas (1966) argues in her text *Purity and Danger* that bodies are reflections of social spaces. She recognises that the boundaries of the body "can represent any boundaries that are threatened or precarious" (p. 155). Symbolically linking the corporeal body and the body politic, Douglas (1966) specifically highlights bodily orifices as representing sites of cultural materiality.

Butler (1990) writes of Douglas's *Purity and Danger*:

> Her analysis suggests that what constitutes the limit of the body is never merely material, but that the surface, the skin, is systematically signified by taboos and anticipated transgressions; indeed, the boundaries of the body become, within her analysis, the limits of the social *per se*. A post-structuralist appropriation of her view might well understand the boundaries of the body as the limits of the socially hegemonic (p. 131).

Boundaries that mark spaces between and of bodies must be regarded as critical to the production of corporealities, and is particularly important for the production of lesbian corporealities. The assertion has already been made that the construction of lesbian bodies was regarded as reliant upon a relationship with the bodies of women, and heterosexuals. As Butler writes, "the very elasticity of the ostensible materiality of the body is shown in *The Lesbian Body*" (Butler, 1990, p. 125). The boundaries of 'the lesbian body' are regarded as volatile in these constructions.

CHAPTER VIII

LESBIAN BODIES AND THE MATTER OF CERVICAL SCREENING

PRODUCING LESBIAN BODIES

This chapter focuses on the constitution of lesbian bodies via cervical screening in particular and sexual health checks in general. Cervical screening is a process inscribed with expectations of feminine interiority and gendered heterosexuality, and is carried out in the heteronormative space of the clinic. The surveillance and regulation of women's sexual health is enacted through process that requires an account of behaviours and/or practices. In the setting of the clinic, this often involves a direct request for women to discuss their sexual activities with a general practitioner or nurse, in response to direct questions like "are you sexually active?" and/or "do you use contraception?" These questions function within a discourse of assumed heterosexuality. For women who fall within the expectations and constructions of (Western) heterosex- Pakeha, middle class, educated, married, not adolescent, not mid-aged, their bodies are also inscribed with a discourse of lack of danger and risk (also associated with purity; see Douglas, 1966). For women who fall outside of this - not Pakeha, working class, promiscuous, adolescents, and lesbians - these bodies are often represented as unnatural or uncivilised. They are often required to tell (recount, confess) their sexual practice, locating such bodies further outside of hetereosex. Women who are assumed to be "good" are rarely asked about their sexual practices. This assumption of a pre-existent script regarding the questioning of sexual practices is not consistent - women who are middle aged or who have a disability are often not assumed to be sexually active and often not asked.

Cervical smear taking: A functionalist account of the process

A cervical smear test is a process used to determine the status of cells in the cervix - as changes in the cervix or "abnormal" cells may be indicators of a precursor to cervical cancer. In New Zealand, registered (medical and nonmedical) smeartakers may take cervical smears. These include general practitioners, nurses, midwives, other medical specialists, and lay smeartakers (certified "smeartakers without a formal medical, nursing, or midwifery qualification" (Ministry of Health, 1996, p.43)). Cervical screening is recommended for women who are aged 20 years and over, who have had intercourse

(sic), including lesbian women.[75] The guidelines are for regular smear tests - one every three years - or more frequently if there has been an abnormal smear in the past, or some time since the last smear test.

I outline here, briefly, an account of a best practice model for cervical smear taking in New Zealand (Lindsay Moore, Cervical Screening Trainer, personal communication, 4 October 1999). The first step involves taking a history from the woman, which for the registered smear taker includes asking whether the woman is sexually active. General practitioners often will also ask questions about contraceptive use as well. The preferred approach is to talk a woman through the process of the smear test and results, including informing her of the National Cervical Screening Register, and her rights regarding this. Having left the woman to disrobe in private (removing underpants only if she is wearing a skirt or otherwise removing trousers and underpants[76]), she is then asked to lie on the couch. There are two options for having a smear taken - lying supine on her back, or on her left hand side. It was suggested that some women may prefer the left hand side position because their eyes cannot be seen, although it may be more difficult for a smear taker to view the cervix at this angle. The cervix is looked at to distinguish if it is "normal" and "healthy". The speculum is inserted, and "locked" into place. A scrape of cells is taken by a small spatula, followed by a second process using a small bottle-brush higher in the neck of the cervix. Alternatively, another item that is able to do both of these things at once may be used. The cells must be set on the slide immediately - within seconds. After the speculum is taken out, if the smear taker is a doctor they may do a further pelvic exam, or other checks for sexually transmitted infections (STIs). Notably, many women assume that a cervical smear is a full sexual health check. The cervical smear trainer with whom I spoke suggested that care is taken during the smear process itself to not mention sexuality (for example, sexual behaviours, evocative statements like 'lie back and think of England'). The intention of this was to respect the safety of the woman. One common effect of a cervical smear - the result of the cervix being awash with fluids, and because water is used as a lubricant for the speculum - is that there is often some discharge of these fluids following the smear. From here, the slides are sent

[75] Note the contradiction. Intercourse relates to the penis entering the vagina. However, cervical screening is recommended for lesbian women who have been engaged in sexual activity with other women only.
[76] It was indicated that women may feel more vulnerable having removed trousers than underwear only. Dress codes mean that lesbian women may be more likely to wear trousers (Lindsay Moore, personal communication, 4 October 1999).

to a laboratory where they will be viewed. There are further processes involved in the categorisation of the cell status, and the process for women "diagnosed" as having abnormal cervical smear result which will not be discussed here (see Ministry of Health, 1996).

It must be reiterated here that while cervical abnormalities are linked to sexual activity, screening for cervical cancer does not constitute a sexually transmitted disease (STD) test but rather is part of wider gynaecological health checks. The prevention of sexually transmitted infections (STIs) is considered important to cervical screening, because of the link of HPV virus to higher incidences than usual of cervical abnormalities.

SPATIALISATION OF WOMAN AND FEMINISATION OF SPACE

Cervical screening literally permeates the boundaries of the body, through the insertion of a speculum into the vagina and the removal of cells from the cervix. Cervical screening also engages in procedures that question or ask women about their sexual activities. Considered as occurring in a heteronormative space, cervical screening is inscribed with expectations of feminine interiority and gendered heterosexuality. For lesbians in the context of cervical screening, their body appears obvious and present, revealed by binaries that constitute its interior and exterior and sameness and otherness. It is argued that through a potentially contradictory interweaving of these binaries, lesbian bodies are constituted as fluid. This is considered with attention to notions about the feminised space of the body and the feminising of space.

Women are up there, lesbians are out there

Kirby (1996) proposes that women might have more at stake than men regarding the interiority of the body. Menstruation, vaginas, wombs, pregnancies, and lactating breasts "make the interiority of our bodies seem much more present, obvious, conscious, critical" (Kirby, 1996, p.12). Potts (1999) elaborates on the deconstruction of heterosex. In her doctoral research, participants (men and women) discuss men as being 'out there' by virtue of their sexual organ, and women as 'in'. It is further argued here that sexual health technologies and processes emphasise women's interiority. Max boldly reiterates this in her descriptions of cervical or pap smear, where she talks disquietingly about

having things stuck *up* her 'fanny' - a glove, and "a big silver thing" (or speculum which assists the smear taker to reach the cervix to brush cells from it).

Max Also [my partner] she had *'spread 'em* for him' (laughing). Had a-, had a pa-, Had a pappy-wappy smear. And I just thought 'fuck really. Is that right mate? Well I wouldn't go that far' But you know, I don't want, I wouldn't want a man *sticking his bloody glove up my fanny.* But to hear [my partner] trusting a bloke with a beard. Sticking his finger- hands- you know, doing a pap smear on her.

On another occasion, when her smear-taker is a woman rather than a man, Max emphasises her dislike of having a speculum (large and unwarmed) "up there". Her comments draw attention to her gendered account about the interior of the body as the focus of cervical screening.

Max Anyway then she *stuck this fucking great silver thing up my fanny,* which was quite awful. She didn't even heat it up. And it was *really* cold. It was like a big speculum or something. I don't know what they call them.

This emphasis on interiority is strengthened by Max's use of the word 'fanny' which subsumes or generalises female 'anatomy' (see Braun, 1999). The term 'fanny' is a broadly descriptive slang, and in New Zealand generally refers to female genitals. As a gendered account, the attention is on the interior of her body. Yet, Max's statements also imply a link between cervical screening and heterosexual sexual activity, particularly the dislike of having a male smeartaker 'up there'. Heterosexual sexual activities which normally include 'having a man up there' stand out in apparent contradiction in the current discussion of lesbian sexual health, even in the context of the clinic. This is an effect of a construction of lesbian and hetero- sexuality about sexual activity and related to the notion that lesbians are (or may be) lesbian because they do not want to engage sexually with men. Max's dislike of having a man 'up there' may be read as a consequence of her identification as lesbian. This is not to imply that lesbians do not engage in penetrative sexual acts. However, the specific (and potentially problematic) reading in this context refers to the associations the participants made to having a 'penis' or 'male' inside, as if this is what the cervix and the function of protecting its health is for in the context of sexual and reproductive health. No similar references in the context of the interviews were made in relation to women.

Ariah again refers to this interiority when she refers to sex with a man as having a penis 'inside'. Note however that she refers to men as active (a putting inside), and women as passive (having a penis inside). Additionally, that Ariah remains silent around the possibility that lesbian sex can include 'inside' may be indicative of a supposed or assumed exteriority of lesbian as compared to heterosexual or bisexual (practices).

Ariah I could never get into a relationship with a bisexual woman because...I couldn't deal with it if they went off with a man. But a lot of women think, 'how could they have a *penis inside them*?'

In the practice of cervical screening, it appears that women's bodies are expected to be passive objects, hence the strength of the effect of Max's reference to non-passive bodies. Max says in an apparently excessive way: "Also [my partner] she had *'spread 'em* for him' (laughing). Had a-, had a pa-, had a pappy-wappy smear." Max's comments illustrate Young's (1990) discussion of feminine bodily comportment in space. Spreading her legs - connotative of female sexuality and the allusions to women who have their 'legs wide open' (or sluts) - suggests that the appropriate situation for 'her' legs is to be closed and together (Potts, 1999). As Young (1990) argues, there is a contradiction here. While women experience their bodies as located in space, feminine motility is laden with inhibition. This is not the consequence of some belief about a material interiority, but is because she experiences her body as both subject and object.

In her account of a mammogram[77], Angela suggests that in a medical setting where her breasts will be uncovered, 'being merely a body' may be an appropriate way to behave - a 'body' can not 'be' embarrassed. Experiencing the body as an object, accounts for a closing of her body around herself (Young, 1990).

Angela No - but I wasn't nearly as embarrassed - okay, maybe you're not as embarrassed the second time anyway [having a mammogram]...I mean to heck with who sees me, *it's only a body.*

These interior and passive bodies of cervical screening evoke connotations of femininity. Feminine bodies are inscribed with expectations, in conjunction with or seeping into the functioning of the body (Grosz, 1994). I am arguing that these discourses about women

[77] A mammogram is an x-ray taken of the breast to determine if there are any cell abnormalities which might be indicative of cancer.

and spatiality (as interior and as passive) are also available to, and constitute, lesbian. The lesbian body is produced and enabled through the same mechanism that produces and enables the body of woman, *and* forbids and inhibits 'lesbian'. The recognition that such an enabling occurs draws on work by Foucault (1978) (also see Jagose, 1994). As we have seen, the dominant experience of women's bodies is that they are figured as interior spaces, even in their occupation of the space of the exterior world (Potts, 1999). So 'lesbian' must also be experienced as interior.

The following account from Max verifies this when she discusses being the object of gaze - she refers to a limitation of behaviour and a closing off, including a consideration of being almost confined inside in that "you can't walk outside". Physical movement and touching are self-consciously considered in terms of their possible effects.

Max Oh *you can't walk outside with your girlfriend hand in hand* 'cause like we're going to jeer at ya. And you can't tell your parents because they're going to hate you. And you can't, you know, go to dinner and kiss because people are going to stare at you.

There is however a paradox or a contradition. The most significant effect of theorisation of lesbian bodies in space is that they are figured as *exterior* or *outside*[78] to hegemonic, phallocentric, and cultural space (Jagose, 1994). In fact the charge often laid at 'lesbian' is that there is an openness, a candour which suggests more in common with representations of masculine relationships to space. Barbara Creed (1995) agrees that a pervasive stereotype of lesbian bodies - which cannot be easily applied to that of woman - is that it is active and masculine. It is suggested that as well as experiencing their bodies as interior, for lesbians, the lived body may not be so much realised as internal, rather experienced as exterior. Lesbians have particular concerns as stake regarding the exterior of their bodies.

Jagose (1994) proposes that the available space of, and for, the lesbian body is highlighted as both 'liberatory' and 'utopic'. Utopic space is reflected in the theorisation

[78] I have interpreted Young claim that women's bodily interiorisation, which she links to women's experience of their bodies as object, sufficient to make a tenuous but temporary claim in which lesbians, as other to 'women' can link a presumed lesbian bodily 'exterior' to belonging 'outside' the phallocentric order. There are of course, other claims supporting the view that lesbians exist outside the phallocentric order.

of "a lesbian space that is elsewhere" (Jagose, 1994, p. 2). The space is liberatory because 'the lesbian' has access to knowledge that exists outside the hegemonic, a consequence of the invisibility that results from the refusal of subject positions. Jagose (1994) indicates that this location of the lesbian body outside cultural hegemony is consistent with the perspectives offered by Irigaray, Kristeva, and Wittig. While all offer distinct perspectives, *all* suggest 'lesbian' occupies a space "outside" hegemony. To briefly summarise Jagose, she notes that Irigaray (1985b) locates the lesbian body outside the phallocentric order and due to this exteriority, the lesbian body has a potentially emancipatory locus for restructuring a change to specular femininity. Kristeva's account, she argues, is from a position of legitimated heterosexuality where the lesbian body is located with the semiotic and prelinguistic, but is associated with psychosis and aggression in its exclusion from the paternal law. Finally, Wittig's lesbian body is transcendental, and exists as the ultimate deconstructive term for displacing the man/woman binary. It operates as the third term, having both revolutionary and emancipatory capacities.

Public and exterior space is more fully examined in other parts of Section Three. However, it has been suggested that lesbians share the gendered representations of women's bodies as interior, as well as being constituted as exterior. In addition, 'lesbian' is also figured in progression with women's bodies. Again drawing from Irigaray - who argues that woman is the body-matter for man - maybe 'she' is also the body matter for lesbian. This consideration would locate lesbian in a realm which is in opposition to 'woman' and therefore masculine.

There is therefore a complex arrangement of lesbian in relation to space and materiality, and in relation to gender. While lesbian is posed as exterior to the social and cultural, she is located also as interior to woman. The uncertainties in figuring her body as lesbian or woman or simultaneously as both, coupled with the uncertainties that surround any fixed definition of either concept ('woman' or 'lesbian') requires particular attention to the way in which boundaries and space concurrently produce the lesbian body in particular contexts.

Contraception or criticism

Practices established to discuss sexual health in the clinic clearly mark it as a heteronormative space. To ascertain whether women require a cervical smear, women are asked to discuss their sexual activities with a general practitioner or nurse, through direct questions that ask "are you sexually active?" and "do you use contraception?" These questions function within a discourse of assumed heterosexuality. Information of this type is also used to produce recommendations in research about who should be screened for cervical abnormalities.

Max It was a woman doctor and she said to me 'you want a pap smear?' and I said 'yeah', and she said 'are you on the pill?', and I said 'no'. I said 'I'm going into a new relationship [...] and she said 'you're not going to go on the pill? Well have you thought about using condoms?' I said 'well, look neither of us are going to use the pill' (laughs). And she didn't get it! She didn't click. She said 'neither of you, uh uh ah okay. Right'. She didn't quite click, and she said 'well it's very dangerous' and she got out all this literature for me about STDs, and the pregnancy after- the morning after pill, and all sort of shit.

In Max's account one can hear the smear taker tripping over her thoughts, as she tries to make sense of Max's apparent sexual nonchalance. There appears no other possibility to the smear taker than of Max putting herself at risk from pregnancy and sexually transmitted diseases (STDs). In this extract and the others below, pregnancy (and therefore penetrative male-female sex) is so assumed and expected as a consequence of sexual activity that the only other possibility for a sexually active woman not using contraception is that she is viewed as 'stupid' for engaging in 'unsafe', hetero-sexual practices. 'She' gets told off - literally - and repeatedly throughout the interview accounts. It is in these accounts of being told off that the presumption of heterosexuality is verified.

Vita This doctor [...] she said 'are you on the pill?' and I just giggled, and looked at [my friend] [...] we just started laughing, and I think she got the picture. But [...] You have to give them a reason, or otherwise they're just going to go off. I've had that before.

There is an overwhelming sense in these accounts that sexual activity is inscribed with notions of risk. However, Lee's humour when she comments that she is not using contraception and that "my girlfriend might get me pregnant" highlights that the only legitimised risks in the context of a medical consultation are those which relate to

heterosexual activity. A medical practitioner, she suggests, would rate these other 'risks' hierarchically - to be stupid (heterosexual and engaging in unsafe sex) is to rate higher or be recognised sooner than being gay.

Sara How would both of you respond to the question if you went to a GP, 'are you sexually active? Are you using contraception?'

Lee Yes. No. [...] And then they'd probably ask questions - 'why not?' Because my girlfriend might get me pregnant.

Jo Yeah. I'd say 'yes and no'. And I guess he'd assume from that that I'd either be stupid or gay.

Lee Well I'd say that first of all they'd assume you're stupid. I think stupid people seem to rate higher than gays actually. Among heterosexuals anyway.

These comments, relating to the expectation of heterosexuality, rely on a notion of lesbian bodies as physically indistinguishable from women's bodies. Whether it is questions about sexual activity or the speculum (or smear taker) in the vagina, lesbian is located firmly outside or external to heterosexuality. Lesbian cannot be said to *not* exist since heterosexuality is often only understood in terms of what it is not (and it is apparently not sexual activity without contraception or pregnancy).

As Angela comments in the following statement, the presumption of heterosexuality is related to bodily expression. She elaborates on this theme when she suggests that only through the physical marking of women's bodies as 'other' might the presence of lesbian bodies in this heteronormative space to be recognised.

Angela I think just the very fact that unless you actually put an L sign on your forehead, in some way identify yourself, you are going to be assumed to be heterosexual.

Angela's comments are supported by patient and activist, Kathleen Martindale (1994) who argues that mastectomy recovery programmes are a further example of how normative heterosexual femininity is disposed towards images and appearance of the body. Heterosexual assumptions that operate in clinic spaces and medicine can predominate in a range of things. They may carry assumptions about who the primary carers for a person are, or who the likely partners are who risk the transmission of infections. Mastectomy recovery programmes are often focused on maintaining a sense of femininity for one's (assumed) boyfriend or husband (Barnett, 1985). This is not to

say that femininity may not be a concern for lesbians, but there is a supposition in these contexts, as Martindale (1994) asserts, about its relation to a woman's heterosexual worth.

> Based on my experiences and my reading of the literature handed out in hospital waiting rooms, as well as of many autobiographical narratives by breast cancer survivors of diverse sexual orientations, I believe that the very mode of understanding the disease, its treatment and its consequences for those who suffer from it, has been heterosexualised. By that I mean that breast cancer is framed overwhelmingly as a crisis in and for heterosexuality. Breast surgery is regarded as a symbolic assault on a woman's femininity and, hence, her value in heterosexual terms. The literature I was given and which is displayed in radiation and chemotherapy waiting rooms doesn't mention the medical or other existential dilemmas women with breast cancer face - it deals with how to use makeup, wigs, scarves, turbans and prostethes to hide the disease and how to pass for normal (Martindale, 1994, p. 138).

Wigs are promoted to women in mastectomy programmes, for example, to cover heads that have lost hair. In addition to the desire for things to appear normal, without change or sickness, hair length is regarded as a part of the performance of heterosexual femininity, and its maintenance in this context is a reflection of the production of heteronormativity.

At one point in her interview when Jade is asked whether she thinks there are gynaecological issues of concern to lesbians, she asks if the interviewer is referring to the "raw material body". She comments that gynaecological issues are relevant, since the materiality of the lesbian body is already always assumed 'to be' heterosexual in the space of the clinic. 'She is' a heterosexual body, and the marking of heterosexuality is assumed at the bodily level. The reduction to the physical body described by Jade, is most clearly evidenced when the research participants commented on the questions asked by general practitioners and doctors relating to pregnancy, cervical screening and sexually transmitted diseases.

Sara How do you respond to the questions "are you sexually active? are you using contraception?"

Morgan I just- I say "No" (laughs). Because I know that she means "are you having intercourse with a man!". So I just say "no" to everything. "Are you sexually active?" "No!" If I thought that it was relevant [I'd tell her] but it's usually totally irrelevant when they ask those sort of questions about your sexual orientation. "Are you having sex?" and "da da dadada". That's what she tried to put it down to when I went with this hormone problem. "Oh it's because you're not having sex" she told me. I wanted to say "*well yes I*

> *am*!". So you can't say it's because of that. Sometimes I just walk away smiling thinking "Oh god you're so ignorant". So I usually just answer "No. No. No". 'Cause they're talking about heterosexual sex anyway. And if I was honest with her and said I am a lesbian, she probably wouldn't ask me those questions because she wouldn't want to know anyway. So they'd be irrelevant.

Morgan acknowledges the complexities that are presented by the assumption of heterosexuality. She wonders *when* it is relevant to say that she does not have sex with a man/men. However the interaction in the clinic over sexual health which she experiences as expecting heterosexuality (and she answers appropriately that she is not having sex(ual intercourse)) means that when an apparently unrelated health concern arises, her body has already been read and presented as heterosexual. This has consequences on the later (and incorrect) causal explanation her doctor provides as her assessment of Morgan's 'hormone problem'. The doctor determines the problem to be due to the absence (sic) of sexual activity, rather than a much later and correct diagnosis of early menopause. The consequences of the heteronormative questioning related to sexual activity have the effect of producing bodies that are consequently read, incorrectly, as heterosexual. The verification of this lies again in the reading of the materiality of women's bodies as heterosexual.

Jade Like when I did go to [a doctor] and she said "do you, about your skin, have you considered taking the pill and it would be beneficial for - not just for your skin but also as a contraceptive". I said 'No'. No no (laughing). And then I could have said "I don't want to take it because I'm a lesbian, and I don't need to for that reason". I can remember [a previous doctor], she made an assumption that I was having heterosexual sex, and I think the whole conversation went something like "you are currently having sex?" and I said "yes", and "what contraception are you using?", "oh well I'm not". And then I said "well I'm a lesbian", and she said "oh I'm sorry I shouldn't have made that assumption", and she told me about a story of how it had come up for some other doctor about assuming that everyone was heterosexual and she'd totally redeemed herself.

As Jade and Kay comment, their general practitioners were making assumptions about heterosexuality. Once the women disclosed and their sexuality was brought to the doctors' attention, they felt their doctors displayed awareness and concern. The women subsequently regarded their relationship with their doctor as good. However, prior to the women marking themselves as 'not' heterosexuals (through verbal disclosure), their bodies were read by their health professionals as heterosexual.

Kay I think that came about when I first went to her. It was soon after that I had had to have smears, and they ask you questions about your sexual history. And I think she asked me about recent partners and she was obviously talking in a male context, and I just "I wouldn't have a male partner, (and) that I will have female partners". But I was lucky again, because a friend of mine worked with family planning for years and knew this doctor, and said 'she's choice'. Like that was an easier process for me because I knew that I think.

Therefore, it can be said that 'lesbian' bodies, as understood by the health care professionals in these situations, appear external to the hegemonic space. This can account for their not being realised as 'lesbian' in the first instance. However, these lesbian bodies are also produced through the heteronormative practices of the clinic (Shilling, 1993, p. 109). Shilling (1993) argues that the social body through which culture is embodied and reproduced transcends the material, biological body. In this way, the assertion of heterosexuality through heteronormative practices of the clinic is an attempt to produce in society bodies that conform to and maintain heterosexuality, even where it is understood that other possibilities, at least for sexuality, can exist. The lived experience of a lesbian body that embodies these understandings also simultaneously realises a lesbian body.

> The most important issue raised by Connell's and Freund's work on the negation and transcendence of biology is that social relations, inequalities and oppressions are manifest not simply in the form of differential access to economic, educational or cultural resources but are *embodied* ... The social reproduction of society also involves the *social reproduction of appropriate bodies* (Shilling, 1993, p. 125, *italics in original*).

What is critically important here is that while sexual health discussions have drawn attention to the invisibility of lesbians, it was through cervical screening that, for the participants of this research, the lived lesbian body was simultaneously brought into being. As indicated by the participants, this realisation of their bodies 'as lesbian' was articulated by these women when discussing cervical screening, or literally, when their own bodily boundaries were permeated by the speculum in the cervix. The lesbian body is both inscribed and produced (in both a material and discursive sense) through the potentially contradictory interweaving of interiority and exteriority, sameness and otherness.

It is important to note that attention to heterosexual assumptions in the space of the clinic dominated the interview accounts. The sense of being exterior to the hegemonic space of the clinic appears as only a small section in this chapter which in no way represents by volume the actual focus on this as an issue in the interviews. The gay positive literature is also overwhelmingly focused on assumptions of heterosexuality as a concern in the contexts of health service provision, and is portrayed there as an enduring phenomenon related to poor education about identities. In addition, presenting the interview material on heterosexual assumptions in proportion to its occurrence would appear to be both repetitive and overwhelming in its reading, as it is both significant and consistent in its volume. The attention to heterosexual assumptions is not dismissed but recurs throughout this thesis in a number of discussions. These can be found in the following section on the abject body, in Chapter Nine, and also in Chapter Five and Six regarding the relationships of lesbian and heterosexual women in the production of 'health' and 'sickness'.

The most significant discussion pertaining to sexuality and ethnicity concerns the issue of *passing*. In a corporeal sense, because the surface of the body can be assessed as reflecting or signifying its interiority, lesbians have the potential to pass as heterosexual, and therefore can potentially avoid or negotiate in which contexts they make lesbian relevant. Gay positive theorists have presumed that this assumption of heterosexuality is the very process through which lesbian invisibility is constituted. The 'oppressions' that lesbian claim must be interpretable in the context of this passing. For lesbians, Maori women and men who are read as Maori,[79] or as 'black', race and ethnicity which are read on the skin are likely to be figured first and do not have the same presumption of agency in this account.

ABJECT BODIES

Gay-positive researchers have argued that the lesbian body, in the context of cervical screening, is invisible. In the last section, it was proposed that in the space of the clinic the technologies of cervical screening expect or emphasise the interior space of women's

[79] Notably, Maori can not be considered to be a heterogeneous identity, representing as it does diverse iwi (or tribes). To be identified as Maori, is to have a genealogy, which links people. Historically identified for a period by Pakeha measurements of blood percentage, or 'colour', identification of Maori is not linked to physical features. However, representations of Maori may still occur in this way.

bodies and highlight lesbians (through questions about sexual activity) as outside of heteronormative sexual activities. However, there appears a simultaneous and contradictory constitution of lesbian bodies in this context as exterior (in terms of bodily spatialisation) and as potentially and materially existing within the hegemonic space. It can be claimed then that the lesbian body has a presence and albeit tenuous existence. Through the technologies of cervical screening which penetrate body boundaries, there is a becoming or recognition of the existence of the lesbian body in the clinic space. This body is constituted as fluid.

Rather than regarding the lesbian body as something that must be brought to the attention of health professionals to encourage the promotion and activity of cervical screening for lesbians, the consequences of the emergence of a fluid and contested body may already be realised. Some of the women interviewed for this research indicated that they experienced or anticipated reactions by health carers to their lesbian sexuality as disgusting and loathsome. In this way, the lesbian body is constituted as abject.

The process of abjection has been theorised by Kristeva (1982), and developed in relation to social bodies (Young, 1990) and one's own body image (Weiss, 1999). This process is explored in the next part of this chapter with regard to boundary formations, exclusions and continual eruptions. It is here, that the processes that locate lesbian as exterior to the hegemonic space are examined as an unconscious attempt to form and sustain boundaries between lesbians and others. They may also be viewed as maintaining 'lesbians' as external to what is possible or expected in the hegemonic space. Abjection attempts a coherent corporeality, and simultaneously recognises the fragility of this pursuit (Weiss, 1999). The process in which lesbian bodies are constituted as abject can be seen to have consequences for the re-production (by lesbians) of the lesbian body as rational.

This section also proposes to add to understandings about the ways in which constructions of invisibility, and solutions to it (for example, the promotion of lesbians in the clinic), may be a simplistic and unsuccessful solution to addressing the lived subjectivities of lesbian bodies in the context of the clinic. There appears to be more at stake than addressing invisibility by being visible as suggested in lesbian health research. It is proposed that lesbian bodies appear threatening or risky and even disgusting in the

context of cervical screening, because the permeability of the boundaries of the lesbian body is unsanctioned.

Disgust and fascination

> There was a moment for me when having a cervical smear five years ago when I distinctly experienced a doctor's dislike of my body. I had told her I was lesbian; indicated it was appropriate for me to have a smear. I was lying on the bed/table with my knees up, speculum in my vagina. She started the process of inserting and scraping, while asking me "have you ever had unsafe sex with gay men?" I think she also said prostitutes. I responded but was stunned into silence with the pain as she turned the scraper up and along my cervix. Did I imagine something in her eyes? I had a clear view of her concentration. Did I imagine something also in the tone of her question? Or was it is her posture, her grip? In my car later I cried. When I got home I was bleeding.[80]

The account I use to open a discussion of the abject is my own. I am anxious about the implications of locating my account in this text, in this place. There is the problematic of privileging my own story. Yet, this experience has led me to a critical understanding about theorising the abject body, and rational space. My own experience of cervical screening in the early stages of this research both unsettled and surprised me. I literally felt shocked into silence by the doctor's questions, which seemed inappropriate and her manner suddenly hard. At the same time I was in the most pain I have ever experienced during a cervical smear. Substantive parts of the interviews also appeared to focus on interactions with health professionals in the clinic where being a 'lesbian' 'body' was encountered with (or perceived as) disgust, revulsion, or unwarranted adverse attention.

Kristeva writes of the abject:

> There looms, within abjection, one of those violent, dark revolts of being, directed against a threat that seems to emanate from an exorbitant outside or inside, ejected beyond the scope of the possible, the tolerable, the thinkable (Kristeva, 1982, p. 1).

Kristeva's (1982) notion of the abject is concerned with expressions of loathing, and disgust (and fascination) which occur when boundaries are threatened. She refers to a deep revolt against what may appear exterior but retains some relationship to what is inside. What is ejected may be regarded as a potential menace. Kristeva indicates three

[80] It is not uncommon for there to be a small amount of bleeding resulting from a cervical smear. However, best practice suggests that the smear taker should explain that this is a small possibility. My later experiences of selecting and going to a highly experienced smear taker recognised as such by the regional Cervical Screening Programme, was that it is possible for my smear tests to be pain free.

forms of abjection toward which social taboos and individual defences are erected; these are in relation to waste, to food, and to sexual difference (defined in terms of orifices for sexual activity - oral, anal and genital) (Grosz, 1989). Each of these is connected with substances that transgress bodily boundaries, passing through orifices from inside to outside, or alternatively are rendered 'other' and invested with a degree of horror or disgust; that is, they are abjectified (Kristeva, 1982; Potts, 1999). With regards to waste, Kristeva evokes aversive reactions which are revealed in relation to body excretions as "matter expelled from the body's insides: blood, pus, sweat, excrement, urine, vomit, menstrual fluid, and the smells associated with each of these" (Young, 1990, p. 144). Oliver (1993) claims that the "abject is disgusting. It makes you want to vomit" (p. 55).

A number of forms of abjection might be expected in a discussion concerning cervical screening and lesbians. The first relates to the leakage of fluids. While cervical screening brings about material fluids leaking from the body, this form of abjection was absent in the participants' accounts. It is the third of Kristeva's (1982) processes, where the rendering of a sexual "other" invests it with disgust or horror, which this text principally refers to. The responses (and perceived responses) from health carers and participants themselves are considered. This regards predominately group experiences of aversion (Young, 1990) and the latter is in relation to body image (Weiss, 1999).

Kristeva's[81] is particularly interested in the source(s) of the abject in the "child's simultaneous longing for and horror of its pre-individuated connection with the maternal body" (Weiss, 1999, p. 91), Kristeva explores the constitution of bodily boundaries and orifices. She describes the becoming of the abject (which is neither subject nor object) as the moment before the boundary of subject and object is formed. That is, it is in the moment of separation when "the border between "I" and the other, before an "I" is formed" (Young, 1990, p. 143). As Kristeva reiterates, abjection is:

> an extremely strong feeling which is at once somatic and symbolic, and which is above all a revolt of the person against an external menace from which one wants to keep oneself at a distance, but of which one has the impression that it is not only an external menace but that it may menace us from inside. So it

[81] In her text *Powers of Horror: An Essay on Abjection*, Kristeva's account of the abject is located in her project of distinguishing Freud's symbolic, paternal realm from the maternal, pre-symbolic or what she terms the semiotic. The latter refers to a pre-oedipal sexuality which is the pre-signifying, or unspoken and unrepresented conditions of signification. Symbolic on the other hand refers to "the order of social and signifying relations, of law, language, and exchange" (Grosz, 1989, p. 194). (For a more extensive discussion see Oliver, 1993)

> is a desire for separation, for becoming autonomous and also a feeling of an impossibility of doing so (Kristeva, 1980, pp. 135-136, cited in Oliver, 1993, p. 55).

I, like Weiss (1999) and Young (1990), am more concerned with the process and operation of abjection itself rather than its source. Using Kristeva, Young (1990) indicates that in order for the subject to become a self (to enter language) there must be a separation and an expulsion.[82] The expulsion, which creates the border between self and other, is experienced as a struggle. She argues that the denial of sex, sexuality, and or colour is the operation of an 'expulsion' (followed by) a 'repulsion' which functions to form 'identities' along these same axes differentiating sex, sexuality and race (Butler, 1990). In this way, the 'other' becomes 'shit' in this process of its excretion (Butler, 1990). The abject is also fascinating, because it is never separate from the body but always in relation to it. As Butler (1990) notes:

> The boundary of the body as well as the distinction between the internal and external is established through the ejection and transvaluation of something originally part of identity into a defiling otherness (p. 133).

The institution of such 'other/s' is consolidated through repulsion operating through exclusion and domination. Young's (1990) appropriation of Kristeva's abject as a means to understand difference or aspects of sexism, homophobia, racism and other group-based fear and loathing is usefully applied here. For example, in the following extract, Kay describes how her membership in a training group was not accepted once she told them she identified as lesbian. Having existed as a member of the group in an internal sense (as part of the social body) Kay's "coming out" as lesbian engendered 'raw hatred' and exclusion.

Kay [I] always used to [come out to my counsellor]. I was always really - like first up. And then I'd gauge that, and whether it was okay or not. Or else I'd go in there knowing that they knew I was lesbian. But [...] Like I had really awful experience of homophobia in a group [...] Before that, it didn't exist for me [...] - it was like, this is me, and that's it! And I could see people didn't like that, but I'd think "oh what the hell". But when I got that *raw hatred*, that these people - [...] I thought I'd worked it through -

In following extract, Max, also refers to the disgust she experiences over being subject to 'overt heterosexual' behaviour. Here, heterosexuality is regarded as being the attention of

[82] The child must separate from the mother. She argues that this can only be achieved by expelling the mother.

loathing and disgust. She claims that such heterosexual behaviour is 'sick making'. Her comments, of course, are somewhat ironic because of the way affections between women are commonly viewed. Abjection by lesbians towards members of other 'oppressed groups', or their own group is able to be accounted for by Young's (1990) theory of the abject.

Max My extended family [are all] really grossly overtly heterosexual. [...] And I hate it. It's like they have some sort of license to be. Yuck. Just stuff, shit like that makes me sick. And yet I can't even touch my girlfriend.

In her reference to the donation of blood by 'gays' in the next extract, Max links two forms of abjection, blood *and* homosexuality. As a bodily excretion (in Kristeva's terms), Max considers how blood which is also 'gay' is regarded as horrible, evil, and contaminating. Max makes a further association between 'gay blood' (and she has assumed a blood services practice of including lesbians under a category 'gay'), and other bodily practices (tattooing, piercing) that are considered to pose risks for blood donation.

Max Like when you go and give blood, one of the very first questions is 'are you homosexual', right. 'Have you had a tattoo recently? Have you been body pierced?' or 'Are you homosexual?' [...] they won't take blood from gays-gay people, [...] to protect the society from [the] horrible, evils of gay blood.

Tattooing and piercing, despite their current popularity, are still mainly regarded as immoderate and exorbitant, because they both apparently belong to the body (raising questions about permanence for example), or do not (are manufactured). Like gay sexuality, tattoos and piercings engender fervent debates and antipathy over their prominent display.

Young (1990) links "group-connected experience of aversion" (p. 123) specifically to the body, indicating that it is experienced as deep-seated and usually subtle. This oppressive experience occurs through the gestures, speech, mannerisms of others, and often defines "Other" in terms of bodily characteristics as ugly, sick and contaminated. Additionally, these bodies are often endangered through violence and harassment. Young (1990) talks about groups being invisible at the same time being marked out as "other". Victims of it, she argues, are constantly called back to, and cannot forget their "identity".

At the time of the interviews, Jo had recently been through a process of telling her friends that her new relationship was with a woman. Lee talks about her girlfriend's anxiety because amongst Jo's friends, 'gays' had been the source of some disgust, and jokes in conversation. In this extract there is a sense that Jo telling the friends is risky, because her friends' aversion reminds Jo that she is at once 'the same person' and the very type of person who was the object of derisive humour.

Lee [...] Jo had a set of friends already [for nearly three years]. And Jo said that they'd talked and joked and been *semi-disgusted about gays* [...] And then she had to deal with knowing that that still may be the way they feel [...] and not seeing that she's still the same person, she just loves someone else.

In response to a doctor's question about contraception, Deb is reminded by the reaction she receives that the expectation is that she is heterosexual. Seeking to inform her doctor that she does not require contraception, she tells her that she is lesbian. Deb relates that her doctor is surprised, shocked, and bewildered - literally 'stunned'. Thus, gestures or responses may not only be verbal but represented in silence and other mannerisms.

Deb Yes. The woman at family planning - I told her [I was lesbian]! Because she talked about contraceptives! (laughs)
Sara What did you say?
Deb I just said "I don't need them I'm a lesbian"
Sara And her reaction?
Deb (laughing) I don't know. I think she was a bit stunned actually. I sort of giggled to myself.

While it may be difficult to read Deb's statement as referring to 'revolt' and 'menace' in reference to Kristeva's account of abjection, it is also difficult to attempt to interpret what is in Young's (1990) terms a silent gesture. In the context of health care situations, I am deliberately reading the interview accounts as an attempt by participants to articulate a sense that health professionals respond to lesbian bodies as if they are repugnant. This deliberate reading must occur because the participants rarely said they had been directly told they were 'disgusting'. Rather, there is the appearance of a discourse in which the women are unsettled by their interactions, as indicated in my narrative. Participants also rarely appeared to have taken up an opportunity to discuss their apprehension with their health carers, and it can not be expected that an attempt to do so would be successful, neither can it be expected given their dependence on the same providers for health care.

It *is* signifcant, that the participants repeatedly and overwhelmingly indicated that any suggestion that they might 'be lesbian' in the space of the clinic was perceived as unreasonable, displeasing (to health carers) as well as bringing unwarranted attention. Furthermore, it was the expectation of responses to the abject lesbian body that dominated over actual responses

As Grosz (1994) notes, disgust and repulsion are not the only conditions for the abject, it is also something that attracts, is envied and desired (see also Oliver, 1993). This is a critical aspect of the abject. Below, Max accounts for the beguilement of lesbians by connecting it directly to the fear and repulse that lesbians appear to generate. She argues that lesbians are viewed as 'incredible', 'proud and loud', 'happy', and smiling, because that is how lesbians manage the sense that they are regarded as disgusting.

Max You know someone said to me a long time ago 'lesbians are so happy. [...] They just so- proud, and loud. And I thought 'Yeah! [...] That's all we've got' -to be proud of something that *everybody else finds repulsive, or is frightened of.* That's what gets us through.

The abjection of lesbian bodies is explored in the following discussions, which consider how such aversion and fascination is recognised and managed in the contexts of the clinic and cervical screening. The following discussion draws attention to the associations between abject matter and lesbian subjectivities, and its management in the context of 'lesbian health'.

Unruly lesbians

In the following account, Jade indicates her anxiety over genital warts and questions whether to discuss them with her current lover. Her concern is reflected in her presentation of genital warts as unruly and unpredictable - they may 'come back'. She suggests that the presence of a sexually transmitted wart virus, which she contracted via sex with men, may be an unpopular reminder to her partner and lesbian doctor that her sexual activity has included heterosexual sex. Jade is aware that any visible sign of the wart virus (HPV) may be a constant reminder of prior heterosexual sex, which her partner may 'not like', and in bodily terms confounds the tenuous borders between lesbian and heterosexual, inside and outside. The constant risk with abjection is that the border cannot be maintained, and because it constantly threatens the border, what is expelled (desire for men, memories of sexual intercourse) becomes loathsome.

Jade [...] do I tell [my partner] that previously I've had - from certain sex with males - um urinary tract infections, thrush, um, what else, um, genital warts. I worried in particular about genital warts coming back. And I do I tell my partner that and feeling that, oh god, you know, she might have feelings about not liking to think about male-female sex, and then having it right - a possible problem right there with her - and so that ties back into going to a lesbian doctor and they may have that feeling as well.

In the presence of these warts, her body boundaries appear precarious. Here, the construction of 'lesbian' as engaging in woman-only sex is potentially threatened by the presence of this virus. Jade's sense of discomfort and risk about the genital warts is not because she understands them as being able to be transferred between women during sexual activity, but because they appear as 'matter out of place'. They are, in addition, visible and uncontainable reminders that exist as an 'outward' sign of an 'inner' virus. What is usually inside and microscopic is displayed on the body, representing for Jade sexual 'ill' health (or the consequence of sex with men).

If lesbian sexuality was regarded as an aspect of normal desire, it should be able to exist without disturbing the border and the separation between what is part of, and outside to, heterosexual desire. Morgan refers to a situation in which lesbian appears to be extrapolated towards a sense of 'matter out of place'. Sexual abuse is viewed as constituting lesbian so that both become effectively separated from the typicality of heterosexuality. The co-disordering (as introduced in Chapter Two) reflects them as linked in their production as well as similarly constituted as inappropriate 'acts'.

Morgan I didn't really want to tell them [my sexual orientation] because it wasn't really a *lesbian* issue. It was a *me* issue. But I thought that that's what would happen. I thought that they would think that I shouldn't really be a lesbian and I've had all these problems because- And I was a lesbian *because* I was sexually abused.

This supports the view by Butler (1990) drawing on Douglas (1966), that lesbian sex (both oral and anal) exists outside the hegemonic order and "establishes certain kinds of body permeability unsanctioned by the hegemonic order" (p. 132). Butler argues that within such a hegemonic view, lesbians are constituted as a threat and a site of danger and pollution even before the presence of any (other) disease, perversion, or regardless of a 'low-risk' status. The boundaries between lesbian and heterosexual are suggested as being maintained for social control (Butler, 1990).

The women I interviewed recognised that lesbianism is in itself a boundary trespass. This is highlighted by their apparent unreasonableness when associated with apparently reasonable activities of heterosexuality, such as childbirth and reproduction. Jade here, refers to the plot line and lesbian characters from a popular daily New Zealand hospital soap opera, *Shortland Street.* Lesbians and children are regarded as 'unnatural' because the process of pregnancy requires sperm donation, rather than heterosexual intercourse.

Jade Yes. It's all hush hush and she's [a character who is lesbian and a doctor] got Annie to be her full-time nurse, twinkle twinkle. Because things have changed for her. So there's those kinds of issues, about being a lesbian and wanting to reproduce goes against complete "natural" order of- Because first of all you're dealing with reproduction as a discourse in medical, western medical knowledge, and then the "unnaturalness" of lesbians and children. And doing it the unnatural way - having to go through the hospital or whatever- the sperm and so forth.

There is an important corollary here. In the context of the clinic setting as Vita says, she feels a constraint or a restraint in asking her doctor about cervical screening as a lesbian. The implication she makes is that 'not (being) an ordinary woman', a 'lesbian' is an intrusion into the space of the clinic. If the boundaries of the body can "represent any boundaries which are threatened or precarious" (Douglas, 1966, p. 155), lesbian sexuality *is* a boundary-trespass.

Vita Like I was saying before, I can't ask the questions that I want to ask. I can't say 'look I'm a lesbian, do you think I need a smear or not?', or 'look I'm a lesbian, do I have to worry about cervical cancer?' [...] Not as an ordinary woman, but as a lesbian' I can't ask those sort of questions. [...] I can't go in and freely admit to these people that I'm a lesbian 'Hey isn't life grand'. I can't go in and say to my doctor, 'I've been having a really good day. I met up with a few of my dykey mates, and we had coffee' So it's just not as free as I'd like to be.

In these discussions, it appears that the participants were aware of the threat represented by lesbian bodies in the context of the clinic. This threat is constituted through the permeability and fluidity of boundaries, as well as a trespassing of boundaries which is unsanctioned and apparently uncontrolled. Yet, the attention to this point has been "more about the fantasies that a fearful heterosexual culture produces to defend against its own homosexual possibilities than about lesbian experience itself" (Butler, 1990, p. 87). The unruliness of boundaries between heterosexuality and lesbians highlighted a

desire (by lesbians also) to maintain and control distinctions between them. It also accounts for homophobia (Young, 1990).

> Homophobia is one of the deepest [sic] fears of difference precisely because the border between gay and straight is constructed as the most permeable; anyone at all can become gay, especially me (Young, 1990, p. 146).

In its formal definition, homophobia refers to a deep-seated fear of gay men and lesbians. Despised groups become objectified because sexism, racism, homophobia exists at a level of discursive consciousness. It is also in their treatment as objects that members of these groups become constructed through, for example, medical and legal discourses. For Young (1990) homophobia is particularly deep-seated when the object becomes less easy to identify from itself, then what is the 'other' becomes more difficult to name and consequently more threatening. As Vita suggests, fear might be experienced by a health professional if they had limited knowledge or experience of lesbians. Her reference to women doctors particularly not wanting to treat a lesbian reflects the kind of threat that Young is referring to. The response by a female doctor, she suggests, is not about prejudice, but some other kind of fear, produced at a bodily level in which the object (lesbian) may be difficult to distinguish from 'women'.

Vita Depending on who the person [health carer] was [...] I think if they really didn't know that many gays, and they didn't really know much about it, I think they'd -I'm not saying they'd be prejudiced, but I think they might be a little bit uneducated and I think they could also be a little bit scared. You know, they might not want to treat you especially if it was a woman doctor.

Abjection, it appears is particularly concerned with aversion rather than repression. Again, this is supported by Vita's assertion that she did not believe that doctors would be prejudiced against lesbians, rather they would be scared. Young (1990) notes, abjection has been shown to rely on anxieties that emphasise it, rather than regarding 'lesbian' as a group containing features making loathing necessary. As she comments:

> The association between groups and abject matter is socially constructed; once the link is made, however, the theory of abjection describes how these associations lock into the subject's identities and anxieties. As they represent what lies beyond the boundaries of the self, the subject reacts with fear, nervousness, and aversion to members of these groups because they represent a threat to identity itself (Young, 1990, p. 145).

Unholy splits

Lesbians appear to be produced as abject through a 'non-lesbian' gaze and simultaneously being aware of the abjection that 'lesbian' constitutes. In exploring what it means to be constituted as abject, it is understood that there may be consequences on lesbian corporeality that includes an internalising of the knowledge that dominant groups despise them[83] (Kristeva, 1982). However, as Ellen suggests, this may not be consistent with the body image that lesbians hold of themselves (Weiss, 1999). A theory of the abject suggests that the gaze on lesbians (by others) is suggestive of the very good (desired, interesting) or bad (repulsive). However, lesbian is often represented only in extremes and not in terms of the ordinary or the mundane.

Ellen however [...] there's a danger of the so called non-lesbian gaze I guess. Thinking that that's all there is within lesbianism. I think like a lot of things - you only hear the good and the bad. You don't really hear about the mundane. Once again I'm sort of composing this sort of discussion or letter to my parents, and I know that their concept of lesbianism is what they've heard. And I guess it's going to be the extreme. And I mean there's a lot of mundane (laughs).

There is, as has been shown, a double consciousness in the dialectic between the dominant view of the other as fearsome, but the view of the self as ordinary. These accounts attempt to conceptualise how lesbians, constituted as abject, deal with abjection. It raises questions about the possibilities for its management. As Kay comments, she is stunned when, having accompanied a friend to a specialist consultation, is told by him to leave.

Kay [...] And it brings to mind an incident that I [...] went with a friend last year to a specialist up at the hospital. And she was a lesbian woman, she had stomach bowel things going on. And she asked me to go with her, and be with her, and so on. And during the course of him talking with her, he was kind of watching me quite closely, and obviously trying to suss out who I was to her. And things like that. And I think he kind of made an assumption that we were lesbians, and probably that we were partners. And he went off to examine her, and he came back, and kicked me out. Told me I had to leave. And I was so stunned, I did!

[83] As Kristeva discusses in her essay, *To Jew Or Die.*: "being objects of hatred and desire, or threat and aggressivity, of envy and abomination" (Kristeva, 1982, p. 172 cited in Weiss, 1999, p. 94).

Kay's perception is that the grounds for his action were her sexuality (and the presumed nature of her relationship with her friend). She indicates that the specialist paid attention to and assessed her relationship with her friend incorrectly. In this situation, the specialist determined that the appropriate place for her was not 'with' her friend, requiring her in the context of his consultation to accede to his authority. Kay did say later in the interview that she had thought her friend had requested that she go home, but because she had no opportunity to check this, only found that out later. Ellen discusses a similar experience.

Ellen Actually a friend was telling me recently - she was having a lot of dealings with specialists – 'cause of this breast cancer scare. And yeah, one of the guys just took a real instant dislike to her, and she believed it was because she's a really open lesbian. And he didn't refuse to deal with her, but he wouldn't give her any information.

As Jo reflects, opportunities for health and wellbeing are available to gay and lesbians. However, while gay and lesbian may be able to realise these opportunities, they are obstructed by the threats that come from homophobia, and homophobic people who are 'not understanding', and able 'to punish'. Reading this in the context of Kay's account above, not only are lesbian bodies threatening, but also open to threat. Recognising that abjection occurs at the level of the unconscious, these fears of being punished may be perceived or indirect, but are lived as material possibilities.

Jo The only people who are ever going to punish you, or whatever, for being that are the people that don't understand. Homophobic people. Other than that, every opportunity is yours. It's the same I guess.

It is in the particular contexts of health care that the threats to and of lesbian bodies can be understood as being particularly significant. When people are unwell, they are particularly vulnerable. Subjectivities, and material borders of the body often have to be reckoned with. In the following extracts from Cinderella, she recognises that homophobic attitudes that already represent the abjection of lesbians, are more difficult to contend with when unwell.

Cinderella [...] the homophobia I've had to deal with in my working life. I mean I've lost jobs because they can't deal with the fact that I'm a lesbian [...] when I go and see a doctor, I'm in a low space. I hate being crook. And to have to deal with possibly their homophobic attitudes I just haven't got the energy to deal with that.

Cinderella discusses 'being lesbian' in terms of multiple subjectivities that are actually split, reflecting "a body subjectivity that is decentered, myself in the mode of not being myself" (Young, 1990, p. 162). She asserts that where a health carer may be attempting to manage or deal with the diversity that she offers, in the context of the clinic she is attending to her individuality and physicality. She does this in order to have her health needs met and to not have to mange the difficulties that being lesbian presents her health carer.

Cinderella One aspect is that I am a lesbian. So I mean when I go to professional people there's that whole block of issues for them [...] in the meantime, I'm fighting as an individual. "If you can't deal with my physical- the way I think, well I hope you sort it out quick, because we're not actually getting on with what we're supposed to be doing here"

In a brief reflection, another possible reading of 'homophobia' is that it produces 'heterosexual' as an 'abject' other to 'lesbian'. The activities associated with homophobia, such as 'punishment', 'poor understanding', or 'poor care', could also be viewed as aspects of heterosexuality which are undesired, external to and do not belong to gay communities. However, reading the texts in this way may be presumptive. Homosexuality always is located as the abject other because abjection is also presumed upon the hierarchical relation of lesbian to the privileged group 'heterosexual' (Young, 1990).

Comments and critiques

The participants appeared to experience the fluidity of their bodies, in the space of the clinic, as constituting a normal state of being. However, the fluidity of lesbian bodies constitutes them as the abject other to heterosexuality. The corporeality of lesbians as indistinct from women in bodily terms, occurs at the particular disjunction between this bodily fluidity and the secular image of a body.

Young' s (1990) own work on pregnant embodiment is a reflection on this disjuncture. She refers in her work to the awareness in pregnancy of a pre-pregnant body "that does not entirely leave my movements and expectations" (p. 163). What Young manages to express, which resonates with the discussion about lesbian bodies, is the sense that the materiality of the lesbian body is acutely aware of a prior (to coming out) or other body which is *not* separate from lesbian, that is namely the embodiment of female

heterosexuality. While the idea of a 'prior' body left behind in a 'coming out' process is somewhat problematic, Young (1990) contends that the integrity of the body is undermined because its boundaries can be realised as being in flux. I would consider that to 'be' lesbian recognises and engages with this boundary flux at once being in the body of a woman, but in de Beauviour's words 'not woman'. The implications for thinking about this in corporeal terms are significant.

Kristeva distinguishes two kinds of body - the symbolic and the abject - and posits the female body as the quintessentially abject body because of its reproductive functions. As 'other' to woman's body, the lesbian body becomes represented in terms of those things which are most threatening to representations of so-called 'normal' woman (masculine, narcissistic, animalistic), and which are refused in the representations of this (a non-lesbian, 'woman's') body (Creed, 1995). In a critique of Kristeva's theory of the semiotic (on which the abject is based), lesbian is posited as 'other' to culture (Butler, 1990). Heterosexuality is, for Kristeva, solidly linked to the notion of a coherent selfhood; lesbianism is a loss of self - which in psychoanalytic terms is translatable to psychosis. The critique of Kristeva lies in her *not* allowing for the possibility that heterosexuality only exists because its position is culturally sanctioned. Lesbian is outlawed - and to view lesbian in any way other than outside is to acknowledge the legitimacy and homogeneity which are allocated heterosexual (and Butler adds, maternal) expression (Butler, 1990, pp. 87-88). Butler (1990) argues that this premise precludes any possibilities for cultural subversion in Kristeva's analysis.

In contrast, the work of Gail Weiss (1999) on disordered body images and anorexia nervosa suggests that the pathology of body image (such as anorexia nervosa) is not associated with the fluidity of bodies, but rather with a desire to fix the representation of bodies too rigidly. This supports the assertions that lesbians are constituted through abjection as pathologised via an attempt to create rigid distinctions between lesbians and heterosexuals. As part of the process marking those who do and those who do not yet constitute as subjects, Weiss (1999) and Butler (1993) argue that abjection is a refusal of corporeality. That is, what it is to manage heterosexuality and not appear too distinct in the clinic, is exactly what leads to difficulties (otherwise an image being too coherent, fixed and stable). Fluid body images are regarded as a normal state that balances and

allows people not to fix too much on one area. As such, the consequence of abjection is often theorised as a refusal of corporeality - of lesbian corporeality.

Weiss's (1999) use of the abject is a corporeal one. In her consideration of the formation of body image, Weiss is concerned with what resists incorporation into it. Drawing attention to both boundaries, and what is lost or refused in the formation of the body image, abjection she argues is necessary because some aspects of our corporeal existence must be excluded to enable a coherent construction of ego and body image. The work on the abject is therefore considered as focusing on the corporeal processes of boundary construction and deconstruction. Weiss draws attention to the issue that the abject sphere is not simply symbolic, it is corporeal - a refusal of corporeality.

Additionally, in the context of the clinic, in a version of internalised homophobia, lesbians would be seen to have aversive reactions to their own bodies, which there is an attempt to avoid or repress. The debate over the potentially pathologised and individual intent of (a theory of) internalised homophobia will not be considered here. However, a Foucauldian interpretation would suggest that Kristeva's abject focuses not only on the prohibitive effects of repression but also on the productive effects (Weiss, 1999). That is, the process that denies lesbian bodies also produces them. The implications are that notions of abjection and lesbian existence are based in a legitimating heterosexuality, and so lesbian is always read in relation to this. 'Lesbian' remains as an adjunct to both heterosexuality and the clinic space.

RATIONAL SPACES IN AND OF THE CLINIC

In the context of the clinic and cervical screening, the lesbian body is produced as unruly and threatening. Its consequences are the experience of being 'matter out of place', in a territory in which lesbians become inauthenticated and trespassing. This is despite increasing collaboration on the recommendation of cervical screening for all sexually active lesbians. However, Douglas (1966) suggests that there is a desire to keep the boundaries of the body intact, and, it is proposed that this occurs, for lesbians in the space of the clinic, through the re-production of the lesbian body as rational. As Butler (1990) writes, there is a particular construction of lesbian in which the potential threats posed to hegemonic bodily boundaries also allows for a re-inscription of those boundaries.

> The construction of stable bodily contours relies upon fixed sites of corporeal permeability and impermeability. Those sexual practices in both homosexual and heterosexual contexts that open surfaces and orifices to erotic signification or close others down effectively reinscribe the boundaries of the body along new cultural lines (Butler, 1990, p. 132).

In particular, lesbian bodies engaged in cervical screening appear to be reproduced as rational, so that the experiences of the clinic are treated as controllable and amenable to will (Frosh, 1997). Interview extracts discussing the questions 'are you sexually active?', 'are you using contraception?' appear earlier in this chapter. The responses to these sexual health questions can be characterised as both indirect and truthful (sexually active -'yes', contraception -'no'). However, the responses were often indirect enough to allow the women to be identified as lesbian only if the smear taker was attuned to it. In this way, leaky boundaries are not professed, and *self*-control is maintained.

It is possible to read my narrative about a cervical smear test, in many ways - that the doctor was a poor smear taker; that as a theorist of lesbian health I was/am 'over sensitive' to notions of 'being lesbian' in health settings; that bleeding after a smear is not unusual; that the questions pertaining to sexuality were appropriate at the time they were asked. In my account I have relayed or observed the subtleties of the actions of the smear taker, which can bring about a sense of being crazy or paranoid, or of misperception of the situation (Young, 1990).

In the following account, Vita talks of 'reading' the nuances of a situation, in order to avoid or protect herself from a potential negative reaction. The emphasis here is on a rational logic in which unpredictable outcomes are potentially avoided. Young (1990) comments that the recognition of the status occupied by oppressed groups as ugly, fearful and despised bodies, occurs at a semiotic level of signification. That is, at the level of "gesture, tone of voice, musicality of speech, arrangement of words, the material aspects of all language that are expressive, affective, without having definable significance" (Young, 1990, p. 143). So, the intricate details of an interaction may be used to determine whether there will be a consequence of being identified as lesbian in this health setting.

Vita I think I really wouldn't want to tell a doctor- a male doctor, that I was gay. I don't know why, it's just the ones I've seen lately have been, excuse the expression, but they've been real pricks. And I just haven't really had any reason to tell them, and plus I wouldn't want to anyway because of the way *they might react, because I can usually read people really well, and I don't want to get a bad reaction*, and I don't want my time to be cut short at the doctors just because he doesn't want me in there [emphasis added].

Toni adds that she also assessed the responses of her health carer when she revealed in her medical history taking she is lesbian. Her attention was on body language, amongst other things, which she used to measure her health carer's acceptance. This was like her other and earlier experiences that constitute a history of coming out.

Toni I guess giving a history at the beginning, and I said I was lesbian and in a lesbian relationship. And that - that was just like all a history of coming out. And that has been quite comfortable with her. But there was that checking of the response. You look for the body language, and I guess acceptance.

The assessment of lesbian bodies in the clinic also involves the re-production of bodies which are not volatile but rather constituted as *not exceeding*, or *conforming* to cultural expectations (Shilling, 1993). For cultural expectations to not be exceeded means that any potential for bodily excess is to be curtailed. Conforming to cultural expectations refers to "the conditions under which the clean and proper body, the obedient, law-abiding, social body, emerges, the cost of its emergence [designated] by the term abjection, and the functions that demarcating a clean and proper body for the social subject have in the transmission and production of specific body types" (Grosz, 1994, p. 192). The construction of lesbian bodies as intemperate reflects the impulse to re-construct these bodies as manageable within the cultural hegemony.

Deb Some I know have talked about feeling ill at ease because of going for a smear and talking about contraceptives - contraception and they have not been able to feel comfortable to say that they are lesbian. They have said "Oh I know. I've got it worked out." You know what I mean "I'm under control" or something.

Deb responds to questions that could potentially identify her as lesbian (and by implication find her 'in excess' of cultural expectations) by saying to her doctor that she

already has her contraceptive needs 'under control'. The emphasis is on things being 'anticipated' or 'worked out'. In this way the conversation about contraception is potentially avoided, and there is not the opportunity for her 'body' to be considered 'excessive' (and engaging in non-procreative sexual activities) in the space of the clinic.

Sara How do you respond to the questions "are you sexually active? are you using contraception?"

Morgan I just- I say "No" (laughs). Because I know that she means "are you having intercourse with a man!" So I just say "no" to everything. "Are you sexually active?" "No!" It's wrong! Because if I thought that I had a problem in that area, or if I thought that it was necessary for her to get a good picture, I'd probably come out and tell her. [...] Sometimes I just walk away smiling thinking "Oh god you're so ignorant." So I usually just answer "No. No. No" Cause they're talking about heterosexual sex anyway. And if I was honest with her and said I am a lesbian, she probably wouldn't ask me those questions because she wouldn't want to know anyway.

Returning again to an extract by Morgan that appeared earlier in this chapter, Morgan is at pains for her body to be considered indistinct from other heterosexual bodies. Her body, she perceives, must conform in order for her to get health care although she paradoxically asserts that the doctor is not getting 'a good picture' and she is not receiving that health care. Morgan's clean rational body in which non hetero- sexual activities do not figure, is not one necessarily produced through a free and agentic action on her part, but is encouraged by the recognition that her doctor 'wouldn't want to know'. It appears that the emergence of the rational and conforming body is consequential on wider regimes of power, and, by both the participants and their smear takers, is concerned with the attempt to deny the lesbian body which is simultaneously present and obvious.

Furthermore, Ellen's extract reflects how she is able to conform, by not saying to her doctor that she is lesbian and through ensuring she is not listed as such on her medical records. The risks would be that that information would also be uncontrolled, because anyone could 'pick up my charts and have a wee look'.

Sara Do you think sexual preference should be asked routinely on a health history or recorded on a health chart?

Ellen I got stuck on this one last time. I think I have a problem with it, given that I don't - I have a bit of a problem with confidentiality in places like hospitals- I mean doctors' surgeries and what not. I mean, I don't know

who's going to pick up my charts and have a wee look. I think it is a safety issue for me again. I think I choose to tell who I want to tell. And some people have such stereotypes about lesbian women. I mean I've got lesbian on my doctor's chart, my doctor leaves or is away, and someone else picks it up and what are they bringing? What stuff are they bringing into that consultation?

In the following two extracts from Wyn, she considers that the consequences of disclosure are such that she may lose the care that she currently receives from her doctor. In order to act rationally, she must assess the potential of her disclosure to lose or have her care affected. She must also assess whether care will be affected for a long time or only briefly. And as Cinderella stated earlier, being unwell makes it much more difficult to act rationally.

Wyn He's a very caring person, but I actually couldn't tell him about my sexuality. That would be the end of getting help from him I guess.

Wyn You're not sure whether you should say it [that you're lesbian]. Not wanting to get a kick back from anybody. Wanting to be sure that you've got some kind of reassurance that it's okay. Because I mean it all very well when you're really healthy you can say "I don't care I'm strong" but if you're not feeling well you don't want to get anything else that's going to knock you.

Again, in the following extract, Max is reminded by a general practitioner that rationality is preferred by his ignoring the emotionality and irrationality she produces. The response contrived for her is that the proper order for her body can be achieved through a mechanistic approach - blood testing. Metaphoric representations of heterosexual discourses provided by nuclear family portraits and (large, obviously sized) crucifixes in the consultation room, reinforce these messages.

Max All I needed to do was talk to him about my situation. But he was just a creepy GP with very clean hands and a picture of his wife and sprogs on his table. And a christian- he had a bloody great crucifix in his office, um, he didn't want to know about anything I did...All he wanted to do was take a blood test...In the end I started crying in his office and he very hurriedly pushed me out really [...] Tried to talk to him about the amount of stress I was going through because of what was happening with my partner, yeah.

Sara And did you identify to him that your partner was-

Max -a woman [...] And he was like ohh ah (makes disconcerted sound). You know, it makes me sad because they learn all this factual shit but they don't

learn how to relate to human beings [...] I've had that [happen] to me before. He was almost like that, 'take a blood test, love. You'll be fine'.

Rationalism is also achieved by a conforming to cultural expectations. However, in the context of cervical smears and other sexual health tests the boundary-trespass *is* homosexuality (Butler, 1990). The modality by which there is a possibility for cervical abnormalities, is a pollution enacted by bodies outside the social order. Beyond this, cervical abnormalities are the result of leaky boundaries, for example, through the exchange of a wart virus 'uncontrollable' in sexual activity. A virus which is notably present in cold sores and whose materiality is vanquished (civilised) with over-the-counter products well known in popular culture via advertising. The modality (lesbian sex) for these polluting agents is represented as unnatural, even if it is potentially less polluting than intercourse.

Vita I think - I don't really know about the other consequences. It's just opening up yourself basically. You've got to really know someone to say 'Look, I'm gay'. Otherwise, you know, you're not- I don't really want to be prepared for the flack I might get. I mean, I probably wouldn't from a lot of people, but there's always someone. But most people, most health professionals I think are really good about it, and I don't think they seem to mind. But I'm just not really sure, I think I'd just rather not say it unless I had to.

Within the regime of the body politic, the attention to a rationalist body acknowledges the potential for any excess, which is to be curtailed. Lesbian bodies are already constructed as intemperate. To present a body in control where things are "worked out", is to move towards the rationalism of masculinity rather than into more feminine excess. This, in itself, is an idealisation of a masculinist logic of rationality (Frosh, 1997).

CONCLUSION

Health care in the clinic and in the context of cervical screening (its constitution through hegemonic discourses of heterosexuality and its scrutiny on sexual practices) highlights for the participants of this research, the fluidity of the lesbian body as uncontrolled and uncontained as a lived bodily experience. As I suggested, my account of cervical screening located at the start of this section led me to a critical understanding about theorising the body. The most important aspect of the abject is that it is not a lack of

cleanliness or heath that causes abjection, but a disturbance to identity, system, order. The abject is a sense of the immoral - the improper.

> If the (process of) abjection is necessary for the development of a coherent body image, the repudiation of what lies beyond the "fragile limit" that marks the border between "I" and what is "not-I" will give rise to its own body image distortions as certain bodily fluids, bodily activities, and body parts are disavowed and refused a "legitimate" place in the construction of a corporeal identity (Weiss, 1999, p. 93).

This account of abjection is important to lesbian and cervical smear taking. The border of 'woman' is fragile, and is highlighted by the scopic gaze on the cervix - a site for woman. At this site there is a disavowal that the (presumed or assumed sexual) activities of lesbian, and in fact the actual cervical cells are legitimate to her corporeal identity. Her body is paradoxically lesbian and not lesbian, but woman. It is relevant here because the demarcations of lesbian and heterosexual women's bodies remain unclear, and lesbian bodies are often threatening as a consequence. Relying heavily on Douglas's work on purity and danger, it draws attention to the expression of desires to keep the body intact. The 'natural' body is merely something that has been constructed (by taboos - in her anthropologic terms) in order to keep stable boundaries.

> Expelling (parts of) myself to establish myself as a member of the symbolic order, I create corporeal boundaries between myself and what is not myself, and in doing so, actively constitute myself as an idiosyncratic entity (Weiss, 1999, p. 92).

In the interviews we (participants and myself) rarely talked about the abject, there are few or no references to it - and as the researcher I had a particular role in the formation and constitution of those questions and discussion. That is, the texts constructed in the interviews did not talk of menstruating, leaking, vaginal fluids or the like.[84] Contrast this to publications on lesbian health and sexuality, my own bleeding, pain and discharge, and to my understandings of an inexplicably expressible abject body. When we (researcher/d) constituted discourses about lesbian health, the lesbian bodies we

[84] Elias (1978, cited in Shilling, 1993) describes the development of civilised bodies in the context of abjection, when he discusses how humans are able to carve and eat animal flesh. He reminds us that the food meat dish is so altered in its preparation and carving that one is scarcely reminded of its animal form. The blood, sinew, smell, fat, skin, fur/hair, offal, eyeballs are avoided to the utmost. He argues that this is in part due to defining human embodiment in opposition to nature, or animals (Shilling, 1993).

constructed were civilised bodies. Bodies in the spaces of a doctor's surgery, health clinic, or medical centre attempted to act in a rational manner.

Rational bodies are associated with masculinity (Frosh, 1997), and are valued against nurturing, emotion, and "femininity" (Lloyd, 1984). Rationality is considered a particular attempt to shift away from feminine excess, and towards a "maleness of reason" (Lloyd, 1984, p. 103). It also encourages individualisation. As overall critique, this assessment of a requirement to act rationally can be applied to the '15-minute' doctor-patient consultation in general (Murphy, 1995), but it is the particular theorisation of rationality as an attempt to repudiate or deny the body that is significant and important here. What has emerged from the interviews was an assertion that 'lesbian' in its many contested and contestatory understandings, is relevant and is figured (materially and discursively) through the processes and procedures of lesbian cervical screening. Cervical screening literally permeates the boundaries of the body. The accounts provided by participants suggest that they experience their bodies as ambivalent, fluid, in flux and, importantly, menacing and rational. I would assert however that in the re-constitution of the lesbian body as rational, the body may be attempted to be denied. Yet it is the *reliance* of 'reason' on the 'body' which re-asserts the lesbian body and its corporeality in cervical screening. Thus in order to deal with the current re-production of discourses in lesbian cervical screening, which consequentially has seen very little change in health information or processes, I propose that exploring lesbian corporeality in health settings may be a valuable inspiration to an area of rapidly growing concern.

CHAPTER IX
(DENTAL) DAMMING LESBIANS

The earlier chapters in Section Three focused on how lesbian bodies are constituted as fluid and 'leaky', as simultaneously interior and exterior to the hegemonic, heterosexual, masculinist space. These lesbian bodies are also constituted as abject. In the particular context of sexual health practices, producing rational (masculine) bodies out of threatening ones in the public[85] space of the clinic may simply be read as a strategy for lesbians to act out, in order to gain access to cervical screening which they have been traditionally excluded from.

In this chapter I consider how public[86] health messages are literally 'taken home' - into private[87] spaces. Specific attention is given to the latex barrier or dental dam,[88] promoted as safer sex gear for women engaging in sexual activity with other women. This chapter serves more as a discussion piece than the earlier analyses, but it includes two important considerations. The first is that there appears to be a reconstitution of lesbian bodies as outside and exterior to the hegemonic, in which the lesbian body is maintained as marginal, fluid, and private. This is evident in the ways in which dental dams are promoted. The promotion of dams appears to represent public health strategies, though the targeting of dental dams is limited. The second is that the dental dam attempts to reseal lesbian bodies. I propose that dental dams in this way re-inscribe lesbian as part of heterosexual hegemony, and this re-inscription exists paradoxically with the first effect. To not use dental dams is to resist this simultaneously exterior and interior body. In summary, the overall impact on health and its promotion will be considered here in

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[85] Linda McDowell (1999) distinguishes between public and quasi-public spaces. The 'clinic' is more likely to be referred to as quasi-public, in which the emphasis on public is retained as it exists outside the space of the home.

[86] There are differences in the ways that 'public' space and 'public' health are understood by the concept of 'public'. This is elaborated on later in this section. The specific link between 'public' in both terms is the notion of citizenship (McDowell, 1999; Nettleton & Bunton, 1995). Citizenship is not specifically addressed in this chapter, but the diversity of approaches in how public is defined, and the fluidity of public/private discourses, is examined in the context of 'public' health in 'private' spaces.

[87] Private space is identified by McDowell (1999) as the "internal spaces of the home" (p. 150), and is distinguished from public spaces which refer to "the open spaces of the street or park" (p. 150), which include quasi-public spaces or leisure spaces such as gyms, bars, cafes, department stores, and I add here 'the clinic'.

[88] Dental dams are also referred to in international literature as oral shields or latex dams.

terms of the tenuous relationships between the public and private spaces - and from the perspectives provided by both cervical screening and dental dams.

WHAT IS A DAM?

Dental dams are promoted as a form of latex barrier as part of safer sex gear for 'women who have sex with women'. That is, they are promoted as an effective means of preventing infection from vaginal or anal secretions (Troyer, 1995, July 20). They are promoted in safer sex health guides and some sexual health kits produced for these (women having sex with women) groups.

An American-based lesbian health guide advises:

> A dental dam is a thick piece of square latex that is placed over a lubricated vagina and clitoris and held in place with the hands. Straps can be used to hold the dam in place. Dams can also be used for oral-anal sex (rimming) (McClure & Vespry, 1994, p. 164).

It needs to be added that dental dams are now made of thinner latex and are now much larger than when McClure and Vespry (1994) compiled their health guide.

Jo [...] dental dam has such a *dumb name*! (emphasis added)

Dental dams have an interesting her-story, and as Jo asserts "a dumb name". Literally referring to its use in dental practices, dams are an oral latex barrier for use during dental surgery to prevent foreign objects (bacteria, tooth filings) from going down into the mouth and throat. These barriers are clamped to a stainless steel frame or tied with a latex cord. They are available from dental suppliers (including those on the internet) as precut squares, in rolls, and come in various gauges (thin, medium, heavy). They can be purchased coloured and "supplied scented [flavoured] for greater patient comfort", including berry and mint flavours (Coltène/ Whaledent, 1999, November 14).

Dental dams form only part of a number of latex barrier options that can be used in safer sex between women. Other safer sex material include condoms, finger cots, and latex gloves - condoms are promoted for use with penetrative sex toys, and gloves and finger cots for penetrative sexual activity (McClure & Vespry, 1994). Alternative (and cheaper) oral sex barriers include the cutting of condoms, or gloves to form a flat sheet, or the use

of Glad Wrap (called cling film, plastic film or saram wrap in other locales) in its standard form and excluding the perforated and microwaveable varieties.

DENTAL DAMS, LESBIAN BODIES AND THE PUBLIC/PRIVATE CONUNDRUM

Dental dams, it is argued, are promoted as if part of a public health strategy, for use in the so-called private spaces of sexual activity between women. Dental dams can be considered an 'intervention' and an interloper into sex acts. It is argued here that the teleological constitution of lesbian bodies via dental dams is a double bind in which lesbian bodies are produced as marginal and fluid, outside heterosexual hegemony while *simultaneously* being re-inserted into this hegemony. This double bind is uncovered by exploring the technologies of dental dams - their functions, promotion (including accessibility), inscriptions of risk behaviours/groups, and finally a consideration of the symbolic aspects of dental dams. The boundaries between the public and private realms considered in this section are regarded as fluid. It is considered, for example, that the sites of the private space/home represent sites of lesbian identity and construction (Johnston & Valentine, 1995), and are also sites for the regulation of lesbian bodies from external influences. Public health is regarded as a mechanism, which in the context of dental dams, operates on the individual in the private spaces of this home.

The meanings of 'private' are important, contested, and often contradictory in the context of 'lesbian' and 'home/bedroom spaces'. The discussion here attempts to find some way of understanding 'private' in these contexts. A discourse of the 'private' is significant in the constitution of lesbian (bodily) subjectivities. The use of 'private' in this context is associated with existing outside of the hegemonic realms, rather than being internal or inside. 'Private *space*', is identified by Linda McDowell (1999) as the "internal spaces of the home" (p. 150). Notably, the use of the term 'private space' may be particularly contested for lesbians whose home spaces may represent "clashes with heterosexuality" or alternatively, "[a meeting of] the needs and desires of lesbians" (Johnston & Valentine, 1995, pp. 111-112). As such even the internal spaces of the home may be recognised as place which is impinged on and regulated from outside (so no longer really private), or "subverted", a place of "resistance" (Johnston & Valentine, 1995, p. 111) and thus existing outside the hegemonic (as the following examples will highlight). Notably, there are problems associated with discussing dams as belonging to sexual activity in bedroom spaces (as this discussion determining 'private space' infers)

rather than toilet sex, or sex in other places and opportunistic moments. However, the concept of 'private' space used here refers to the bedroom since the participants discussed this kind of sex (as in 'taking a girl home'), and because addressing sex in broader contexts would have added additional complexities out of the scope of this section.

Additionally, in discussing the relationships between 'lesbian' and home or private space it is also useful to reflect on contemporary labels for lesbians identifying each other. In social and public spaces these labels include "sista/sister" (New York) and "family" (Hamilton/Auckland) as in the questions which ask if someone is gay/queer: 'are they *family*?', 'is she a *sista*?' These labels refer directly to western notions of the home, and evoke connotations of a private dwelling space. The potential to destabilise family discourses via these interpretations is significant but can be read, for the most part, as a device for not exposing 'gay' people in public spaces (see also Valentine, 1996). A reliance on terms that are both familiar and connote the private realm are another means by which the distinctions between private and public spaces, in which 'lesbian' is predominately constructed in relation to public space.

Research by Lynda Johnston (1993) and a later collaborative piece with Gill Valentine (Johnston & Valentine, 1995) in which 'lesbian' women were interviewed about the spaces they make in their 'lesbian' (not parental) homes, suggested that these 'lesbian homes' are "sites of lesbian identity and construction ... [where there is] a greater freedom to perform lesbian identity" (Johnston & Valentine, 1995, pp. 111-112). They are spaces in which posters, books may be displayed, and affections between women more openly demonstrated. Shared flats with other lesbians or 'gay-friendly' people may provide spaces in which 'challenges' that invisibilise or marginalise 'lesbian' can be addressed through humour, shared cultural understandings or by 'yelling' together at commentators on the television (Johnston & Valentine, 1995). Therefore, the private spaces of the family/home appear to carry significance and meaning in relation to the production and maintenance of lesbian subjectivities and embodied experiences. As Johnston and Valentine (1995) note "conceptions of what constitutes [a 'lesbian'] 'home' [...] may have greater meanings in terms of 'identity' and 'privacy' but less in terms of material security as 'shelter' or 'abode'" (p. 111).

A persuasive liberal discourse related to homosexuality is that it should remain within the confines of the home or bedroom space. In addition, the corollary to the apparent acceptance and tolerance of same-sex relationships is the promulgation by straight commentators of the idiom, 'just don't flaunt it' - in other words, keeping expressions of 'gayness' hidden (Brickell, 2000). This discourse is pervasive, as the saying 'what you do in the privacy of your own home is your business' indicates. This saying was used as the by-line for a recent television advertisement for one of New Zealand's national banks (Bank of New Zealand). The characters in the advertisement include a gay male couple standing next to each other with their arms entwined in the context of an apparent shared home. This is located amongst a number of other heterosexual couples engaged in (and to be read as) *peculiar* behaviour - including role-playing, and Latin dancing. Therefore, the message 'what you do in the privacy of your own home is your business' appears to recognise gay relationships, while simultaneously requiring them to conceal their 'perversity'.

So here, the discourse is that gay should be kept private, where 'private space' is identified as the bedroom in the home. Already inserted into the discourse of the private space (in which gay identities are constructed) is the maintenance and regulation through the technologies of public institutions. In the bank example, the phrase 'what you do in the privacy of your own home' is completed with the phrase "but how you get there is our business". This is also evident in the state control of same-sex relationships in the military. In the United States armed forces, the current policy on sexual orientation is a 'don't ask, don't tell' policy. Introduced during the Bill Clinton presidential term, "this ban states that you could be gay in the military, as long as you never let it be known ... and if you did tell it would be grounds for discharge" (Shawver, 4 May 2000). The requirement is that one must be discreet, and never publicly announce 'being gay'. It is the same discourse about the acceptability of 'being gay' in public spaces only when any 'gayness' is kept private and hidden.

The attention in this chapter to safer sex in 'bedroom spaces' is therefore not incidental. The discourses of 'private' and gay/lesbian are interwoven, contested, and often contradictory. Private - in the context of lesbian, and even in the 'internal space of the home' - refers overwhelmingly to an existence outside or external to, or regulated by, the hegemonic heterosexuality.

The regulation of bodies in private space occurs, often legitimately, via technologies generated outside this space, or in the public realm. Public health - which is part of a strategy to which the promotion of dental dams may be applied - is usually still promoted in public or quasi-public spaces. 'Public space' is importantly "the open spaces of the street or park" (McDowell, 1999, p. 150), where 'quasi-public space' includes leisure spaces such as gyms, bars, clubs, cafes, department stores, and I add here 'the clinic'. That is, 'public' refers to the spaces outside of the home.

Public health is characterised in a traditional sense as something that includes the promotion of strategies aimed at the prevention of 'negative health outcomes'. As introduced in Chapter Three, public health is traditionally conceived of as large scale screening programmes such as that for cervical cancer, or 'public' education campaigns aimed at the prevention of sexually transmitted infections (STIs). Public health is viewed as an activity that functions in the control of bodies en mass, and includes a role in the maintenance and regulation of health (Petersen & Lupton, 1996). Petersen and Lupton (1996) add that:

> The term 'public health' itself is used in a number of different, and sometimes competing ways ... 'public health' implies a focus on health states of populations rather than individuals; 'the public' in this case standing for the masses ... sometimes associated with governmental action; that is the public sector ... [or] also the participation of the organised community; that is 'the public' ... [or] services that are targeted not at an individual but at 'the environment' (Petersen & Lupton, 1996) pp. 3-4).

'Public', in this context no longer refers to simply 'existing outside the home', but to a kind of citizenship. However, Petersen and Lupton (1996) conclude their text on public health noting that contemporary discourses, or the 'new' public health, have shifted the responsibilities for protecting 'public' health from the state to the individual, or members of the public themselves. In a sense, the underlying binary between public and private is continually unstable and destabilised.

PUBLIC? HEALTH CAMPAIGNS

I have already claimed that dental dams may be considered as part of a public health strategy. However, the following discussion focuses attention on how the promotion of dental dams by lesbians at queer/gay dance parties to 'women who have sex with

women', reflects dental dams as existing outside mainstream health messages. It is argued that lesbian bodies are re-produced via the teleology of dental dams and their promotion, as marginal and private. The leakiness of public health discourses regulating the private spaces of sexual activity, and the limitations of a dance party as constituting public space for the provision of dams, are regarded as particularly consequential in the constitution of lesbian bodies in this context.

Promoted by lesbian communities

The predominant focus here is on the promotion and form, rather than the source and availability of the supply of dental dams. Lesbians, it appears, are primary promoters of information about sexual health and dental dams, to lesbian communities. As Kay comments, lesbian women have provided the information that she has about safe sex.

Kay I haven't. I haven't sought out specific information [about safe sex]. I suppose that what I have known, or what I have learnt has been because of other lesbian women.

Overwhelmingly, the participants indicated that dental dams were encouraged through social venues, radio stations, magazines, and bookshops that were all orientated to and organised by lesbian/gay communities. That is, lesbian communities were involved in presenting or compiling the written or verbal information that might accompany the provision of dental dams. As the following quote by Ariah indicates, the lesbian organisers of safe sex information dealing with dams (included in material for a dance party and festival) were very careful to ensure that the safe sex information provided to women was substantial and informative.

Ariah Like this dance party - one of the best ones gave out safe sex kits before and after the dance party. [...] I knew a couple of the women who were involved in organising it, and I knew their views on safe sex and so I could understand where it came from. [...] the women's ones, they had literature in them about safe sex. The actual magazine [from which the information came] had safe sex articles in it that were *really* well prepared. [...] They were just perfect - this perfect description of what to do, how to do it, and da da da. On safe sex! But they provided condoms, unlubed, but extra lube as well. Plus dams plus gloves.

The local student radio station in the Waikato (then called Contact), had a *Queer* Show on Sunday evenings which was consistently one of the station's top ten rating shows. The presenters were gay, lesbian and bisexual women and men who formatted the entire

show including the safe sex advertisements, which Jo comments on as follows. These advertisements included the promotion of dams for sex between women (only).

Jo On the radio when we listen to- *Contact* on Sundays[...]
Lee [...] 'Always use a dental dam, or condom, or- when fucking!' Wrong station mum! Yeah -it's on air. And those things [dental dams] are handed out at dance parties.

Jade adds that latex barriers were encouraged by well known New Zealand performers and lesbians, The Topp Twins. Their performances are non-threatening and humorous, facilitating the uptake of a safer sex message. As celebrities at a music festival which has a large lesbian presence, the effectiveness of the safer sex message is reflected in the fact that Jade is still able to recall the safer sex slogan.

Jade I remember a story that the Topp Twins told, about when they were at Michigan Women's Festival, and they were talking about poster that says, 'no glove, no love' stuff, which I thought was interesting - for lesbians. And then conversations with other lesbians about [it]-

It was indicated in Chapter Two that lesbian health texts are one of very few sources of written information about dental dams. The texts I am referring to appear to be directed at 'lesbian' audiences, providing specific information to the non-medical (and I presume lesbian) reader. Produced by and for lesbians, these lesbian health texts have a content and it could be conceived, a cultural 'style', which is intended to specifically target lesbian communities.

All of the examples outlined above appear to reflect a kind of conversation 'within' 'lesbian' communities. As Jade recounts, having safe sex packs at dance parties, with or without dental dams, served to elicit conversations between lesbians about latex barriers for women. In the interview texts, dental dams were discussed more as a curiosity rather than anything anyone had used during sexual activity. Anecdotal evidence at the time of writing suggests this is still the case. As Jade indicates below, while safe sex packs encouraged discussion about what dental dams (latex squares) look like, how to use them, what sensations were like using them, and so forth, these discussions occurred in a context of an absence of information. The absence of dams in safe sex packs at a queer social event was productive in that it raised questions about 'what is in here for us?', and provided a space that offered opportunities for collective discussion.

Jade 'So would you use a latex rubber?', or 'would you use a glove?'. You know, trying to work 'oh who is actually doing this?' or not?! [...] At one dance I was at in [...] and it was a gay and lesbian dance [party], and on each table it had packs of condoms and little information sheets. And I think was mostly geared at gay male sex- gay at risk sex or whatever. And that just prompted us to talk about, well, what's in here for us. And would you use a glove, like the 'no love, no glove' slogan?. I think there was two, three, four, five of us talking about it- six of us, and 'what do these latex squares look like anyway?' and 'how do you keep it actually on and in place?' [...] And 'is it- can you still feel things?' or 'is it very sensitive?'

Doctors, nurses, and others in a potential role of acting as a sexual health advisor frequently do not advise dental dams for use between women. This includes them not being offered in visits to general practitioners or Sexual Health Centres (including Family Planning) even when attending for a sexual health check. Kay 's discussion reflects earlier comments which note there is limited sexual health information available for lesbians.

Kay But one thing that springs to mind [...] and that was safe sex. And it's very easy to go to family planning and young women or het. women to go up there and find out about what safe sex is for them. And I think that even for gay guys, the information is more readily available. But (not) for lesbian women. There again, it's like you could, but it's not out there. Because you're not hearing it you could tend to think "oh well, you don't need it".

In the situation she describes below, Jade was pursuing HIV sexual health checks having been concerned about confirmed genital warts. Despite identifying herself to sexual health centre staff as lesbian, she was surprised that she was given a sexual health pack that included no dental dams.

Jade I got genital warts...I [later had a] HIV test, at the [New Zealand city] hospital [...] I had two kind of counsellors there - she and he, both of them didn't give me any information on safe sex as a lesbian even though I had made a point of saying it to them - but they did still insist on giving me condoms and, you know, a safe sex pack for, I guess the regular- like there were condoms in it, and I don't- I can't remember what else. I don't think there was any gloves, there was definitely no piece of latex square.

As Jade emphasises, there are protocols surrounding HIV tests that include ensuring that each person given one has support and information, often including counselling. Yet, even at a sexual health centre where she would have expected to get 'best practice'

treatment, Jade notes gaps in the information and resources she was offered. This appears to confirm that medical professionals may not be actively engaged in the promotion of dental dams.

Information about dams is available to an internet-using public - but it would appear that this information is unlikely to be accessed by lesbian communities. A search of the internet using the key words "dental dam", provides a number of sites dedicated to how to practice safe sex with dams, or dental supplies (where dental dams can be purchased) (Coltène/Whaledent, 1999, November 14; Encyclopaedia Britannica Online, 1999, November 14; Troyer, 1995, July 20). The public availability of information about dental dams on the internet make them appear to form part of the global discourses about safer sex. I argue that, given the very small uptake in the use of dams, it would be uncommon for lesbians to access these web sites or search for information on safe sex and dental dams. It is also unlikely that a general search for queer/gay/lesbian resources or activities would point to material on dental dams, as the sites I found were not specifically dedicated to lesbians, but nor are they linked with gay and lesbian web sites. As the earlier cervical screening analysis indicated, lesbians are more likely to access material produced by, and for, lesbians due to the awareness that most health information assumes heterosexuality. It is unclear whether information about dental dams on the internet represents, for lesbians, a broadening of their public health promotion.

Only available at specific venues - dance parties

The focus is not only on who is providing information on dental dams, but where and how, the use of dental dams is being encouraged. While dental dam *information* has been available in certain and limited venues including the internet, and lesbian texts, venues, radio shows, entertainment events, and dance parties, the *supply* of dental dams, however appears restricted. McClure and Vespry (1994, p. 164) in their *Lesbian Health Guide* suggest some places where dams can be sourced in North America: "You can get [dental dams] from dental suppliers, your dentist, you local AIDS committee or some drug stores" (McClure & Vespry, 1994, p. 164).

While dental dams are not available in New Zealand Chemist or Pharmacy stores (our equivalent of drugstores) they are (at the time of writing) available from dental suppliers and the New Zealand Prostitutes Collective (NZPC). A private New Zealand company

(D'Vice) that makes sex toys for mail order distribution also has safe sex packs for women that include dental dams. Dental dams were supplied to dance party organisers in New Zealand for a time from the national New Zealand AIDS Foundation (NZAF) and the regional Hauora (Health) Waikato Sexual Health Centre. This was in response to requests for safer sex (woman-to-woman) packs in which dental dams were included. D'Vice has in recent times made safe sex packs for men and women available at 'gay' events.

Dental dams were discussed in the interviews in conjunction with the other ingredients of safer sex packs (gloves, condoms, and lubricant) but were viewed by participants as having been distinctly promoted for sexual activity between women. The men's safer sex packs for example did not include dental dams. These packs were requested for, and provided at, dance parties and other significant at 'gay-community' organised events.[89] The availability of dental dams at dance parties is important given that the potential use of safer sex gear might be immediate (i.e. taking a lover home).

Max When I went to a Devotion[90] someone handed me a little safe sex kit bag, and inside was specific, woman to woman contact, what to do[...] KY jelly, gloves, a dental dam, how to use it, what they're for. That was really powerful knowledge. And it was really sad that I had to go to a bloody gay dance party to get it.

At the time of the interviews dental dams were promoted to lesbians and were widely available at 'gay pride' dance parties in Hamilton, Auckland and Wellington. As interview extracts suggest, dance parties were the *only* venues in which dental dams were offered to women despite being more widely promoted.

Lee They had a package out at [a dance party] and-
Jo That was the first bit of safe sex information I've ever seen, for lesbian people.

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[89] New Zealand AIDS Foundation (NZAF) and Health Waikato Sexual Health Centre both recommend (on a one-to-one basis) latex barriers but do not actively promote dental dams. As dams are expensive and hard to access the Sexual Health Centre is much more likely to recommend cutting up a latex glove. Other options are available for people with allergies to latex (Personal communication, Kitty Flannery, 8 May 2000 and Dan Kumey, 8 May 2000).

[90] Devotion is a dance party for gay, lesbian, bisexual, takataapui and their friends. Devotion is a Wellington equivalent of Auckland's Pride and Sydney's Mardi Gras.

Dental dams are obviously limited in their availability because they were (and are rarely now) distributed at dance parties in New Zealand, and only to women who have sex with women. Condoms and lubricant (lube) are still sometimes offered.

Ariah adds that while dental dams are often available at gay dance parties, it is the input of women in the organisation that has ensured that the women's safe sex packs included dental dams. She notes that when men have been the primary organisers of an event, dental dams have often been overlooked. This reinforces the idea that it is lesbians concerned about the inclusion of the dam as a lesbian safer sex device.

> Ariah [...] the last major dance party, they just had men's safe sex kits. They don't give a fuck about women! [...] It's run by men mainly, and they don't really supply more than for men. Which is rude - the AIDS foundation is supposed to be a community thing. You can't even get dams through them. And it sucks! - what about us? We are part of the community.

The supply of dental dams at 'community organised' events raises a number of issues regarding public health. Can the role of lesbians promoting dental dams to lesbians be regarded as public health if it appears that this occurs outside of any mainstream practices? Distributed en masse and in conjunction with informative explanations to encourage their use, dental dams can be considered to be performing many of the functions of a public health strategy. In addition, their distribution within a venue with the opportunity for conversation makes dental dams appear publicly accessible. However dance parties and other such events are not necessarily 'public' as they are advertised to a predominately gay audience. They may only capture a small part of the population who feel comfortable at dance parties. Dance parties also cannot be considered private since they are generally advertised and open to people who do not identify as queer, lesbian, or gay.

Outside mainstream health messages

The promotion of dental dams by and to lesbian communities in specific but often limited venues or events, signals that dams appear to represent a sexual health strategy that is outside of mainstream and public health messages. Dental dams form part of the safer sex information specifically provided at events or in resource packages that target 'lesbians'. However, in the New Zealand context, these appear as the only forum in which dental dams (or any latex barrier) are supplied as part of health promotion. The

recognition that the supply and promotion to lesbians of safer sex gear is more extraordinary than ordinary is highlighted by Vita, who comments:

Vita I think they were really good because they sent out safe sex packs. They didn't just give them out to the men they sent them out to the women as well. I thought that was really cool, and I haven't seen anywhere else that does that.

Rather than reflecting a strategy of public health promotion, the promotion and distribution of dental dams by lesbian communities at predominantly dance party events, is a mimicry of public health. This is a consequence of the fluidity in the notions of public and private in the particular context of dental dam promotion. For example, the boundary between what constitutes public and private space appears fluid when public events or dance parties are targeted and attended by predominately lesbians and gays. Naming such an event as a 'gay community event' reflects this delimitation of the concept of public.

As a public health campaign, the intent of the distribution of dental dams is not clear. If they were intended to reduce oral-vagina transfer of infections then they would presumably also be encouraged for use with heterosexual populations. However, women who have sex with men also practice oral sex, but dental dams are not promoted to these communities. However, dental dams are included on a functionalist list of "safer sex supplies" for women who have sex with other women (see McClure & Vespry, 1994, p. 168), but not for heterosexuals or gay men (Da Choong cited in O'Sullivan & Parmar, 1992).

Focussing too on the advertising of dams for use by women who have sex with women - and inconsistently for gay men, and not for heterosexuals - it can be argued that dental dams reconstitute lesbians as marginal or invisible. The discussion by Jade earlier heralded a "what's in here for us?" directed at the safer sex information included at a dance party for lesbians and gay men. The exclusion of dental dams (as in this case) or their inclusion is productive of a marginality where a discourse about the need to 'be safe' sexually is retained for all. Notably, this is also supported by the promotion of dental dams rarely occurring in contexts other than dance parties. They are therefore distributed on a 'one-off' basis. Such 'one-off' promotion, because it appears to exclude

more sustained sexual interactions, implies attention towards casual woman-to-woman sex. Jade reasserts this in following account.

Jade I went at the end of that year to have that HIV test, at the [New Zealand city] hospital, and then I told them I guess I identified as lesbian, out of the concern that they would assume that I would continue to have heterosexual sex [...] I think they might have given that to me [safer sex pack with condoms] just in case I did that kind of stuff again. I don't know, because I'm sure they didn't give it to me and say 'well here's for your sex toys with your girlfriend' - which would be the safe thing for a lesbian to do if she was using it for whatever.

Dental dams retain a focus on oral sex. The idea of the dental dam as a 'device' for oral sexual activity between women appears at the exclusion of alternative (and cheaper) oral sex barriers, with the implication that penetrative sex is the only real sex. Paradoxically, dental dams also recognise the vulnerability and fluidity of the boundaries. Jade and her friends were uncertain about how the 'barrier' is maintained and kept in place. How is it possible to 'separate the exterior from the interior?' This damming - though temporary - is a technology of latex or plastic, again signified at particular sites (vagina and anus). Dental dams would appear ludicrous to use over the ear, for example. The lesbian body is thus re-constituted as a danger to hegemonic boundaries, which are reasserted in the face of an *apparent* 'low risk' transmission of sexually transmitted infections.

Sara You mentioned before that you hadn't been safe with women. What does 'being safe with women' mean for you?

Max Well, I found out later through dance parties, when they give out, you know, dental dams and shit like that- *I didn't know what a dental dam was. Um. That you're supposed to use them over vaginal areas, and, even kissing really.* There's such a fine line, I still don't know really what causes- what you can get AIDS from and what you can't. If you eat off the same plate, if you drink from the same cup, is that all fishwives tales, or is that true? I mean, does it come from saliva? (emphasis added).

In their concurrent uses as a dental product and as a barrier between the vulva or anus for oral sex, the relationship of dental dams to the oral remains intact. Max reiterates this in her discussion, where she also refers to plates, eating, and saliva. Oral sex is simultaneously linked to 'kissing'. The referral to the allegorical and perverted representation of 'fish' as in 'fishwives' ('who are the fishwives?') in this context is strikingly uncanny, given that fish is also a term of abuse for women.

As identified by participants in this research, the dental dam has both a peculiar name and a specific set of 'constraints' that characterise its promotion and supply. As a safer sex device to prevent sexually transmitted diseases in oral and oral-anal sex, the dental dam is promoted at dance party venues to lesbians, by lesbians. The dental dam is promoted through an apparently public health strategy, represented also by its presentation in safe sex packs that usually include guidelines regarding their use. However, 'queer dance parties' are semi-public events only, and the strategy of promoting dental dams in these limited spaces appears to reassert and maintain the lesbian body as private, and marginal. The lesbian body is further represented as marginal because these bodies are targeted only as risky for oral sex practices in public contexts. Dams do not appear to be encouraged by other health promoters in other contexts. It is not promoted to heterosexuals (women or men) or in the context of health promotion (with some individual exceptions).[91] While other latex barriers (condoms) may be promoted to other audiences, these do not feature very strongly in discussions about lesbian safer sex.[92] Thus, in the context of a health promotion strategy, dental dams produce particular constitutions of the lesbian body as marginal, invisible, and dangerous, through the positioning of lesbians, as both outside and internal to mainstream and hegemonic practices.

RESEALING THE LESBIAN BODY

Paying attention to the material aspects of dams and lesbian bodies, and to the production of lesbian bodies in constant flux, may be helpful in the discussion of the uptake of dental dams as a safer sex strategy. I would like to follow two strands of an argument. The first considers the potential that dams attempt to seal the volatile lesbian body, and the second is that dams are resisted by those lesbians expected to use them. The analysis is somewhat preliminary.

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[91] A recent conversation with a sexual health worker at Waikato Hospital revealed that dental dams may be encouraged for use with nonlesbians when their sexual health needs require it, particularly for gay men when given advice about rimming or oral-anal sex. This advice is usually given to individuals attending the service rather than as wider promotion.

[92] Nor does the use of condoms for sex toys, or finger cots for digital penetration.

The duplicity of dams

In an earlier comment made by Max where she links dental dams to the oral, a complex set of relationships between bodies, saliva (fluids) and AIDS (infection) is evoked. As bodies are reflections of social spaces, ideas about bodily infection can be viewed in light of an understanding of the body as a bounded system (Douglas, 1966). Attempts to manage infection or pollution, which represent threats to the system, are about imposing order. As Douglas (1966) argues, there are particular points of bodily vulnerability - orifices - which map dangers or powers that threaten the social system (McDonald, 1997, p. 41). Douglas (1966) adds, "pollution dangers strike when form has been attacked" (p. 104).

A dental dam attempts to achieve the containment of fluids, acting as a barrier to the expulsion of fluids that may pose a risk to health. However, as Douglas (1966) argues, the kinds of pollutants that the dental dam attempts to protect lesbians from, may also represent the danger that lesbian sex poses to the social order:

> I believe that some pollutions are analogies for expressing a general view of the social order. For example, there are beliefs that each sex is a danger to each other through contact with sexual fluids. According to other beliefs only one sex is endangered by contact with the other, usually males from females, but sometimes the reverse. Such patterns of sexual danger can be seen to express symmetry or hierarchy. It is implausible to interpret then as expressing something about the actual relation between the sexes (pp. 3-4).

Dental dams therefore are metonymically linked to a sense of the hegemonic order. They - literally - seal the body. The view that is taken up briefly here is that via dental dams the 'lesbian body' no longer leaks. As a flat and 'virus-proof' barrier, the lesbian body is sealed. Laid on the surface of her body, she (lesbian) is not penetrable, and in particular, no longer symbolically penetrated by another woman. The lesbian body is potentially reinscribed in the hegemonic order, where bodies have 'solid' bodily boundaries. Unlike condoms, gloves, or finger cots, dental dams operate at the 'entrance' of orifices. Dental dams do not penetrate, but rather are 'held' in place by hands or gusset-less pants, seemingly following the contours of the 'exterior' body. To use dams, or even its cheaper alternative - Glad Wrap - is to reassert body boundaries and a sealing of the body.

In this context, dental dams as safer sex gear can be considered something that attempts to create a seamless bodily barrier. As Lupton (1994) adds "in public health discourse,

the body is regarded as dangerous, problematic, ever threatening to run out of control, to attract disease, to pose immediate danger to the rest of society" (p. 30). Recommendations for lesbians to engage in regular cervical screening, and encouragement of the use of dental dams, are messages concerned with notions of risk. They contain suggestions that risks must be contained and not disturb the social order.

In this analysis, the relationship between the corporeal body and the body politic is important. I suggest that dental dams constitute 'lesbian' as marginal and threatening to the social order and simultaneously reinsert 'lesbian' in the social order. Dental dams are linked to the social order because they appear to reassert bodily boundaries, paradoxically emphasising the fluidity of these boundaries. I suspect also there is something of a double bind here. The understanding that dental dams may attempt to reassert 'lesbian' within the social order may also account for the resistance to them.

Resistance

In the current discussion, it seems that while lesbians appear to know very little about dams, even when they have the opportunity to do so, they are often not used. Jade recounts her experience of going to a dance party.

Jade And then, where I was, they gave out lesbian safe sex packages. I know [a friend] gave me hers 'cause she thought I'd get lucky before she did.

In her discussion, Lee comments that dams are discussed 'in jest'. They are things that she regards even sexually active women would not consider using. The promotion of dams reflects that many lesbians do not know what they are, to use in a material sense, although as Lee comments, they may know enough to joke about them (and to terrify 'straight' women with).

Lee In fact half the people don't know what they [dental dams] are. I think you'd find pretty- apart from- they make jokes about them and don't know what they're for. I don't think there's much awareness about what options there are. I mean it- yeah sure, it's becoming a bit better. Like that package. They had a package out at [a dance party] and-

Jo That was the first bit of safe sex information I've ever seen, for lesbian people. But I mean.

Lee I hassled all of my straight mates about the dental dam. They didn't know what it was for.

Jo I didn't know what it was for!

Lee Making little balloons, see. And gave them the shits. That was quite a bit of fun.

Lee asserts that while she does not think that lesbians know about dental dams, she also notes that she does not believe lesbians would purchase or use them. Dental dams therefore appear to be refused in the bedroom spaces that they are intended to be used in.

Lee *I have never heard anyone at the club talk about a dental dam other than in jest.* And most of the people that we go to the club with have all slept with each other, and I've never heard anyone talk about using them. In fact I don't think they'd be on the best seller list at the Chemist. No one ever considers using them [...] No I don't think most lesbians really know what safe sex is. You know - or they know, but no one really seems to talk about it or do anything about it. But I don't know what goes on in the bedroom, but -

Lee builds on her discussion and suggests that dental dams are being promoted or 'pushed' by gay community organisations. In response to the pressure, there is a refusal to use dams which is highlighted by her account here (and earlier) that dental dams are laughed about and lesbian safe sex is absent of them.

Lee [Safe sex] like everyone's trying to push it and push it. Up here you've got all your committees, your Pride and your GLB [gay, lesbian, bisexual student representatives] and that, but as much as they push it, people will look at it, laugh at it, but seem to carry on without it.

This analysis of dental dams offers a useful reflection on public health measures in the context of self-regulation and corporeality. Notably, public health is regarded as most effective when bodies are self-regulated. In the so-called public space of the clinic (discussed in the context of cervical screening), 'lesbian' was discussed as being reproduced as a rational 'body' because lesbians were aware that lesbian bodies were leaky and risky, and were engaged in self-regulation. In the discussion on dental dams as a 'bedroom device', it could be argued that dental dams are resisted because they represent attempts to reproduce lesbian bodies as non-penetrative, non-leaky bodies.

This is a controversial argument because it could be seen to indicate that lesbians can resist such hegemony by refusing to use dental dams. While the participants did not appear to use dams, including dental dams as part of a safe sex 'kit' for lesbians so that they appear to be the only bodies in apparent need of a barrier for oral sex can potentially be regarded an attempt to reassert the hegemony of heterosexuality as the

only practices for erotic possibilities. Notably, Max reasserts the distinctions between lesbian and heterosexual women in the following extract.

Sara Are you saying that you see that as different for heterosexual women?
Max They don't use dental dams. Maybe they should, right, may be they should.

Notably, there is an another issue here about the unavailability and cost of dental dams which indicates that because there are alternatives to dental dams that are low cost (for example Glad Wrap, or cut up gloves), even these options were not included in the interview discussion. It would be useful to explore further, whether low cost alternatives have any impact on the use of barriers. I, however, do not anticipate that it would.

It might appear that this discussion about dental dams, occurs without a consideration of the risk possibilities of transmission of HIV and AIDS, HPV and other infections. What is at stake here is not an inadmission of the lived corporeal reality of such infections and viruses. However, as asserted above, with certain heterosexual practices representing the (only) erotic possibilities, dental dams become refused in 'lesbian' communities because they reconstitute the relationship between the lesbian body and the social order as threatening *and also* produce a body which is technologised to not transgress bodily hegemony.

CONCLUSION

Da Choong, a worker for a high profile AIDS charity in England (O'Sullivan & Parmar, 1992), should have the last word here. She notes that:

> Dental dams have never been pushed for heterosexuals: but they always are for lesbians. So I do think it was a way of introducing the subject [of safer sex] to the lesbian community (p. 45).

As Da Choong (cited in O'Sullivan & Parmar, 1992) indicates, dental dams may introduce the subject of safer sex to lesbians. However, the apparent ambiguity with which lesbians treat dental dams must be contextualised. Here, dental dams are regarded as constituting 'lesbian' as external to the hegemonic while simultaneously reconstituting her as internal to it. If health services provide no dental dams for lesbians, lesbians are constructed as invisible (as with cervical screening) and are not treated as a threatening

body that needs to be sealed (even though this body might be aware that it is threatening). Conversely, if health services do provide dental dams then lesbians are acknowledged and treated as 'dangerous' and in need of containment. If dental dams were more readily available, distributed to a wider (including heterosexual) audience, promoted and provided in contexts other than dance parties, it is contestable whether dental dams would be taken up as a safer sex device by lesbian communities. Whether lesbians use (self-regulate) or refuse (resist) dental dams can be understood as complexly related to lived corporealities. The interweaving of the public and private, in an apparently public health context, reflects that the management of the material aspects of safer sex practices constitutes lesbian bodies as retained within or external to a heterosexual hegemony.

CHAPTER X
CONCLUSION

This thesis has been presented as a process emerging from positivist, epidemiological, gay-positive research, and progressing to social constructionism and critical and queer theory about corporeality. While epidemiological work represents a point of departure for the analysis, the thesis is informed by, and situates itself in relation to this pre-existing approach. Thus, the thesis is understood as a number of overlapping and intertwining approaches that stand in relation to each other and in the context of the wider project of examining sexualised, and gendered bodies in the contexts of health. It is hard to resist the temptation to try to collect the arguments as if part of a clear progression from one to the other, or to synthesise the contradictions in an Oprah Winfrey-like manner (Squire, 1994). The challenge is to leave open and contestable the territories that the thesis has covered and discussions that the thesis has raised, rendering them at once familiar and unfamiliar.

The lived and embodied experiences of the participants are important, crucial even. Delayed health care for serious health problems, dismissal of health concerns, questioning and removal of support people by those in authority, isolation from families, lack of or poor and inadequate information, are only a few of the reflections of participants discussed in the context of these pages. Cervical screening and sexual health, breast cancer, dis-ability, and depression were just some of the health concerns the participants raised. However, what this project intended to reflect, was that health concerns were and are never far from the ways in which lesbian subjectivities and bodies are represented, constituted, and produced. The risk is that by holding 'lesbian' and 'health' up to scrutiny here, it makes both available to increased regulation.

The first aim of this thesis was to create an understanding of health analyses in which sexuality is embodied and enabled, and in which constraints (both unconscious and institutional) and resistances inform a contestation of the hegemonic and traditional approaches. To explore this, I attempted to chart a process through a number of theoretical frames, thus representing lesbian health simultaneously as an area of study, a discursive field, and a lived corporeality. In Chapter Two, I presented a summary of the lesbian health research undertaken up until the mid 1990s. While research in lesbian

health has continued past this point, it is less prolific than previously. However, more recent research still reflects limitations in its arguments, as well as continuing to be difficult to access. There have been a number of larger scale studies carried out since the mid 1990s, supported by national gay and lesbian organisations, as well as health bodies in larger western nations (Roberts et al., 2000). Many of these studies again measure lesbian experiences. In the medical sciences, the suggestion that lesbians do not appear to have legitimate health concerns is reflected by lesbians still not being included in research. My concern remains that the research on lesbian health is still attempting to paint a picture of lesbian health (including issues and prevalence), but that its frameworks are limited for such an analysis and it remains uncritical of the assumptions underlying the research approach. In recent years, alongside the discussions of health concerns, there appears to have been changes in lesbian visibility in popular culture and television, as well as advances in human rights. Yet, these developments in lesbian visibility appear to reflect representations of lesbians and heterosexuals as similar, and restrained by heteronormative notions in which lesbians are viewed as not requiring any particular attention.

I have explored the discursive production of notions of lesbian health. 'Lesbian', I argued, is constituted through gendered and sexualised subjectivities, and produced via the hegemonic institutions of medicine and other institutions and technologies of health. In particular, discourses of lesbian 'health' and 'sickness' are mainly constructed through social and cultural discourses, and these constructions appear similar to contemporary representations of lesbian subjectivities. A focus on 'lesbian health' appears to highlight and reproduce lesbian as different to heterosexuals, particularly women, in health contexts. This critical discourse analysis suggests that in health contexts, which can be regarded as heteronormative, 'lesbian' is produced as perverse, pathological or abject. While attention to lesbian subjectivities in the context of discourses of health and illness risks the reconstitution of lesbian as repressive, the analysis accounts for the constitution of health gains as a continual overcoming of the exclusions and invisibilities associated with being 'lesbian'. In addition, the participants avoided accounts of sickness or health that relied upon a notion of the materiality of 'lesbian', highlighted by the absence of inferences to lesbians as pathological or as definable only through sex acts. When I explored the corporeality of lesbian bodies, I found that lesbian bodies did exist in both a material and discursive sense in the space of the clinic. In fact, the technologies of

cervical screening appeared to literally bring the lesbian body, which was ambiguous and fluid, into being.

My second aim was the deconstruction of the dominant discourses of lesbian health, paying attention to the dichotomies that exist in the production of health knowledges. In the discursive analysis of participant's accounts, lesbian 'sickness' was dominant and overwhelmingly represented in terms of lesbian mental ill health. The production of 'health' accounts was constrained by the regard for it as a paired, but reverse account of sickness. Where lesbians were regarded as unhealthy or unwell through the stresses of society, health was the effect of overcoming the pressures imposed on being lesbian. In addition, lesbians were represented as having sick minds but healthy bodies. Where lesbian communities were regarded as unhealthy, the attention to lesbian health focused on the agentic actions of the individual. I argued that 'lesbian' was both materially and discursively constituted. Health checks and other public health activities highlighted lesbian bodies are particularly threatening because these bodies were simultaneously the same and the other to heterosexual women's bodies. In these contexts, 'lesbian' was constituted as abject. The resistances to abjection attempted to reproduce lesbian bodies as rational, reflecting that lesbian bodies were present and obvious and risky in the context of the institutions and practices of cervical screening.

My final aim was an examination of the fluid corporeality of lesbian bodies, and their re-constitution through various spaces and health contexts. Most clearly emerging from these analyses was the constitution of 'lesbian' as sexualised, and gendered through the interweaving of bodies and subjectivities. Notably the model initially assumed to represent this co-constitution was Grosz's (1994) Mobius strip (an interweaving figure eight). Yet, following the analysis of the fluidity and leakage of the body, it appears that the very boundaries of the strip already appear too fixed. Through the technologies and apparatuses of cervical screening, dental dams, public health promotion, 'lesbian bodies' were simultaneously represented as exterior/interior, public/private, woman/lesbian. It was in the lived, embodied experience of the interweaving and leaking of 'lesbian' across these spaces, that lesbian's refusal to use dental dams, for example, could be understood. Dental dams appear to attempt to seal the lesbian body and reinsert her within the hegemonic space.

Although the analysis for this project was developed in the context of understandings about queer theory, I have continued to discuss 'lesbian health' with the risk of appearing to make claims about lesbian identity. It is important to be aware of the consequences that this has in appearing to reproduce the concerns I am concerned with addressing. I suggest that my exploration of lesbian health emphasises constraints on the study and practice of health in general, as well as the limits of the construction of heteronormative sexual practice in health contexts. The promotion of latex barriers to lesbians only, for example, suggests that oral sex is not viewed as a 'normal' activity in hetero sex, highlighting limited expectations about the expression of 'normal' desire for heterosexual women and men.

In the context of this queer health project, I now ask whether 'lesbian health' can exist in medicine given that sexuality, gender, and the body have been historically absent or ignored? What are the possibilities for 'lesbian health' given its constitution as material, discursive, fluid, and changing? Will claims about the lived experiences of sexuality or gender be too risky, and culminate in forms of resistance that reproduce bodies and sexualities within hegemonic and heteronormative notions of the 'material'? What are the possibilities given that medicine provides some legitimisation for determining whether, for example, lesbians are a valid concern for screening?

During the process of this thesis, I had the experience of developing a pamphlet on lesbian cervical screening (OutSkirts, 1997). In light of a desire to improve the health experience of lesbians, this experience provided me with some useful reflections on the institutions and apparatuses that enabled the publication of this brochure. It was a project that required having the time available to negotiate and address new issues and concepts for understanding health promotion. It was necessary to have the involvement and feedback of people with a diversity of relationships to communities and public health bodies, involving groups whose objectives were supportive of community-orientated and critical health approaches. Research, both biomedical (linking lesbian sexual transmission of HPV to cervical abnormalities) and sociological, was important. Producing the cervical screening pamphlet was achieved by attention to a complexity of issues and overlapping interests, but I believe that its potential for representing concerns and contestations lies in its ability to be continually critiqued and reinvigorated.

At the conclusion of this project I am reminded of a cartoon I saw early on in my process of gathering articles, reports, pictures and images about 'lesbian health'. The sketch shows a woman standing at a pharmacy counter, and there amongst the packets of condoms, lube, and pregnancy kits, a display loudly proclaims "Dental Dams". Suppose I suspend for a moment, my analysis of dental dams as having regulatory functions. Is this, I wonder, an image of the possibility of queer health? Is it an image of the proliferation of sexualities in a public space? Anybody may take their pick of the items on display.

The argument of this thesis is that the image of such a pharmacy counter is desirable and important to a queering of health. Yet, it is not possible to suspend any of the practices and technologies (repressive and productive) that produce such a display, exclude other items, or provide access to those able to purchase. Nor is it possible to assume that dental dams (or other items on display) with their associated representations and meanings are sufficiently desired by or convincing to users as a strategy for 'health'. This is because the 'body' that each item is used on and by, constitutes and embodies, diverse and changing, material and discursive, subjectivities of gender, sexuality, and health. It also begs the question of whether dominant health practices are unsettled by the presence of dental dams if their use is constructed as being for lesbians only. This project also recognises that the queering of health represents health possibilities that must be understood in multiple contexts that include past or historical events, the immediate present, the potential of the future, and also the lived realities of sickness, or death. The implication, is that health practices, concerns, and promotion are 'in queer street', literally troubled by the unsettling of hegemonic assumptions. Focusing on the lived, sexed body in health research may offer one more way of challenging assumptions about sexuality and gender, and raise questions in its practice and analysis about how to engage with diversity and difference.

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APPENDIX ONE

INTRODUCTION SHEET for Linkpeople

Street Talk, Straight Talk: Lesbians and Health Care

This research is about lesbians and health.

As a researcher, I would like to introduce myself and give some description of where I come from in terms of carrying out this study.

My name is Sara MacBride-Stewart. I am a lesbian woman, and have lived in Dunedin, Auckland and Hamilton since coming out. I am Pakeha, born in Britain. I am doing this research about lesbian health as part of my university study. I am currently doing both an MPhil and a diploma in community psychology at Waikato University in Hamilton.

My interest in looking at issues surrounding lesbian health comes mainly from my experiences in coming out. I realised that I was no longer sure what health issues were of relevance to me, and I had difficulties in finding information that was useful.

In researching lesbian health, I am aware that it raises quite a number of questions; from 'what is health?' to 'who is lesbian?', as well as raising issues about the politics of health, community and so forth. My hope in this research is to explore some of these issues. The perspective that the research takes will be guided by the information brought up in the interviews and from my own understandings and positioning. Of course, all research is political, and I hope to be able to incorporate both the diversity and the duplications of our discussions about health.

This will not be a representative study of all lesbians, but will explore the diversity of issues surrounding lesbian health. Ultimately this study will focus on how we as lesbians represent our health, and the medical systems responses to and representations of lesbian health.

I am aware of the conflicts that this research raises in terms of being both an academic piece of work, with community involvement and input. It is essential for me, that in completing this work, I will be able to give something back to lesbians. To this end I will ensure that the findings are disseminated throughout the communities and its networks in some 'user friendly' form.

I hope that this has provided some information about who I am, and the research I am undertaking. If you wish to contact me further my address is included. Please feel free to raise any issues that you consider to be important to this study.

Thank you for your time,

Sara MacBride-Stewart.

APPENDIX TWO

INFORMATION SHEET for Potential Participants

Street Talk, Straight Talk: Lesbians and Health Care

This research is about lesbians and health.

In the first part of this research I want to raise some discussion on how we as lesbian/gay women talk about our health needs, and what we do about our health needs. This is where you have been invited to take part.

In the following interview, I'd like to spend some time talking with you about:

i) how you define 'health' and 'wellness', and other terms related to your health care

ii) your personal health strategies, and health issues

iii) health services and service providers you use, and your experiences of them

iv) the health issues that may be relevant for lesbian/gay women

v) perceptions of how health professionals and service providers perceive health issues for lesbians

vi) sources of health information, including difficulties in accessing information.

As the focus of the interview will be about health there may be questions that you find are too personal for you to answer. You do not have to answer any questions, or provide any information, you do not want to. Please feel free to say that you would rather not reply.

You will be asked to sign a consent form to participate in the research of which one copy is yours to keep. This is the only place where your name will be recorded. Your name will not be used in the thesis report. Any identifying information elicited from the interviews will be removed in order to maintain your confidentiality.

Often when the interview is finished people feel they would like to change, or add to their answers. I would like to offer you an opportunity to comment fully on the transcript of your interview, so that you can change any of your answers. The final report of the study will also be made available for you to read.

You can contact me, or my supervisors, any time after our interview if you want to add any comments, or you want more information.

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APPENDIX THREE

CONSENT FORM

Street Talk, Straight Talk: Lesbians and Health Care

I agree to participate in the interview about lesbians and health care as explained to me by the researcher Sara MacBride-Stewart.

I am willing to participate in the research under the following conditions:

* I will allow the interview to be tape recorded. I understand that it is being tape recorded so that nothing is missed and so that my words are not changed or misunderstood.

* I understand that I do not have to answer any questions that I do not want to. I can decide to stop the interview at any time.

* I agree to allow Sara MacBride-Stewart use the information from the interview for the study she is writing on lesbians and their health care for her MPhil thesis.

* I understand that my privacy and confidentiality will be protected by the fact that neither my name nor any other identifying information will be used in the report.

* I understand that I can change any of my answers when I am given the interview transcript to comment on.

* I understand that I have a right to see the final report should I request it.

* If I have any concerns I can address them to the researcher herself, or to either of her supervisors. I can also address concerns to the University of Waikato Ethics Committee.

Name: _____

Address: _____

Signature: _____

Date: _____

APPENDIX FOUR

INTERVIEW QUESTIONS - LESBIAN HEALTH

General

* What is your age (in years)?
* What ethnic groups(s) do you identify with?

* How would you describe your sexual orientation?
  Prompt: lesbian - gay woman - woman identified bi - or other terms you like to use?
  Prompt: do you identify with any of these categories?
* Can you tell me what ---------- (this term, being lesbian/bi etc) means to you?

* *Can you tell me a story that highlights your identity as lesbian?*

* How long have you privately identified as ----------?
* What people know about your sexual orientation?
  Prompt: family, where you live, work/study, friends, community/sports activities
  Is it important for people to know your sexual orientation?

* What is your current occupation / major activity(s) / community involvement?
  What are other occupations/activities/community involvement you have had/been involved in?
* What activities/sports activities are you involved in?
* What level did you finish school at?
  Have you done any further training since? Can you tell me about it?

Defining the terms:

* What does 'being healthy/well' mean for you?
  What does 'being ill' mean for you?
  Prompt: Is it the opposite or is it something else?

* What is 'health care' to you?
  Prompt: What is caring for yourself in terms of your health about?

* Are these terms you use or do you use others?

* How would you describe your health at present?

Seeking Health Care:

* Can you identify the types of health care providers you use?
  Can you tell me which one(s) you use most often?
  Reasons? Why do you use these most often?
  Prompt: Female/male doctor; gay/straight.

* Can you identify the health services you use?
  Prompt: are these different from above?
  Can you tell me which one(s) you use most often?
  Reasons? Why do you use these most often?

* Do you have a preference in regard to/for your health care provider?

Prompt: Preference could be: type of HCP; location; price; sexual orientation; gender.
Prompt: Could you explain your preference/having no preference?

* What health strategies do you use (when you've got a health problem)?
Prompt: What kinds of behaviours / practices? What do you do?
Prompt: Include parents, friends, health centres, alternative health, own cures, books etc. Include preventative, service providers, superstitions/behaviours
* Say you got flu? What would you do? (remedies, who from etc)

* What self care methods do you use in relation to your health?
Prompt: Stress, home remedies, resting etc
* What kinds of health problems do you feel you can treat without professional help?
Prompt: headaches, allergies, stress, vaginal infections, cancer, heart/circulation?
* What home remedies do you use for these problems?
Prompt: Diet, exercise, medicines from chemist, from friends/family, essential oils, spiritual means, vitamins etc.
* How have you learned to treat these health problems

* What are you reasons for not seeking health care from paid health professionals? (GP's, nurses, chiropractors etc)

* When are you likely to seek health care?
Prompt: Only when necessary, go to HCP regularly?
* How often do you seek health care
Prompt: Annually, biannually, regularly?
* What are you reasons for not seeking health care?
Prompt: if health care was delayed - What are you reasons for delaying?
* Barriers to health care?
What are the things that might stop you from going to a health care provider?
Prompt: Child care, physician attitude, fear of disclosure.
* How did you find (evaluative) the services you've used?

Health Issues for Lesbians:

* *Can you tell me any experiences that yourself or others have had, that has highlighted for you something that might be a health issue for you as lesbian?*
- positive experience - negative experience

* *Can you tell me about a time that you have discussed health concerns with i) a friend, ii) a HCP that was relevant to you as lesbian?*
* What health concerns were raised?
* Did you feel that your knowledge was adequate or whether you wanted more information?
* Have you or any of your friends has experience in trying to deal with any of these health issues? Can you tell me something about it?

* Are there any health issues you think are of specific concern to lesbians?
Prompt: gynaecological; STD's; cancers; substances; mental health; service provision; heart; any others?

(after each one)

* Can you tell me why they might be of concern to lesbians?
  Prompt: lifestyle factors?
* Where did you learn this information?

* Which of these health issues would you like to know more about?
  Are there any other areas you would like to know more about?

* *Can you tell me about a time that you or anyone you know has attempted to find out more information about a specific health concern?*

* Have you experienced any of the health concerns that we have just talked about?
* What information did you receive about them?
* Did you seek out additional information?
* Where did you seek it out?
* Have you sought intervention?
* Which ones did you not seek intervention?

* Have you discussed any of these topics with your health care provider?
  Prompt: Can you tell me about it?
  How do you feel about the information you received?
* Are there topics you can't discuss with your HCP but would like to?
  What are they?
  What stops you?

Disclosure:

* Has anyone you have gone to / approached / accessed in terms of your health care known of your sexual orientation?
* Not known of you sexual orientation?
  Can you tell me about these?

if yes

* Did you tell them your sexual orientation or did you assume they knew?
* Under what circumstances did you tell your HCP your sexual identity?
* What were your reasons for disclosure?
* Describe the reactions of the health care provider you told you were lesbian/gay etc?
  Prompt: Was the HCPs response positive, negative, ignored, otherwise?
  Please explain.
* Is it important that your health care provider know your sexual identity?

if no

* Under what conditions did you not disclose your sexual orientation?
* What were your reasons for not disclosing?
* Would you disclose if you thought it was important?

* What are you fears about disclosure?
* What do you think the consequences of being out to your HCP might be?
  Prompt: Benefits / Disadvantages
* What strategies do you use to manage relations with your health care providers?

Accessing Health Information:

* *Can you tell me about an experience that yourself or someone else has had, where you have sought to find out about a health concern you had?*
* At any time have you wanted to find out some health information that you wanted to know regarding your own health, where did you go?
* Did you get the information you wanted?
* How did you find accessing that information?
  Prompt: Was it easy/hard?

* If you wanted to find some information about some health issues where would you go?
  Prompt: Information from friends, family planning
  (would you bother?)

* If you wanted to find out some information specifically about some lesbian health issues where would you go?

* *Can you think of a time when friends discussed a health concern*
  Can you tell me about it? Are there things you haven't discussed with friends but would like to?

* Do many people ask you, or do you talk to friends about health issues?
  Prompt: What are those issues? Can you tell me about it?
  Have you talked about any health issues that might be important to lesbians?
  What were those issues?

* Have you ever seen pamphlets? articles? posters? media? stories? about lesbian health care.
* What were they about?
* Where were they?

Lesbians Seeking Health Care:

* *Can you tell me about any experiences that you or your friends have had when using HCP's?*
  - positive experience - negative experience

* What things are important or essential in your health care provider relationship?

* Can you tell me about your experiences as a lesbian in seeking health care?
  How did you feel about the care you receive?
* Did your identification have any effect on the care you have received?
  Prompt: Can you describe this?

* When did you first identify yourself as lesbian in terms of your health care?
  Prompt: Can you think of a time when you identified...
* Can you describe this?
* Can you explain why was it important for you to identify as lesbian in terms of your health care?

* Have you ever not sought health care because of your sexual orientation?
  If not, can you describe why?

* Have you had any experiences with partners or close friends regarding health care provision?
  Prompt: Can you tell me about them?

* Have you ever felt your being lesbian/gay was a problem in terms of your health care?
  Prompt: Can you tell me about it?
* Have you ever felt invisible as a lesbian in terms of your health care?
  Prompt: Can you tell me about it?
* Have you experienced discrimination for being lesbian in respect of your health care?
  Prompt: Can you tell me about it?

Some Discussion Questions:

* Should sexual preference be asked routinely on a health history, and or recorded on a chart? Why/why not?

* How do you respond to the questions - are you sexually active? are you using contraception?

* Given this statement, tell me what you think of it? Lesbians are more healthy than heterosexual women

* A healthy lesbian is? Comment on or complete this sentence.

Wrapping Up:

* What changes, improvements, or recommendations you would like to see in health care services for lesbians?
* What other areas that are important to you have been left out of this questionnaire?
* Any other stories/experiences to relate?