

ORIGINAL ARTICLE

Lesbian and bisexual women's sexual healthcare experiences

Siân Munson and Catherine Cook

Aims and objectives. To develop insight into the experiences of lesbian and bisexual women accessing sexual health services and an understanding of their needs within the New Zealand context.

Background. Lesbian and bisexual women are typically invisible in healthcare settings due to heteronormative assumptions. As lesbian and bisexual women are reluctant to come out to clinicians, opportunities for targeted opportunistic health education are often missed. Lesbian and bisexual women have different needs from both heterosexual women and gay men when seeking healthcare. There has been little exploration of the experiences of lesbian and bisexual women accessing healthcare in the New Zealand context.

Design. Qualitative descriptive design.

Methods. Participants ($n = 6$) were recruited via advertisements and snowball sampling. Those recruited lived in a provincial city in New Zealand; self-identified as lesbian or bisexual; and met the inclusion criteria. Semi-structured, face-to-face interviews were used to obtain narrative data about participants being recipients of healthcare.

Results. Five themes were identified within the data set: Heteronormativity; The conundrum of safer sex; Implied and overt homophobia; Engagement with health promotion; and Resilience.

Conclusion. This study highlighted the difficulties that lesbian and bisexual women face when seeking sexual healthcare, primarily due to clinicians' heteronormative assumptions. Lesbian and bisexual women have found ways of navigating the health system that make them feel safe(r) despite experiencing many adversities such as homophobia.

Relevance to clinical practice. This study's findings can be used to guide further research to identify ways to optimise clinicians' engagement with lesbian and bisexual women. Recognition of diversity and skilful communication are essential to rectify inequities and effectively target health information.

Key words: bisexual, heteronormativity, homophobia, lesbian women, nursing, sexual health, sexuality, women's health

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What does this paper contribute to the wider global clinical community?

- This study provides insight into the difficulties that lesbian and bisexual women seeking sexual healthcare experience due to heteronormative assumptions and homophobia;
- The research also highlights the resilience that enables lesbian and bisexual women to continue to utilise 'good enough' healthcare that goes some way towards meeting their needs;
- Education is required by clinicians about the sexual healthcare needs of lesbian and bisexual women so that safe and effective care is provided.

Introduction

Lesbian and bisexual women (LBW) are frequently an invisible minority when seeking sexual healthcare (see for example de Carvalho *et al.* 2013). This marginalisation echoes their experiences within the broader health system (Clear & Carryer 2001, McDonald *et al.* 2003, Røndahl *et al.* 2006, Baker & Beagan 2014). Due to this invisibility within a cultural milieu of heteronormativity the sexual health needs of LBW are frequently poorly managed (McDonald *et al.* 2003, Baker & Beagan 2014), which impacts detrimentally on the provision of appropriate healthcare. Quality, comprehensive sexual healthcare depends in part on the relationship between the health professional and the patient (Baker & Beagan 2014). However, discussions about safer sex, reproduction, or inclusion of a significant other in a woman's healthcare may differ based on a woman's sexual orientation (Kreps *et al.* 2014).

Women's health is typically viewed through a biomedical lens; synonymous with heterosexual reproductive, maternal and sexual health (McDonald *et al.* 2003). However, lesbian and bisexual health needs fall outside of this heterosexualised 'umbrella' of women's health (Goldberg 2005). Failure to delineate LBW's health from women's health has resulted in limited research that explores issues from LBW's perspectives (Williams 2010). The resultant effect of LBW's unseen needs is that these women not uncommonly receive culturally unsafe sexual healthcare. In this article the concept of culture is used to argue that LBW, although diverse, share many commonalities, such as values and language, that elude assimilation with mainstream heterosexual ideals and preferences (Cramer *et al.* 2015, Brown n.d.). The concept of cultural safety encompasses safeguarding people's cultural identity and well-being, which includes clinicians' attention to managing power relations. Culturally safe care for sexual minorities can only be delivered by reflective practitioners who routinely challenge their own culturally imbued values that shape their practice (Wilson & Neville 2009).

Inclusive, culturally safe care includes attention to how language is used. Dominant discourses in safer sex guides focus on heterosexual intercourse, reflecting heteronormativity (MacBride-Stewart 2007); heterosexual sex practices represent 'normal' sex (MacBride-Stewart 2007). In a heterosexist context all sexual activities that are not intercourse, even between men and women, are not considered sex, and are usually labelled foreplay (Dolan 2005). This belief is facilitated by mainstream sexual education programmes that focus on sexual intercourse. Heteronormative clinical education may mean that clinicians are ill-informed

about sexual health issues between women (Cox & McNair 2009).

The perspective underpinning this research is that, while sexual orientation may be stable across an individual's lifespan, for many, sexual partnering may vary on a continuum from same sex to heterosexual relationships. It is important for clinicians to understand that sexual orientation is not a diagnostic category, and that how people identify does not necessarily bear a clear relationship with the gender/s they choose to be sexually active with. The terms used within the article are not rigidly categorical, but are adopted to focus attention away from heterosexuality. For some women, terms such as lesbian and bisexual are strongly linked to identity. The following terms are used throughout this article and are operationalised below: bisexual; coming out; heteronormativity; homophobia; heterosexism; lesbian; queer; sexual orientation.

Bisexuality refers to men and women who experience diverse sexual behaviour or feelings of attraction or desire across genders.

Coming out refers to lesbian, gay, bisexual, transgender, queer, questioning and intersex (LGBTQQI) people's self-disclosure of their sexual orientation and/or gender identity.

Heteronormativity is the weaving of heterosexuality into the fabric of society as the 'normal' sexual orientation; all other orientations are construed as deviant. Thus, people are assumed to be and are treated as heterosexual until they do or say something that proves otherwise. This expectation leads to incorrect assumptions about people's lives. Heteronormativity leaves the onus on the non-heterosexual person to decide whether to come out.

Heterosexism occurs when heterosexuality is seen as natural and normal within society; taken-for-granted as superior, compared to the 'unnaturalness' of homosexuality.

Lesbian women have social, emotional and sexual relationships primarily with other women. Women who identify as lesbian may have had past or have current sexual relationships with men.

Queer is an overarching term for Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex (LGBTQQI) which denotes sexual and gender differences. 'Owning' the label, queer, is a way of contesting boundaries of who is 'normal'.

Sexual orientation describes to whom on the gender continuum a person is sexually and romantically attracted.

Background

Although there have been significant gains for LBW over many decades there is abundant evidence that LBW do not

receive culturally safe care. Despite considerable research over several decades, numerous studies highlight that LBW are still less likely to undergo routine cervical screening and sexual health checks than heterosexual women (Stevens 1992, Marrazzo *et al.* 2001, Power *et al.* 2009, Charlton *et al.* 2011). In a quantitative study in the USA of 4224 LBW aged 17–24, Charlton *et al.* (2011) highlighted that while bisexual or predominantly heterosexual women (women who occasionally had sex with other women but considered themselves heterosexual) had lower rates of sexual health screening than heterosexual women, lesbian women had the lowest screening rates of all. Misinformation may contribute to the problem. In a qualitative study of 248 women who have sex with women (WSW) in the USA, Marrazzo *et al.* (2001) identified that 10% of lesbian women had been informed by a healthcare provider that they did not need to undertake cervical screening because they had not been sexually active with men.

Clinicians' verbal and behavioural cues of acceptance are 'scanned' for by LBW prior to disclosure of orientation (Stevens 1992, Daley 2012, Baker & Beagan 2014). There is a strong correlation between disclosure and service use in LBW populations (Steele *et al.* 2006, Baker & Beagan 2014). When women are asked about sexual orientation, they are more likely to come out, and coming out is facilitated by a health professional being 'gay positive' (Steele *et al.* 2006, Baker & Beagan 2014). An affirmative approach includes openness to disclosure, a non-judgemental manner and cognisance of equity issues.

Furthermore, when LBW do not reveal their sexual orientation this contributes to invisibility in the healthcare setting (de Carvalho *et al.* 2013, Baker & Beagan 2014). Women report that healthcare providers do not ask questions about intimate relationships. Many women fear that they will face discrimination if they are open about their sexual orientation, despite the more liberal climate towards diversity in westernised countries (Clark *et al.* 2003). When sexual orientation is either invisible or uncomfortable for clinicians there is a risk that unequal access to healthcare provision may occur (de Carvalho *et al.* 2013). Clinicians ideally are able to facilitate and respond confidently with disclosures of sexuality, and accept and understand the sexual orientation of lesbian or bisexual women (Bjorkman & Malterud 2009). However, some women are concerned about the lack of knowledge demonstrated by providers on how to respond to the information if sexual orientation is disclosed (Clark *et al.* 2003, Baker & Beagan 2014).

Heteronormativity is common in healthcare practice. Healthcare systems are built around normative notions of sex, gender and sexuality (Baker & Beagan 2014). Failure

to recognise diversity in practice can lead to the assumption that LBW do not exist in one's practice, or that their health issues are identical to heterosexual women (Rosser 1993, Steele *et al.* 2006). Many of the studies identify that women were presumed to be heterosexual until they said otherwise, and little appears to have changed in the practice despite multiple research articles emphasising the problems associated with heteronormativity and heterosexism over several decades (Stevens 1992, Rosser 1993, Clark *et al.* 2003, Bjorkman & Malterud 2009, de Carvalho *et al.* 2013, Baker & Beagan 2014).

There is a deficit in quality education programmes for LBW and also for their healthcare providers (Hinchliff *et al.* 2005, Baker & Beagan 2014). It is important to raise the awareness that cervical screening and sexual health checks are integral to sexual health for LBW (Marrazzo *et al.* 2005). Internationally, undergraduate and postgraduate medical and nursing curricula typically lack education in sexual minority healthcare (Clear & Carryer 2001, Fish 2009, Baker & Beagan 2014). Insufficient education limits clinicians' ability to communicate appropriate and evidence-based advice. There is difficulty in accessing safer sex information, with a lack of pamphlets and online resources outlining safer sex guidelines and a hierarchy of behaviours as related to STI risk (McNair 2009). Merely modifying heterosexual models of risk to construct safety messages for women who have sex with other women may not equip these women with the necessary information to reduce their risk of STI transmission because of the diversity of women's sexual practices with other women (Schick *et al.* 2012).

There is a dearth of literature about LBW's sexual health in New Zealand (NZ) and LBW are usually not accounted for in population studies (Saphira & Glover 2000). The limited NZ literature is either dated or does not focus on the sexual health needs of LBW. It is necessary to have research that focuses on LBW as a distinct group rather than as a subset of either women or homosexuals. A common theme throughout the NZ studies is the invisibility of health needs and specific vulnerabilities for people who do not identify as heterosexual. Discrimination and homophobia were identified in several of the studies highlighting the risks that lesbian, gay, bisexual, transgender and intersex (LGBTI) people may encounter (Rankine 2001, Saphira & Glover 2001). Heteronormativity and invisibility of LGBTI people when receiving healthcare in NZ were features in other studies (Clear & Carryer 2001, Saphira & Glover 2001, Neville & Henrickson 2006). Themes highlighted in the NZ research echo international studies' results: fear of discrimination; choosing when and who to come out to; the sense that on disclosure there were risks of being ignored

or mistreated; and the effects of clinicians' in/sensitivity to specific minority groups (Clear & Carryer 2001, Saphira & Glover 2001, Neville & Henrickson 2006).

Aim of the study

To develop insight into the experiences of LBW accessing health services and their understanding of their needs within the NZ context.

Methods

Design

This study was inflected with Queer Theory. Queer theory allows the social positions and perspectives of sexual minorities to be 'read' from a standpoint that enables them to be viewed inclusively. Queer theorists focus on 'queering' ideas concepts and practices that are usually exempt from analysis because they are considered 'normal' (Alice 2004, Zeeman 2014). Queer theory challenges heteronormativity and the multitude of ways that heterosexual privilege is woven into the fabric of society (Chevrette 2013). It also challenges homophobic power and traditional notions of heterosexuality, femininity, masculinity, sex and gender (Krane 2001).

Ethical considerations

Prior to recruitment ethical approval was given by the University Human Ethics Committee. Pseudonyms were used to protect participants' privacy and any names or locations named by participants in the interviews were changed to general non-identifiable terms.

Recruitment

Recruitment of participants was undertaken in a regional NZ town and was facilitated by a health promoter, who acted as an intermediary between the lead researcher and potential participants. The health promoter approached women identifying as lesbian or bisexual. Potential participants were given an advertisement. Interested participants contacted the researcher directly through phone or text. The researcher informed these women about the study. They were given an information sheet and had the opportunity to ask any questions prior to confirming whether they would join the study. Consent forms were signed by the participants. The participants included six women between the ages of 23 and 47; four who identified as lesbian and

two who referred to bisexual experiences. Five of the participants had completed a university degree.

Data collection

Face to face, semi-structured interviews were conducted to explore LBW's experiences of encounters with clinicians. Demographic data (age, ethnicity, education) were collected. The interviews were conducted at a time and place convenient to the participants, and lasted between 45–60 minutes. A semi-structured interview guide was used in each interview. All of the interviews were digitally recorded and transcribed verbatim.

Data analysis

Data were analysed using the General Inductive Approach (Thomas 2006). This approach allows the emergence of dominant or frequent themes from raw research data. The process condenses raw textual data into a brief summary format. It establishes clear links between the research objectives and the research findings while ensuring that the links are both defensible and transparent. Themes and sub-themes are extracted and presented as findings (Thomas 2006).

The coding process involved repeated initial reading of the text data which identified specific segments of text relevant to the study aim; labelling of segments of text to create themes; reduction of overlap and redundancy of the themes; and then reporting of the most important themes. Eight sub-themes were also created which then provided clarification of the six main themes (Creswell 2002, Thomas 2006).

Rigour

The lead researcher identifies as lesbian, which gives her the position of an 'insider' researcher. 'Insider' researchers choose a project which has meaning for them; in which they may have experience; and where they are invested as a way of changing outcomes (Kanuha 2000). Advantages can include being close to the subject, knowing the language and a deeper level of understanding (Taylor 2011). However, insider status is compromised when research is being conducted due to a power imbalance. Potential difficulties involved with being an insider researcher include the possibility of generalities not being pursued further by the researcher because they or the participant may think that the researcher knows what is meant (Kanuha 2000, Taylor 2011). To minimise this, regular review, both prior to and

subsequent to each interview was undertaken with the second author. Questioning techniques to avoid assumptions were adopted, such as asking for further explanations and examples.

Using only a single interviewer and transcriber who used semi-structured interviews increased the dependability and conformity of the study. Member checking occurred as participants all reviewed and verified their transcripts. All agreed that their thoughts and statements were clearly represented in the transcribed data. Member checking allows the participants the chance to check, update or change any information they have given, allowing veto on what can and cannot be included in the analysis (Liamputtong 2008). The transcripts were read independently by the second author, who also undertook the process described by Thomas (2006). The two authors then collaborated on the development of the final themes.

Reflexivity

Reflexivity was practiced throughout the research process to ensure rigor was maintained. As the lead researcher identifies as a lesbian, the peer review process was used with the research supervisor which is a way of reducing researcher bias (Liamputtong 2008). Peer review allows for discussion and analysis of the data with a person who is not directly involved in the research, allowing discussion around different analysis of the data (Liamputtong 2008). The themes were then used for data analysis along with quotations which provided evidence to support the interpretation of the data. This allowed the meanings that the respondents gave to be expressed in their own words (Liamputtong 2008).

Results

Six women agreed to take part in this study. Four women self-identified as lesbian and two women referred to bisexual experiences. For some women in this study to label themselves as lesbian or bisexual was significant whereas others had much more queered perceptions of their sexual orientation. Queered perceptions refer to shedding dichotomies of sexuality such as straight/gay and exploring other ways of experiencing sexuality. Although the authors have grouped LBW's experiences within the data analysis we acknowledge that this conflation of LBW experiences is contestable. For example, LBW share a number of concerns about health professionals' attitudes with women across the sexual orientation spectrum. Lesbian and bisexual women may and do at times see that their needs differ significantly.

Labelling as lesbian or bisexual may mislead clinicians into the misperception that sexual orientation is fixed; whereas the authors advise a more queered understanding of sexual orientation.

Interviews were 45–60 minutes in duration. Based on textual data extracted from the transcripts the following themes were identified: heteronormativity; implied and overt homophobia; the conundrum of safer sex; engagement with health promotion and resilience. The theme 'heteronormativity' discusses the women's experiences of being queer within a heteronormative health system. The theme 'implied and overt homophobia' examines the barriers the participants faced when seeking healthcare. 'The conundrum of safer sex' theme explores the health literacy of the participants around safer sex practices for same sex attracted women. 'Engagement with health promotion' considers the experiences of the women with seeking sexual health information and cervical screening. The theme 'Resilience' highlights the ways that the participants managed the ongoing navigation of the sometimes hostile healthcare system. The data analysis explores the question of how LBW perceive the contribution of clinical interactions to their understanding of pertinent gynaecological and sexual health information.

Heteronormativity

Heteronormativity was evident throughout descriptions of clinical settings. There were many examples participants gave of being treated as heterosexual. Clinical conversations and clinical environments reflected heteronormativity. The example below highlights this point with a woman's observation about the exclusion of LBW in posters and information in waiting rooms:

I think it would be nice to be represented with sexual health ... for the youth coming through too, so that they're seeing themselves represented. I mean if there's a poster on the wall at your GP's about safe sex for lesbian partners then that pathway of communication has been opened already. (J, 38)

Women also noted that standard documentation only accounted for heterosexual women's experiences; for example forms did not readily accommodate recording women's partners or sexual orientation. Even if women had come out to a specific health professional this step did not mean that the information was documented for future consultations:

So it obviously doesn't pop up on MedTech [medical data system] that you're in a relationship with another girl. (N, 32)

One participant, who had had sexual partners across the spectrum of genders and orientations, highlighted that even when health professionals try to be inclusive, bounded questions can be problematic:

So the reason I came out with my health professional was that I was asked what gender people I have had sex with, so male and or female, that was all I got. So I can't say anything else, I can't define myself within that process. So while the nurse who was dealing with it [trying to address sexual orientation] had a really good reaction to it, the format they've got doesn't allow much "wiggle room". (M, 23)

Participants commented that clinicians gave sexual health information without questioning women's sexuality:

[He] discussed everything related to heterosexual sex, all the things, not even considering that it might not be a factor. (M, 23)

Some participants were out to their clinician, some were not, and some thought their GP knew anyway. The participants gave examples of sexual orientation being overlooked by clinicians, and the discomfort women endured as a result:

[Heteronormative assumptions] makes it awkward; it makes it hard to divulge that information that's already hard to give out because nobody likes talking about their sex life. (M, 23)

Contraception was a consistent theme in heteronormative consultations, whereby premenopausal women were routinely asked about birth control. The woman below inferred that it was easier to go with a doctor's incorrect assumptions than to come out to someone who has already assumed she has sex with men:

The doctor in particular [asked], "what kind of contraception are you using, you just use condoms, right?" "Um, OK, let's go with that". (M, 23)

All participants wanted clinicians to understand that as LBW they felt unseen and sometimes they felt that their sexuality was excluded:

I often feel really under-represented and not important health-wise as a lesbian; important health-wise in everything else but not as a lesbian. (J, 38)

Repeated experiences of marginalisation when using health services meant that women actively decided at every consultation whether they would come out to that health professional. Some participants highlighted positive instances on coming out to a clinician, and had developed something of a tolerance to encountering less-than-ideal care:

It's usually gone pretty well. We've certainly encountered institutional discrimination because of our relationship, but usually clinicians have been fine. (A, 38)

The result of positive encounters was that participants reported they were more likely to come out in the future to clinicians. However, unlike heterosexual women, these women usually cannot predict a positive experience ahead of time, which means each appointment with a new clinician involves uncertainty:

It's horrible and if you do go to the doctor and how do you say at the GP "well I'm not straight"... and they have no concept of what different people are out there, it's horrible and then ... if you do go and tell your doctor ... some people have a stigma about gay chicks and so then they might not want to talk to you and then you're like "oh now you don't want to talk to me" and you have that stigma attached because some people have a real issue with it. They really do. (K, 26)

If you're single it's much more difficult to bring up in conversations and people [clinicians] assume you're straight and then... what I find happens and one of the reasons I try to get it out early is if people assume I'm straight and then I say something about my partner and then say I have a female partner they act like I've lied when in fact I didn't; it was their assumption in the first place that caused the problem. (A, 38)

Each woman also had to decide at different times with different clinicians whether to come out or not; they might come out to one clinician and not to others. As one participant explained:

It's not by choice, but if I'm asked, I do. I wouldn't openly disclose it, it's too awkward. Like "Oh, by the way, I'm gay"... because you don't be like "Hey I'm [name] and I'm straight", who does that? (K, 26)

Coming out is never a single event and women experienced enduring perpetual outing. The quote below highlights a participant's awareness of her vulnerability, given the power dynamics. Fear that her care would be detrimentally impacted shaped coming out:

I think if it's relevant it [sexual orientation] definitely matters, I mean it's not something I would discuss and I'm out. I've been out for years, and I'm confident to be out, but it's still not something I would discuss with my doctor unless I had a really good relationship because again that's quite a difference in power imbalance and you've have to wonder about how that was going to affect the care that you were going to receive from that person. (J, 38)

Forced disclosures occurred when women were unable to accurately reply to health comments and questions without

identifying that they were not heterosexual. Occasionally participants experienced a change in the clinician's attitude after disclosure:

It was interesting, [the doctor] changed his approach to us, which made me realize that even though the notes were there, there had been an assumption that wasn't how our relationship worked [that they had been together for 18 years and were not there as a new couple], and that was really frustrating. (A, 38)

These participants' experiences highlight that despite some positive experiences, their cultural safety was often compromised. Women had to navigate uncertainty about clinicians' attitudes. If clinicians exposed heteronormative perspectives, women were reluctant to disclose.

Participants wanted diversity in sexual orientation to be normalised in healthcare, so that instead of being seen as women with 'deviant' needs, they were seen as having 'ordinary', normal healthcare needs:

It's what I'd like to say. It doesn't make you any different. It doesn't matter what your sexual orientation is, it doesn't change anything about you. It doesn't change anything about whether or not you're having safe sex because it's all the same. Like it's not different just because I'm with another woman. That's it. That's the main thing. (K, 26)

Women considered that while it was important for their clinician to be aware of their sexual orientation, women did not want clinicians' awareness of their orientation to eclipse attention to LBW's broader health needs; those they shared with all women.

Participants perceived that sometimes clinicians were quick to change the subject if sexual orientation came up, which led to women's discomfort. Even when sexual orientation was spoken of, women perceived that clinicians did not know how to continue a discussion about possible related concerns:

I think sometimes they just don't... like once you've said it they don't want to go any further, like "ok, you're with a chick" [woman], that's it, that's kind of all they want to know. (N, 32)

The participants wanted clinicians to be comfortable with considering sexual orientation as a continuum rather than fixed; for clinicians to consider sexuality outside of the parameters of their lived experiences:

I suppose it would make sense if they would just "look out of the square" in general because there's no norm. (N, 32)

Women hoped for a clinician who felt comfortable around diversity and who related to LBW as 'ordinary

women'. Comfort included acknowledgment of differences, not capital 'D' difference:

It's really complicated because some people will say that there is actually no difference, it's just a choice of label, some people will say that pansexual is more inclusive and includes people who are gender-blind, gender, queer, transsexual, anything like that. Since late the number of people who I've been interacting with and interested in who are not in the binary gender scale is growing quite a lot... [but] you don't have to choose a label. (M, 23)

Women discussed their willingness to explain any pertinent information to a clinician or discuss their sexuality or sexual orientation if asked, but they wanted to be asked for information. They did not want their sexuality or sexual health needs to be assumed:

It's not different and it doesn't have to be embarrassing, if you [clinician] want to know something, ask... it would be nice to be asked and not assumed. (J, 38)

These data highlight that there are some specific actions health professionals can take that may counteract heteronormativity and enhance the wellbeing of LBW: ask about sexual orientation; record the response so that this information is clearly accessible in future consultations; develop inclusive language; and create clinical environments that signal affirmation of diversity.

Implied and overt homophobia

Women's accounts of homophobia ranged from covert to blatant discrimination. Participants were of course aware that health professionals' attitudes were likely to reflect those of the broader population. Therefore, they made links between their general lived experiences and those specifically related to healthcare. Their perceptions were that although in general, opinions around homosexuality are changing (for example, support for marriage equality), not all society accepted equity for sexual minorities:

Obviously being gay in NZ and in the whole Western world is a lot easier than 20–30 years ago, but it's still not fully accepted... [but] yes, definitely a lot more accepted.... I was 19 when I had my first same sex relationship and there was no way I was going to come out at all then. It wasn't common then... and now I'm actually quite surprised how many gay people there are. (N, 32)

Participants highlighted their views about what acts are seen as sex within society. Culturally and socially, 'real sex' is penetrative sex. Anything else is 'not-real' sex. One

participant described how this distinction invalidated her intimate relationships:

It would be good if we could have a [societal] discussion; that sex doesn't have to include a cock to be sex... because no one considered them [women with women] to be legitimate partners – no cock equals no sex. (M, 23)

Participants reported the misconception that sex between two women does not include penetrative sex, despite women experiencing non-penile, penetrative sexual activity with other women. Women explained that the realness of lesbian sex and lesbian relationships is dismissed or contested, in their broader lives and in healthcare:

They're [clinicians] like "you're women you're all good, and if you're lesbian you're not engaging in penetration anyway so that's all good". (J, 38)

Another participant discussed several conversations she had with a colleague, a clinician, who dismissed the reality of sex between women:

She said a few times, "it's not real sex". Well it depends on how you view sex. Is it sexual intercourse as in male-female? No, it's not, clearly, but I don't think a lot of people do think that it's real sex. (N, 23)

In contrast with the invisibility of same sex relationships, participants were aware that they were sometimes perceived as 'dangerous' patients. Women reported that a homophobic response they noticed was heterosexual clinicians assuming that LBW might 'come on' to them inappropriately in the consultation. Participants were aware of the myth that LBW are hyper-sexualised and undiscerning. As a result, one participant found it easier to see male clinicians:

I prefer a male doctor; I don't have to worry about the doctor thinking I'm going to jump across the table. (J, 38)

Women described harrowing experiences of unethical, culturally unsafe care, sometimes during periods of considerable vulnerability, such as becoming a parent. What follows is an example of one couple's birthing experience that continues to colour their encounters with clinicians:

Another really big negative one [homophobic experience] was the midwife at the hospital... [she] was quite a Christian lady who had some very definite views on our relationship and on having a child. And she was very unpleasant and she wouldn't let [partner] into the recovery room to start with, and when [partner] did come in she took the baby out of my arms and wouldn't give him to her. And of course I'd just had a C-section [caesarean section] and I

couldn't move I was numb was from the waist down and she wouldn't give [child] to [partner]. [Partner] had to wait in there... she was in tears and she had to wait for about 15 minutes before we could convince her to just hand him over to her. She says, "she's not even family", that was what this woman said; she was very, very horrible. (J, 38)

Although these women were educated and articulate professionals, in their vulnerability as new parents they felt unable to complain, and instead tolerated this treatment in silence.

Participants lived with the knowledge that societally, their relationships and sexual practices were either dismissed or constructed as dangerous. This pervasive dismissal led women, for the most part, to have very limited expectations of the role of clinicians in their lives, engaging with services partially and strategically.

The conundrum of safer sex

Although all participants had a theoretical grasp of safer sex issues, in practice they made inaccurate assumptions about safer sex and STI risks. Participants discussed the options available to LBW for safer sex practices including the use of dental dams, gloves and using condoms on sex toys:

I think when dental dams came out and they were a big thing, I think that they were kind of like "we've done our service to the dykes that's all we need really, you've got dental dams now, you're covered". (J, 38)

The participants felt that the options were limited and not particularly user-friendly; that no products had been created for women having sex with women – all were adaptations of heterosexual or men who have sex with men (MSM) sex:

My experience has been with adapting pre-existing items. So... less successfully. Unfortunately. There have been situations where we've adapted what we are doing so that there will be very little or no contact that will involve transfer of any fluids or anything... there's just so little information about what you can use though. [We've used] a small square of linen, hand sanitizer – which is not fun to use, silicone based lube with toys that can deal with it, and adaptation of condoms. (M, 23)

The lack of products on the market highlights the societal perception that lesbian women do not have real sex and therefore it is not a product niche.

Participants believed that sexual health promotion for the most part overlooked LBW. Rather than observing evidence

of an ongoing public health commitment to LBW health, women felt that there were inconsistent pockets of information and safer sex aides. Where some of the women had trialled various options they were not routinely using them in a sexual situation:

I've never used condoms on sex toy; it just never occurred to me until quite recently that that's even something people do. I've used dental dams a couple of times and I don't think I'd be in a hurry to do so again... I mean who's going to be whipping out a dental dam, and if you're talking about a one night stand, nothing's going to kill the moment faster than whipping that sucker out of your pocket. (J, 38)

There was discussion around the unpleasant feel and taste of latex based options:

Condoms... even the flavoured ones taste like shit. (M, 23)

Well obviously [partners] got the flavoured ones at work and they're yuck, they don't taste like banana, don't smell like banana, they taste like a condom with a little bit of banana thrown at it, they're gross. (N, 32)

This highlights a difficulty for all women who want to engage in safer oral sex; options were unpleasant.

Participants indicated their perception that younger lesbian women's beliefs reflected incorrect societal assumptions that they have a negligible chance of contracting STIs:

I think there's a lot of complacency around young lesbian women that they're not at risk and therefore they don't need to worry. (A, 38)

Data showed that lesbian women too were vulnerable to the heteronormative assumption about what constitutes real sex and therefore risky sex. Therefore, women could misjudge the relevance of safer sex to their lives:

There are so many [myths] around, like "gay chicks can't get STI's", "you'll be right with a girl so don't worry about it", but yeah, yeah you can. (K, 26)

All participants knew there was some STI risk when having sex with another woman. This knowledge did not readily move into engaging in safer sex practices:

I guess people think that because it's two females they don't need to be safe, I don't know. It's quite obvious with two guys there's a definite need and they do need to use a condom. But I think that with two females that people are quite ignorant to it... (N, 32)

Although there are NZ health promotion materials available for LBW, these had not been promoted to the extent that the women in this study were aware of them. This point is significant as participants used the internet

as a resource but had not found information which would direct them to local services. Women described using the internet as a resource but had not found NZ specific resources. Participants wanted resources which were NZ specific, to direct them to appropriate local services. Participants did not know that there are pamphlets for same sex attracted women available from the Family Planning Association, in the clinics and online. The participants discussed the lack of pamphlets available and the lack of posters and gay friendly information in the waiting room at their practices:

That "Hubba Hubba" promotion that came out [NZ safer sex promotion about using condoms for safer sex], there were two young boys, there was a lot of controversy around it, not a lot of people liked it, so it's not a poster that's seen around very often, but I can't say I've ever seen a poster with two females. (N, 32)

Women particularly wanted to see evidence that medical practices welcomed diversity. Health promotional messages aimed at the assumed majority may 'backfire' in terms of inadvertently adding to the marginalisation of those who do not identify as heterosexual. Where same-sex relationships are acknowledged in health promotion campaigns, the focus is predominantly on HIV and gay men.

Engagement with health promotion

All participants spoke of a commitment to routine cervical screening and were up-to-date with smears:

I think that for any woman it's absolutely necessary, it's really important, because if a cell can change quite quickly or has a capacity to change, most definitely need to get checked. (R, 48)

I've always thought that it's the same for any woman, it's about ensuring that there's no cervical cancer or checking for cervical cancer or cells that you know, and I've always understood that to be as necessary for bisexual and lesbian women as for any woman. (J, 38)

One participant had, until recently, gone for 10 years without screening because she thought it was unnecessary as a lesbian, but was encouraged back into the programme by a clinician who took the time to discuss the importance of regular screening while being aware of the woman's lesbian identity:

She said "you really need to go, even though you're not sleeping with men, you really need to come regularly... you know this needs to be a priority" and I was very aware of that, and it was a good message at the time. (J, 38)

The reality that most lesbian women have had sex with men at some point in their lives was highlighted by participants:

How many gay chicks or lesbian chicks are there who haven't had sex with guys? Not many. Many people at one point and time have been there and tried it out. Or realised that you're however many years old and that it's not what you want. (K, 26)

All the participants had the skills to seek and recognise good quality health information on the internet if they needed it. The participants said that they would not choose to seek healthcare information about sexual health from their clinician. Most said this reluctance was due to their previous experiences of receiving heterosexual information. One participant explained how she navigated her information needs:

My mum's a nurse so while I don't like talking about sexual health with her, there are questions that I can phrase in ways and ask them. I have got another nursing friend I can go to with this information and she's a wonderful resource. (M, 26)

Participants considered that the significance of screening was no different for them from the importance for heterosexual women. It is possible that because the health promotion of cervical screening focuses on cancer prevention and only gives minimal attention to the relationship between HPV and sex that lesbian women have experienced inclusion in these messages.

Resilience

Resilience refers to participants' courage to re-engage with health services despite homophobic experiences. Participants strived to maintain some control, often by choosing when to come out and who to come out to and also by developing relationships with clinicians to meet specific needs. A participant talked about how she had recently come out to a clinician:

The first time I [came out] was last week. It was pretty good, the nurse I was speaking to was really quite accepting. (M, 23)

Women struggled to find a clinician with whom they felt comfortable. One participant located her GP through a community organisation using 'hot' and 'cold' files; files of information from other women about their experiences with clinicians:

I rang the [community organisation] when we first came to [town] and they recommended [Doctor]. (A, 38)

Another went on a waiting list, and although she was able to specify that she wanted a female GP, and she was

placed with a practice that has a female GP, she had only seen that GP once. She usually had to see the male GP instead due to limited appointments:

I didn't have any choice at all because I had to ring the [free] number and go on a waiting list. So I ended up at [practice]. But I put down "female doctor", but I don't get a choice at [practice] anyway, you get to see who you get to see. (K, 26)

A third had a negative experience with a specialist at the hospital but had no choice in seeing that clinician as it is not possible to choose a specialist in the public hospital in most instances:

When you go to the public hospital you get to see the clinician who's put in front of you. (M, 23)

While choice may be limited in regional centres there may still be issues nationally with accessibility, affordability and acceptability although there may be more options for free or low-cost services in main centres. Despite the difficulties, most of the women in this study had managed to find healthcare provision they found acceptable.

Discussion

Invisibility persists

This study's results and the wider literature provide compelling evidence that heteronormativity persists in healthcare both internationally and in NZ (Clear & Carryer 2001, Neville & Henrickson 2006, 2009, Daley 2012, Curmi *et al.* 2015). Limited NZ literature addresses LBW's health needs, yet the evidence suggests little has changed attitudinally in clinical encounters. This study's data illustrate contemporary heteronormativity. Examples include women repeatedly being asked about contraception; and a midwife's exclusion of a lesbian partner. Clinicians' provision of culturally safe care depends on self-awareness of their own potential heterosexism (Davis 2005). Clinicians may overlook that some of their patients could be lesbian or bisexual (Marques *et al.* 2014).

When seeking healthcare LBW often navigate an invidious choice: to come out or not. These choices can jeopardise the healthcare women receive as a result of their decision (Daley 2012, Baker & Beagan 2014). Fear of homophobic or heterosexist treatment and lower quality of care inhibit LBW's decision to come out to clinicians (Kerr *et al.* 2013, Baker & Beagan 2014). Coming out can place barriers to healthcare for LBW, further reducing their ability to easily and safely access healthcare (Neville & Henrickson 2006). Although LBW who are comfortable with

their sexual orientation are more resilient and therefore more likely to come-out (Baker & Beagan 2014), our study results indicated that comfort did not protect from prejudice. The reluctance of most participants to come out routinely is also seen in other studies, often due to fear of the reaction (Neville & Henrickson 2006, Formby 2011, Baker & Beagan 2014, Marques *et al.* 2014).

Lesbian and bisexual women may not be willing to initiate disclosure of their sexual identity to clinicians, waiting instead to be asked directly (Kerr *et al.* 2013). Some clinicians do not ask for fear of offending heterosexual women (Hinchliff *et al.* 2005), highlighting an assumption by many clinicians that inferring diversity is abnormal and risks offence. Clinicians may argue that they 'treat all patients the same', by not making assumptions. However, the desire of a clinician to remain neutral and 'treat all patients the same' reinforces the heteronormative culture of health, because neutral means heterosexual (Baker & Beagan 2014).

Safer sex confusion and vulnerability

Quality safer sex information aimed at the lesbian and bisexual communities is needed because the diversity of their sexual practices means that heterosexual women's models of risk may be inadequate (Schick *et al.* 2012). Several participants emphasised limited choice in barrier methods for safer sex. They described the choices as less-than-ideal, including the off-putting smell and taste of latex, and embarrassment at bringing out dental dams for oral sex use. Absence of public health messages, along with a paucity of products designed for safer sex between women, may feed perceptions of limited sexual health risk (Schick *et al.* 2012). Messages about transmission potential need to be accessible for LBW so that they can make appropriate, informed decisions about safer sex and protective measures (MacBride-Stewart 2007).

Development and promotion of products specifically aimed at LBW may encourage safer sex through highlighting the need for safer sex practices (Schick *et al.* 2012). Although there are barrier methods available for use by LBW, modifying products from their intended use can be problematic (Schick *et al.* 2012, de Carvalho *et al.* 2013). We concur with the argument for risk reduction education for LBW (Cox & McNair 2009, Richters & Clayton 2010). Risk reduction involves practices such as not having sex if a partner has active herpes simplex virus, having short fingernails if performing digital penetration, human papilloma virus vaccination and having regular STI screening (Cox & McNair 2009, Richters & Clayton 2010).

Homophobia persists

Homophobia is amplified by stereotypes of LBW. Those who are marginalised are either overlooked or attract attention where none is sought. Implied homophobia occurs where anything other than the heterosexual norm is seen as 'less than' (Baker & Beagan 2014). To some extent homophobia may account for why clinicians may 'forget' they have LBW patients in their practice, especially if those patients do not fit a stereotype (Marques *et al.* 2014). One of the participants reported homophobia in general practice when she commented that she would rather have a male doctor because female doctors were afraid they might get 'hit on'. This is a common myth in stereotyping lesbian women: that they are out to seduce heterosexual women (Randall & Eliason 2012). As highlighted earlier, one participant experienced extreme homophobia from a midwife who the participant knew to be a Christian. Religious homophobia is based on the belief that homosexuality is morally wrong; objectionable to God (Rowniak 2015). However, nurses have an obligation to treat patients ethically, irrespective of their personal belief systems (New Zealand Nurses Organisation 2010).

Clinicians have the potential to enhance the health of LBW through awareness that these women are potentially less likely than heterosexual women to have had timely cervical screening. Although studies undertaken in the US point to lower rates (Marrazzo *et al.* 2001, Power *et al.* 2009), Australian studies report screening rates similar to heterosexual women (Power *et al.* 2009, Curmi *et al.* 2015). Lower levels of education and income in LBW are linked to irregular cervical screening (Marrazzo *et al.* 2001, Power *et al.* 2009). In the current study, not all women had undergone routine, timely cervical screening, even though most had tertiary-level qualifications. Cost was not a barrier to cervical screening for these women, most of whom were in full-time employment or were able to seek free cervical screening in the community.

Resilience

Participants indicated the resilience they had developed, often having overcome multiple adverse clinical experiences. Resilience is about rebounding from adversity and regaining or surpassing the previous level of functioning prior to the stress taking place (Connolly 2006, Henrickson & Neville 2012). Resilience was evidenced by the ability of all participants to find healthcare professionals that they felt comfortable enough with, whether they chose to be out to that clinician. Good relationships with clinicians are often linked to communication, values and social skills (Fish & Bewley 2010). When a clinician has an open attitude it is easier for

LBW to discuss topics of concern and to develop a working relationship (Fish & Bewley 2010, Baker & Beagan 2014). Women recognise an open attitude when clinicians are not silent or embarrassed with sexual orientation diversity (Fish & Bewley 2010, Baker & Beagan 2014).

These women's clinical experiences highlight the recurrent stressors faced by women who are not heterosexual. Adaptation and stress management strategies produce resilience (Connolly 2006). These participants had means to foster resilience, and all reported examples of flourishing in their lives. Resilience enabled women to continue to re-engage with health services they deemed to be 'safe enough', if not ideal, and through so doing, to protect their health. Of note, they wanted the health service experiences of younger LBW to be easier than their own. What is of ongoing concern to the researchers is that women's resilience enabled them to tolerate and navigate experiences of culturally unsafe care. Thus, the engagement of LBW with health services may mean a service received is tolerable rather than optimal.

Limitations

Findings were limited by the small size of the research. A snowball sampling method was used, in which sampling bias can occur (Magnani *et al.* 2005). The women who chose to participate in this study were more likely to be 'out', and to have strong views on LBW's sexual health interactions with clinicians. Most participants had tertiary level education, which has strong co-relations with health-seeking behaviour. The participants were from a regional centre in NZ and their experiences may not be consistent with experiences of comparable women in larger centres. One participant identified as Maori (indigenous to NZ); the study findings did not address the ways culture inflects experiences of sexual orientation. There were two participants who described bisexual experiences. Their experiences may not be consistent with those of other bisexual women.

Conclusion

The aim of this study was to develop insight into the experiences of LBW accessing health services and their understanding of their needs within the NZ context. Both the international literature and our results concur; LBW have multiple difficulties when accessing healthcare. Experiences of heteronormativity are commonplace, resulting in a lack of understanding of the needs of the LBW population when seeking healthcare. LBW had found ways of navigating healthcare in ways that made them feel safer, despite the

issues they had previously encountered such as unintentional or overt homophobia. It is positive that in contrast to the US literature this group of NZ LBW are all actively engaged in the cervical screening programme. This study highlights gaps in the NZ literature on the care of LBW in healthcare and establishes opportunities for further research.

Relevance to clinical practice

Heteronormativity results in unsafe care – research repeatedly identifies that LBW are frequently harmed emotionally through interactions with healthcare professionals. Clinicians' ability to communicate an appreciation of diversity enhances the likelihood that LBW will feel safe enough to come out to their provider, thereby enhancing care provision. Clinicians who know about women patients' sexual orientation are more able to ensure better health outcomes and better screening uptake through providing relevant education. Attitudes and beliefs gained from living in a heteronormative society are evident in nursing. If nurses are to provide optimal care, changes in education and clinical practice are required.

Education about inclusive communication skills and issues pertinent to LBW might better enable clinicians to provide culturally safe care for sexual minority patients (Chapman *et al.* 2012, Baker & Beagan 2014, Cramer *et al.* 2015). Affirmation of LBW allows provision of targeted health education. There is potential for these women to be educated on risk evaluation of their sexual practices and options for risk reduction. Support could include inclusive practices such as pamphlets and posters aimed at LBW in waiting rooms, which convey that a practice is 'gay friendly' and promotes targeted health education.

Education ideally addresses the following key points: stereotypes are misleading; diversity is not necessarily discernible. Clinicians may benefit from guidance about communication strategies to ask about sexual orientation and sexual practices, and to be alert to the possible impact of their own verbal and non-verbal responses. Partner inclusivity matters. Clinicians could benefit from specific education about STI transmission in LBW, sexual practices and safer sex options. Education around inclusion of the healthcare needs of all LBGTQI is recommended for undergraduate and post graduate nursing curricula.

Contributions

Study design: SM and CC; Data collection and analysis: SM and CC; Manuscript preparation: SM and CC.

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