Disclosure of a Social Stigma: Sexual Identity Disclosure Issues as Reported by Lesbians

by

Susan Little

TABLE OF CONTENTS

APPROVED:

[redacted]

Marie Scott Brown, RN., Ph.D., PNP., Professor,
Research Advisor

[redacted]

Christine A. Tanner, RN., Ph.D, F.A.A.N., Professor,
Committee Member

[redacted]

Barbara J. Limandri, R.N., D.N.Sc., Associate Professor,
Committee Member

[redacted]

Carol A. Lindeman, RN., PhD., FAAN., Dean, School of Nursing

This project was supported by the Professional Nurse Traineeship Program, Grant Nos. 2 A11 NU00250-14 (1989-90) and 2 A11 NU00250-15 (1990-91)

ACKNOWLEDGEMENTS

I would like to thank the following people whose support and encouragemnt made this project possible and successful.

My gratitude goes to the members of my committee who devoted time and energy to the project. To Marie Scott Brown, my advisor, who understood my personal struggles and guided me through the research process. Thanks to Barbara Limandri for her optimisim and special knowledge of interacting with vulnerable populations, and to Chris Tanner for her inspiration and gentle guidance while I learned the process of qualitative research.

I gratefully acknowledge my dear friends and classmates for their unfaltering and genuine sense of caring which helped me through the best and worst of times.

My deepest gratitude goes to the women who shared their life stories and allowed my entry into their private lives. They are strong and courageous.

Most of all, this thesis is dedicated to my best friend and life partner, Marianne.

CHAPTER I

INTRODUCTION

Problem Statement

Nurses who work in any aspect of the health field, but especially those who work exclusively with female populations, may be ignoring the needs of a significant number of clients if they deny the possibility that some are lesbian women, and fail to incorporate that information into their care. The challenge of identification of lesbian clients, however, is complex.

The central task of many lesbians in managing their identity is to conceal information so others do not become aware of this attribute. Lesbian clients may not volunteer information about themselves for several reasons, but primarily the following:

a) the stigma attached to a lesbian lifestyle,

b) fear of rejection or reprisal, and

c) preference not to disclose themselves even when it is to their advantage to do so.

Although "being out" seems to make it easier for lesbians to get the kind of help and support they need, they pay for this visibility with a greater likelihood of being discriminated against. The majority, therefore, learn to avoid rejection and stigmatization by remaining "in the closet" and/or trying to "pass" as

heterosexual. Health professionals, in turn, lack the ability to identify which patients are lesbian since identification depends largely on the disclosure of this information by the patient.

For the lesbian patient, a critical factor for disclosure of her sexual identity is the perceived sensitivity and non-judgmental attitude of her health care provider. If health providers accept the responsibility for facilitation of an environment conducive to disclosure, then understanding the dynamics of perceived sensitivity and a non-judgmental attitude is paramount to giving permission to the lesbian to safely reveal her identity.

The purpose of this study are to (a) describe the interaction between lesbian and others in concrete behavioral terms so that health care professionals may incorporate them into everyday practice and, thereby, increase the likelihood that the health care environment is perceived as a safe place for lesbians to be out,
and, (b), to describe the interaction between the lesbian and health care providers, that facilitates or inhibits disclosure of sexual identity.

REVIEW OF LITERATURE

Stigma

Lesbian identity has been conceptualized by

various sources as a "discreditable" stigma (Fein & Nuehring, 1981; Jandt & Darsey, 1981). The exact number of lesbian women in America is difficult to determine because of this stigma surrounding homosexuality. It is estimated that one in ten women is a lesbian (Kinsey 1953). According to Love (1972), this number is underestimated due to the "invisibility" of lesbians and the difficulty in identifying them from the general population.

Although the "disease" label was officially dropped in 1973 from mental illnesses listed by the American Psychiatric Association (DSM III, 1980), today public opinion remains predominantly negative (Gartrell 1981). There is abundant historical and sociological evidence that lesbians, when identified, are viewed negatively in this society, often rejected by their families and subjected to discrimination in education, housing, and employment.(Levitt & Klassen 1974).

Stigma affects homosexual identity formation by creating problems of guilt, secrecy, access, and identity (Plummer 1984). Since stigma creates silence, the struggle then, is to find the right words to use and the right person to approach. Attempts to cope with the internalized stigma has been recognized as a health risk for lesbians (Maylong, 1985). In a recent qualitative study of twenty-five lesbian women, 96% of

them felt
risk if their health care professional knew they were gay (Stevens & Hall, 1988). The sense of control a woman has over the disclosure of her lesbian identity may be related to the level of stress that she experiences in any social interaction, including health care. The commitment of the profession of nursing to holism and advocacy in the care of vulnerable groups makes nurses the logical health care practitioners to facilitate a positive, helpful experience for lesbians (Stevens & Hall, 1988). Therefore, the mark of lesbian identity conspicuously affects interactive outcomes.

Disclosure

Disclosure of a lesbian identity, commonly called "coming out", is a concept critical to the understanding of lesbian behavior. Coming out, and being out, refers to a reality which has no counterpart in the lives of non-gay people (Bradford, 1988)

The decision to disclose sexual identity to straight friends, co-workers, and family members reflects choices which must be made on the basis of a number of factors over which lesbians have little control. Among these factors are the personal attitudes and prejudices of significant others, and the presence or lack of civil rights protection (Minton & McDonald, 1984). The use of identity management refers

to the extent to which the person chooses to be identified as gay, by self or others, in interpersonal or public situations. Being out requires each woman to determine her individual version of "rational outness": as open as possible because it feels healthy to be honest, but as closeted as necessary to protect against discrimination (Bradford, 1988). Outness is rational to the extent that the lesbian perceives the response will be sensitive and non-judgmental. As pivotal as they are, the qualities of "sensitivity" and "non-judging" are highly individual, and as such, are not clearly defined in the literature reviewed for this study.

Lesbians must always consider the implications of their stigmatized identity as they participate in health care (Fein,& Nuehring, 1982). To disclose oneself has its costs. Everyday interactions may suddenly become uncomfortable. Social acceptance can never be guaranteed since each new situation holds the possibility of rejection (Minton & McDonald, 1984). While self-disclosure is generally considered to be necessary in the formation of authentic interpersonal relationships (Jourard, 1971), the potential negative consequences in the behavior of others often act as effective deterrents to self-disclosure by lesbians (Brooks, 1981).

Confronted with the ongoing problem of identity

management, most "closeted" lesbians need to engage in some deception. This can be a serious problem, making it difficult for women to fully discuss their needs when seeking health care, as well as compromising their authenticity in interpersonal relationships. Revealing a homosexual identity may be an "all-or-none" phenomenon for some, but most will "fluctuate back and forth in degrees of openness, depending on a variety of personal, social and professional factors" (de Monteflores & Schultz, 1978). Disclosure of sexual orientation is a lifelong process, comprising decisions on whether or not to disclose, how and when to disclose, and how to face the consequences of disclosure.

Cass (1979), Troiden (1979), and Kus (1985) describe lesbians as developing an acute awareness of sensitivity in others. This detection leads to selective disclosure of their sexual identity to significant heterosexual others: they may choose to disclose on some occasions, but not in others. Self-disclosure can be facilitative when interpersonal support is available or detrimental when it is lacking. Lee (1978) also found that because of the perceived multiple costs of going public with sexual orientation, only a restricted social network of some gay and some straight individuals are allowed to know they are

lesbian. In a qualitative study of 33 lesbians who were interviewed regarding self-disclosure, it was found that lesbians do not leave disclosure of their sexual orientation to chance (Hitchcock, 1989). Deciding whether or not to disclose, how and when to disclose, and how to face the consequences of disclosure, are daily decisions faced by lesbians.

Homophobia

Homophobia is defined as the irrational fear, hatred, and intolerance of homosexual men and women and has both a social and internal aspect (Weinberg, 1973). Internally, homophobia is the adoption and acceptance within a lesbian or gay man of the negative attitudes of society regarding homosexuals. Moses (1978) points out that attempting to pass as a non-gay person can be motivated either by an accurate perception of a potentially dangerous situation, or by internalized homophobia.

Lesbians face some life experiences that differ from heterosexual women. Homophobia, a shamed based identity, and the coming out process are two of the issues not faced by heterosexual women (Rothblum, 1990). A number of studies indicate that U.S. society is extremely homophobic. Levitt & Klassen's survey (1974) found that three-fourths of our society disapprove of homosexuality. In response to societal

homophobia, lesbians are reluctant to trust the heterosexual society. Because of widespread societal homophobia, many lesbians choose to keep the fact of their lesbianism hidden, or to remain in the closet (Rothblum, 1990).

Interaction with Health Care Provider

Lesbians will disclose their sexual identity in light of what they encounter in the behavior of others (Stevens & Hall, 1988). Studies on the interaction of lesbians with health care providers suggest that lesbians found them to be judgmental, non-supportive and negatively responsive when the sexual identity of the lesbians became known (Smith, Johnson, & Guenther, 1985). Many lesbians wished they could be open about their identity in health care situations but never were, fearing such a disclosure would hinder the quality of care they received (Johnson, Guenther, Laube, & Kettel, 1981).

According to Caviglia (1989), if a woman's perception of the attitudes, behavior and knowledge of her health care provider was such that she anticipated negative consequences from disclosure, she would remain closeted no matter how openly she usually lived her lesbian identity.

Self-disclosure is a complex process that consists of both the person and the situation in interaction.

Self-disclosure seems to be optimal in those persons who can modulate their disclosure appropriately to meet the existing conditions. There is a tendency, therefore, for some to take cues from the person to whom they are disclosing regarding the amount and kind of disclosure that is appropriate. (Hitchcock, 1989)

Limandri (1989) found that the circumstances for such a voluntary disclosure must yield sufficient anticipated reward to counterbalance the lack of self-esteem and rejection that might result. Any stigmatized person, and homosexuals are no exception, struggles with the conflict between the need to reveal due to an accompanying stressor, versus the need to conceal due to further stigmatization.

According to the National Lesbian Health Survey (NLGHF 1988), of 1,925 lesbians from fifty states, 26 percent believed that they could not disclose their lesbian identity to health care providers or their therapists. Lesbians in the sample experienced a wide range of difficulties in seeking satisfactory health care: the most common ones were the assumption of heterosexuality made by providers, and the inability to come out to them.

In a study of 236 lesbians, Caviglia (1989) found that 62% of these women had omitted discussing matters of personal importance with their health care provider

rather than reveal their lesbian identity.

The importance of disclosure of sexual identity to health professionals has been emphasized repeatedly (Dardick, 1980; and Gartrell, 1983, 1987). Bradford and Linn (1986) have noted a linkage between the resolution of the problem of being "out" and a greater access to needed health information, as well as increased emotional and psychological health. Since gay women feel hesitant to discuss their sexual preference with their care providers for fear it might negatively affect the quality of care they receive, nurses must recognize the potential for this hesitancy and be able to establish a relationship that fosters mutual acceptance. Lesbian clients should not be put in the position of defending who they are when they are in need of a health care service. Instead, they should be invited through verbal and non-verbal cues to enhance their health care through disclosure.

Studies leading to a more sophisticated understanding of the contextual relational reasoning by lesbians are limited, particularly with respect to disclosure to health care professionals. This study, then, will attempt to fill the gaps regarding the interactive process between nurse and client by further developing definitions of sensitive and non-judgmental behaviors which are facilitative to the lesbian

experience of self-disclosure.

CONCEPTUAL FRAMEWORK

Two concepts of interest to professional nurses are examined in this study. They structure both the data collection and the analysis.

First, the concept of stigma, as an identity "spoiled" by a discrediting attribute, which leads to an individual's disqualification from full social acceptance. The person whose stigmatizing characteristic is not visible and who is "passing" must cope with the psychological price of "living a life that can collapse at any moment" (Goffman, 1963).

Second, this study will use the concept of disclosure as defined by Jourard (1971). He describes self-disclosure as the process by which one person allows him or herself to be known by another person. Self-disclosure is viewed as an essential component in the development of interpersonal relationships.

The relationship between stigma and disclosure has been demonstrated in several studies. Troiden (1988) found that stigma affects what homosexuals are willing to disclose about themselves, with whom they are open, with whom they associate, and how they feel about themselves. Stevens and Hall (1988) found that stigma and identifiability in lesbian women are complex issues that affect their social experiences, interaction with

health care providers and use of the health care system.

According to Brooks (1981), disclosure of one's sexual identity to others appears to occur more often as a specific "person-situation" phenomenon than as an "all-or-nothing" phenomenon. Stigma and disclosure are situationally related or are situation dependent. Essentially, then, lesbians must evaluate whether the level of fear or anxiety that may be perpetuated by non-disclosure is more or less costly than the potential negative consequences which may or may not result from disclosure. The optimal decision-making process would include sufficient time to rationally assess the degree of risk in disclosure (Brooks, 1981).

Significance of the Study

This study will begin to describe a process by which lesbians decide whether or not to disclose their sexual orientation to a health professional. While most literature acknowledges the issue of disclosure as an important one, few studies have identified the process that lesbians use to make their decision on this matter. This study will attempt to describe the cues from the health provider that act to facilitate self-disclosure of sexual orientation, and what strategies the lesbian uses to determine whether or not to disclose, and under what conditions and with what

consequences does the lesbian self-disclose. The findings are expected to provide insight into the concerns of lesbians who seek health care so that nurses can help improve the quality of health care for lesbians.

RESEARCH QUESTIONS

In order to explore these issues the researcher investigated both the general experience of "coming out" and some specific characteristics of that experience. One major research question guided this study: **What experiences have lesbians had in disclosing their sexual identity?**

Two sub-questions were also important in structuring the study:

(a) Under what conditions do lesbians feel safe enough to disclose their sexual identity?

(b) What practices provide a supportive environment for lesbians to disclose their sexual identity?

CHAPTER II

METHODS

Design

The purpose of this study was to describe the experiences lived by lesbians as they disclose their sexual identity to others. In order to describe the multiple and complex experiences of lesbians' self disclosure, the design chosen was descriptive qualitative. Qualitative research aims to understand how a group of people define their reality and strives to "interpret and understand" rather than to "observe and explain" (Munhall & Oiler, 1986). Qualitative research also seeks the insider's view and is more reflective of the complexities of the natural world (Lofland, 1971).

Interviewing is the predominant mode of data collection in qualitative research and was used in this study. Interviews are a useful instrument in nursing research since they allow the investigator to question participants about ideas, behaviors, feelings and to explore events and their meanings (Woods & Catanzaro, 1988). The use of the interview in this study allowed the researcher to explore in depth lesbian women's subjective experiences in their coming out process.

Sample and Setting

The initial participants were subjects known to

the researcher who fulfilled the criteria for inclusion. In addition to being volunteers, the sample consisted of those who were at least somewhat comfortable with disclosing their sexual identity. Merely experiencing coming out to others was not enough to qualify an informant for this study. Informants also needed to be willing to critically examine the experience and their response to the situation of self-disclosure.

A purposive sample of 10 lesbians was chosen with characteristics representing degree of outness, age, rural and urban lesbians, coupled and single status, church-member and non-church member. The sample consisted of professional white women from six states, between the ages of 40 and 70. In addition, as data analysis was conducted it became clear that informants who represented additional characteristics of degree of outness were needed to provide a complete description. Informants continued to be sampled until there was redundancy of information or saturation of categories (Glaser & Strauss, 1967). In this study, efforts were directed toward obtaining a sample representing maximum variation in degree of outness.

Since coming out as a lesbian today is a different process than it was 30-40 years ago (Lewis 1984), the subjects chosen for this study were between 40 - 70

years of age. In the 1940s' and 1950's identifying oneself as a lesbian and feeling good about that identity were sometimes impossible tasks. Today the process is different due to greater social support, positive literature, and role models which often did not exist in visible numbers before the 70's. Therefore, because their experience may have been different than that of younger lesbians, the subjects chosen for this study were between 40-70 years of age.

Criteria for inclusion were as follows: women who were self-identified lesbians for at least one year (to allow adequate time for self-reflection and stability); and women who had undergone or were undergoing the experience of coming out to others, and were able and willing to reflect and provide detailed information about this process. Ten women who volunteered met these criteria.

Since the researcher herself is a lesbian there is some possibility of insider bias in relation to data selection and formulation of conclusions. While there is some possibility of bias in studying one's own peer group, Lipson (1984) mentions advantages which include ease of entry, prior knowledge of some relevant research questions and an enhanced capacity to elicit in-depth data.

Instruments

An interview guide was constructed using open-ended questions about disclosure of sexual identity in general and to a health care provider in particular. The participants were asked to speak about situations that were both positive and negative and how they felt about these events. The interview included questions on degree of disclosure of sexual identity to a variety of family, friends, acquaintances, work colleagues, and health care professionals. The question format used a leading general question, followed by more specific questions and probes (Appendix A). The purpose of the interview was to draw out from the participants the qualities of the situation which gave it significance and influenced them to disclose or not to disclose their sexual identity. The researcher attempted to gather specific verbal and non verbal behavioral cues which indicated a sensitive and non-judgmental environment in which to come out. This was done with regard to how these women perceived others both verbally and non-verbally, and what specific aspects of behavior conveyed such an impression.

Protection of Human Subjects. Lesbians must be considered a vulnerable population with regard to participation in research studies because public knowledge of their sexual identity may constitute a

perceived, potential, or actual threat to their physical or emotional well-being. Responses were kept confidential, and the tapes transcribed without any direct references to the participants or anyone mentioned by them. Tapes were then erased after transcription.

Since some of the subject matter recalled by participants had potential for emotional distress, each woman was called the following day after the interview, to see if follow-up counseling was needed. A psychiatric mental health nurse practitioner was made available to these women if the need arose.

This research project was reviewed and approved by the Committee on Human Research.

Procedures

The initial four participants were subjects known to the researcher who had fulfilled the criteria for inclusion. These women were asked to contact acquaintances/friends who also fulfilled the stated criteria. These new contacts then had the opportunity to call the researcher and volunteer for the study. This process helped eliminate the risk of disclosure against a participant's will. The researcher selected informants who could provide the "best" information for the study. Participants were chosen based on inclusion criteria of being "out" at least one year. Ultimately

10 individual disclosers were interviewed. A signed written consent was obtained (Appendix B).

Since informants represented a wide geographical spread, most of the interviews were conducted over the telephone. Three interviews were face-to-face. Approximately one hour was allotted per interview, and sites chosen were free from interruptions and distractions. The interview sessions were tape recorded.

CHAPTER III

ANALYSIS

The analysis was conducted simultaneously with data collection in roughly 3 stages. The first stage in data analysis was to identify and define patterns which described the coming out experience, and to develop specific codes for these coming out episodes which could be used later for management and retrieval.

The codes identified from the initial interviews were applied to all transcripts; they were revised as needed to ensure that they correctly captured data elements. The coded transcripts were entered on Ethnograph, a computer program designed for management of qualitative data. The major purpose of this stage of analysis was for organization of data and retrieval for subsequent indepth analysis.

The second stage of analysis was directed toward assuring that the identified patterns and themes were the best interpretation of the data, and that all important data segments had been included in the interpretation.

Each of the major patterns and the specific codes within them were used to retrieve all excerpts using Ethnograph. The excerpts were examined for commonalities, and descriptions of each pattern were written. Codes were reviewed independently by members

of the theses committee.

Theoretical memos were used to analyze and elaborate on concepts found in the interviews. Broad categories emerged describing a process of self-disclosure from which further descriptive categories emerged.

The third stage involved consensual validation with two interview participants to evaluate the concepts with regard to the fit with their experience. These experts were asked to review preliminary interpretations and indicate areas in which they believed the interpretation might be inaccurate or incomplete. All agreed that the concepts describing the process of self-disclosure captured the lesbians' experience of coming out to others.

CHAPTER IV

FINDINGS AND DISCUSSION

One primary research question formed the basis for the findings in this study: **What experiences have lesbians had in disclosing their sexual identity?** Two follow-up questions probed the conditions under which lesbians feel safe enough to disclose their sexual identity, and the practices of the person disclosed to (the "disclosee") which provide a supportive environment for this disclosure.

The experiences reflected upon by the interviewees in response to these questions showed that lesbians go through a definable process in their disclosures. Their descriptions of this process revealed four principal concepts:

1) evaluation of the significance of the relationship between the lesbian discloser and her disclosee;
2) the strategies of appraisal which are consciously undertaken by each lesbian prior to disclosure;
3) the components of discomfort, relative to the lesbian's self-esteem, which become motivational toward disclosure; and,
4) post-disclosure responses by the disclosee, some of which are considered preferable to

others.

Finally, these four principal concepts are shown to be part of the same disclosure process in the lesbian's experiences with health-care professionals.

The disclosure process will be examined using quotations from the coded interviews with interpretations to clarify them.

Process

Relationship

Coming out is a process that begins in the context of a relationship. It is a complex process involving interaction between a person and a situation. What the discloser is willing to invest in the relationship is proportional to the significance of that relationship to her. A lesbian must first recognize the significance of a relationship to her before she will choose to disclose her sexual identity.

Comments by those interviewed about their relationships are grouped into three themes: (a) the value of the relationship to the lesbian's life; (b) the lesbian's need for honesty in the relationship; and, (c) the level of authenticity the lesbian needs in the relationship.

Value. The degree to which the relationship is valued depends on the degree to which the other person is involved in the lesbian's personal life, health or

work. This respondent felt that an important family member, or a friend with the potential of becoming important, needed to know:

> Q: Why did you decide to tell your sister?
> A: Because no one in my family knew and I think I just wanted someone in my family to know, to know me that well, and she was important to me.... [Also] if it's somebody I'm interested in being friends with and who I want that person to know me because I usually tell them because they don't know me if I don't tell them.

The next two respondents indicate that disclosure must take place if the relationship is going to continue to be valuable to them:

> Respondent #1 She was the hardest person in the world to tell. We had known each other ten years and used to share homophobic jokes. It was so clear I had to tell her at some point. Because we were such good friends. It was just like this huge thing was missing. I felt I was not being honest with her, and we just didn't have secrets from each other, we just didn't do our friendship that way.

> Respondent #2 Q:Do you evaluate everybody before telling them about your sexual identity?
> A: Anybody I have to spend time with, yes. If this person is going to have anything to do with my private life they have to be either gotten rid of, or told.

Respondent #2 first decided the value of her relationship and then made an all-or-nothing decision about disclosure.

Honesty. Some interviewees specifically mentioned their discomfort with dishonesty in a relationship. This comment describes a passive dishonesty where she

simply did not mention significant facts:

> I would just say "I" skied and not mention (my partner)--it would seem like I did it alone. I think I felt really dishonest, like I was lying by omission.

Another respondent described her active dishonesty in response to questions about her sexual activity. She implied that she had a relationship with a man so she would not have to tell the truth:

> I lied, out of fear, and I don't want to put myself through that again.

Actively lying may take the form of pronoun change, as this respondent described:

> The last straight person I told was a nurse practitioner where I work, and I've known her about three years. We off-and-on talk about what's happening in our personal lives, we're both single people, and for several months I have changed the pronoun--inserted "he" instead of "she" and I just decided that I didn't what to do that any more.

In a larger context, this respondent believes deception is a two-way street, that she is not ultimately benefitted by any kind of dishonesty:

> There isn't anybody in my life who is not aware of my lesbianism--who's significant to me anyway. There's that whole principle of honesty. It doesn't feel good after a while when you have to deceive yourself and everyone else. I don't think it's relevant in every situation. I think about the people I work with and I think that in the situations and interactions I have with people that are a little bit on a personal level when we talk about values, and who we are intimately interacting with, then that is when it's important to me to disclose, because otherwise I deceive not only myself but the other person.

Finally, one respondent reported that staying in the closet creates political and social consequences for her personally as well as the larger gay community:

> Not only is honesty important but, you know, the other thing is, as I get older, sometimes we talk about whether a situation has to be safe and sometimes--socially and politically-the issue for me is not whether it is safe, it goes beyond taking a risk. It just becomes a conscious social, personal statement to be honest...and I really don't care, I mean, you can't always care about whether or not you're going to be safe. As long as we're going to worry about whether or not we're going to be safe, I don't think we can be who we are, and our community certainly won't survive.

Honesty was a widely reported need in relationships with individuals and communities.

Authenticity. To be an authentic person with a friend requires some measure of self-disclosure. Investment in a relationship requires sharing and mutual transparency. The condition of having a relationship with a person sets up the consequence of being authentic within that relationship. As this respondent explained, a person who is liked is also valued, and the worth of the relationship to her required openness:

> I came out to a straight person at work, a colleague, someone I'd known for about four years, and was getting better acquainted with. I just really enjoyed her, liked her very much, she was one of my favorite people at work and I always felt she was, uh, being forthright with me about her own life and feelings, and I was not being with her. It's frustrating not to be authentic with people you admire.

In this excerpt, the respondent perceived that to achieve a satisfactory level of authenticity in a valued relationship, her own self-disclosure, even in the area of sexual identity, was a key factor.

Appraisal

Comments by those interviewed concerning the process and strategies of appraisal which they consciously undertake prior to disclosure can be grouped into three themes: (a) the constant scanning, or information gathering, that a lesbian undertakes in relationships; (b) evaluation of the disclosee's personal characteristics; and (c) the risk-to-benefit ratio, a measure of whether being out is rational or worth the risks.

Scanning. In addition to phrases such as "I would not come out to someone who...", "I would also look for...," "That was a real distinct clue," one interviewee revealed one of her direct scanning techniques:

> I talked to some lesbian friends, and some of them knew this person, and I said I had wanted to tell her about myself, and they said, well, that's a good choice. So somehow all of us were agreeing on the same person so I thought it would be ok.

Remembering prior comments, verifying perceptions with others, and listening and watching for clues are scanning techniques in frequent use.

Personal Characteristics. Lesbians use many cues

in their assessment of personal characteristics of others. This "information gathering" process prepares the lesbian to determine who is safe to tell. Informants reported feeling safer and more positive about people who are not religious, are feminists, could be called liberal, show compassion for minorities, are comfortable talking about sex, and/or have had some life experiences which fall outside social norms.

One informant stated that she paid attention to the person's style of dress and self-presentation:

> Beth is sort of laid back 60s. When I say 60s, to me that is a very casual comfortable style of dress, and a lot of people I don't think are comfortable when they get dressed anymore.

This next respondent noted a similar cue:

> I'd also look for what they dressed like; if they were looking like Anita Bryant I wouldn't pursue it, you know, if they had a polyester shirtwaist dress on. But if they were in shorts, tank top, with sun visor and a tennis racket, I would think they had a possible ok chance.

"Casual comfortable" dress style could be a positive personal characteristic of an individual being appraised.

Religion creates a condition which makes it more difficult for a lesbian to disclose:

> I would not come out to a person who was strongly religious, evangelical, fundamental or those denominations that are the Bible thumpers. Even though I belong to a Bible-thumping group myself--we are pretty strict and I'm not out in my church

> at all--I wouldn't come out to someone who had moral values in terms of heaven/hell approach/avoidance philosophy. You know, someone who has their religion, anthropology, and psychology all mixed up.

Perceived manifestations of conservative or fundamental religiosity were regarded as a warning flag to this lesbian. Religion was also a problem for this respondent:

> I'm sure religion has something to do with my decision to tell people about my sexuality. If I knew they were an evangelical I would make certain assumptions which were, of course, not correct, necessarily, but I'd conclude they might not be a safe person. So, I wouldn't even consider anything unless they made some flippant remark about sexuality, or something that gave me a clue they weren't rigidly uptight about sex or sexuality.

While acknowledging that her assumptions might not be correct, this lesbian, nevertheless, evaluated certain religious connections as negative factors in her appraisal of personal characteristics amenable to disclosure.

As the next respondent explained, if a person is comfortable with talking about sex and seems comfortable with their own sexuality, then a lesbian finds it easier to disclose to that person.

> There was this person at work that I told. She was an upwardly-mobile-thinking-type person, a person of color, and we talked about sex a lot--joked about vibrators and various stuff. She was very comfortable with any sexual issue. Even though I don't perceive lesbianism, per se, a sexual issue, when thinking about people that I'll tell, it's useful for me to know that they are

> comfortable about sexual issues 'cause for them it's for sure a sexual issue.
>
> Like vag. exams. I work with a nurse who, just thinking about a vag. exam just grosses her out completely. She would not be a person I would right off tell I was a lesbian. But Inez was basically comfortable with any aspect of sexuality. Her husband had an affair, not that this was a good thing, but it was dealing with sexual issues in a way other than the traditional, straight-and-narrow type thing. So your average, everyday "missionary position, lights out, disgusting vag. exams"--those are clues to me. It has to be someone who's comfortable being a sexual person. And Inez was definitely comfortable being a sexual person.

References to ease with sexuality topics was an important cue.

Many women believe that a person's attitudes toward others are synonymous with their attitudes toward lesbians, and try to assess those attitudes before disclosing. This lesbian believed that the disclosees respect for a pregnant teenager would transfer over to respect for the lesbian's sexual identity:

> I told someone once because she had a daughter who was pregnant and I knew this was a source of pain to her because things had not gone the way she might have chosen. Yet she was handling it with a great deal of mutual respect and emotional balance, even humor.

The next excerpt shows a similar expectation of respect and compassion based on observation of the person's interactions with patients:

> Another reason I came out to this particular person: she was in the chemical dependency

> rehabilitation field, and dealt with people all the time who were doing self-destructive behaviors and yet she admired them, enjoyed them, liked them. She dealt with HIV-positive people or people who had the potential for that, and she always spoke about them with a great deal of respect and compassion.

Some comments indicate that positive attitudes toward minority groups offer some clues about positive attitudes toward lesbians. Such a clue was evident in a description of this respondent:

> And I knew that one of her most favorite people in the world is a gay man. That was a real distinct clue that she would probably be safe to tell.

Finally, having life experiences which fall outside social norms was mentioned as a positive indicator of safeness for disclosure:

> I think one of the qualities I'd look for in someone I came out to would be an occurrence in their own family that would crack this shell of perfection that so many people try to have, and I would know that they had handled more than, uh, handled the potential for social recrimination more than other people had.

This lesbian presumed that someone whose life experience had included events that were tragic, unexpected, or unchangeable might have empathy for her situation. The assumption was correct; the subsequent disclosure was a positive experience.

Risk-to-benefit ratio. Although the sample as a whole was more alike than different in outness to gay friends, being out to people other than gay friends requires each lesbian to develop an individual version

of rational outness.

One condition which creates a relevant need to disclose to others is whether the lesbian is currently in a love relationship. Lesbians are influenced in their decisions about outness by whether or not they actually live with or have a primary relationship with another woman. Lesbians in these interviews were more likely to be out if there was a significant woman in their lives.

> I decided to come out to my office manager because I was in a relationship with someone and it was important to me that she feel comfortable calling my office. When you're excited about someone, you want to share that happiness with other people. I hadn't told anyone in my office, for, oh, many years. I just don't do that.

This interviewee decided the benefit to her partner outweighed the risks to either of them.

> We decided we had to go over and tell our neighbor, because it was clear that she was going to find out because [my partner] and I were dropping a lot of clues, and just sort of being ourselves, but we realized that we needed her to be a little bit cool about it in terms of the other neighbors because of [my partner's] job, so we had to tell her that we wanted her to know, but we needed her confidentiality.

Some women who are not in a relationship are not motivated to take action regarding disclosure of sexual orientation. This respondent did not think it was relevant to do so because she had not been in a relationship for 15 years.

I haven't told anyone I was gay since, oh, about

> 1978 partly because of my profession but also because I am not living that lifestyle and haven't for 15 years. I think there are safe people out there to tell, but I guess I don't need to because it isn't central to my life right now, it's very peripheral to my life at present. You know, if I had a partner, I would continue to make some decisions and observations of people and come out to them more, but not now.

Motivational Discomfort. Comments by those interviewed concerning their mental health issues about coming out are grouped into three themes: (a) "in-deeper-ism," which is the pressure to elaborate a lie further to prevent disclosure; (b) isolation from others due to being hidden; and (c) personal censorship, which can exist in nearly every social situation.

"In-deeper-ism". In this excerpt, the respondent is describing the effect on her of making up more and more complex cover-up stories:

> I just decided that I didn't want to lie anymore. I was digging a hole. You know, you dig this hole, make up a story, you pretty soon get so complex you don't know what you said and what you haven't said. It got to the point where I didn't even want to talk about it (our personal lives). I hoped she didn't ask me because I'd dug this hole. So I think it didn't have so much to do with whether I thought she was safe, it was a matter of principle for me.

"Digging a hole" means having constructed so many stories about one's existence that it becomes impossible for the discloser to even remember the stories.

Isolation. Lesbians often pay a price by not being known by others and lying by omission to protect themselves. This respondent made a conscious decision to be more real to herself and to others.

> I think more important than her response was my response. I just don't feel so isolated. I feel like I'm just a little bit more a real person in my environment to a few people. And what they think is not the real issue here for me, it's what I get out of it personally.

Personal censorship. Discomfort exists in social situations when lesbians are not able to use the process and strategies of thoughtful self-disclosure. Women either deliberately present themselves as heterosexual or do not contradict the assumption that they are heterosexual. This respondent felt forced to disclose by the nature of the social encounter, and choose personal censorship out of fear.

> I was flying back from L.A. and I was sitting next to this guy who was going hunting. And I didn't even want to talk to him but I thought later, I'm not telling him I'm gay when he is going out killing animals? I should have told him I'm a dyke and we could have had our standoff..he's a killer and I'm a dyke and so what? I thought, What am I afraid of? and why did I censor myself?

This censorship made her reflective and angry. Lesbians are intuitively aware that society can be very hostile toward homosexuals and, thus, in casual social encounters when appraisal methods are impossible, censorship is often the rational choice.

Post-Disclosure Responses. Comments by those

interviewed concerning the disclosees' post-disclosure responses can be placed into two groups: preferred responses and non-preferred responses.

Preferred responses. When a lesbian reveals her sexual orientation, it is important that a person give a verbal response that acknowledges an awareness of the risk taken by the client and of the client's need to know the provider's reaction to that risk. Such positive responses by the disclosee will reinforce the lesbian's judgment and original appraisal that, "Yes, it was right to tell this person, I said the right things, and it's good that they know."

It is important for the disclosee to verbally express acceptance rather than expect the lesbian to assume acceptance in the face of a neutral response, as this respondent indicates:

> I'd seen this doctor a couple times before, but I'd never talked about being gay, and for some reason when I saw her this last time, I'd had enough history with her and trusted her or something that I knew it was ok to talk to her about it. I told her that I was a lesbian and that I had a partner and was in a monogamous relationship. She was really supportive, and said, "Well, that's good to know, because I really don't have a lot of the medical risks heterosexuals have because of STDs--AIDS and stuff."

Responses regarded as positive also include non-verbal behaviors:

> I think the first thing I'd like someone to do after I told them I was gay would be to hug me, or

> touch me in some way which says to me immediately that they are not afraid of a sexual advance from me. It also says that I am not an outcast...and I don't mind questions. I discussed it with this straight friend of mine who I told and its just like its part of our normal conversation, like how is your book coming? How is your life? Have you found anyone special yet? Stuff like that.

Non-preferred responses. The attempt to respond to disclosure by a neutral or indefinite response was viewed as negative. When asked what lesbians wanted from others after disclosure the majority agreed that to acknowledge the disclosure rather than leave them wondering how it was accepted was the best response. Neutrality was viewed as negative.

> I remember when I had a vaginal infection one time and I went to this woman and told her I was gay and she didn't really acknowledge anything, didn't respond at all..I've never been back to her since..I feel I'd have to come out all over again..since, even though she didn't respond negatively, I felt she was professionally trained not to react.
> She could have done it differently: she could have acknowledged how difficult it was--what I'd just said--in some way. I mean I don't know if I've just come out to a Jerry Falwell-type person or what, and my reaction to her was, my god! I've no idea what she is thinking. She could have said, "This must be difficult for you.." That at least acknowledges my fears and anxiety.

Behavior with Health Care Professionals

Lesbians go through the same process of self-disclosure with health care professionals as they do with anyone else. Comments by those interviewed concerning their experiences with the health care profession were not as numerous, but fall into the same

four aspects.

Relationship

The discloser's relationship to her health care provider is proportional to the seriousness of the medical problem.

> Early on I didn't think there was any reason to run the risk [of disclosure]... until I was ready to have surgery, and then it became an issue. Then when I decided to have surgery, I wanted her to speak to whoever my significant other was so she could talk to her after the surgery, so I had to let her know who that was. I said my significant other was, in fact, a woman.

The most common concern among respondents was the condition of a serious illness where the partner needs to be involved which creates a consequence of disclosure. It was important to this respondent that she and her partner be treated as a family unit.

> My first partner died of cancer after we had been together 12 years. We had many, many encounters with the health care system, both acute and long term. It was, um, sort of a process with the hospital situation, of having to claim the beachhead every time we met a new person. I had to almost demand to have attention paid to me in terms of being a partner to her in fighting the disease or in knowing the medical information. I was not treated like I presume a spouse would be treated in terms of sharing that information equally or being asked or offered special information or having a chance to talk.

Appraisal

A positive attitude toward minority groups on the part of her health care provider was interpreted by this lesbian to indicate that a positive attitude would

be shown her upon disclosure.

> Other things about her are: activities she's involved with, who she is as a health care professional. She's somebody who's involved with health care issues of minority groups, stuff that the majority of society isn't involved with or [doesn't] care about, and she's an advocate for women's rights, children's rights, and is a feminist definitely.

Motivational Discomfort

Most respondents said the feeling of having to deal with a prejudicial health care professional that assumed heterosexuality was cause for embarrassment and fear. Most reported that providers tried to force birth control on them, obliging them to reveal their sexual identity under pressure. The assumption of heterosexuality made it difficult for most women to fully discuss their health needs. The phrasing of questions regarding sexual activity that assume heterosexuality and a need for birth control were issues that this respondent reported.

> If I were to choose a physician today I would choose someone who is gay or knows a physician who is safe so I don't have to go through all those awkward questions they ask.
> I remember, a physician who asked me if I was sexually active and I said no, and then asked if I used birth control, and when I said no, he said, Why not? The average physician assumes you are heterosexual if you are sexually active at all. I don't think they ever offer any options.

Post-Disclosure Responses

As lesbians reflected on the responses they received to their disclosure to the health care

provider, they again indicated a preference for verbal acknowledgement and non-verbal reinforcement.

> Then we went on to some other stuff, she left the room and when she came back in she talked about it again in a positive way. She also here and there just touched my arm or elbow when she was talking to me, like it just made everything OK. She was looking right at me, and wasn't being, you know, afraid or hesitant.

A non-preferred response to this discloser was simply no response at all.

> She didn't have a stroke or heart attack or anything. She didn't say a word. Well, I think she might have said OK, but that was it. She said OK. And she kept looking at the chart.
> Q: How did you feel about that?
> Well, she didn't make comments, no judgmental statements, I couldn't tell if it was good news or bad news. I guess you could say she was professional about it that she didn't go, Oh, my god, that's disgusting. She probably did the best thing under the circumstances. If she'd opened her mouth she probably would have put her foot in it.

CHAPTER V

SUMMARY AND RECOMMENDATIONS

Summary

The ability of health care professionals to diagnose and treat health care problems, particularly those with a psychosocial component, is facilitated by accurate information concerning the life-styles of their patients. Lesbians have been shown to be generally reluctant to disclose sexual orientation (Cochran, & Mays 1988). Since many lesbians are indistinguishable from heterosexual women, they often go unrecognized unless they choose to indicate otherwise. In almost every social encounter a lesbian uses a strategy which helps her decide whether to disclose her lesbian identity or to remain "invisible." Disclosure is an interactive process (Limandri, 1987), involving considerable personal risk-taking (Hitchcock, 1989).

The purpose of this study was to explore the experiences lesbians had in disclosing their sexual identity, and to describe those factors involved in this self-disclosure. The primary research question addressed was: 1) What experiences have lesbians had in disclosing their sexual identity?

The two secondary research questions were: 2) Under what conditions do lesbians feel safe enough

to disclose their sexual identity? and, 3) What practices provide a supportive environment for lesbians to disclose their sexual identity?

A purposeive sample of 10 lesbians ages 40 to 70 were interviewed with efforts directed toward obtaining a sample representing maximum variation in degree of outness. Tape recorded interviews were used as data collection, and all interviews were coded on Ethnograph.

The findings from this study suggest that lesbians go through a thoughtful process of self-disclosure and do not leave disclosure issues to chance. They described having to assess each individual encounter for both potential antigay sentiment and positive cues before disclosure took place. Every respondent identified factors which they believed would be important to know before disclosing sexual identity. The individual perception of what was a rational moment to "come out" is a combination of factors that include a significant relationship with someone, the appraisal of characteristics of the person through verbal and non-verbal scanning, strategies to evaluate safety, and post-disclosure reflection. This process is one which lesbians use to help them determine when or when not to disclose their sexual identity.

Recommendations for Further Study

This study highlights the complex nature of disclosure of sexual identity by lesbians. While it does provide insights into the decision making process of self-disclosure, there is much that can be done to incorporate information about lesbians into the knowledge base of nursing. It is recommended that further work be undertaken to elaborate on strategies and conditions of disclosure which focus on the relationship between the lesbian and others. "Rational outness" or selectively choosing individuals and situations for self-disclosure is an on-going process and rarely a once-and-for-all event. Detailed descriptions of particular scenarios and a clearer picture of what is important to scout out or scan when interacting with others, would provide valuable information for health care professionals caring for lesbian clients.

Are there more dimensions to the conditions? Are there additional conditions? Which conditions are most important?

How many cues does it take at the appraisal stage until a lesbian feels it is rational to be out? Are some cues weighed heavier in value than others?

Of particular interest would be an exploration of the study of passive disclosure of sexual identity by

those who find no need to actively disclose due to a stereotypical appearance. Such individuals seem to disclose by presenting themselves, rather than through a process of active disclosure by those who are able to "pass."

An area of investigation fundamental to lesbians is the nature of oppression and fear. Lesbians are often subject to unjust and harsh exercise of authority over them. Therefore, does disclosure make the person feel less oppressed and afraid? With continued disclosure do lesbians feel less isolated and fearful, with greater self-esteem?

Continued study of differences between partnered and non-partnered lesbians and the ways in which these influence disclosure decisions likely should continue.

In addition, the differences in the disclosure process between older and younger lesbians, rural and urban, and minority lesbians is justified.

References

Albro, J.C. & Tully, C. (1979). A study of lesbian lifestyles in the homosexual micro-culture and the heterosexual macro-culture. Journal of Homosexuality, 4, 331-344.

Berger, R.M., & Kelly, J.J. (1986). Working with homosexuals of the older population. The Journal of Contemporary Social Work., 67, 203-210.

Bradford, J.B;, & Caitlan, R.,(1988). The National Lesbian Health Care Survey. Washington D.C., National Lesbian and Gay Health Foundation.

Bradford, J.B. (1986). Reactions of gay men to AIDS; A survey of self-reported change. Unpublished doctoral dissertation, Virginia Commonwealth University, PhD Program in Social Policy and Social Work.

Brooks, V.R. (1981). Minority stress and lesbian women. Lexington, Massachusetts: D.C. Heath and Company.

Cass, V. (1979). Homosexual identity formation: A theoretical model. Journal of Homosexuality, 4 (3), 219-235.

Caviglia, A. (1989). Factors influencing disclosure of lesbian identity in the women's health care setting. Masters thesis. Oregon Health Sciences University. Portland.

Cochran, S. & Mays, V. (1988). Disclosure of sexual preference to physicians by black lesbian and bisexual women. Western Jr. of Medicine, 149, 616-619.

Corbett, S., Troiden, R., Dodder, R. (1974). Tolerance as a correlate of experience with stigma: case of the homosexual. Journal of Homosexuality, 3 (1), 3-13.

Cronin, D. (1974). Coming Out among Lesbians. In Sexual Deviance and Sexual Deviants. ed. Goode, E.B., Troiden, R. 268-77. New York: Morrow.

Culbert, S.A. (1970). The interpersonal process of self-disclosure.

Dank, B. (1971). Coming out in the gay world. Psychiatry, 34, 180-197.

Dardick, L. & Grady, K.E. (1980). Openness between gay persons and health professionals. Annals of Internal Medicine, 93, (Part I), 115-119.

de Monteflores, C. & Schultz, J. (1978). Coming Out: Similarities and Differences. Journal of Social Issues, 34 (3), 59-72.

Fein, S.B., & Neuhring, E.M. (1981). Intrapsychic effects of stigma: A process of breakdown and reconstruction of social reality. Journal of Homosexuality, 7(1), 3-13.

Field, P.A. & Morse, J.M. (1985). The application of qualitative approaches. Rockville, Maryland: Aspen Publishers.

Friend, R.A. (1987). The individual and social psychology of aging: clinical implications for lesbians and gay men. Journal of Homosexuality, 14, 307-331.

Gartrell, N. (1983). Gay patients in the medical setting. Nadelson, C.C. & Marcotto, D.B. (Eds.) Treatment Interventions in Human Sexuality. Plenm.

Gartrell, N. (1987). Meeting the needs of lesbian patients. PA 87: Physician Assistants in Primary & Hospital Care, 4(8), 248-255.

Glaser, B.G., & Strauss, A. (1967). The discovery of grounded theory: strategies for qualitative research. Chicago: Aldine.

Goffman, E. (1963). Stigma: Notes on the management of spoiled identity. Englewood Cliffs, N.J.: Prentice-Hall.

Hanley-Hackenbruck, P. (1988). 'Coming Out' and Psychotherapy. Psychiatric Annals 18:1.

Hitchcock, J. E. (1989).Personal risking: the decision-making process of lesbians regarding self-disclosure of sexual orientation to health providers. Doctoral dissertation. University of California. San Francisco.

Jandt, F.E., & Darsey, J. (1981). Coming out as a communication process. In J. Chesebro (Ed)., Gayspeak: Gay male and lesbian communication, New York: Pilgrim Press.

Johnson, S., Guenther, S., Laube, D., & Keetel, W. (1981). Factors influencing lesbian gynecologic care: A preliminary study. American Journal of Obstetrics and Gynecology, 140(1), 20-28.

Jourard, S. (1971). Self-disclosure: An experimental analysis of the transparent self. New York: Wiley-Interscience.

Kus, R.J. (1985). Stages of coming out: An ethnographic approach. Western Journal of Nursing Research, 7(2), 177-198.

Levitt, E.E., & Klassen, A.D. (1974). Public attitudes toward homosexuality: Part of the 1970 national survey by the Institute of Sex Research. Journal of Homosexuality, 1(1), 29-43.

Linn, M.W. (1986). Elderly women's health and psychological adjustment: Life stressors and social support. In S.E.Hobfoll, Ed., Stress, social support and women. Washington, DC: Hemisphere Publishing Corporation.

Limandri, B. (1989). Disclosure of stigmatizing conditions: The discloser's perspective. Archives of Psychiatric Nursing, 3(2), 69-78.

Lofland. (1969). Deviance and identity. Prentice-Hall.

Love, B. (1972). Sappho Was A Right-on Woman. New York: Stein and Day.

Margolies, L; Becker, M; & Jackson-Brewer, K. (1987). Internalized homophobia: Identifying and treating the oppressor within. In Boston Lesbian Psychologies Collective (Eds.), Lesbian Psychologies.(pp. 229-241). Chicago:University of Illinois Press.

Maylon, A. (1985). Psychotherapeutic implications of internalized homophobia in gay men. In J.C. Gonsiorek, Ed., A guide to psychotherapy with lesbian and gay clients. New York: Harrington

Pack Press.

Minton, H.L. & McDonald, G.J. (1984). Homosexual identity formation as a developmental process. Journal of Homosexuality.(9), 91-103.

Morse, J.M., (1989). Qualitative nursing research: a contemporary dialogue. Rockville, Maryland: Aspen Publishers.

Moses, Alice. (1978). Identity management in lesbian women. New York: Praeger Publishers.

Munhall, P.L. & Oiler, C.J. (1986). Nursing research: a qualitative perspective. Norwalk, CT: Appleton-Centruy-Crofts.

Neisen, J.(1990) Heterosexism: redefining homophobia for the 1990's. In Journal of gay & lesbian psychotherapy. 1, (3), 21-35.

Owen, W.F., (1980). The clinical approach to the homosexual patient. Annals of Internal Medicine. 93, 90-92.

Plummer, K. (1975). Sexual Stigma: An interactionist account. London & Boston: Routledge & Kegan Paul.

Ponse, B. (1978). Identities in the lesbian world: the social construction of self. Westport, Connecticut: Greenwood Press.

Robinson, Mina Kay. (1979). The older lesbian. Unpublished masters thesis, California State University. Dominiquez Hills.

Rothblum, E.D. (1990). Depression among lesbians: An invisible and unresearched phenomenon. In Journal of gay & lesbian psychotherapy. 1, (3), 67-87.

Simon, & Cragnon. (1967). Homosexuality: The formulation of a sociological perspective. Journal of Health & Social Behavior, 177-185.

Smith, J. (1988). Psychopathology, homosexuality, and homophobia.Journal of Homosexuality, 15, 59-73.

Sophie, J. (1987). Internalized homophobia and lesbian identity. Journal of Homosexuality, 14, 53-65.

Spradley, J.P., (1979). The ethnographic interview. New

York: Holt, Rinehart & Winston.

Taylor, S.J. & Bogdan, R. (1984). Introduction to qualitative research methods: the search for meaning. 2nd Ed. New York: Wiley-Interscience Publication. John Wiley & Sons.

Troiden, R., (1984-85). Self, self-concept, identity, and homosexual identity: constructs in need of definition and differentiation. Journal of Homosexuality. 10, 97.

Troiden, R., & Goode, E. (1980). Variables related to the acquisition of a gay identity. Journal of Homosexuality 5(4): 383-92.

Troiden, R. (1988). Gay and lesbian identity: a sociological analysis. New York: General Hall, Inc.

Woods, N.F. & Catanzaro, M. (1988). Nursing Research-Theory and Practice. Toronto: C.V. Mosby Co.

Appendix A

Interview Guide

Disclosure of a Social Stigma:

Sexual Identity Disclosure Issues as

Reported by Lesbians

1. Tell me about the first time you came out.
Tell me everything you can remember about it.

Probe: Why did you choose to tell them?
How did you know it was safe to tell this person?
What exactly did you say?
What exactly did they say?
What exactly did they do?
Describe further what they did or said that made you think they were a "safe" person to tell.

2. Tell me about the easiest and hardest experience of coming out to a straight person.

Probe: What was positive about the expeience?
What was negative about the experience?
How did you feel?

3. What was the most memorable or significant time you told someone you were a lesbian?

What made it so?

4. Tell me about your experiences with coming out to a health professional.

Probe: Tell me about any hospital experience you have had, either as a patient or with your partner as a patient.

Did you tell anyone you were a lesbian while in the hospital?

What was positive about the experience?
What was negative about the experience?
How did you feel?

Some lesbians have told me it is important for the

medical staff to know of their sexual identity. Was that true for you?

How did you know it was "safe" to come out to the medical staff/nurses?

What else would you like to tell me about your experiences with the health care profession?

What would you like nurses to know when taking care of a lesbian client?

What do you wish they had said or done differently?

Some lesbians have told me it is important for the medical staff to know of their sexual identity. Was that true for you?

5.) Describe the perfect scenario around which you would tell someone you were lesbian.

OREGON HEALTH SCIENCES UNIVERSITY
Consent Form

TITLE: Disclosure of a Social Stigma: Sexual Identity Disclosure Issues as reported by Lesbians.

PRINCIPAL INVESTIGATORSS:

Susan Little, RN, BSN (phone 503-292-0958)
Dr. Marie Scott Brown, Faculty Advisor
(phone 494-8382)

PURPOSE: The purpose of this study is to describe the interaction between a lesbian and nurse during the experience of disclosing their sexual identity.

PROCEDURES: I will be asking you some questions about when and to whom you have disclosed your sexual identity. Your responses will be kept confidential; I will tape our interview to maintain accuracy. The tape will be transcribed without any direct references to you or to anyone mentioned by you. After transcription the tapes will be erased.

You will be asked to participate in a formal interview session lasting about an hour. This interview will be tape recorded and notes will be taken. You will be asked to describe a situation or situations surrounding the first time you came out to someone. I will also be asking you everything you can remember about coming out to a health professional.

RISKS AND DISCOMFORTS: The formal interview may present an inconvenience as it will take about an hour of your time. Also, some of the situations may be uncomfortable to recall. Please consider this in your consent to participate. If at any time the interview poses a risk or inconvenience you may withdraw from the situation.

BENEFITS: Potential benefits are:
1.) You may derive personal satisfaction in collaborating in a nursing rsearch study.
2.) You may contribute information which will benefit lesbian patients in the future.
3.) The study will contribute to the body of nursing knowledge, particularly in the area of disclosure of sexual identity.

CONFIDENTIALITY: Identities will be coded for purposes of the study and will be kept strictly confidential. Neither your name nor your identity nor anyone you mention will be used for publication or publicity purposes.

LIABILITY: This study is not sponsored or funded by any agency or institution.

The Oregon Health Sciences University, as an agency of the State, is covered by the State Liability Fund. If you suffer any injury from the research project, compensation would be available to you only if you establish that the injury occurred through the fault of the University, its officers or employees. If you have further questions, please call Dr. Michael Baird at (503) 494-8014.

Susan Little (503) 635-8340 will be happy to answer any questions you might have about the study.

Participation in this study is voluntary. You may refuse to participate, or you may withdraw from this study at any time, without affecting your relationship with or treatment at the Oregon Health Sciences University.

You will receive a copy of this consent form.

Your signature below indicates that you have read the foregoing and agree to participate in this study.

Signature of Participant_____

Date_____

Witness_____

Abstract

Title: Disclosure of a Social Stigma: Sexual Identity Disclosure Issues as Reported by Lesbians

Author: Susan Little, BSN

Approved_____

Marie Scott Brown, RN., Ph.D., Research Advisor

A descriptive study design was used to describe the self-disclosure experiences of lesbian women. Ten women, ages 35 to 70, from a purposive sample, were interviewed who had experienced the coming out process and who had acknowledged they were lesbian for at least one year.

One major research question guided the study: what are the experiences of lesbian women in disclosing sexual identity? Two sub-questions were also important in structuring the study: Under what conditions do lesbians feel safe to disclose, and what practices provide a supportive environment for lesbians to disclose?

Results showed that lesbians do not leave self-disclosure issues to chance. They go through a deliberate process of evaluating others to determine whether or not it is rational and safe to disclosue their sexual identity.

The ability to diagnose and treat health care problems, particularly those with a psychosocial component, is facilitated by accurate information about a persons sexuality and life-style. Therefore, further research is needed to describe the complex nature of disclosure of sexual identity by lesbians, and elaborate on the strategies of "rational outness."