

Nurse Educators' Experiences of Including Lesbian Content in Teaching:
Impact on Pedagogy

by

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ABSTRACT

Over the past 30 years, research studies and personal accounts from lesbians have universally reported judgmental attitudes from care providers and negative experiences of lesbians receiving health care. Authors of these studies recommend, but do not discuss, education of nursing students regarding lesbians and their health care needs. Little is known about the ways in which faculty members include lesbian content within undergraduate nursing education. This research project asked that nurse educators (all of whom hold a particular degree of privilege within the profession) look at their perpetuation of the dominant social structure, and interrupt unexamined privilege through the exploration of including lesbian content within their teaching.

The lack of teaching intervention on the part of nurse educators led to the development of an eclectic research design that incorporated aspects of feminism, consciousness-raising, critical inquiry, and participatory action research. Twelve undergraduate nursing faculty members (masters or doctorally prepared) agreed to participate. They represented five different nursing programs from a major metropolitan area of Western Canada, and identified themselves as holding a positive regard for lesbians and the inclusion of lesbian content in nursing education. In one semester, each participant was asked to include three self-determined teaching interventions in which lesbian health care concerns were incorporated. Participant-determined interventions varied and demonstrated a limited range of teaching strategies, rationales for inclusion, and specific content related to lesbians and lesbian health care issues. Participants' strategies ranged from as little as assuming the topic would naturally come up in class within discussions of marginalized groups in health care, to developing learning activities that reflected a broader pedagogical approach and an articulated personal commitment to challenging their own and students' assumptions regarding this marginalized group.

Data collection methods included individual interviews during the semester of teaching and focus group meetings two months following the end of the semester in which lesbian health care content was included. All participants reported having limited knowledge about lesbians and, with the exception of two participants, had not previously

given much thought to including lesbian health care content within their teaching. All participants reported having had their consciousness raised regarding lesbians and lesbian health care concerns and directly related this to their participation in this study.

Numerous themes arose from the data; most noteworthy were: never having knowingly cared for lesbian clients; limited knowledge about lesbians or their health care needs; not enough time to learn about new topics; fear—of being asked questions, offending someone, dealing with homophobic comments, and negative evaluations from students that might have employment consequences; and uncertainty and confusion about the meaning of curriculum and its purpose in informing faculty regarding their teaching.

An unanticipated conceptualization related to nursing pedagogy arose during analysis that describes four distinct teaching patterns among the participants: “fill them up”, “learner centred”, “co-creation learning”, and “survival”. While the context for these approaches to teaching was the experience of including lesbian health care content, they appear to be general patterns that these teachers used. This has led to recommendations regarding the need for further exploration into areas of nursing education, pedagogy, curriculum, and faculty development. This in turn will impact the ways in which our teaching practices influence the development of nursing students and ultimately practicing nurses. In addition, further discussion is needed with respect to the inclusion of meaningful lesbian health care content, values clarification, exploration of concepts such as heterosexism, homophobia, heteronormativity, and ways in which nursing education can expand on the understanding of what is viewed as normal within human relations.

Supervisor: Dr. Virginia E. Hayes (School of Nursing)

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CHAPTER ONE:

BACKGROUND AND CONTEXT OF RESEARCH PROBLEM

The impetus for this research project has grown out of my frustration and continual disappointment with nurse educators regarding the lack of inclusion of information about lesbians and lesbian health care content within nursing education. For over 25 years, there has been documentation identifying and exploring the negative experiences of lesbians within health care; the various negative attitudes and behaviour of health care practitioners (including nurse educators) toward lesbians; and the paucity of attention to issues of marginalization within nursing education due to heterosexism and homophobia. Repeatedly, scholars have identified the lack of research on lesbian health care issues, the continued marginalization of lesbians within health care, the lack of knowledge by health care professionals regarding lesbians and lesbian health issues, the consequences of homophobia and heterosexism, and the negative attitudes toward lesbians held by those within health care. Yet, very little research has been done to address these concerns in a systematic way within nursing education from the perspective of either practice or research.

Stevens and Hall (1991) summarize the location that lesbians occupy within the health care system:

Deeply entrenched stigmatized meanings about lesbian health remain influential in the education of health care providers, the quality of health care they deliver, their comfort in interacting with clients, and the institutional policies under which they work. The intensity of stigmatizing interactions experienced by lesbians over time has been fueled by moral condemnation, legal proscription, medical diagnoses, and intervention. For nearly a century, lesbians have been characterized by the medical profession as sick, dangerous, aggressive, tragically unhappy, deceitful, contagious, and self-destructive. They have been made to suffer exploitive treatments aimed at curing their homosexuality and have repeatedly been objects of research designed to confirm the pathology of their condition. Such a history underscores the vulnerable position lesbians occupy today as health care clients. (p. 301)

Numerous studies both qualitative (Deevey, 2000; Hall, 1994b; Hitchcock & Wilson, 1992; Platzer & James, 1997; Stevens, 1994a, 1994b; Stevens & Hall, 1988; Trippet, 1992, 1994) and quantitative (Gillow & Davis, 1987; Heimberg, 1991; Martinson, Fisher, & DeLapp, 1996; Young, 1988) indicate that lesbians are dissatisfied with the care they

receive from nursing personnel. Additionally, there have been a number of studies that identify a bias or prejudice against lesbians and gay men within health care (Belote & Joesting, 1976; Berkman & Zinberg, 1997; Dardick & Grady, 1980; Douglas, Kalman, & Kalman, 1985; Garfinkle & Morin, 1978; Glass, 2002; Mathews, Booth, Turner, & Kessler, 1986; Morrissey, 1996; Rondahl, Innala, & Carlsson, 2004; Saghir & Robins, 1973; Schlub & Martsolf, 1999; White, 1979). Rose (1993) addresses the working environment of lesbian nurses, reporting that 100% of the lesbian nurses in her study heard derogatory comments made by co-workers toward lesbian, gay, and bisexual people. The vast majority of these nurses did nothing to interrupt the behaviours of their colleagues for fear of retaliation. Likewise for scholars in the area of lesbian health, homophobia, and heterosexism, there have been some subtle and not so subtle ways of making it known that these topics are not worthy of rigorous intellectual examination within the academy. Eliason (1997a) reports her experiences of veiled threats against pursuing lesbian research and course development such that she believes her tenure and promotion have been adversely affected. Glass (2002) revealed that lesbian nurse academics from Australia, the United Kingdom, and the United States experience homophobia and as a consequence suffer adverse emotional health effects. Recent research, while scant, suggests that there have been no remarkable improvements over the past 25 years for lesbians within nursing either as recipients of health care, or as nurse educators.

Repeatedly, studies have called on educators, as well as nurses, to interrupt the misunderstandings and negative attitudes about lesbians (Bullough & Seidl, 1987; Eliason, 1993, 1998; Eliason & Randall, 1991; Giddings & Smith, 2001; Rondahl et al., 2004; Schlub & Martsolf, 1999). These researchers also seek to understand the impact these attitudes have on the experiences of lesbians in health care settings. Yet, there are no published research accounts that explore how to change the misunderstandings and promote new understandings of lesbians and lesbian health care concerns. There are no guidelines for nursing faculty members to develop specific strategies for addressing these findings, nor suggestions on how faculty members might go about introducing lesbian content into undergraduate nursing curricula. There is evidence that faculty members have difficulty including lesbian content (Randall, 1989). Gray, Kramer, Minick,

McGehee, Thomas, and Greiner (1996) support this conclusion and challenge nurse educators to explore and reflect on the heterosexism present within their own practice of nursing. Similarly, researchers who studied nursing students noted that there was a significant degree of heterosexism present (Eliason, Donelan, & Randall, 1992; Eliason & Randall, 1991). Additionally, there have been few studies in the past 10 years exploring the response of others toward lesbians, and those reported (Glass, 2002; Morrissey, 1996; Rondahl et al., 2004; Schlub & Martsolf, 1999), show no remarkable change within nursing practice or nursing education. This is cause for alarm, since one would anticipate an improvement given the greater societal acceptance shown in the recent opinion polls (Gallop, 2004) and evidenced in legislative changes to the definition of marriage in British Columbia, Ontario, and Quebec, Canada, and in Massachusetts, USA.

Nursing authors across North America stress principles of empathic caring (Bevis & Watson, 1989; Paterson & Zderad, 1976) that entail mutuality (Chinn, 1995) and "presencing" by the nurse (Hartrick, 1997; Travelbee, 1971). Gaut (1983) stresses that this occurs when the recipients of care feel respected and regarded positively by caregivers. Yet, far too many researchers (Hall, 1986, 1990; Johnson, Guenther, Laube, & Keettel, 1981; Johnson & Palermo, 1984; Roberts & Sorensen, 1995; Stevens, 1994a, 1994b, 1995; Stevens & Hall, 1988) report that lesbians, as seen through their individual stories, and by their reports of delay in seeking health care (Reagan, 1981), are negatively affected by the attitudes and behaviours of health care practitioners (Berkman & Zinberg, 1997; McGhee & Owen, 1980).

Nursing has legal, ethical, and practical directives that address health care concerns of lesbians (American Nurses Association [ANA], 1985; Registered Nurses Association of British Columbia [RNABC], 2000). Yet, research findings over the past quarter of a century (Belote & Joesting, 1976; Deevey, 1988a, 1988b, 1990, 1991, 2000; Gillow & Davis, 1987; Hall, Stevens, & Meleis, 1994; Heimberg, 1991; Hitchcock & Wilson, 1992; Martinson et al., 1996; Platzer & James, 1997; Rose & Platzer, 1993; Stevens, 1994a; Trippet, 1994; White, 1979; Young, 1988) indicate that lesbians are not being provided with the quality of care mandated by the Standards of Practice (RNABC, 2000) and Code of Ethics for Nurses (Canadian Nurses Association [CNA], 2002) and

considered to be fundamental within the profession of nursing. Nursing scholars have raised questions regarding what nursing educators are doing in response to these concerns (Eliason, 1996a; Gray et al., 1996; Randall, 1989; Stevens, 1986, 1994a, 1995; Zurlinden, 1997). Yet, there are no published research accounts that address specific strategies or content that nursing faculty members might use to introduce lesbian content and lesbian health care concerns into undergraduate curricula.

Insufficient attention is placed on issues of marginalization within nursing education (Hall et al., 1994). The prevalence of homophobia and heterosexism among those in the nursing profession discussed in multiple studies gives cause for concern (Deevey, 1988a; Eliason, 1996a, 1996b, 1997a, 1997b; Eliason et al., 1992; Glass, 2002; Gray et al., 1996; Morrissey, 1996; Randall, 1989, 1994; Richmond & McKenna, 1998; Rondahl et al., 2004; Schlub & Martsolf, 1999; Stevens, 1992, 1994a; Stevens & Hall, 1988; Zurlinden, 1997). As educators and nurses, we can probably all give one or more specific examples of positive health care or nursing interactions where lesbians are involved and this is to the credit of the profession. Yet, studies indicate there are serious issues of discrimination, rejection, fear, assumptions, and negativity toward lesbians. The real challenge lies not in debating whether disparities exist, because the evidence is overwhelming that they do. The challenge lies in implementing strategies to reduce or eliminate them.

This research is intended as an act of social change. The intent of this study is to ask that nurse educators, people who hold a particular degree of privilege within the discipline, take a look at their location in the world, their behaviours, their involvement, and their own perpetuation of the dominant social structure, and do something to interrupt unexamined privilege through the exploration of including lesbian content within undergraduate nursing education. Freire (1970) warned of the consequences to society of perpetuating the status quo when the current situation creates barriers to freedom or liberation. In this context, I thought it would be interesting to look at nurse educators and the inclusion of lesbian content in their teaching. In exploring the idea of perpetuating the status quo within nursing education, it seems that the central issue is not so much the exclusion of lesbian material per se in the curriculum, but the acceptance of heterosexual privilege and the assumptions that lie therein. I began to wonder if it were possible to

interrupt these heterosexual assumptions of “normalcy” and to deliberately include lesbian content. And, if that were possible, I wondered what the experiences of nurse educators would be who took action to include lesbian content within their teaching. Braun (2000) draws this to the attention of nurse researchers and I would argue likewise for nurse educators:

Just as it is possible to talk in non-sexist ways, so is it possible to talk in non-heterosexist ways....As a heterosexual researcher, we need to be particularly attuned to the possibility (indeed probability) that our research is heterosexual—even if, and I think this is an important point, our participants have been explicitly recruited as heterosexual. We shouldn’t stop considering heterosexism just because there’s no lesbian present to challenge us (as we wouldn’t want men to be sexist just because no women were present to challenge it). Challenging and eliminating heterosexism is everyone’s responsibility, not something that should just be left to lesbians or gay men. Moreover, heterosexuals need to consider that what we might not hear or recognize as heterosexist might be experienced that way by lesbians, gay men, bisexuals and some other heterosexuals. Therefore, we need to look carefully for the possibility of heterosexism in our research practices and written output, and develop strategies to eliminate it. (pp. 139-140)

Research Goals

The present qualitative study was designed to gain understanding of the experiences of a selected group of nursing faculty members who agreed to introduce lesbian content into their undergraduate nursing courses. This research was designed to help faculty members make constructive additions or changes to their teaching practices at the undergraduate level in order to more readily and comfortably include lesbian content in their teaching of basic nursing knowledge and its application in nursing practice. It was also designed to study systematically what the changes were like from their personal perspectives. I anticipated that the participating nurse educators would in turn assist future nurses in being more inclusive in their practice, since nurses will encounter lesbians, knowingly and unknowingly, as clients and colleagues. The long-term goal of this research, although not its direct focus, is to improve the care that lesbians receive from nurses when accessing the health care system.

Research Questions

The primary research question addressed in this study is:

- What are the experiences of undergraduate nurse educators when they include lesbian content within their teaching?

Secondary questions include:

- What methods of learning and specific teaching strategies did undergraduate nurse educators engage with when requested to include lesbian content in their teaching?
- What information specific to lesbians and lesbian health care did undergraduate nurse educators include prior to being in this study?
- What were the reasons undergraduate nurse educators gave for participating in this research?
- What teaching materials, faculty development programs, and other tools or information are needed for undergraduate nurse educators to continue to include lesbian health care concerns in their teaching?

Organization of the Dissertation

The present chapter has provided an introduction to the research topic and specific research questions that were addressed in the project. In Chapter Two, I review the literature concerning the definitions of heterosexism and homophobia, and the historical context of these definitions. This chapter also explores the literature regarding the experience of lesbians within health care and the treatment of the lesbian experience within nursing education. Lastly, this chapter explores the use of consciousness-raising as a process of change.

In Chapter Three, I present the research methodology, discuss the procedures used to obtain participants, collect and analyze data, and maintain scientific rigour. This chapter also includes a reflective analysis of how my social and professional location as a nurse educator, a feminist, and a lesbian has shaped this research process.

In Chapter Four, I present demographic information about the participants, why they agreed to participate, their previous inclusion of lesbians and lesbian health care concerns, examples of consciousness-raising, and learning activities they selected or developed. Also, in this chapter, I examine the thematic summaries derived from the data and discuss what it was like for these participants to include lesbian health care concerns in their teaching. These thematic summaries included: role of the curriculum, interactions

with colleagues, student readiness and attitudes, lack of nursing education materials, fear, myths and stereotypes, heterosexism, safety and the need to protect some students, and responding to students' religious objections to lesbians.

In Chapter Five, I explore a most interesting and unanticipated finding of four teaching patterns used by participants while including lesbian health care content. These patterns were descriptively labeled: "fill them up", "learner centred", "co-creation", and "survival". While these patterns were used in the inclusion of lesbians and lesbian health care concerns, it is my belief that these patterns are probably indicative of teaching styles used by participants regardless of the specific content being taught.

Lastly, in Chapter Six, I explore the need for, and implications of, nursing pedagogy and future research regarding the teaching of inclusion, diversity, and difference in undergraduate nursing programs. I also discuss the various limitations to this particular study. I conclude by recommending ways to improve the inclusion of lesbian health care content within nursing education.

CHAPTER TWO: LITERATURE REVIEW

In the first section of this chapter, I define and differentiate between the two terms most commonly used in discussing the marginalization of lesbians and gay men: heterosexism and homophobia. I also discuss the literature concerning how and why heterosexism and homophobia are perpetuated in nursing and ways that their occurrence may be interrupted. I summarize the mandate of health care practitioners, particularly with regard to concerns about providing inclusive care to all clients, and show how homophobia and heterosexism are inconsistent with this mandate. I tease apart both the obvious and the subtle differences between these two terms to better understand how and when they are used to describe some of the negative experiences of lesbians and gay men in our society. Distinguishing between these two terms makes it easier to identify ways discussions can take place in the classroom and clinical settings between nursing educators and students to help interrupt the consequences of their manifestation in health care settings.

In the second section of this chapter, I explore the reported experiences of lesbians as clients within the health care system and the substantial documentation that lesbians are marginalized within health care and specifically within nursing. The final section of this chapter explores two theoretical perspectives that have influenced my thinking and development of this research project: emancipatory inquiry and feminism. It also examines their relevance to the use of consciousness-raising as an avenue for change within nursing education to interrupt the effects of heterosexism and homophobia.

Distinguishing Between Homophobia and Heterosexism

The terms homophobia and heterosexism are often used interchangeably to describe the oppressive situations and societal attitudes that lesbians and gay men struggle with on a daily basis. A more precise understanding of these terms is necessary for further discussion.

Homophobia

The word *homophobia* comes from the combination of two Greek word forms: a prefix, *homo-*, meaning the same, and in this instance referring to the same sex

(*homosexual*), and a suffix, *-phobia*, meaning an irrational fear of something. *The American Heritage Dictionary* (Bankston, Matejka, Sisak, & Mallatt, 1992) defines homophobia as an “aversion to gay or homosexual people or their lifestyle or culture” and “behavior or an act based on this aversion” (p. 549). Other definitions identify homophobia as an irrational fear of homosexuality. Smith (1971) used the term in the development of a tentative personality profile of those individuals with a negative or fearful reaction to homosexuals.

The 1960s was a period of broad social unrest that included the birth of a gay liberation movement, which is credited as beginning with the Stonewall Riots in New York City in 1969 (Cooper, 1989). A wider discussion within the greater social structure followed the birth of this movement regarding the “visibility” of the gay population and its consequences to society. The word homophobia first appeared in print in 1969 and was subsequently discussed at length in George Weinberg’s 1972 book, *Society and the Healthy Homosexual*. In this book, Weinberg, a heterosexual psychologist, used the term homophobia to label heterosexuals’ “dread of being in close quarters with homosexuals” (p. 4) as well as homosexuals’ self-loathing (later termed “internalized homophobia” to mark the distinction between outward experiences of others’ prejudices and those internal processes that limit self-acceptance). Since Weinberg’s early use of the term, the definition has taken on expanded meanings, which include disgust, anxiety, and anger (MacDonald, 1976). Weinberg’s use of the term homophobia was a giant leap in shifting the focus away from the “homosexual’s problem” to exploring an attitudinal bias held by those uncomfortable with homosexuality. This shift coincided with a shift in thinking among many Western scientists regarding the pathologizing of homosexuality.¹ Researchers began looking at attitudes toward homosexuality rather than seeking a biological cause for homosexuality or placing blame on individuals for their homosexuality (Terry, 1999).

Over time, and with changes in political awareness, an expanded definition of homophobia developed. This can be seen in Pharr’s (1988) definition of homophobia as

¹ In 1973, The American Psychiatric Association (APA) formally removed homosexuality from its list of diagnostic criteria for mental illness, however, this removal has not occurred world-wide and the International Classification of Diseases still includes homosexuality as a form of pathology in its categories of diseases (World Health Organization, 1997).

“the irrational fear and hatred of those who love and sexually desire those of the same sex” (p. 1). Zurlinden in his 1997 book, *Lesbian and Gay Nurses*, includes both feelings about, and responses to, lesbians and gay men when he defines homophobia as:

hatred, willful ignorance, mean-spiritedness, and narrow-mindedness. It is not a psychiatric diagnosis. People suffering from homophobia do not run screaming in terror when they encounter a lesbian or gay man. Instead, they assume they are justified to be cruel: to discriminate in housing, employment, and education; and to pass laws to prevent gay men and lesbians from enjoying the civil liberties that other Americans take for granted. (p. 11)

The definition of homophobia has expanded since the early use of the term. Often the meaning is quite broad and loosely defined as “any belief system which supports negative myths and stereotypes of homosexual people” (Garfinkle & Morin, 1978, p. 30) and “negative attitudes, which arise from fear, or dislike of homosexuality” (Martin, 1982, p. 341). The primary use of the term has been to focus on an individual’s attitudes or responses to homosexuality.

Lehne (1976) was one of the first individuals to connect homophobia to the context of a larger social structure and to draw connections between oppressions, in this case making links to sexism, gender, and power differences. This analysis is further supported by the works of Henley and Pincus (1978), Kite (1992), and Kurdek (1988), which link hostility toward homosexuals with negativity toward women and ethnic/racial minorities. Lehne suggested that homophobia is but one aspect of a larger concern, which he terms “homosexism”. He defines homosexuality as “similar to sexism in that sex roles are maintained by members of society, however, this occurs within the confines of the same sex and in so doing lacks some of the power differential inherent in sexism that exists between males and females” (p. 67). While Lehne is attempting to use another term to gain clearer understanding of the oppression of lesbians and gay men within a broader societal context, the coining of a new term only further complicates confusion regarding how terms are used and what their underlying meanings convey. This definition, while perhaps a bit obscure, is one of the first to begin locating homophobia within the context of a larger social structure and to find similarities among oppressions, in this case making links to sexism and power differences between genders (Young-Bruehl, 1996). At the

same time, this expanded definition begins to raise questions as to what meanings are encompassed by the term homophobia.

The work of Kite (1994), MacDonald (1976), Morin and Garfinkle (1978), Nugesser (1983), and Weinberger and Millham (1979) also suggests that homophobia is connected to maintaining traditional sex roles. While these previous studies primarily looked at gay men, a relatively small study by Eliason and Randall (1989) found a correlation between nursing students maintaining female sex roles and homophobic attitudes. This suggests that the adherence to traditional sex roles by either women or men increases the likelihood of homophobic attitudes.

Critics have observed that the use of the term homophobia is problematic for several reasons. First, empirical research does not indicate that heterosexuals' anti-gay attitudes can reasonably be considered a phobia in the clinical sense (MacDonald, 1976). Indeed, the limited data available suggest that many heterosexuals who express hostility toward lesbians and gay men do not manifest the physiological reactions to homosexuality that are associated with other phobias (Shields, 1994; Weinberg, 1972). Second, use of the term homophobia implies that anti-gay prejudice is an individual, clinical entity rather than a social phenomenon rooted in cultural ideologies and inter-group relations. Third, a phobia is usually experienced as dysfunctional and unpleasant. Anti-gay prejudice, however, is often highly functional for the heterosexuals who manifest it (Kite, 1992; MacDonald, 1976; Weinberg, 1972).

Another problem with the term homophobia is its lack of specificity. Within the general set of negative attitudes about homosexuals, various permutations of homophobia exist. For example, male heterosexual homophobia toward gay men, male heterosexual homophobia toward lesbians, female heterosexual homophobia toward lesbians, female heterosexual homophobia toward gay men, and in the case of those who self identify as lesbian or gay, as internalized homophobia. Internalized homophobia encompasses the hatred and fear of lesbians and gay men toward themselves and each other (Pelligrini, 1992).

The term homophobia has multiple possible meanings and causes confusion when it is used. This lack of a clear meaning for the term has led many people to wonder if perhaps it needs to be used less frequently and indicate only a very specific kind of

response to homosexuality and homosexuals. Fyfe (1983) suggests abandonment of the term except in rare cases of overt phobic avoidance. Nugesser (1983) feels that the term homophobia is misleading and unsatisfactory. He indicates that its use “distracts us from the truth about patriarchal procreation, gender differentiation, and the human potential” (p. 162). Neisen (1990) feels that the term homophobia is an outdated term that “has become a catchall word for any type of negative attitude or action directed toward homosexuals” (p. 21). Neisen further suggests the need for clarification in the definition, wanting to differentiate between the impact of cultural prejudices for individuals who hold prejudicial attitudes, and for individuals who are recipients of the prejudice (p. 24). In making this distinction, Neisen suggests the use of the terms “heterosexism” and “shame due to heterosexism”.

The term homophobia is still widely used today in spite of the lack of clarity and its sweeping definition. In response to this generality, and in light of understandings brought about by exploration of heterosexual privilege through feminist, post-modern, queer, and critical social thought, the term “heterosexism” will be discussed. By using the word heterosexism in place of, or in conjunction with homophobia, the dialogue about oppression is able to move into a broader, more political realm.

Heterosexism

Like homophobia, heterosexism is a term that has received considerable use in conversation among lesbians and gay men as well as in the literature about and in response to lesbians and gay men. The term heterosexism began appearing in the mid-1970s as a term analogous to sexism and racism, describing an ideological system that denies, denigrates, and stigmatizes any non-heterosexual form of behaviour, identity, relationship, or community (Herek, 1990). Morin (1977) and Morin and Garfinkle (1978) referred to heterosexual bias as placing a superior value on heterosexual over homosexual lifestyles. Rosental (1982) reports the derivation of the notion of heterosexism from feminist literature that focused on themes of sexism and anti-homosexuality. Lorde (1984) describes heterosexism as a form of oppression that incorporates a belief of inherent superiority of one form of loving over all others.

Gray and colleagues (1996) describe heterosexism as “a belief that the only right, natural, normal, god-given, and therefore privileged way of relating to each other is

heterosexually” (p. 205). These same authors point out that while there are exceptions to this “rule”, for example mother-daughter or father-son relationships, it remains clear that “opposite sex relationships are privileged both socially and legally above other forms of relationships” (p. 205).

Neisen (1990) defines heterosexism as:

the continued promotion by the major institutions of society of a heterosexual lifestyle while simultaneously subordinating any other lifestyles. Heterosexism is based on unfounded prejudices just as racism, sexism, etc. are based on unfounded prejudices. When our institutions knowingly or unknowingly perpetuate these prejudices and intentionally or unintentionally act on them, heterosexism is at work. Heterosexism is not limited to institutional oppression. Just as there can be individual acts of racism and institutional racism, there can also be individual acts of heterosexism. (p. 25)

Neisen’s definition points out that institutions can and do perpetuate a belief system that plays out individually and socially. This definition puts heterosexism on an equal playing field with sexism and racism, thereby legitimizing both the obvious and subtle experiences of lesbians and gay men as a social concern rather than minimizing it as an individual’s problem.

Using the term heterosexism highlights the parallels between anti-gay sentiment and other forms of prejudice, such as racism, anti-Semitism, and sexism. Like institutional racism and sexism, heterosexism pervades societal customs and institutions. It operates through a dual process of invisibility and attack. Homosexuality usually remains culturally invisible; when people who engage in homosexual behaviour, or who are identified as lesbian or gay, become visible, they are subject to sanctioned attack. This is carried out in the form of compulsory heterosexuality (Rich, 1980) as evidenced by legal, social, and religious practices, and by individuals whose behaviour runs the gamut of subtle teasing to overt acts of violence (Brenner, 1992). The intention of compulsory heterosexuality sends messages to the individual and others that being and acting outside a prescribed set of heterosexual norms limits or prevents the rewards and privileges extended to heterosexuals in our society.

Although usage of the terms homophobia and heterosexism has not been uniform, homophobia has typically been employed to describe individual anti-gay attitudes and behaviours, whereas heterosexism has referred to societal-level ideologies and patterns of

institutionalized oppression of non-heterosexual people. Since the 1980s, as anti-gay and lesbian attitudes have become increasingly central to conservative political and religious ideologies, the distinction between the terms homophobia and heterosexism has become blurred. Both are used, often interchangeably, to talk about the range of responses from discomfort to outright hate and violence toward lesbians and gay men.

Perpetuation of Heterosexism

Regardless of language limitations, or perhaps in spite of them, there is nonetheless a need to be able to discuss the oppression that is experienced by lesbians and gay men in society. One of the ways that this marginalization is perpetuated is through compulsory heterosexuality (Rich, 1980). Nursing education is not exempt from this perpetuation, as faculty members continually make decisions to include certain content and exclude others. Assumption and acceptance of heterosexuality as the norm—"norming" or "heteronormativity"—is so pervasive it is invisible as a cultural phenomenon. It must be brought to the surface and examined in detail in order to bring about a substantive change in thinking.

Widespread cultural conditioning leads members of society to believe that heterosexual relating is, or should be, the only way to express one's sexuality. Cultural conditioning ensures that heterosexuality does not appear to be a cultural artifact, but is biologically determined and beyond questioning or human manipulation (Gray et al., 1996, p. 205). This conditioning begins at an early age and is pervasive throughout all aspects of society (legal, religious, and social). Compulsory heterosexism is prescribed and inscribed in the myths and stories of a society. It is reinforced in the dreams and expectations of parents for their children; and the construction and enforcement of the laws and traditions of a society demand it as well. There is no escaping heteronormativity in Western society. Compulsory heterosexism is recreated and enforced daily through the use of the media in advertising, television, movies; socially rewarded through traditions such as wedding showers, jobs, and political careers; legally sanctioned through marriage, tax law, spousal benefits, inheritance law, and immigration law; and moralized by religious institutions.

Since we learn directly and indirectly that heterosexuality is the only right and normal way to be, there is, by extension, a social assumption that everyone is

heterosexual. This presumption of heterosexuality protects people from experiencing or examining their responses to non-heterosexual ways of being. It also helps explain the defensive and sometimes emotionally charged responses by some toward non-heterosexual people who speak up and/or act out about their experiences living in a compulsory heterosexual society.

The Incompatibility of Homophobia and Heterosexism With Nursing Standards

The reported prevalence of homophobia and heterosexism among members of the nursing profession gives cause for concern (Deevey, 1988a; Eliason, 1996a, 1997a; Gray et al., 1996; Randall, 1989, 1994; Zurlinden, 1997). In Canada and the United States, Registered Nurses' actions are guided at the national level by a Code of Professional Conduct, Standards of Practice and Ethical Statements set out by federal associations—Canadian Nurses' Association (CNA) and the American Nurses Association (ANA). They are guided more specifically in Canada by individual Provincial Registries, for example, Registered Nurses Association of British Columbia (RNABC), and in the United States by individual State Boards of Nursing. In each case, these organizations determine the rules of responsibility and accountability regarding standards of practice in professional nursing. These agencies and their governance, along with licensing procedures, help assure that clients have a right to respect, dignity and high standards of care, that is, protection of, and service to, the community (ANA, 1985; CAN, 2002; RNABC, 2000). Additionally, autonomy, self-determination, and acceptance of characteristics that make a person unique are central in the philosophies and theories of nursing (King, 1981; Orem, Taylor, & Renpenning, 1995; Rogers, 1970; Watson, 1990a, 1990b).

Are Nurses' Behaviours and Attitudes Different Than Other People's?

In light of these professional and public mandates about nursing care, it is quite surprising to learn that not all clients experience the quality of care expected from these directives and that nurses do not approach all clients with an attitude of openness and reflective practice. Patients' rights are accorded great importance in the nursing literature (American Nurses Association [ANA], 1985; Canadian Nurses Association [CNA], 2002; Gadow, 1980; International Council of Nurses, 2000; Registered Nurses Association of British Columbia [RNABC], 2000) although, as reported in numerous research studies, the experiences of receiving health care are often very different for lesbians than for

heterosexual women. This will be discussed in greater detail later in this chapter as it pertains to lesbians in particular.

Given the focus on caring throughout the nursing literature (Benner & Wrubel, 1989; Bevis & Watson, 1989; Gaut, 1983; Gray, 1992; Keen, 1991; Leininger, 1988, 1996; Morse, Bottorff, Neander, & Solberg, 1991; Orlick & Benner, 1988; Watson, 1997, 1998, 2002, 2003; Watson & Foster, 2003; Watson & Smith, 2002), one might expect that nurses would be considerably more insightful and experience fewer prejudicial behaviours and attitudes than the general population. But in fact, nurses report beliefs similar to those held by the general population regarding marginalized groups (Rondahl et al., 2004; Rose, 1984). Reports of racism, homophobia, ageism, classism, and sexism, are becoming more common in discussions among nurses and in the nursing literature. For example, discussion of racism in nursing is beginning to have a place within discourses on cultural diversity (Maeda Allman, 1992; Reimer Kirkham, 2000; Vaughan, 1997) and on the negative consequences of prejudice on health (Hogue & Hargraves, 1993; Williams, 1993). Sexism is touched upon in studies and papers addressing the roles of women and how these play out in a profession dominated by women (Ashley, 1976; Gray, 1992; Heide, 1985; Henderson, 1992). Aging populations have fared somewhat better as nursing has embraced the elderly as a population group in need of special consideration and attention. Yet, some authors raise concerns about ageism (Pohl & Boyd, 1993; Shellenbarger, 1993) within nursing practice. There is limited discussion regarding disability and this conversation occurs more with a focus on the rehabilitation of clients than on "ableism" within nursing or nursing care. Street (1990) maintains that nurses' stated beliefs and values are not always in alignment with their actual practice. She urges nurses to begin to examine their values in light of their actual practices.

Insufficient attention is given to issues of marginalization within nursing education (Hall et al., 1994). Nursing education is not alone in this. An investigation into the growing literature on lesbian and gay issues reveals that adult educators very rarely write about, or research this segment of the adult population (Hill, 1995). This suggests that the first issue needing to be raised among nurse educators and nursing students is one of awareness or consciousness-raising about the similarities and differences between the lives of those who are homosexual and their heterosexual counterparts. An increased

awareness of the experiences of lesbians and gay men could well begin with an examination of the terms homophobia and heterosexism and how these concepts and their reality play out in the health care arena.

Heterosexism and Homophobia Within the Health Care Arena

In this section of the chapter, I look specifically at the discussions of heterosexism and homophobia within the health care arena and of the need to address lesbian content in particular within nursing education. This is a deliberate and conscious position, as the responses of individuals and society toward lesbians and gay men manifest themselves differently (Blumstein & Schwartz, 1983; Herek, 1989; Herek & Glunt, 1988; Kite, 1994; Kite, 1984). The work of Harding (1991a; 1991b) and Hartsock (1997) regarding feminist standpoint theory has shown that women and men are not the same and that a purely lesbian focus offers the possibility of insights that would not necessarily occur when combining lesbians and gay men as one group. Additionally, the comprehensive work of Blumstein and Schwartz (1983) in *American Couples*, gives strong support to the idea that lesbians and gay men are perceived and are responded to by others quite differently. Other scholarship suggests that different factors account for lesbianism and gayness (Golden, 1997; LeVay, 1996). This is not to say that a focus on one is more significant or important than the other, but it is to say that there are significant differences when addressing issues and experiences of lesbians and of gay men (Garnets & Kimmel, 1993). This limitation, or focus on lesbians, also provides boundaries to my work. My intention within this research is to focus on lesbians in order to come to understand the nuances of making a shift within nursing education to provide quality health care specifically to lesbians.

Experiences of Lesbians in Health Care

Historically, as well as in the present day, medical professionals have taken a "pathologizing" position regarding lesbians (Stevens & Hall, 1991; Taravella, 1992; Wilkerson, 1994). Similar attitudes are found in nursing (Glass, 2002; Platzer & James, 2000; Randall, 1989; Richmond & McKenna, 1998; Schlub & Martsolf, 1999). This manifests itself despite an "ethic of caring" and legal mandates to provide individualized care that reflect the needs of people in different communities and settings.

In creating a knowledge base for nursing practice, nursing has historically taken its lead from medicine regarding details and the uses of science, as well as the attitudes held by practitioners (Reverby, 1987). Much of the foundational information taught in nursing schools is based on knowledge obtained from other disciplines (Ashley, 1976). These include medicine, psychiatry, sociology, anthropology, physics, and chemistry, which do not necessarily locate their knowledge within a theoretical framework of caring, nor advocate for the visibility of minority groups such as lesbians.

There are many accounts of personal experiences and stories of mistreatment and even physical harm experienced by lesbians in day-to-day activities not related to health care (Brenner, 1992; Gallagher, 1995; Herek, 1989; Russell & Van de Ven, 1976). Given the heterosexual assumptions prevalent throughout society, there is little reason to think that health care practitioners would be any different. Because clients are generally in a state of vulnerability or crisis when making initial contact with health care providers, it makes sense that they would be cautious, waiting to reveal information until it appears "safe" to do so, or avoiding the topic altogether so as to prevent their worst fears from happening.

Fear of Disclosure

McGhee and Owen's (1980) study reports that lesbians are afraid to approach health care providers and fear negative reactions when they do disclose their sexual orientation. This fear is important to recognize as it causes a lesbian seeking health care to lie about her lesbianism, seeing this information as unnecessary and fearing that her lesbian status will cause her to be treated differently or possibly harmed. These fears are supported by Darkick (1980) who found that 27% of the lesbians studied reported having experienced overt hostility after disclosing their lesbian identity to a health care practitioner. This study further reported that lesbians were more reluctant to share information about their lesbianism when previous interactions with health care providers had been negative. Saghir and Robins (1973) reported that over one third of the respondents had had negative experiences with mental health providers and felt that they had experienced prejudice. Belote and Joesting (1976) reported that 30% of their respondents felt discriminated against by health care practitioners. Reagan (1981) found that 25% of lesbians responding in this study delayed seeking health care because they

feared disclosure consequences. Johnson and colleagues (1981) found that 40% of the lesbians responding to their survey feared the quality of their health care would be adversely affected if they became known as lesbians. Glascock (1983) reports that over 50% of their subjects avoided disclosing their lesbian identity to health care practitioners for fear of negative consequences regarding their health care access.

Since the mid-1980s, fewer studies have been published specifically identifying heterosexual and homophobic research findings within health care. This is more likely related to trends in funding and repetition of findings rather than a remarkable change in the experiences of lesbians or the attitudes of health care providers, as no studies have shown overly positive experiences of lesbians at the hands of health care providers. Geddes (1994) found that 32% of the lesbians in this survey had directly denied their sexual orientation to a health care provider out of fear of discrimination and that 19% who had come out had had a negative experience. Harris, Nightengale, and Owen (1995) surveyed 97 health care providers (nurses, social workers, and psychologists) and reported that nurses were more homophobic as a group than social workers or psychologists. Additionally, nurses in this study had lower scores on the knowledge section of the survey regarding lesbians than either social workers or psychologists. Rose (1993) surveyed 44 lesbian nurses who reported that many had witnessed discriminatory acts by their colleagues; 25% had experienced another nurse refusing to care for a gay or lesbian client; and 100% of them reported having heard co-workers make derogatory comments about lesbian, gay or bisexual people. Over half of these nurses reported being afraid of social and workplace discrimination and felt they could not challenge the anti-gay or anti-lesbian remarks of their colleagues.

A study of attitudes and homophobia in psychiatric nurses found that the majority of nurse respondents (77%) indicated either moderate (57%) or severe (20%) homophobia (Smith, 1993). Rondahl and colleagues, (2004) found that 36% of the responding Swedish professional nursing staff “would choose to refrain from nursing homosexual patients if that possibility existed” (p. 23). This seems a rather high number given that Swedish law demands that all patients shall receive equal care” (p. 24). These Swedish findings support similar findings of studies from the United States a decade earlier in which nurses were found to be less willing to care for homosexual patients than

heterosexual patients with the same illness (Kelly, Lawrence, Hood, Smith, & Cook, 1988). These more recent studies strongly support that there is still a pressing need to address issues and concerns regarding lesbian health care and attitudes of care providers within the entry level of practice.

Even though lesbians have conditions and health challenges similar to those of heterosexual women, lesbians need health care based on knowledge of their own experiences. This is preferable to a demand that lesbians "translate" the experiences of heterosexual women to themselves (Deevey, 2000; Glascock, 1983; Hall, 1986; Johnson et al., 1981; McGhee & Owen, 1980; Stevens, 1986, 1994a; Wojciechowski, 1998). For example, two common questions that women are asked in a routine health encounter are, "Are you married?" and "What method of birth control do you use?" While the questions in and of themselves are not inappropriate, they do leave a lesbian in an initial quandary if asked early in the encounter. The questions assume a heterosexual reference and make it awkward for a client who is not heterosexual to answer. Additionally, it communicates that the nurse is perhaps unable to see the client outside the boundaries and limitations of heterosexuality and thereby acts as a "warning" to the lesbian client that it is not particularly safe to answer honestly.

While many of the above-mentioned studies looked at health care providers as a group rather than specifically singling out nurses, there is nothing in the literature to support the idea that nursing care stands out as more positive toward and less threatening to lesbian clients than the care of other health care practitioners. It is conceivable that clients do not distinguish on an emotional response level the differences between the responses of one health care practitioner and another. In this case, once the experience of fear or actual mistreatment occurs, it is likely that a client would act to protect herself. Unless overt steps are taken to ensure the client's emotional and physical safety, she is likely to respond to all health care providers from a place of caution, fear, and skepticism.

Lesbian Health Care in Nursing Literature

The experience of lesbians as they approach health care professionals is interesting and perhaps not surprising when viewed in the context of nursing literature. In reviewing literature on lesbian health care from 1970 to 1990, Stevens (1992) concluded the following:

The empirical literature on lesbians' health care experiences suggests that deeply entrenched prejudicial meanings about lesbian health remain influential in the education of health care providers, the quality of health care they deliver, their comfort in interacting with clients, and the institutional policies under which they work. Knowledgeable, empathic, and fully accessible care cannot coexist with such conditions. The present findings indicate that many lesbians interpret health care interactions as abusive and perceive high-quality, safe health services to be unavailable to them. Such findings are of serious concern and call for immediate radical changes on the part of educators, practitioners, administrators, and policy makers. (p. 114)

Nursing textbooks have limited information available regarding lesbians and their health care needs. For the most part, lesbians are not addressed as a group of people with significant needs or considerations. What is included in textbooks is primarily a token gesture acknowledging that there are lesbians in the world. Any substantive dialogue about concerns or issues regarding lesbian health care or the process by which nursing students and thereby nurses, might be therapeutic in assessing their unique circumstances or needs is grossly lacking.

Jackson (1995) looked at the characterization of lesbians in nursing literature between 1969 and 1984 and concluded that

the analyzed texts provide evidence of a professional structure that could not accept lifestyle variation and, typically, addressed the issue of lesbianism in one of two ways, either to ignore its existence altogether or to include it as an afterthought to any discussion about male homosexuality. (p. 28)

Jackson's review spanned just under 20 years and her review of the nursing textbook literature included only five nursing textbooks, one each from the years 1969, 1974, 1976, 1980, and 1984. While Jackson's work is helpful in providing a glimpse into history regarding what information was presented, this study lacks a methodical and comprehensive review of nursing textbooks. While it is limited in its scope, it suggests that insufficient general nursing knowledge regarding the concerns and needs of lesbians is readily available to nursing students and faculty members.

In a review of 25 nursing textbooks (See Appendix A) published between 1995 and 2001 regarding lesbians and lesbian health care concerns I found little information regarding lesbians and none regarding lesbian health care concerns. This supports the conclusions drawn by Jackson (1995). Lesbians were mentioned only superficially within

chapters on assessment in basic nursing textbooks, and again in sexuality chapters within psychiatric/mental health textbooks. No examples were given of how a nurse might use therapeutic communication to approach concerns of youth exploring their sexuality or what a nurse might need to know when working with such a client. One textbook included a reference to and a national address for the support group, Parents, Family and Friends of Lesbians and Gays (PFLAG). Two of the textbooks offered general information that a local crisis line could be used as referral when working with lesbian clients.

None of these books presented lesbianism as a normal and healthy variation of sexuality within society. Also, they contained almost no discussion of legal concerns, social mores, cultural identity, relationship issues (such as dating, breaking up, adoption, blended families), heterosexism, homophobia, the development stages of coming out, or the consequences of remaining closeted. Nor were there any discussions about possible health care needs of lesbians that might differ from those of heterosexual women or how nurses might go about approaching subjects of concern to lesbians receiving nursing care. Examples of these latter possible subjects of concern include: family visitation rules; consent for medical procedures for child or "spouse" with whom there are emotional ties but no legal bonds; exploration of coming out concerns; fear of discrimination; domestic violence; death and dying; community support networks; or insemination concerns for lesbian couples wanting to get pregnant. With so little relevant information available in the standard textbooks, how can these situations be addressed in the clinical environment when it is evident that a nurse does not have sufficient knowledge or experience to proceed in caring for a woman who identifies as being lesbian?

In contrast to the lack of examples regarding lesbians, these same textbooks offer examples involving non-white, non-Christian, and non-middle class situations within discussions of issues arising from ethnic, racial, national, cultural, and religious differences. This is not to suggest that writings in these subject areas are outstanding, or even sufficient—I would argue that they are not—but it is to say that authors and publishers are including this information in nursing textbooks. By bringing the topics and possibilities to students' attention, legitimacy is brought to discussions when faculty

members explore and challenge students regarding matters of race, ethnicity, nationalism, culture, and religious affiliations.

There are only rare examples of lesbians being depicted in nursing textbooks. Lesbians are not pictured engaged in activities of daily living in the same way as heterosexual individuals—for example, looking after a sick family member or choosing healthy foods. Only one case study involving a lesbian could be found within these 25 textbooks, a client, labeled as lesbian, within a medical/surgical setting with no related discussion about being a lesbian or how a nurse might go about approaching the topic with the client. This situation may leave the reader with the idea that lesbians rarely exist or do not have contact with nurses or the health care system. At best, lesbians are mentioned as sexual variances. The textbooks did not contain even minimal information regarding how nurses might approach the provision of therapeutic nursing care to women who identify themselves as lesbians within a heterosexually biased society and health care system. Until there is a general understanding of heterosexism and heteronormativity and the affects it has on people, the quality of nursing care provided to lesbians will be inadequate.

What is most disturbing, given Stevens' (1992) comprehensive review of the nursing literature almost 15 years ago, is that very little is being done within nursing scholarship to address these concerns. Additionally, within nursing education literature, there is even less information readily available regarding the integration and intersections of various “isms” within the practice of nursing. These findings generate important questions: Where are the educational research studies designed to address nursing practice concerns regarding marginalization? Where are the discussions of teaching strategies to deliberately confront the underlying bias and prejudice in education and practice? Where are the discussions of seeing the interconnectedness between heterosexism, homophobia, racism, sexism, ableism, classism, and so forth? Why do the experiences of lesbians and the negative attitudes of nurses go unaddressed and unchallenged in both nursing education and nursing practice?

The answers to these questions are complex and not solely the responsibility of nursing educators. Until there are major changes in social, political, religious, and legal sectors of our society, heterosexism will remain a factor in the interactions between

nurses and lesbians (and possibly between lesbian nurses and their colleagues and clients, although this topic remains unexplored). Eliason and Randall (1991), Jackson (1995), and Randall (1989) point out that heterosexism is partially a result of insufficient knowledge within the discipline of nursing, and partially due to a lack of discussions between students and faculty members regarding the concerns and needs of lesbians. As Stevens and Hall (1991) point out, heterosexism is partly due to nursing's deeply entrenched roots in medicine and its history of "pathologizing" those who are seen as "different". It is also partly because of subtle and not so subtle forms of heterosexism and homophobia within nursing (Eliason, 1996a; Gray et al., 1996) and society (Pharr, 1988).

The Teaching Environment and Lesbian Content

Clearly, there is a call for educators to take the concerns and experiences of lesbians seriously (Eliason, 1996a; Eliason & Macy, 1992; Eliason & Randall, 1991; Gray et al., 1996; Randall, 1989, 1994; Zurlinden, 1997). So why is this issue so seldom addressed in nursing education and research literature? Randall (1989) provides a glimpse into the position of nursing faculty members toward lesbians. "Many nursing educators, whose behaviours and attitudes dramatically shape students' beliefs about clients and their comfort and skill in delivering nursing care, are ill informed about lesbians and hold negative attitudes toward them" (p. 305). This study of 100 nurse educators found that a substantial number of faculty members held attitudes that would make it difficult to work with lesbians or to assist nursing students in working through their own bias or prejudice. Thirty-four percent of faculty members responding in this study indicated that they found lesbian behaviour to be disgusting; 28% indicated that they would find it difficult to talk with a woman once they learned of her lesbianism; 52% held the belief that lesbianism is unnatural; 54% reported never discussing lesbian issues in the classroom; and of those who did, 60% only discussed it when a student brought it up. While this sample was limited, it is the only such research that identifies attitudes of nursing faculty members regarding lesbians, and it gives cause for concern.

With faculty members conveying such negative attitudes, it is not surprising to find similar attitudes among nursing students. Eliason and Randall (1991) found that students (N=120) were no more positive about lesbians than faculty members, reporting that 50% of nursing students believed lesbianism to be unacceptable. Similar attitudes

have been found among students of other health care disciplines such as psychology, social work, and medicine (Berkman & Zinberg, 1997; Cain, 1996; Levy, 1978; Wallick, 1997). Such attitudes help explain why lesbians seeking, or in need of, health care may be reluctant to disclose their sexuality as part of their routine interaction with health care personnel.

In my Master's thesis study (Randall, 1989), faculty members most commonly reported obtaining information about lesbians from sexuality textbooks (56%). Reviews of nursing textbooks (Jackson, 1995) as well as sexuality textbooks (Whatley, 1992), psychology textbooks (McDonald, 1981), and general health science textbooks (Newton, 1979) report a deplorable lack of lesbian content of any sort. This is further supported by the work of Deevey (1988b), Eliason (1996b), Gray and colleagues (1996), Stevens (1994a), Stevens and Hall (1988), and Zurlinden (1997) who call for accurate and vigorous support for faculty members incorporating lesbian content into their teaching. It would appear that faculty members have had limited exposure to lesbian content and are at a loss as to how to integrate lesbian material into their teaching.

The disparities between the reported experiences of lesbians and attitudes of nurses regarding lesbians, and the substantial directive of caring within nursing theory and practice, are cause for even greater concern. What is alarming and disappointing in this situation is that there has been almost complete silence regarding the findings of research or recommendations for altering practices of nurses and nurse educators toward lesbians. The pressing issue at hand is more serious than a few individuals who choose not to disclose their lesbian status to nurses or a few nurses who think that lesbians are "icky". The serious concern here is the relative silence within nursing education about the gap that exists between the stated mandate of professional nursing and the health care experiences of a significant population group.

In light of the strong evidence that lesbian health care needs are not adequately addressed, it is essential that nurse educators become leaders in addressing the attitudes of nurses towards lesbians and how they are treated. A few scholars have written about approaching the matter (Deevey, 1988b; Eliason, 1996a; Gray et al., 1996; Hall, 1994a; Richmond & McKenna, 1998; Roberts, 1985; Stevens, 1993, 1994a; White, 1979; Zurlinden, 1997). Their insights and conclusions, painful as they may be, require us to

ask what is being done within nursing to contribute to the ending of these stereotypes and mistreatments. What specific actions may be taken to integrate knowledge regarding heterosexism and homophobia into the nursing classroom? How are lesbian health care concerns and needs to be addressed in nursing education and nursing practice?

Creating Change

It became evident in talking with participants and in the analysis of the data that matters such as curricula, course content, institutional environment, policies and specific teaching strategies needed to be discussed in order to begin including lesbians and lesbian health care concerns into undergraduate nursing courses. I suggest a proactive response to the above mentioned concerns without discussing in great detail curricula, course content, institutional environment, policies, or specific strategies. I further suggest that nurses, and more specifically nurse educators, engage in a process of consciousness-raising about cultural diversity and the inclusion of lesbians and lesbian health care. They may do this by discussing concerns of heterosexism and homophobia within education, along with specific lesbian health needs and responses that they and the general public have not addressed. I would argue that this discussion most certainly belongs in the classroom where new nurses begin to encounter paradigm shifts in the process of professional socialization.

This section explores two theoretical perspectives that have influenced my thinking and development of this research project: emancipatory inquiry and feminism. A fundamental process shared by both, although not one that has been studied much, is that of consciousness-raising. I will explore consciousness-raising as a process and a method of inquiry, by means of which the effects of heterosexism and homophobia can be acknowledged, and dialogue can begin in an attempt to interrupt the related tensions experienced directly and indirectly by people regardless of their declared sexual orientation.

Emancipatory Inquiry

Emancipatory inquiries are ways of viewing the world that seek to understand oppressions in society and, through this understanding, transform it (Lather, 1986). Within this broader heading of emancipatory inquiry are a variety of similar yet slightly different focused subsets, which include: critical social theory, feminist theories, Marxist

theory, gay and lesbian liberation studies, queer theory, post-colonial movements, and social work structural theory (Stevens & Hall, 1992). Each of these is grounded in a political resistance movement and embraces an ideology that perceives society as consisting of groups that possess unequal levels of power and resources. They share a theme of emancipation through knowledge production.

Emancipatory approaches require that research be participatory and that those in positions of power and privilege be accountable for interrupting behaviour that marginalizes and perpetuates discriminatory beliefs and practices. The opportunity to explore other aspects of privilege is an essential component in what Bishop (1994) calls becoming an ally and Reagon (1983) terms coalition building. Coalitions are built through a recognition and validation of difference. An example of this can be seen in Pratt's (1984) exploration of her own identity as a privileged Southern white woman or McIntosh's (1988; 1992) work on white privilege. Pratt, Reagon, and McIntosh articulate the push-pull inherent in exploring the difficulties of coming to terms with the benefits of privilege and simultaneously being aware of the rage associated with oppression.

The goal of emancipatory inquiry is social change (Lather, 1986; Skillings, 1992). Emancipatory inquiry looks at the ways that dominant groups within society use various forms of social, political, and ideological power to create and maintain positions of privilege (Moreau, 1990). More specifically, emancipatory inquiry examines the forces of oppression and the interrelated factors of class, age, sex, race, sexual orientation, and physical or mental abilities (Adamson, Briskin, & McPhail, 1988; Carniol, 1992). Emancipatory theorists have proposed interventions explicitly aimed at improving the situations of marginalized individuals and groups (Findlay, 1991; Freire, 1997; MacKinnon, 1982; McLaren, 1996).

To explain in more detail how social relations of inequality are maintained, emancipatory inquiry describes the consequences that stem from the experience of being dominated by those in power. Emancipatory theory is descriptive in the sense that it offers a framework from which unequal relations in society can be understood in social, political, and psychological terms. In addition, this theory is prescriptive as it actively seeks to improve the situations of those who are experiencing oppression. Further, emancipatory inquiry advocates for political, social, legislative, and ideological change in

order to “transform the conditions and social structures that cause...negative effects” (Mullaly, 1993, p. 125).

While emancipatory inquiry offers a valuable framework from which to support people who experience oppressive conditions, less emphasis has been given to the development of interventions that create personal and political awareness among those in positions of privilege. This oversight is important to address, as socio-political change is often resisted by individuals and groups who are either unaware of their power over others, or who are unwilling to lose certain benefits. From an emancipatory perspective, nurse educators can gain a greater understanding of ways in which the experience of heterosexual privilege influences people’s perceptions of themselves and others. “Individually, each of us can act towards creating a future free of heterosexism” (Livingston, 1996, p. 20). This research study asks the privileged within nursing, the nurse educators, to take such a step; to act in ways that begins to create a future within nursing that is free of heterosexism.

Engagement with emancipatory education has various names. hooks (1994) calls it *engaged pedagogy* whereby “teachers must be actively committed to a process of self-actualization that promotes their own well being if they are to teach in a manner that empowers students” (p. 15). Freire (1997) called it *liberatory education* and suggested that teachers and students are co-responsible for education and its outcome. Freire advocated methods that involve dialogue and problem posing, where teaching is done “from the inside out, by the [students] themselves, with the collaboration of the educator” (p. 48). As Freire explained, “the educator’s role is fundamentally to enter into dialogue with the [students] about concrete situations and simply offer [them] the instruments with which [they] can teach [themselves]” (p. 48).

In nursing, some scholars have referred to this emancipatory, focused education as the “curriculum revolution” (Allen, 1990; Bevis & Murray, 1990; Bevis & Watson, 1989; Clayton, 1989; de Tornyay, 1990; Diekelmann, 1988; Munhall, 1988; Rentschler & Spegman, 1996; Tanner, 1990b). Regardless of what it is called, the focus is on teaching (both the delivery and the content) that is congruent with a philosophy of emancipation where teacher and student are actively engaged in life. “When what actually occurs between and among teachers and students becomes curriculum, then the emphasis shifts

from the objectives...to teaching/learning, which is the living curriculum” (Bevis & Murray, 1990, p. 326). Education in the form of schooling then is not mere preparation for life: it *is* life. Although how this is done exactly has not been clearly identified by nursing education scholars, it likely happens through the way in which teachers teach.

Feminisms

Feminist theory is a “worldview that values women and confronts systematic injustices based on gender” (Chinn & Wheeler, 1985, p. 74). Numerous scholars have tried without complete success to capture the essence of what feminism is and thereby what feminist research addresses. “It is well to remember that feminist research is highly diverse...Moreover, even within the same wings of feminist research...there are disagreements on issues” (Olesen, 2000, p. 216). Due to the depth and diversity of feminist thought, it is probably more accurate to speak of a plurality of feminisms and types of feminist research. Because there is ongoing debate within feminist literature regarding the various subsets of feminism, I sought to capture a general understanding of feminism rather than a narrowed definition. Therefore, for this study I used the work of Bricker-Jenkins and Hooyman (1986) to capture what most feminists have accepted as a broad generalization of what feminism is. Bricker-Jenkins and Hooyman (1986) identify the following broad ideological themes that feminists agree are embraced by feminisms. These include:

- emphasizing the ending of patriarchy as a societal social structure, whereby men as a class have power over women and how society is structured
- structuring relationships to be egalitarian and re-conceptualizing power as limitless, collective, and interactive; a central tenet within egalitarian relationships is empowerment
- seeing process not as a means to an end, but rather as the product itself; the end is the means; feminist processes enact feminism as a way of being and coming to understand the world
- viewing the personal as political; seeing the political nature of one’s actions and the importance of connecting action to structural change within society
- valuing unity and diversity; feminists emphasize the need for community and solidarity while simultaneously respecting differences

- accepting the existence of multiple realities, recognizing the subjective and contextual nature of human experience and valuing non-linear, multi-dimensional thinking
- recognizing that the transformation of societal structures requires a process of consciousness-raising about the hegemony that constrains all of society; this process involves a praxis whereby liberation occurs through people's own actions (pp. 9-20).

These ideological themes are picked up within a general discussion found in the methodology chapter, where I discuss the eclectic design of the study. Feminist principles informed every aspect of this research from the conception through the dissemination of the findings.

Addressing Homophobia and Heterosexism in the Classroom

Over the past 20 years, a small and vigilant group of nurse researchers has been addressing issues of importance to lesbians and gay men within health care. Roberts (1985), a public health nurse, states that "homophobia, or fear of homosexuality, is one of the most pervasive forces that can influence the health care of the gay community" (p. 683). She argues that homophobia is based on three factors: (a) insecurity about one's own sexuality or gender identity; (b) strong religious indoctrination; and (c) lack of knowledge. This is similar to an earlier study by White (1979) that concluded that education and religious beliefs affect heterosexual nurses' attitudes toward homosexual clients. Heterosexism and homophobia are learned responses (Lipkin, 1999) and as such can be unlearned or learned differently.

Critical and progressive educators (hooks, 1994; McLaren, 1995; Palmer, 1998) agree that the classroom is the place for exploration. Some find this a radical notion, and hooks (1994) in her book, *Teaching to Transgress*, writes:

The classroom remains the most radical space of possibility in the academy. ... Urging all of us to open our minds and hearts so that we can know beyond the boundaries of what is acceptable, so that we can think and rethink, so that we can create new visions, I celebrate teaching that enables transgressions—a movement against and beyond boundaries. It is that movement which makes education the practice of freedom. (p. 12)

hooks suggests that the classroom is an ideal location for exploring and gaining insight into one's own experiences and those of others. Asking how homophobia and heterosexism are experienced by others and how educators might go about participating in interrupting their consequences would be one way nurse educators could begin an exploration of these issues and raise students' consciousness about homophobia and heterosexism.

If nurse educators were to embrace hooks' declaration of radical space within the classroom, then it would be quite appropriate to have discussions (Knoedler & Shea, 1992), even heated debate, about how best to explore assumptions, values, beliefs, or differences (Wadsworth, 1992) among and between nurses, clients, and others who interact within the health care system. This would allow understanding of how those on the margins experience health care and how practitioners can learn to be more empathic and understanding rather than contributing to the distrust and negative milieu.

A discussion of heterosexism and homophobia tends to fall into a generalized discussion of various "isms", all of which are of serious concern within nursing practice and education. It would be important to begin such a discussion by establishing a general understanding of the terminology. This could be followed by an overview of issues that has been well studied in the literature:

1. How lesbians have been included/excluded within society historically (Faderman, 1994; Heger, 1980; Katz, 1983; Roscoe, 1988a, 1988b)
2. How medicine has, until very recently, pathologized homosexuality (Bailey, 1995; Stein, 1993; Terry, 1999)
3. Ways in which the current social, political, and health care systems perpetuate and challenge notions of heterosexism (Deevey, 2000; Hall et al., 1994; Pharr, 1988; Stevens, 1994b)
4. Ways in which the denial of heterosexual privilege keeps us from recognizing, acknowledging, lessening, or ending heterosexism and homophobia (Pharr, 1988).

This view of the classroom as a radical place may be seen to be at variance with the reality of most nurse educators' places of work. Before such radical discussions can take place, consciousness-raising may be needed to interrupt the silent acceptance of the present heterosexist and often homophobic teaching and learning environment.

Consciousness-Raising

Few authors have focused attention on heterosexism and homophobia within nursing education. Gray and colleagues (1996) challenged nurse educators to examine their positions: "We must address ways in which heterosexism pervades and limits our curriculum, our ways of thinking, our language, and our research" (p. 210). Zurlinden (1997) addresses ways in which faculty members can be supportive of lesbian and gay nursing students. Eliason (1996a) provides in her book, *Institutional Barriers to Health Care for Lesbian, Gay, & Bisexual Persons*, a chapter entitled, "Making health care safe and inclusive", wherein she provides concrete examples of exercises that health care providers might want to explore in coming to understand the experiences of lesbians and gay men and their responses to pervasive heterosexism within our society. These exercises could easily be adapted to the nursing classroom. However, none of these authors focus primarily on the actions of nursing faculty or on their perpetuations or interpretations of heterosexism. Neither do they focus on nursing educators' abilities to directly impact the heteronormativity of nursing curricula or the "tacit" heterosexism brought to the classroom by students or faculty members alike. What is missing from these works is a discussion of the fundamental need for consciousness-raising around the inclusion of lesbian content and lesbian health care concerns in nursing practice and education. Such a consciousness-raising process would make an important contribution to the practice and education of nurses.

Consciousness-raising is both a process that individuals move through as they become aware of the world around them, and a theoretical framework that can guide the actions of emancipatory education and nursing practice. Consciousness-raising has been an integral part of the feminist movement from its inception (Abarbanell & Perl, 1979). Born in the late 1960s, consciousness-raising was foundational in raising the political and social self-awareness of women in North America (Abarbanell & Perl). Feminist consciousness-raising focuses on power imbalances based on gender and the experiences of women (Donovan, 1987; Jaggar, 1983). The process of consciousness-raising discussions among feminists was (and continues to be) a tremendous step in bringing about awareness of women's understanding of themselves and each other. The

consciousness-raising movement of the 1970s “called on its participants to act, speak out, and grow up” (Faludi, 1991).

At its core, consciousness-raising is a method of seeking and producing knowledge (Henderson, 1995a). Knowledge obtained through consciousness-raising can create paradigm shifts, much like the radical shifts that Kuhn (1991) addresses in traditional science. Once a scientist moves outside the "old" paradigm and into a new space of understanding and questioning, the old way of approaching problems becomes impossible to recreate. There has been a shift in how one sees problems, how one approaches problems and in how one goes about trying to solve these problems. Consciousness-raising allows an individual to think and thereby act differently through coming to understand another's experience in the world. This generally occurs through one's interactions with others. It is my assertion that this would be true for consciousness-raising regarding lesbians and lesbian health care content within nursing education.

The general idea of consciousness-raising is not new. An early example is found in the activity of Socrates' assisting people to recognize the limits of human wisdom (Gardner, 1996). It has always been the business of philosophers, artists, reformers, and teachers to develop society's sense of awareness, and to make us more fully conscious of matters we are inclined to take for granted. The contemporary influence of the concept, however, is undoubtedly due, in part, to the work of feminists of the mid-twentieth century who saw a fundamental link between the personal and the political (Felski, 1991). It is also due to the work of Freire (1997) who used the term “conscientizacao” to mean the process used to raise one's consciousness to action. Both feminist and Freireian consciousness-raising lead to an awareness of those in power and the effects of domination, and to an exploration of what actions might be taken to create not only a change in thinking but also a change in behaviour.

To explain further what consciousness-raising means, two stories outside nursing practice provide helpful insight. The first story describes a consciousness-raising experience where the "group" is quite informal and broadly defined, and the second shows the effects of a formal consciousness-raising group on an individual and in less detail on the entire group.

Freire (1994), renowned for his work on understanding oppression, tells a story in his book, *Pedagogy of Hope*, of his own consciousness being raised. Assisted by numerous women who engaged him verbally and in writing regarding his “sexist, and therefore discriminatory, language, in which women had no place” (p. 66), he comes to understand this exclusion to be the result of learning a language steeped in male and female gendered terms (an example of institutionalized sexism and patriarchy) and his socialization in what it means to be a man within his culture. He concludes in re-telling this story, that

discrimination against women, expressed and committed by sexist discourse, and enfolded in concrete practices, is a colonial way of treating them, and therefore incompatible with any progressive position, regardless of whether the person taking the position be a woman or a man. (p. 67)

Freire describes the results of his consciousness being raised as a shift in his internal paradigms resulting in a radical change in his thinking and, more significantly, in his behaviours. This was important to him, not because this new view pleased women, but because it was consistent with the world that he wanted to create.

Pharr (1988) tells another story of consciousness-raising in her book, *Homophobia: A Weapon of Sexism*. In it, she describes her experience within a feminist group:

After I had attended two sessions...I realized that this experience was one of the most important that had ever happened to me, a time of transformation, and that if I was going to talk about my life, then I had to talk about my life, my whole and real life. Nervous and extremely fearful yet excited, I went to the third session and said openly at age 30, for the first time in my life, I have to tell you something. "I am a lesbian." And those good women gave the response that set me on the path to finding my freedom: "Tell us what that is like". (p. xv)

What a profound statement these women offered! From reading various excerpts from research studies of lesbian experiences, such a comment would have been most welcomed if any nurse had said with such interest and acceptance, "Tell me what that is like for you". Nurse educators need to bring nursing students to a place where they are able to explore with sincere interest and acceptance, “tell me what that is like for you”.

In both of these examples, the individuals sharing their stories have been irrevocably changed. Each has been able to step outside her or his individual comfort

zone of knowing to ask what life is like for another. Each has come to understand that the old ways of being in the world do not always facilitate the kinds of interactions that lead to understanding of another's experience. Like the above women, nurses need to be able to step outside their comfort zone of knowing and ask what life is like for another. They need to gain understanding and appreciation for another woman's lived experience rather than assume they know about her experiences from their own lives. Additionally, nurses, like Pharr, need to realize early on that the only way to understand another's experience is through the sharing of it.

Shulman's (1982) record of early consciousness-raising sessions gives a valuable insight into the consciousness-raising process.

Early consciousness-raising sessions were really fact-gathering sessions, research sessions on our feelings. We wanted to get at the truth about how women felt, how we viewed our lives, what was done to us, and how we functioned in the world. Not how we were supposed to feel but how we really did feel. This knowledge, gained through honest examination of our personal experiences, we would pool to help us figure out how to change the situation of women. (p. 33)

MacKinnon (1982) argues that

women's distinctive experience as women occurs within that sphere that has been socially lived as the personal, so that what it is to know the politics of woman's situation is to know women's personal lives...Through consciousness-raising, women grasp the collective reality of women's condition from within the perspective of that experience, not from outside it. (p. 18)

Consciousness-raising is simultaneously a process of expanding awareness and insight and a method by which this process may occur. Hare (1986) suggests that consciousness-raising is more the name of an intended outcome than the description of a specific method. Allen (1985) describes the experience of consciousness-raising as "experienced literally as an epiphany, a revelation, a paradigm shift that comes not from a divine source but from the consensual reflection and analysis... there is no dichotomy between theory and practice, fact and value" (p. 63). Cheek and Rudge (1994) write of the consciousness-raising process as one in which

the personal is transcended and women were able to recognize the effect that patriarchal structures had on their everyday reality. The issues that were generated were then able to form the basis for political action to redress the inequalities and injustices that women identified. (p. 59)

“The process is transformative...the pursuit of consciousness becomes a form of political practice” (MacKinnon, 1982, pp. 21-22). Consciousness-raising affords the potential for shared concerns to enter the public domain, to become visible and acted upon as a political action.

Students...are typically unaware of how oppressive ideologies function through them in their work with clients. Consciousness-raising is the mechanism by which these ideologies and their impact on the individual are brought into awareness, and consciousness-raising should be an essential element in training mental health worker[s] regarding issues of diversity. (Leonard, 1996, p. 91)

This reasoning would apply to nursing education as well. Cheek and Rudge (1994) claim consciousness-raising, “in exposing the unsaid, the invisible and the hitherto unacknowledged, is the first step in a process that allows for the development of the capacity to resist oppressive social expectations” (p. 60). In application to my research, the use of consciousness-raising, both as method and process, allowed nurse educators to explore the effects of heterosexism and, in some cases, homophobia, to generate discussion, and begin to recognize the rippling effects of their silence in maintaining heterosexual privilege.

Henderson (1997) has been instrumental within nursing scholarship in incorporating consciousness-raising as a nursing action. She defines consciousness-raising as a:

process of increasing the state or quality of being aware, particularly as it applies to issues of personal and political freedom...Consciousness-raising has been presented as an ideal method of applying feminist principles (such as nonhierarchical power relations and linking the personal and political) to emancipatory nursing practice. (p. 158)

Henderson describes this process as occurring in a "tripartite, overlapping experience of enlightenment, empowerment, and emancipation" (p. 160).

Stevens and Hall (1992) suggest that nurses take a stand against oppressive conditions that damage health, engage in critical dialogue with communities, and act within communities for change. They embrace the need for nurses to have their consciousness raised regarding the bigger picture of what is involved in improving health care for all people. Critical and feminist theorists agree on the fundamental emancipatory purpose of higher education (hooks, 1994; Lather, 1991b; McLaren, 1995; Palmer, 1998).

To date, there is little direct and deliberate application of consciousness-raising within nursing literature or within nursing education. Hagedorn (1995) describes the use of consciousness-raising within an action research study where a group of young women came together to discuss their experiences of menarche. Henderson (1995b) describes her use of consciousness-raising within an action research study focused on working with women in a drug treatment program, and where she comes to understand moments of racism within her own actions as a nurse. In this research, consciousness-raising is addressed in two ways, both as a method and as a process. The agreement of participants to include lesbians and lesbian health care concerns can be viewed as a means of consciousness-raising, and, in turn, the development of strategies for inclusion in the learning environments can be viewed as a method. The process and the method aspects of consciousness-raising can be seen within the individual and group discussions regarding their reflections and experiences in the study.

The oppressor within. Henderson (1997) asks a most insightful question and one that must be addressed by all participating in emancipatory types of research, “How does consciousness-raising occur when the oppressor is located not outside the group, but within the group, within ourselves?” (pp. 166-167). Similarly, Lorde (1984) writes of her coming to consciousness of the oppressor within: “For we have, built into all of us, old blueprints of expectation and response, old structures of oppression, and these must be altered at the same time as we alter the living conditions which are the result of those structures” (p. 123). Indeed, how does consciousness-raising occur when the very nature of the awareness needs to come from inside one’s self? As with other social assumptions, individuals are often socialized so completely that they do not even notice their assumptions. In the case of heterosexuality, it is assumed to be the normal, natural, and the only way of relating to others. Henderson said the following in coming to understand the issue of race, but her words could be used about heterosexism as well: “I found my consciousness raised as I encountered my own assumptions about race and class and my difficulty in admitting to or letting go of those assumptions” (p. 167).

In early consciousness-raising experiences, women became aware of the oppression experienced by women as a class. In sharp contrast to this, the focus of consciousness-raising in this research project sought to shift the focus of nurse educators

away from self-identification as an oppressed group and toward one of coming to understand the ways in which they, nurse educators, perpetuate heterosexism, becoming in essence the oppressor. At the same time, this research offered them an opportunity to interrupt this process through inclusion of lesbian content in their teaching.

Conclusion

Nursing has legal, ethical, and practical directives to address health care concerns of lesbians, yet research findings indicate that lesbians are not being provided the quality of care that is so valued within the profession of nursing. Questions have been raised regarding what nursing education is doing in response to these concerns. I have shown that there is a deplorable lack of information and articulated strategies readily available for nurse educators and students to begin addressing the problem of the marginalization of lesbians due to heterosexism.

In developing a way to address the concerns resulting from heterosexism and homophobia within nursing, this research project draws on the strength of the process of socialization of nurses within education. I assert that through consciousness-raising it is possible for nurse educators to interrupt heterosexism and to have an impact on how nurses provide care and thus provide better quality of care to all women, not just lesbians. As part of the socialization process that occurs within any profession, it is possible for nurse educators to create an environment that reinforces the principles of the various feminisms and an emancipatory approach to providing care. This environment can have a profound effect on students and how they, in turn, view their provision of care.

In suggesting that nurse educators begin exploring their personal beliefs and values as well as challenging the underlying institutionalized heterosexism present in health care, I also suggest that the classroom is an ideal location for this exploration to begin. The foundations of nursing practice demand such changes of nurse educators, and the classroom offers us a suitable place for discussions that can explore both the consequences of and the solutions to the immobilizing grip of heterosexism.

I further suggest that through the use of consciousness-raising, both faculty members and students can have the opportunity to explore their positions and values, and create an opportunity for constructive discussion about how to approach various differences among people. By coming to understand the impact of heterosexism on

individuals' beliefs and values, as well as health care practices, nurse educators might be able to welcome the challenge of coalition building across differences rather than following the current trends of silence, assumptions, and misunderstandings. This change requires nurse educators to learn to investigate differences with a welcoming curiosity rather than fear. Nursing should welcome the dismantling of our silencing walls and the advent of a climate in which a nurse is likely to ask with openness, sincerity, curiosity, respect, and genuine interest, "Tell me what that is like for you".

The nature of this research is not to measure outcomes among students, but to understand the experiences of nurse educators as they actively engage in their own consciousness-raising and the enactment of an aspect of emancipatory education. Through this knowledge development, nurse educators can gain greater understanding of how and why nursing faculty members can and need to engage in teaching/learning activities that promote understanding of lesbians, lesbian health care concerns, and discussions of heterosexism, homophobia, and privilege. The next chapter will provide details of the methodology guiding the research.

CHAPTER THREE: METHODOLOGY

In this chapter, I explore the personal perspectives, theory, and methodology of what were evolving approaches during the conception and design of this research. The idea for the research was rooted in my education and personal experiences. The methodology was conceived and developed through the “lenses” of feminisms, emancipatory inquiry, and consciousness-raising, which have been discussed in detail in the previous chapter. These lenses focused and informed all aspects of the research process from initial identification of the problem, through the literature search and encounters with individuals during data collection, to the data analysis and dissemination of the interpretations.

The Genesis of My Personal Perspectives on Nursing Education

Nurses in general, and nurse educators in particular, have a mandate to provide ethical caring. In order to meet this mandate it is evident that an improvement is required within nursing education regarding health care of individuals whose orientation is not heterosexual. The purpose of this study was to explore the experiences of nurse educators as they deliberately included lesbian content within their teaching. In designing this study, I was committed to do more than add to the nursing literature that identifies poor conditions or prejudices where lesbians are concerned. I sought to interrupt an aspect of current nursing education practice of side-stepping or silencing the topic of lesbians within nursing education that I have experienced as a student and a faculty member over the past 25 years. Rather than working within the marginalized group, lesbians, I decided to take a different approach and work with a group who might be considered the privileged group—nursing faculty. I wanted to work with those who could directly change the *status quo* within nursing education—the teachers within undergraduate nursing programs—and thereby have a ripple effect on those who will become nurses and who in turn will have contact with lesbians seeking health care.

I give credit to my initial experiences within a hospital nursing program for this perspective. My initial introduction to nursing was through attendance at Lutheran Hospital School of Nursing, Fort Wayne, IN, from 1976 to 1979. At that time, hospital

schools of nursing in general were known to be institutions of “doctors are always right,” rule-following, hierarchical structures, and being told what to do and when to do it (Ashley, 1976; Reverby, 1987). Thinking was not always valued or appreciated, especially when this led to questions that challenged the *status quo*. During the three years of my initial nursing program, I was provided an exceptional education, which in retrospect seems out of character for the reputation of hospital schools. I learned more than nursing skills. I learned about the cutting edge of change, the power of the collective whole, and the inherent strength within women. During my initial education within the profession, most nurse educators were returning to institutes of higher education to complete masters and doctoral studies. At the time, I was unaware of the significant contribution this would have on my own understandings of becoming a nurse. I was exposed to an incredibly insightful feminist nursing scholar, Jo Ann Ashley, through her work, *Hospitals, Paternalism, and the Role of the Nurse* (1976). Ashley’s commitment to questioning the *status quo*, not only within nursing, but also in society as a whole, continues to challenge my own understanding of what it means to be a nurse.

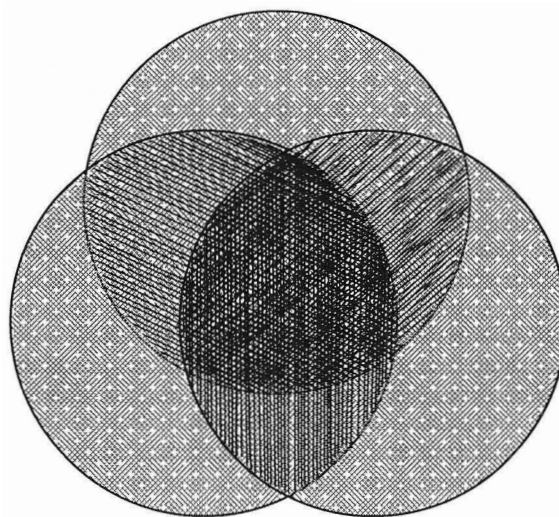
We nurses need to begin making astute observations about what is wrong with our society. We need to set our sights on correcting some, if not all, of these wrongs. We need to begin shaping ourselves and our destiny. We need to begin the slow and tedious process of creating a different kind of society, a society fit for humans to live in freely with a minimum of psychological, social, and physical distress. We cannot eliminate all distress, but we should at least prevent that distress which can easily be prevented by professional nursing care. (Ashley, cited in Wolf, 1997, p. 71)

Basis for Development of an Eclectic Design

In beginning to design a specific research study, I explored numerous options and ideas. Baker, Wuest, and Stern (1992) cautions researchers against “slurring methodologies” and I started this project looking to use one design. Soon after beginning, I realized that any one method I considered using became too limiting and, in some critical way, inadequate for the knowledge being explored in this study. It became evident early in the development of the research design that an eclectic approach was necessary to explore the experiences of nursing faculty members who were asked to include lesbian content within the courses they were teaching. In exploring various particular methods, I was repeatedly confronted by limitations and assumptions that

hindered the research design. These limitations and assumptions tended to direct the research away from my areas of interest and the concerns that I wished the study to address. Mostly this had to do with the fact that very little teaching was being done about lesbians and lesbian health care concerns within nursing education. Whenever I made a decision to adopt a specific approach, it became obvious that the method changed the very nature of the research. It was tempting at various times during the development of this study to give up on pursuing this eclectic form of research and follow the “rules” of one specific design. However, it seemed impossible for a project of this type to follow a single set of prescribed rules since it was specifically addressing areas not previously explored within nursing literature. The research design required a fusion of various approaches to stay focused on emancipatory ideals through the exploration of those who have privilege within the education system—the faculty—while engaging in a liberating intervention consisting of including lesbian content within undergraduate nursing courses. Thus, because numerous ideas and research methods have influenced the development of this research, it is not possible to succinctly label a specific type of research design.

This research embraced the lenses of feminism, emancipatory inquiry, and consciousness-raising. Each of these lenses has contributed to the overall view of nursing faculty when they deliberately include lesbian content within nursing courses. This might be depicted in the following way:



The intersection of these three circles, the darkest shaded area, is the refractive part of these combined lenses and it is this space, or focus, that is explored within this research. Each of these lenses provides clarity for one aspect that is being examined. It is similar to the ophthalmologist asking “is this clearer (click of the lens being changed), or this one?” As you look at the letters on the wall, one can only see clearly when a particular combination of lenses is applied. In this research, if you were to place any of these lenses in the background or foreground, or use different lenses, it would alter the view in such a way that clarity of one aspect would be compromised while something else would be the focus.

The eclectic design created for this research required special care and argument by the researcher to ensure methodological rigour and credibility. Baker and colleagues (1992) make it clear that while blurring boundaries may be necessary to achieve the researcher’s goals, it necessitates the researcher doing additional work to explain and highlight the process and “decision tree” used along the way, as well as the findings and conclusions. This need for additional explaining and highlighting of the process is consistent with the emergent design that Tom (1996) explores:

Research plans must change if the research is going to be effective and relevant. It is therefore essential that researchers learn how to change research strategies, while continuing to honor their research intentions. Reflecting on how decisions were made and plans were changed supports that goal. (p. 347)

The research used an emergent qualitative design (Marshall & Rossman, 1995; Tom, 1996) incorporating underpinnings of feminism (Bricker-Jenkins & Hooyman, 1986; Fonow & Cook, 1991; Lather, 1991a) and emancipatory philosophies (Harden, 1996; Heron & Reason, 1997; McLaren, 1996; Reason, 1994c). Three qualitative methods comprised the design:

1. Group interviews (Fontana & Frey, 1997; Marshall & Rossman, 1995)
2. Individual interviews (Fontana & Frey, 1997; Marshall & Rossman, 1995)
3. Limited participatory observation (Marshall & Rossman, 1995)

In addition, a derivation of feminist action research (Reinharz, 1992; Reinharz & Davidman, 1992) and emancipatory research (Hart & Bond, 1995; Reason, 1994c; Streubert & Carpenter, 1999) was used. This research also embraces aspects of feminist

participatory action research (Boutilier, Mason, & Rootman, 1997; Henderson, 1995a; Reinharz & Davidman, 1992).

In describing the research design so that others may understand what to expect from this research, it relies heavily on descriptive, ethnographic methods (Tedlock, 2000), and participatory inquiry (Boutilier et al., 1997; Hall, 1992; Reason, 1994a; Reason, 1994b, 1994c). Additionally, the underlying philosophies of feminism (Bricker-Jenkins & Hooyman, 1986; Reinharz & Davidman, 1992) and emancipatory inquiry (Heron, 1996; Heron & Reason, 1997) have heavily influenced my thinking and approach.

Action Research

Boutilier and colleagues (1997) describe three types of action research: technical, practice-based, and participatory. The primary differences between these are the degree to which insiders or outsiders have primary control of the research. Boutilier and colleagues describes practice-based action research as recognizing the:

knowledge and accumulated wisdom of the participants regarding their own practice. Practice based action research is often found in education settings, focusing on teaching practice. Intended to improve practice through considered reflection and personal insight, the process may or may not be facilitated by a researcher. The resultant changes occur within individual practitioners, rather than at the organizational level. (p. 72)

In regards to power—that is, who has it and who gets to exercise it—the focus is located with “the facilitator [who] works with [the] group to illuminate what is known in practice; decision-making lies within the group” (Boutilier, et al., 1997, p. 72). In the present research project, decision-making lay primarily with me as the investigator. My goals and values include “improvement of practice and application of participants’ personal wisdom” (p. 72). While participatory involvement is highlighted in the strategies chosen and created by the participants, other aspects of this research project are very much within the control of the researcher alone. These include the overall design of the study, the criteria used to select participants, the analysis of the data and, ultimately, the need to tailor the research in such a way as to meet doctoral requirements at the University of Victoria.

In light of these considerations the use of the term “participatory action research” in this case is limited since I, as researcher, have identified the problem to be addressed in the research; asked the overview research questions; designed the open-ended comments, prompts, and questions to be incorporated into the interviews; selected the time and place for the focus groups; had a major leadership role in the focus groups unfolding; and conducted the analysis of the data and write up of the findings. Additionally, I have been solely responsible for any papers or conference presentations regarding the outcomes to this research.

While I have been amenable to participants coming forward and suggesting additional research, presentations, or articles based on this work, this has not happened. The bottom line in this process is that I am responsible and accountable for this research and for using it as a partial requirement in meeting the expectations for my doctoral degree. This differs from true participatory research in which the group process and involvement is highlighted as pivotal in the overall research (Boutilier et al., 1997; Hart & Bond, 1996; Reason, 1994a).

In spite of, or more accurately, because of the control and limitations inherent in feminist, action, and emancipatory philosophies, an emergent design was embraced. Throughout the research, decisions were made that altered the course of the research. It was my intention to make these decisions as transparent as possible, be responsive to, and incorporate input and opinions of participants throughout the entire process and reporting of the project. A detailed record was kept so that I could readily and easily recall both the decisions and the rationales for paths taken, changes made, and alterations in my thinking as I recounted the findings.

Implementation-Further Methodological Implications of the Theoretical Lens

The adoption of feminist, emancipatory, and consciousness-raising lenses carries specific implications for the way research is carried out. These implications arise within the larger context of attempting to break free from the confines of traditional patriarchal science. Feminist critiques of traditional science have objected to the demand that science be neutral and objective, with a clear distinction between researcher and subject (Fonow & Cook, 1990; King, 1994; Reinharz & Davidman, 1992). Several key methodological

implications arising from this theoretical lens merit further explication including non-hierarchical relationships, reciprocity, intersubjectivity, reflexivity, and praxis.

Non-hierarchical Relationships

Non-hierarchical relationships are a key tenet within Bricker-Jenkins' and Hooyman's (1986) definition of feminism. In an effort to overcome the power imbalances inherently present in most research, I have attempted to establish close, nonhierarchical relationships with the nurse educators who participated. Reciprocity, relations of respect and partnership, reduction of barriers to participation in research, honesty, openness, and clarity of communication are some avenues toward such nonhierarchical relationships (Campbell & Bunting, 1991; Hall & Stevens, 1991; Reinhartz & Davidman, 1992). It must also be acknowledged that many participants were my colleagues and peers, although some have greater academic standing. Our shared experiences as nurse educators provided the group of participants a common ground for coming together within a collegial atmosphere.

Despite these commonalities, it also was important to leave room for the possibility of differences among and between the participants. These could have, and in some cases did include: academic rank, sexual orientation, age, able-bodiedness, gender, race, nationality, ethnicity, or health challenge(s). In light of this, I was vigilant in identifying my assumptions and exploring what all participants meant when sharing their stories with me, rather than assuming I understood because of our similarities. Additionally, I acknowledged my role and responsibility as researcher and facilitator of the overall project. I have determined the overall design of the research and I reap the benefit of submitting the process and findings as my doctoral dissertation.

Reciprocity

During the course of each encounter with participants, I worked toward ensuring an interaction that was both reciprocal and dialectical. Feminist scholars such as Oakley (1981) emphasize the importance of a dialogic rather than hierarchical interaction. Lather (1991a) also emphasizes the dialogic, give-and-take nature of reciprocity as a "mutual negotiation between meaning and power" (p. 57). In this way, reciprocity acts as a link between the researcher and participants and between data and theory. Influenced by Oakley and Lather, I used several strategies to promote and encourage reciprocity. These

included engaging in an interactive dialogic manner that included self-disclosure; providing \$10 to each participant for parking and transportation expenses they accrued in attending the initial group meeting and the focus group; and offering to provide a skilled childcare provider to provide on-site childcare. (this service was not requested by any of the participants, although two mentioned that it was appreciated). Refreshments were provided at group and individual meetings (Vaughn, Schumm, & Sinagub, 1996), which added to the generous and friendly atmosphere conducive to conversation, and refreshed the participants who were making time for these interviews within very busy, full teaching and personal schedules.

Perhaps even more significant, reciprocity was witnessed through an exchange of ideas among participants as well as between me and the participants. It has been my experience as a nurse educator that little formal time is devoted to discussions of teaching strategies and the telling of our stories. And yet, when it does occur, the discussion is rich and it is time well spent. This research experience offered participants an opportunity to share their ideas and experiences among peers, while at the same time offering them an opportunity to engage in emancipatory education.

Intersubjectivity

Intersubjectivity was also described in the literature review as a significant tenet of feminism (Bricker-Jenkins & Hooyman, 1986). I acknowledged the epistemological implications of my own position as researcher (for example, my location, my personal experiences, and the context of this research) in shaping knowledge construction. Hence, I understand knowledge as relational and contextual. In putting this understanding into practice, I have struggled to reject traditional science's rigid dichotomy between researcher and researched (Campbell & Bunting, 1991; Fonow & Cook, 1990; Reinhartz & Davidman, 1992).

Reflectivity

In order to accomplish non-hierarchical relationships, a high degree of reflectivity was required of the researcher, which involved examination of values, characteristics, and motivations to see how they affected all aspects of research (Anderson, 1991; Hall & Stevens, 1991). The insights derived from this reflective approach were incorporated into the data of the study (Dyck, Lynam, & Anderson, 1995). I kept a detailed journal of my

own experiences of consciousness-raising during this research, and the overall experience of engaging with peers within a research project. Additionally, I was in frequent contact with my supervisor, committee members, and two other PhD-prepared nurse scholars, both of whom identify as lesbians. Following discussions with these advisors, I would often write journal entries about our talks and would later e-mail or talk again to follow-up on my reflections. These discussions were most valuable in challenging my thinking and helping me convey my ideas in written form.

Praxis

The explicit aim of this research was constructing transformative knowledge and bringing about social change (Reinharz & Davidman, 1992; Thomas, 1993). Within this project of social change, the powers of agency, resistance, and subjectivity are necessary components of the socially transformative struggle (Lather, 1991a). In light of the emancipatory and social changes sought through this implementation, there has been a ripple effect. Others have heard of this research along my journey from conception to dissertation writing and have been impacted in many ways: asking for articles, discussing ways to alter scenarios/case studies, or questioning why they had not previously thought to include lesbians and lesbian health care concerns in their teaching. And while these developments have not been specifically documented within this dissertation, they do speak to the success that a project of social change can have on those directly involved within the research, and perhaps even more profoundly on those who hear about it and choose to act.

Research Design—Structure of the Study

Feminist aspects of the design of this study addressed issues of equality, marginalization, access, and consciousness-raising. Action and participatory research involvement were included in the research design by asking participants to specifically and deliberately include lesbian content within nursing courses, while at the same time acknowledging their teaching expertise. Thus, participants became co-creators of the interventions. The study had at its core the potential, if not the expectation, for emancipatory outcomes.

Throughout this project, Bricker-Jenkins and Hooyman's work (1986) guided my understanding of feminism, informing and directing my actions, the questions asked or

prompts given, the information gleaned, and the interpretation of the data. These ideas underlie much of the need to interconnect the ideologies of emancipatory education, feminisms, nursing education and consciousness-raising that are foundational to this research project. For example, the idea of liberation is key to feminism as well as emancipatory action. Hamlin, Loukas, Froehlich, and MacRae (1992) tie feminism to liberation by suggesting that feminism has developed into an inclusive model of liberation for everyone, although particular attention is given to the status of women. In this context, research into the particular experience of lesbians and liberation from heterosexist or homophobic bias within society may be viewed as one part of feminist research.

Feminist participatory research attempts to uncover oppression and express the realities of women via dialogue between the researcher and the participants. Within this non-hierarchical relationship, there is the assumption that the participant has experience and knowledge to share and is capable of critical reflection and analysis. Thus, this research project, which included participants' actions, their reflections, the individual interviews, and group discussions that focused on the participants' inclusion of lesbian content in their courses, was representative of emancipatory feminist action research. Feminism also affects the following aspects of the research design:

1. The choice of approach and types of statements or prompts that I asked. In approaching this research, the kinds of prompts or questions asked focused on concerns of those with a degree of privilege, nurse educators, and ways in which the standpoint of myself, as researcher, intersected. Within my teaching and practice of nursing, as well as my neophyte researcher role, I have been greatly impacted by the fact I am an "out" lesbian. This has led me to understand certain things about heterosexism and homophobia within the teaching of nursing.
2. The goal of being emancipatory within a group. The long term goal of my research is to bring about a change within nursing education whereby lesbians and lesbian health care concerns may be incorporated into teaching practices. The aim of this is that new nurses may learn to explore issues of heterosexism, homophobia, and difference in such a way that they come to embrace the journey rather than being resistant or negative.

3. The intersections of privileges and oppressions. This research challenges those in positions of privilege to begin to explore their own locations of privilege and to incorporate this reflective process within their teaching and work with nursing students.
4. The problematization of the social structure rather than framing the individual as the sole problem or concern. In this study, participants are asked to begin to address the systematic silence and invisibility of lesbians within the practice of nursing and health care. The focus has been on seeing ways in which the individuals with privilege, nurse educators, routinely in daily acts of teaching, enact social norms of “heteronormativity” and heterosexism.

In the development of this research project, I specifically looked at the experiences of nurse educators as they introduced lesbian content into their teaching/learning environments. This is in keeping with one of the themes of feminist research mentioned by Bricker-Jenkins and Hooyman (1986) whereby the process is not a means to an end, but rather the process is itself the end. Participants were asked to deliberately include lesbian and lesbian health concern content into their teaching. In asking them to do this I have made an assumption that they would explore, for themselves, and in some way with students, their location within heterosexual privilege. The assumption of exploring one’s own relationship with heterosexism is a critical step in the consciousness-raising process that brings about change in thinking and actions. To this end, I asked questions about participants’ personal experience with heterosexism, homophobia, and heterosexual privilege, as well as asking about specifics regarding the lesbian content included by the nurse educator.

The research method brought together participants within the focus groups and encouraged group interaction and discussion of personal experiences in an atmosphere of respect and acceptance among themselves and with the researcher. The coming together and sharing of ideas is another theme within feminism (Bricker-Jenkins & Hooyman, 1986). By asking participants to include lesbian content in the classes they were teaching, I attempted to change the status quo and the assumptions of privilege. This overall process was designed to have the effect of consciousness-raising on participants, thereby bringing about liberation through personal action (Bricker-Jenkins & Hooyman, 1986;

Freire, 2000; McLaren, 1995; McLaughlin & Tierney, 1993; Pharr, 1988). This would ultimately have a positive effect upon the students they come in contact with regarding their knowledge of lesbians and their health care concerns.

Sample and Sampling

Individuals participating in this research were nurse educators from college and university Schools of Nursing in a major metropolitan city of western Canada.

Participants were selected through a criterion-based screening process. Criteria for participation included:

1. being a full-time, part-time, or sessional nursing faculty member
2. currently teaching at least one course in an undergraduate nursing program that included at least 15 hours of individual or student-group contact
3. working at a school of nursing within this metropolitan area of western Canada
4. not being a member of the researcher's Supervisory Committee
5. agreeing to attend an orientation meeting prior to the start of the semester, an individual interview mid-semester, and a focus group at the conclusion of the semester
6. agreeing to explore with the researcher and other participants in a focus group the personal meaning of the inclusion of lesbian content within their own teaching practice
7. agreeing with the importance of including lesbian content in nursing education.

Snowball Sampling

The research participants were obtained through snowball convenience sampling. Snowball sampling involves a chain of informants. It is a procedure that follows the pattern of social relations; hence the sample involves individuals and relations among them (Biernacki & Waldorf, 1981). Morse (1991) reports this sampling technique as being most helpful when those being studied belong to a more or less connected network, such as nursing educators within this metropolitan area as described above.

Because separate, non-overlapping social networks exist, starting a snowball in one network does not guarantee connections to others. Therefore, even in snowball recruitment efforts, action may be needed to facilitate the participation of faculty members from each program rather than relying solely on snowball sampling. This

included letters to faculty members asking for volunteers, direct requests through attendance at a faculty meeting, and requests for volunteers disseminated through e-mail networks and newsletters of the individual schools. These activities were not necessary as an adequate number of volunteers surfaced from varying backgrounds, schools, and teaching assignments through the implementation of the basic snowball sampling technique.

Homogeneity of Participants

Early models of consciousness-raising within groups emphasized the homogeneity of the group members. Indeed, homogeneity was a factor that was thought to contribute to the process of enlightenment, as individuals were able to hear their own stories in the stories of others (Henderson, 1997; Weilerik, 1991). Since this study looked at the experiences of nursing faculty members when they introduced lesbian content into the classroom, the fact that there is a high degree of homogeneity among nursing faculty members (American Association of Colleges of Nursing [AACN], 2003; Hinshaw, 2001) need not be viewed as a hindrance or significant limitation to the study (Krueger, 1988).

Number of Participants

Morse (1994) suggests using at least six participants in studies where one is trying to understand the “essence of experience”. In regard to the overall sample size, Sandelowski (1995b) suggests that a sample size of 10 may be judged adequate for certain kinds of homogeneous or critical case sampling. Sandelowski (1995b) warns the beginner qualitative researcher that more sampling units may be required than those needed by the experienced researcher. With this in mind, along with the need to over-recruit to allow for attrition, conflict of schedules, or the unforeseeable, a goal of 14 participants was sought for this study.

Twenty nursing faculty members were contacted or volunteered to participate in this research project. Of the eight that did not participate four did not meet the criteria as outlined—three did not have direct teaching assignments that particular semester and one was a member of my research committee. Of the remaining four invited nursing faculty members, one declined indicating that she did not see how anything new could be added into the prescribed content of the course, two declined outright giving no reason, and another did not return calls after our initial exchange, although later at a chance meeting

mid semester, she verbally declined the invitation reporting that she was too busy. In the end, 12 nursing faculty members were successfully recruited.

Another argument made by Sandelowski (1995b) in support of determining sampling size prior to the collection of some data is what she refers to as “selective or criterion sampling”, whereby participants would be selected for having met specific criteria for inclusion. My research proposal incorporated this through the development of specific selection criteria (see section on sample and sampling p. 51). The size of this sample is appropriate to qualitative research inquiry, as the intent is to understand individuals’ experiences and the processes they use in creating meaning within that experience; and to understand how the proposed intervention was experienced within the classroom setting (Patton, 1990; Strauss & Corbin, 1998) by the participant.

Twelve participants were successfully recruited from five different schools of nursing within a metropolitan area of western Canada. Participants were from BSN or college programs, and included generic students² as well as returning degree completion registered nurses³. Teaching locations and formats included traditional classroom, distance on-line education, courses in community settings, and condensed courses offered in face-to-face or classroom settings. Content included first-year nursing courses, skills laboratories, second year clinical, research courses, and upper division courses that included content on ethics, population health, aging, nursing inquiry, nursing research, empowerment, change theory, access, diversity, and feminism. Participants were all female, ranged in age from 40 to 60 years, had been in nursing for 10 to 33 years, and had been teaching from 1 to 25 years. Seven had master’s degrees (two of these were enrolled in PhD programs) and five had PhDs. All but one participant was employed full-time and all self-identified as heterosexual.

In an attempt to have additional diversity among the participants, I approached two faculty members who I know to be lesbian and who teach within undergraduate programs. Both were hesitant in their initial response to a request to participate as evidenced by a delay in returning phone calls, and while one indicated that she would think about participating she declined two months later when I ran into her at another

² Student attending university for the first time.

³ RNs who graduated from a diploma/college program and are returning to complete their BSN.

meeting, well after the research had started. Both lesbian faculty members indicated that they were unable to participate because of time constraints; adding that they were not able to see how the content directly related to the courses they were teaching that semester. Their reasons for declining to participate were not directly discussed while attempting to recruit them for the research. However, both seemed uncomfortable and awkward that I knew they were lesbians and that, if they were to participate in the study, other faculty members participating might learn of their lesbian status.

Data Collection

In order to explore the perspectives of nursing faculty members about the inclusion of lesbian content into their teaching, data collection for this study depended primarily on interviewing strategies, focus groups, and limited observation of participants. I conducted both open-ended, unstructured, individual interviews and focus group interviews. I observed the participants during the interviews, focus groups, and other interactions that occurred regarding this research project. Participants were made aware in our initial discussion that I would be collecting observational data, and were reminded again in the consent form, at the orientation, and at focus group meetings.

In general, interviewing captures the immediacy that characterizes interpretive research (Spradley, 1979). It provides a means of reality reconstruction in which the basic source of data consists of stories members of a group tell about their lives and the environments in which they live and work. Verbalizations themselves are significant as units of comprehension, which transcend behaviour and are not simply descriptive of it (Marshall & Rossman, 1995). Verbal interactions form definitions and justifications for actions, and consequently act as gateways for communicating interpretations that individuals make about their social worlds (Lofland & Lofland, 1984). The focus of the research, then, was to elicit from the participants accounts of their experiences and any insights they gained when introducing lesbian content into the courses they taught.

The purpose of using focus groups in conjunction with individual interviews in this study was three-fold. First, it provided a rich source of data about the collective understandings of inclusion of lesbian content in nursing education courses. Second, it provided an opportunity for participants to share their successes and challenges regarding the interventions. They could brainstorm about ideas and ways to overcome roadblocks

they may have experienced while offering suggestions to one another regarding possible modifications. And third, it offered a chance to validate themes emerging from individual interviews regarding the experiences of participants.

First Meeting—Orientation and Information

The first meeting of the group served as an orientation and information meeting. (See Agenda Outline, Appendix B) Participants were given an overview of the research (See Information Letter, Appendix C), had the opportunity to ask any questions they might have, and consent was obtained from those willing to participate (Appendix D). All those in attendance consented to participate. Demographic information was collected (See Appendix E).

Participants had the opportunity to meet one another and to briefly discuss their reasons for participating in this project and what they hoped to gain from the experience, and to share questions and information with one another. Resources were provided in the form of a bibliography (see Appendix F) that included research articles, educational strategies, and community resources. Available for participants to look at and listen to, was a collection of books and music (from the researcher's private collection) that provided further ideas regarding the development of strategies for including lesbian content in their classes.

The group orientation meeting took place in a classroom at one participant's school of nursing. Four other orientation meetings occurred one-on-one in individual faculty members' offices because these participants were unavailable to attend the group orientation. The focus groups took place in the conference room at one of the schools. Refreshments were provided.

Individual Interviews

The open-ended, unstructured research interview has become one of the most widely used techniques for collecting data in qualitative research (Denzin & Lincoln, 1994, 2000). It is also used widely in feminist qualitative research (Reinharz & Davidman, 1992), although feminist researchers often approach the interview in unique ways. Rather than viewing the interview as simply a means for obtaining information in a quick or efficient manner, feminist researchers tend to incorporate a reflective aspect to

the relationship between participant and researcher (Anderson, 1991; McRobbie, 1982; Oakley, 1981).

The goal of interviewing individual nursing faculty members in this study was to elicit stories about their experiences when introducing lesbian content into the learning environment. Story telling is a common activity in everyday conversation and is a vehicle by which women communicate the meanings of everyday experiences (McGuire, 1990; Riessman, 1989; Sarbin, 1986). Therefore, their stories provided a window into the daily lives of these educators and the meanings they construct regarding lesbians and lesbian health care concerns within their teaching practices. As Jonnes (1990) suggested, "Story breaks down walls and removes barriers and in this way opens up a critical area of interaction and relation to public view" (p. 243). The telling of stories is a distinct way of recapitulating experiences that situates events in context, preserves temporal ordering, incorporates evaluative statements, and communicates values (Agar & Hobbs, 1982; Mishler, 1986).

In the present study, individual interviews were conducted with each participant after she had implemented two lesbian-content interventions during the semester. This was done to capture their "in the moment" experience of having included lesbian content in their teaching. The interview process was non-linear and directed by the experiences of the participants (Marshall & Rossman, 1995; May, 1991). The interviews were loosely structured around the research questions of the study which were listed in Chapter One. A list of trigger statements and questions was used to help the interviewer ensure that specific topics were covered (see Appendix G). Participants were asked open-ended prompts that were designed to examine what they previously taught and ways in which this experience affected their teaching. Due to the emergent design and format of the research, as well as my inexperience as a researcher, I referred to the trigger ideas/questions throughout the interviews as prompts. The specific prompts or summaries reflected back statements that I constructed "in the moment" during the interviews and included some aspect of including lesbian content in the following areas:

- previous teaching experiences
- current participation and interest
- experiences in classroom; teacher comfort

- student reaction
- academic freedom, curriculum issues, institutional philosophy, and social mandate for entry-level practice
- awareness and personal insights.

Each interview was audio tape-recorded following confirmed consent of the participant, and was later transcribed. The time between interview and transcription varied from 1 week to 13 weeks. The first transcriptionist hired was delayed in getting the transcripts completed due to family illness, and after 7 weeks was replaced. The second transcriptionist took 6 weeks to “catch up” on the transcription backlog. Following this delay, the remaining transcripts were completed within 15 days of the interview and reviewed by the researcher within another 10 days. The interview procedures evolved in response to ongoing data analysis and collection (Marshall & Rossman, 1995; May, 1991). For instance, questions varied from participant to participant to validate findings, to explore some issues further, and to move towards a comprehensive description of these educators’ experiences.

As I had expected, there was minimal extended contact with participants outside of scheduled appointments regarding the research. There were four occasions where I “ran into” a participant and discussion moved into the area of this research project. None of these interactions were more than 10 minutes and the content was a general review and recall of something they had read or gained insight about. Notes were made following these interactions and the data were considered within the analysis along with all the other data.

Focus Groups

Focus groups were used as a second means of data collection. The type of focus group activities I incorporated are known by at least three names: focus group interviews, focused interviews, and group in-depth interviews (Vaughn et al., 1996). Several researchers have investigated the usefulness of focus groups as a method of data collection. “Focus groups provide insight into beliefs and attitudes that underlie behavior” (Carey, 1994, p. 225). Focus groups are best used when conducting explorative research (Vaughn et al., 1996), and are particularly useful when there is a lack of reliable and valid measures for obtaining information on the selected topics (p. 20). Since

research on the experiences of nursing faculty when including lesbian content in their teaching is non-existent, an explorative approach to this topic is warranted.

Focus groups, by design, elicit rich experiential data through the dynamics of the group interaction, which stimulate thinking and verbal contributions (Asbury, 1995; Morgan, 1995; Smith, 1995; Stevens, 1996). Asbury, along with others, strongly suggests that these data could not be obtained through other methodological strategies such as surveys or individual interviews. Focus group discussions offer distinct advantages compared to the individual interview, as the coming together of participants offers the opportunity for an exchange between individuals who have had a shared experience. These include: synergism, snowballing, stimulation, security, and spontaneity (Stevens, 1996; Vaughn et al., 1996). A major advantage of focus group interviewing is the possibility of stimulating spontaneous exchanges of ideas, experiences, and attitudes in an atmosphere that can be safer than individual interviews, given the solidarity of the group (Krueger, 1994; Marshall & Rossman, 1995; Stevens, 1996). Focus groups can provide an open and supportive atmosphere that fosters airing a range of opinions (Vaughn et al., 1996). Focus groups offer the benefits of interaction and the possibility of challenging and changing both talk and attitudes (Wilkinson, 1999).

While not inherently feminist, the use of focus groups fits feminist methodologies since it places emphasis on relationships and understanding of others' experiences. It can include consensus decision-making, and community problem-solving, although these were not part of this study. This conforms nicely with those aspects of feminism that seek egalitarian cooperation rather than hierarchical arrangements. Additionally, the nature of conversation "with and among" rather than speaking "at" the participants, may further reduce the possibility of the researcher exerting power over the participants, while encouraging candid and spontaneous exchange. Focus groups are a useful means of collecting data about shared experiences or when wanting to understand an experience within a group. This research included exploring a shared activity, albeit individually experienced by each participant in the classes that they taught.

In light of the lenses of consciousness-raising, feminism, and emancipatory inquiry that frame this research, focus groups can be an important element in the advancement of an agenda of social justice for women, because focus groups can serve to

expose and validate individual experiences (Madriz, 2000). Madriz reports that several feminist researchers who have worked with focus groups reported how participants began to discuss issues of interest to them without even waiting for questions from the moderator; this was true for this group of participants as well. Wilkinson (1998) favors this unstructured approach to focus group interviews, suggesting that it is possible to eliminate the researcher's prejudices from the interaction by not having an interview guide with a list of specific questions to be addressed.

As suggested by Wilkinson (1998, p. 118), participants in this research actually assisted the researcher in several ways. They asked questions of each other. They contradicted and disagreed with each other in ways which, coming from the researcher, might have seemed authoritarian. And they pointed out similarities and apparent contradictions in each others' accounts in ways that suggested interest and a level of reciprocity regarding their own and others' experiences. As I had imagined, the discussions from this well educated and mindful group provided thoughtful and insightful exchanges. Part of my task as facilitator was to stay out of the way so that conversation could unfold in its own way, while at the same time honouring my role as the designated leader and researcher.

Krueger (1994) suggests using questions to guide and focus discussions, although an argument could be made that the theoretical lenses used in this research favour a minimalist questioning approach and more of a fluid structure. While I would like to have followed this idea of minimal questioning structure, my inexperience in this type of research led me to develop a list of trigger questions/statements that helped maintain my focus and ability to facilitate the group calmly and smoothly (see Appendix H). While I did not ask these questions verbatim, I did seek to include prompts in the following areas:

- their experiences of deliberately introducing lesbian content into the classroom
- their inclusion of lesbian content in their future teaching
- their experiences with other faculty members
- their choice of lesbian content—where and why lesbians and lesbian health care concerns was included in the course.

Other questions developed out of my initial analysis of data prior to the focus group meetings. I presented some perceived initial themes or ideas to the group and had

participants comment on my initial analysis of the data as a means of verifying the accuracy of my understanding of the content and the group members' understanding of their experiences. This provided an ideal opportunity for encouraging further comments on their experiences as well as establishing an element of trustworthiness of my analysis (see section below—Ensuring Scientific Rigour).

Censoring and Conforming in Focus Groups

While there are numerous advantages to the use of focus groups, Carey (1994) reminds the researcher of potential pitfalls, primarily of censoring and conforming. These processes occur when a person adjusts her or his own behaviour in response to personal impressions of other group members and in relation to her or his own needs and history.

In conforming, a person elects to tailor contributions to be in line with perceptions of the group members and/or the leader. In censoring, a person withholds potential contributions, often due to a lack of trust of the leader, or the other members, or concerns about the future use of the data. (p. 237)

This may be deliberate, in the form of lies and/or half-truths, or it may be a cognitive reframing of the experience. Unfortunately, none of the authors cited throughout this section on focus groups adequately address strategies to prevent this, nor do they suggest ways of interrupting it.

On some level self-censoring and conforming are likely to have happened with this study's participants. Due to the sensitive nature of this research topic, and judging by the reluctance of known lesbians to participate in this study, it is likely that there was a degree of self-censoring. I chose at times to nudge participants a bit until I found that they would repeat some aspect of their story. I came to understand that this meant they were either finished with their story or were not going to share any more information with me. It was also possible that, at times, participants were reluctant to discuss aspects of issues related to inclusion of lesbian and lesbian health care content because they knew me to be a lesbian. I was careful to try to honour each participant's reality, and attempted to create a space where they felt free enough to share their ideas and thoughts. The success of this effort was confirmed on numerous occasions when at the close of a one-on-one interview or during a focus group, comments were made about the process feeling like a conversation rather than a stilted interview. Other comments included a sense of

collegiality, interest, and safety concerning the interviews and focus group encounters. This is discussed further in the section below on ensuring scientific rigour.

Another way that the design of this research helped address the concerns of censoring and conforming was through collecting data by more than one means (individual interviews, focus group, and observation). The various means of data collection offer a way for me to approach the data from different directions. Participants were consistent with the information they provided in the various formats, sometimes adding more detail or depth to their story, although the essence of their stories did not change noticeably from one method to another. See the section on achieving rigour below for a further discussion on how this was addressed in data collection and analysis.

Focus Group Size

In regard to focus group size, Krueger (1988) indicates that groups are “typically composed of seven to ten people, but the size can range from as few as four to as many as twelve” (p. 27). These numbers are supported by the work of Vaughn (1996) who suggests eight to ten participants and Stevens (1996) who reports ideal size to be between six and twelve. “The size is conditioned by two factors; it must be small enough for everyone to have opportunity to share insights and yet large enough to provide diversity of perceptions” (Krueger, 1988, p. 27).

In constructing these focus groups, all individuals who agreed to participate in the study were invited to attend one of two possible meeting times. For various reasons four participants were unable to attend either of the focus groups. Their reasons included terminal illness in the family, being out of town on a research project, frustration with workload, and being unable to “get away” due to covering teaching assignment for an ill colleague. Individual meetings were scheduled with each of the participants who were unable to attend either of the focus groups. The first of the two focus groups had five participants and the second had three. Clearly, the groups were smaller than ideal.

The Focus Group Meetings

Despite their small group size, the focus group discussions were lively and contained rich dialogue. Participants eagerly engaged in conversation with one another and seemed, overall, delighted to have the opportunity to talk with peers regarding their experiences. They initiated conversation, asked each other questions, and provided

thoughtful feedback about their impressions and experiences of including lesbians and lesbian health care within their teaching. A research assistant (RA) assisted with the logistics of room and equipment set up, refreshments, and child-care coordination (although in the end none was actually needed). Field notes were made within 24 to 36 hours following each focus group and individual meeting. Minimal notes were made during the individual interviews and focus groups so as not to distract the participants. These notes consisted primarily of trigger words and sequencing that I used to clarify or seek additional information during the interview as well as to aid recall when writing field notes. Each of the focus groups was audio taped and the tapes transcribed.

Those unable to attend the focus group were contacted by phone for a follow-up conversation. Much of the discussion from the focus groups was shared with the participants who were unable to attend and they were asked to comment on ideas or conclusions that had been shared within the focus groups. Many of the same prompts, statements, and semi-structured questions were addressed during these individual “focused” interviews. At the conclusion of the focus groups, each participant was given or mailed an Anonymous Response form (see Appendix I) with a stamped return addressed envelope. This provided an opportunity for additional comments about participation in the study. Three forms were returned and these data integrated into the analysis.

Participant Observation

Marshall and Rossman (1995) describe participant observation as “an essential element of all qualitative studies” (p. 78). Observation entails “the systematic noting and recording of events, behaviors, and artifacts (objects) in the social setting chosen for study” (p. 79). Observation played a role within both the individual interviews and the focus groups. Because research interviews are interactive events themselves, documentation of operant communication processes, environmental circumstances, non-verbal behaviours, and researcher ruminations act to preserve context, reflectivity, and accuracy in the recording and analysis of interview and focus group data. Interaction is not confined to verbal exchanges, as a wealth of messages can be transmitted non-verbally. The verbal content of interviews does not fully convey a person’s thoughts, feelings, and behaviours. Problems can occur when a researcher interprets the face value

of statements that were intended to be understood in a different way. Similar semantic content may be transmitted in different ways with very different effects, such as humour, sarcasm, or equivocation. Documentation of subtle signals such as changes in emotional tone, gestures, and movements toward or away from the researcher or, in the case of the focus group, others in the group, can serve as clues to the intent of particular utterances (Angrosino & Mays de Perez, 2000). Documentation of participant observations can also help in the critical analysis of interview techniques (Angrosino & Mays de Perez, 2000; Marshall & Rossman, 1995).

For this study, observations were documented in each of the interactions I had with participants. These included paying attention to the surroundings where we met, the general affect of the participant, the sense of comfort (or not) we had with one another and how interruptions were dealt with, which included planned and unplanned phone calls or drop-in-visits. Since the interviews primarily occurred within the participant's office, I made note of the environment, the sense of welcome that the space communicated and how comfortable the participant and I were within this space.

As mentioned earlier, the majority of our interactions were planned. However, there were four interactions that occurred with different participants that were chance encounters. This included three interactions where a discussion of the research topic took place. In each case, the participant initiated the discussion of the research project. Our conversations were brief and on two occasions, the focus was about how the research was progressing and one slightly longer conversation, perhaps 7-8 minutes, where the participant expressed pleasure in having decided to participate in the study and shared a story about an interaction with a student. Later, in one of the focus groups, she retold the story providing the group with even greater details. Contact with participants that did not involve discussion of the research project was not included as data. Field notes were made of all observations and included as data.

Learning Activities

Participants were asked to include lesbian content on three different occasions over the course of a semester. Responses varied tremendously from participant to participant. Some faculty members designed specific learning activities while others chose to include lesbian experiences within discussions of broader concepts such as

cultural diversity and family. The learning activities that they used are outlined in Chapter Four.

Data were collected through individual interviews after each participant had included at least two learning activities. Two-hour long focus groups were conducted twice during the subsequent semester, during which participants were asked to discuss their experiences with other participants. For the four participants unable to attend the group discussion, an individual face-to-face or phone interview occurred in which many of the same topics were explored.

Data Analysis

Data analysis in this study began with the first interview and occurred continuously throughout the entire research period. The process of analysis involved an ongoing dialogue between the data and the theory (Lather, 1991a). According to Sandelowski (1995a):

Data collection, analysis, and interpretation are processes that overlap temporally and conceptually in qualitative work ...there is no clear line in qualitative work that can be drawn between analysis and interpretation, as the data preparation process itself triggers analysis and an analytic structure is often the basis for an interpretation. (p. 372)

In this study, the processes of data collection and analysis did not occur linearly, but rather were iterative processes (Anderson, 2000). The following describes the process of analysis used in this study, although what appears to be linear was not necessarily sequential. Following each interview, I wrote field notes within 24 to 36 hours of the interview. Within 48 hours, I listened to each audiotape and made additional notes regarding my understanding and impressions. The audiotape was then sent to the transcriptionist for transcribing. Once the tapes were transcribed, I then listened to the tape again and checked the transcript for accuracy against the recording, making notes of emphasis and corrections if needed. I made additional field notes and responded again to the tape and transcript in terms of reflection and initial ideas about what was being said.

After several interviews were completed and their transcripts had been returned, I began reading through the complete interviews and field notes as a whole, to identify recurring, converging, and contradictory patterns (Sandelowski, 1995a). Key concepts and preliminary emerging themes were recorded on the transcripts to inform the ongoing

data collection process, and in particular, revisions of interview questions. Ideas and preliminary emerging themes were recorded as I listened and reread each transcript. As the coded categories developed, I entered large portions of corresponding data into files under those category headings as a means of organizing the data and providing easy access to it.

Field Notes and Journal

The primary tools of this research were semi-structured individual interviews and focus group interviews. In addition to these, I made numerous field notes and journal entries throughout the research process. After each interview, field notes were made using categories recommend by Hall (1994b) including non-verbal communication, power dynamics, rapport, the interviewer's emotional response, the participant's emotional response, the flow of events, comparison to previous interviews, and the setting. While I did not always make notes in each of these areas, I did keep a "cheat sheet" beside my laptop with these eight headings to help remind me of areas to reflect on and include when/as warranted. Often I labeled notations as I was writing and frequently, upon re-reading them, labeled or made notations for later review of the data. These field notes were primarily typed into my laptop following each interview, although on two occasions they were hand-written and then typed into a file within 3 to 4 days. I found typing the field notes and reflective comments immediately after the interviews to be, overall, a relaxing and reflective experience that served to recap and consolidate the participant's reported overall experience of including lesbian health care content. At numerous times throughout the research process I made entries into these field note files as well as another file, labeled "research journal", where I wrote about my ideas, possible connections, frustrations, worries, questions, challenges, exhilaration, wonder, and joys of conducting this research. Essentially this was a chronological record of research activities and insights that included my thoughts, questions, connections, and decision-making trail.

Managing Qualitative Data Analysis

Managing qualitative data requires attention to detail, careful management of materials, and continuous thinking (Knafl & Howard, 1984; Knafl & Webster, 1988). In qualitative research, data analysis begins early in the investigative process, with the

researcher's ongoing self-reflective observations and informal constant comparison during data collection (Marshall & Rossman, 1995). Sandelowski (1995a) recommends avoiding early line-by-line "empty coding", and instead suggests seeking an overview first; looking at your data to see what might be there. As mentioned earlier, data for this study was managed with this approach.

Descriptive and thematic analysis occurred in an ongoing dialectic fashion. Data were listened to, read, and reread to ensure the broadest understanding possible. After obtaining an initial sense of the data, I coded them by meaning units. With assistance from my supervisor and committee members, I discussed and clarified coding, formulation of categories, and the development of an organizing framework. Discussion and clarification continued until I was satisfied with the analysis—this included re-listening to interview tapes, rereading transcripts and field notes, discussions within the committee, and re-contacting three participants to seek clarification and further understanding of the emerging findings.

Analysis was aided by the use of a Microsoft Word™ program, which was determined to be sufficient for data management by both the researcher and supervisory committee. I used various files to create memos, notes, and ongoing notation regarding the progress of the project. While it is perhaps true that other software, such as NU*DIST, or Atlas, might have helped with speed and sorting, there was a fundamental level of engagement with the rudimentary approach used that had me immersed in the data and requiring that I sort my way out methodically (Smith, 1988). Weitzman (2000) mentions serious concerns that data analysis software may encourage the researcher to take shortcuts, fail to check their logic, and "get lazy" (p. 808). As a novice researcher with a preferred hands-on learning style, I followed Weitzman's suggestion that "students benefit from having some experience with manual methods, if only a few coding exercises, so that they can get the feel of what is happening analytically before they start worrying about using the software" (p. 817). I found this to be true and the hands-on method used offered me an intimate relationship with the data that I might not have had, had I used more elaborate computer assisted analysis.

Ensuring Scientific Rigour

The various methods used to ensure scientific rigor within qualitative research differ significantly from those based on positivist or post-positivist approaches (Sandelowski, 1993). Qualitative researchers seek to understand the meanings of people's experiences in the world. One of the dilemmas facing qualitative researchers and readers of qualitative research is the scientific evaluation of this work. Sandelowski (1993) asserts that the best test of rigor in qualitative research is the degree to which the process captures a "true-to life" understanding. She suggests that rigor is "less about adherence to the letter of rules and procedures than it is about fidelity to the spirit of qualitative work" (p. 2). The researcher then begins a journey of attempting to represent this understanding in a manner that others can experience, view, appreciate, and critique.

Lincoln and Guba (1985) use the term "trustworthiness" to describe a variety of methods whereby the process of the study and the credibility of the investigator are considered as important components in determining the rigor of the research. They suggest several criteria through which trustworthiness can be established. These include credibility, dependability, transferability, and confirmability. Furthermore, special attention was given in this study to ensure that the quality factors of focus group development outlined by Krueger (1994) were integrated into the study design. These factors include; (a) clarity of purpose, (b) appropriate environment, (c) sufficient resources, (d) appropriate participants, (e) skillful moderator, (f) effective questions, (g) careful data handling, (h) systematic and verifiable data analysis, (i) appropriate presentation and, (j) honouring the participant and the method.

Credibility

Research findings are credible if the analytic interpretations fairly and accurately reflect the phenomena that the research claims to represent. Member validation is the common approach for determining if an authentic rendering of an experience has been generated (Hall & Stevens, 1991). Opportunity to review the transcript was offered to each participant and each either did not respond or declined. The reason for the lack of response was unclear. In light of this lack of response, I spoke with seven people (in addition to my dissertation committee members) who had similarities to the group of participants. I asked them at various times in the data analysis to read portions of the

transcripts, look at “piles” of coded data, and give me feedback regarding my analysis. They perceived similar meanings in selected portions of the raw data and helped me to feel more confident regarding the credibility of my analysis.

Dependability

In the empirical tradition, reliability means repeatability. Inherent within qualitative research approaches is the emphasis in seeking and understanding the uniqueness of persons’ interpretations and behaviours (Denzin & Lincoln, 1994). Each researcher’s interests, curiosities, and background will create different approaches to the questions being asked and views of the data, which, in turn, will support different outcomes and conclusions. One could equate this to various artists who may choose to represent a landscape with almost unlimited varieties of media, colors, styles, textures, dimensions, and size in determining what it is that the audience will experience. Qualitative researchers choose various arrays of research questions, methods, interview questions and approach, analyses, and words in their many individual processes of engagement in their science. At the same time, there is need for those evaluating this “artful” science to derive some conclusions as to the dependability of the research and any wider meaning that is gained from that research (Hall & Stevens, 1991; May, 1994; Meleis, 1996). This interweaving of artist and scientist is both the beauty and challenge of qualitative research (May, 1994; Thorne, 1997).

Transferability

To understand the results of qualitative research, others must understand why and how certain questions were posed and decisions made. Qualitative reliability, or transferability, therefore, is more clearly ascertained by the ability to follow the “decision trails” used by interpretive investigators (Hall & Stevens 1991; Marshall & Rossman, 1995; Tom, 1996). This has been illustrated in the work of Tom, Hall and Stevens, Sandelowski (1993), and Thorne (1997). To this end, detailed memos were systematically written throughout the research process and served to outline methodological and analytical decisions made by the researcher.

Confirmability

A number of criteria can be applied to help establish confirmability in this study, including establishing coherence, consensus, credibility, congruence, incorporation of the

voices of participants, and collaboration with others (Hall & Stevens, 1991). Given the emancipatory intent of this research, I used what Lather (1991a) calls *catalytic validity* which

represents the degree to which the research process re-orient, focuses and energizes participants toward knowing reality in order to transform it. The argument for catalytic validity lies not only with the recognition of the reality-altering impact of the research process, but also in the desire to consciously channel this impact so that respondents gain self-understanding and, ultimately, self determination through research participation. (p. 68)

This is relevant and important within this research project as the overall design seeks to have participants look at their teaching practices, which largely lacked any inclusion of lesbians or lesbian health care content, and transform them by deliberately introducing three learning activities that included lesbian health care.

Reducing Self-Censoring and Conforming Behaviours

As discussed earlier, when people interact with others, particularly while dealing with a sensitive topic, they are often anxious to please or at least not to give offence. This was observed among some of the participants who voiced concern about not wanting to offend me. One participant addressed this in the following way:

I don't know what's wrong to say. I don't know what might offend you, I might have said things that would offend you but I wouldn't know it... So I'm having this internal dialogue as I'm interviewing and when you go back and hear it, you might hear me hesitate in saying something and all of that is going on in my head around the "othering" and getting the word choice right... But how can I talk about it without falling into the mind trap of language?

It may have been possible that participants said what they perceived (rightly or wrongly) to be social norms. In this study, participants might have wanted to "please the researcher" or "say what they think I wanted to hear" since they know me to be a nurse educator and a lesbian. There may have been concerns about admitting non-politically correct beliefs, thoughts, and practices to their peers or myself. These concerns support the use of triangulation or "crystallization" as Richardson (2000) suggests calling this process, whereby one comes to have a broader understanding or clearer view of the ideas, themes, or concepts being explored. "Triangulation is the act of bringing more than one source of data to bear on a single point" (Marshall & Rossman, 1995, p. 144). This helps to strengthen the research design by allowing for congruency or disparity to surface.

Triangulation is the display of multiple, refracted realities simultaneously. Each of the metaphors “works” to create simultaneity rather than the sequential or linear. Readers and audiences are then invited to explore competing visions of the context, to become immersed in and merge with new realities to comprehend. (Denzin & Lincoln, 2000, p. 6)

In this research, triangulation consisted of using data from individual interviews, focus groups, and participant observation to help identify consistency and areas of inconsistency as well as ambiguity and struggle.

Ensuring Accurate Transcription

Accurate recording of participants’ experiences and discussions is an essential part of good research; it is a way to respect each individual’s perspective and to recognize the validity of each participant’s experience and opinion. Lane’s (1996) research raises issues regarding transcriptionists’ direct and indirect influence on the data. These concerns included the effect a transcriptionist has on the data as she or he tries to capture the spoken word of the audio tape recording and transpose it to the written form of the transcript. Lane observed that typists “were adamant that they were not changing any of the data” and yet changes had been made.

I came to realize that what I first understood to be unintentional typing “errors” were something else again. It seemed that the omissions and changes were mostly the typists’ well intended efforts to “tidy up” our untidy women’s talk, in keeping with society’s norms of good grammar and speech. (p. 161)

From the outset of this research, these concerns were addressed with the individuals hired to transcribe. Additionally, I listened to each tape as an initial strategy for ensuring that the transcription process remained true to the participant’s original intent. When there were concerns regarding the transcription work, I raised these immediately with the transcriber(s). While this may have served to help ensure the accuracy of the transcriptions, it is highly probable that I too brought my own well-meaning assumptions to the understanding of what was meant by the participants. Therefore, participants were offered the opportunity to read copies of their transcripts should they desire. In asking participants to read their transcripts and make any additional comments, it was hoped they would add clarity and strength to the data and subsequent meanings and understandings. No one came forward to do so.

It is important to keep in mind Lane's (1996) insight that:

all the women in this project were influencing the data: the participants were censoring or tidying their speech, as were the typists, and I too was tempted to normalize the data by editing out the nonsensical, untidy, or speculative speech. This is an illustration of how competing discourses influence what we women understand as appropriate for the public record. (p. 165)

There is no reason to suspect that this research unfolded any differently regarding these same issues. I struggled with whether or not to edit sentences spoken by participants and then turned into written text so that the context of meaning could be understood when participants referred to earlier mentioned ideas. This was believed not to be a serious hindrance to the understanding of the experiences of participants and it is hoped that the simple editing served to help the reader understand the experiences of the participant in light of the limitations of bringing interviews to the printed page. Becoming aware of these issues offers insight into the layers through which we, as scholars, must come to recognize the trustworthiness of our research.

Ethical Considerations

Ethics approval was obtained through the University of Victoria. Written consent was obtained from each participant, recognizing that consent was ongoing and that any participant could exit the research at any time. Specific discussion occurred within each of the focus groups and individual interviews regarding confidentiality (Smith, 1995). Participants were initially asked for their consent as indicated by the signing of the consent form and in subsequent interviews they were asked if they had any questions and verbally gave consent to have the interview taped and used within this research project. Participants were again reminded that they could exit the research at any time, or should they desire at some later date to have part of all of their comments withdrawn they could do so by contacting either myself or my supervisor. Additionally, confidentiality of the written record was ensured by removing any identifying information and limiting access of data to myself, the supervisor, and transcribers, who also signed a confidentiality statement (see Appendix J). All cassette tapes, consent forms, field notes, and any other written correspondence are stored in a locked filing cabinet in my home office. These will be kept for 7 years in accordance with the Tri Council Policy Statement: Integrity in

Research and Scholarship. After this, transcripts will be shredded and the tapes erased and destroyed.

The Researcher as Insider and Outsider

The reflective use of self in relation to participants is the primary conduit for knowledge construction in interpretive research (Lipson, 1989). The researcher in this case is a 45-year-old lesbian, born and raised in a working class family in the United States of America, and of English and German descent. I am professionally educated as a mainstream health care provider (registered nurse) and nurse educator. In my political and epistemological commitments I identify as a lesbian feminist (Daly, 1978; Heyward, 1989; Ruby, 1996). My scholarly work has focused on attitudes of nursing faculty members and students toward lesbians, while my practice has involved undergraduate nursing education in the areas of acute and critical care, community and mental health, and communications.

As a member of the broader professional group of nursing educators under study, I have numerous similarities to the research participants, such as ethnic/racial, socio-economic, and age characteristics. The nurse educator subset of nurses is quite homogeneous (American Association of Colleges of Nursing [AACN], 2003; Hinshaw, 2001). Yet, I also maintain an outsider status with this group in that I am acting in the role of researcher when interacting with participants. My long history of being an “out” lesbian may also place me, simultaneously, as an outsider within the mainstream nurse educator subset, since the majority would identify as heterosexual, and within this group in particular, as they all identified as heterosexual.

As Kemmis and McTaggart (2000), Olesen (2000), and Zavella, (1996) point out, there is always a tension between insider and outsider points of view in eliciting and interpreting data from interpretive studies. Researchers move in and out of these perspectives in the process of inquiry. The risk, these authors suggest, lies in rigidly adhering to either an insider or an outsider role at the expense of flexibility, mutuality, and reciprocity. This has been a most interesting dance and one filled with reflection on my personal style and approach, not only to this research, but life in general. I have gained insights into understanding various positions within my dance, those of researcher, educator, member of society, and change agent. At times, I have clearly been

able to identify my location in relationship to others as insider or outsider. At other times, I have struggled with the tensions of being simultaneously on the inside and the outside. What I have come to know is that this place of awareness is helpful in locating one's assumptions, insights, and places of struggle. It is not a matter of simply knowing which side of the fence one is on. I have learned that what matters is a willingness to stretch and be stretched by one's work and to remain vigilant of the relationships that occur within qualitative research.

Although sharing subculture membership definitely facilitates ease of entry and trust-building, such familiarity is not without its risks. First, a researcher may be so well acquainted with members in the group under study that she overlooks relevant data (Field, 1989). I anticipated dealing with this by being in frequent contact with lesbian and non-lesbian colleagues, as well as my research supervisor and members of my dissertation committee. Although I am a member of the participants' subset of nurse educators, there are significant differences as well, which were discussed earlier. It is possible that because I am a lesbian studying faculty members' thoughts and behaviours about a controversial issue, I may be seen by some as potentially threatening or antagonistic. I can only hope that the level of rapport achieved between us as educators helped participants see that the focus is one of emancipation, not personal attack. I have drawn on my interviewing and communication skills, and was in frequent contact with members of my dissertation committee to help monitor this. In addition to these assets, the general design of the research has aided in establishing and maintaining a focus that explores the tensions inherent in looking at the intersections of teaching, oppression, and privilege.

Additionally, I made concrete efforts to consider what Christman (1988) explored in her research. She identified a series of questions that she believed were critical for a feminist researcher to ask while analyzing interview data:

How is this woman like me? How is she not like me? How are these similarities and differences being played out in our interaction? How is that interaction affecting the course of the research? How is it illuminating and/or obscuring the research problem? (p. 80)

I asked myself these questions as I recorded interview field notes after my interactions with each participant. When I was confused, frustrated, or uncertain, I would reflect on what I had written, write further in my journal regarding my responses and consult with my supervisor, committee members, and on numerous occasions I spoke with two other Ph.D. prepared nurses who are both lesbians. These interactions provided opportunities for more critical reflection and questioning, which in turn uncovered new dimensions of the data and new avenues for exploration. I believe that these interactions were necessary in helping me understand my intuitive, emotional, and intellectual responses as I analyzed the data, thereby adding to the validity and depth of the results.

Assumptions

In order to conduct this research I knowingly made a number of assumptions.

These include:

- Consciousness-raising can and does bring about changed thinking and behaviour and that this occurs through dialectic and embodied knowing.
- Having one's consciousness raised leads to changed behaviours that are empowering and emancipatory.
- Consciousness-raising is a process whereby a paradigmatic shift in thinking occurs and, because of this shift, it is impossible to see the world as one had before (Kuhn, 1991).
- Nursing education is ethically and morally bound to include educational opportunities for students to gain understanding of areas of oppression and marginalization.
- Addressing heterosexism and homophobia in nursing education begins to create a dialectic discourse regarding heterosexual privilege and the consequences of this privilege to both heterosexual and non-heterosexual people (Pharr, 1988).

Freire (1997) reminds us of similar self-exploration and urges us to ask ourselves these questions:

How can I dialogue if I always project ignorance onto others and never perceive my own? How can I dialogue if I consider myself a member of the in-group, the owners of truth and knowledge, for whom all non-members are "these" people? (p. 78)

Summary

An emergent eclectic design was used to learn more about the experiences of nursing faculty when they include lesbian content in their classes. Twelve nurse educators from five different schools of nursing were recruited through snowball technique. The research design included an orientation meeting, individual interviews, and focus group meetings which encouraged exploration of change in participants' teaching practices. The exploration included an individual interview of each participant, two focus group meetings, phone or face-to-face interviews for those unable to attend one of the focus group meetings, observations, field notes, audio-taped interviews, verbatim transcriptions, demographic data collection, and personal reflections. Data were coded, analyzed and explored for themes that emerged from the literature and the experiences of the participants. These themes and interpretations are explored in the next two chapters.

CHAPTER FOUR:

INTERPRETING THE EVIDENCE AND REPORTING THE FINDINGS

In this chapter, I provide information about the participants in the study; who they are, the types of programs they were teaching in, the courses they were teaching at the time of the research, and previous experiences they had with lesbians as a nurse or as a nurse educator. The concept of consciousness-raising is key to interpreting the data generated from this study. Each participant's consciousness was raised in a fundamental way during their experiences of bringing lesbian content into their teaching.

Thematic findings of this study are reported under two major headings: (a) the experiences of the participants themselves; and (b) the intersection of participants with students, learning environments, and lesbian content. Within each of these, I provide an interpretive analysis of the data illustrated with examples of data, and discuss questions and thoughts that arose as I tried to make sense of the stories. I begin with an overview of participant characteristics. I also provide evidence of consciousness-raising, and a thematic summary of participants' experiences when including lesbian content. I then recount the teaching strategies employed for the three requested interventions, and introduce a major finding: variations in their teaching styles and approaches. These variations are explored in greater depth in Chapter Five.

I have used the following editing techniques within quotations from participants. For the remainder of the report I have indicated a slight pause in speech with a comma (,) within the transcript. This may not always be grammatically correct; however, I want the reader to be able to hear the voice of the speaker. When a participant breaks off her talking, or trails off in thought, I have indicated this with a long dash (—). When participants have used a lengthy pause, more than taking a breath within the cadence of their talking I have indicated this with [pause], and in some cases when this pause was exceptionally long, I have indicated this by including [long pause]. To clarify what is being spoken about when the subject has occurred outside of the selected quote, I have added linking phrases or missing words within brackets [].

Throughout the reporting of data and use of specific quotes, the reader may be tempted to connect various stories with an individual. When necessary for the

understanding of the stories I will inform the reader of when data can be attributed to one participant or another; this happens seldom. Unless informed, the reader may assume that stories are not contributed by the same participant. For example, the individual who thought that lesbian content would just come up within discussion of other course material is not the same individual who was fearful that there might be negative consequences to student complaints.

Overview of Participants

Participants' Professional Background

Twelve nursing faculty members from five schools of nursing in a major metropolitan area of western Canada participated in this study. While the programs and faculty varied to some degree, the group as a whole was consistent with national statistics of nurse educators. This homogeneity among the twelve participants was consistent with the demographics of nurse educators within western Canada, as well as the rest of Canada and the United States (American Association of Colleges of Nursing [AACN], 2003; Hinshaw, 2001). Participants were from Bachelors of Science in Nursing (BSN) and college programs, and included faculty members teaching both generic students and returning, degree-completion registered nurses (RNs). Their teaching locations and formats included traditional classrooms, distance on-line education, courses in community settings, and condensed courses. Their teaching-content areas included first-year nursing courses, skills labs, second-year clinical courses, research courses, and upper division courses that included knowledge areas of ethics, population health, aging, nursing inquiry, empowerment, change theory, accessibility of health care, diversity, and feminism. Participants had been in nursing for 10 to 33 years and had been teaching nursing from 1 to 25 years. Seven had master's degrees, two of whom were also concurrently enrolled in PhD programs, and five had doctorates. All but one was employed full-time.

Participants' Personal Characteristics

Participants ranged in age from 40 to 60 years and all self-identified as heterosexual. As mentioned earlier, my attempt to deliberately recruit faculty members who are lesbians was not successful (see Chapter Three, Homogeneity of Participants). Participants were asked if they identified as a minority member and if so, to give details,

only one participant said yes, although she did not give any further details about how she defined herself.

Reasons for Participation

There was no consistent theme among participants as to why they agreed to participate in this study. One participant indicated, “It had never occurred to me to include that content in class...Part of it is that there’s sort of [pause] an unacceptability of bringing that topic up”. This same participant indicated that by being asked to participate and to think of three ways to include lesbian content, she was given “permission” to make such inclusions in her teaching. She said: “When you came along and suggested participating in the study, it was permission to go down that path. It’s like, okay, this is okay to do. It’s *bonafide*.”

Some participants indicated that it was a matter of accountability; of being legally and professionally accountable to clients who would identify themselves as lesbians. They stressed that it did not matter who the client was, nurses were obligated to care for someone, no matter how they might enact their sexuality. Other participants indicated that their desire to participate in this study was a matter of social justice and they would have included lesbian content even if they had not been asked to participate in the study. One participant had already been incorporating some aspects of lesbian health care into her classes, and for her it became a question of how much and when to include this content, not whether she would include it. One participant reported having been thinking about ways to include the topic of lesbians within her teaching and eagerly agreed to participate as a means of pushing herself to do so that particular semester.

Still others knew me personally and agreed to participate out of a desire to help me in my dissertation work, and thought their participation would be an easy extension of their current teaching practices. Another participant spoke of valuing the research process and said that she felt it was her duty to participate in research studies when asked. Another participant indicated that it was because she felt challenged and thought it would be interesting.

I knew I couldn’t devote a whole class to lesbian health issues ’cause I know what we have to accomplish in 14 weeks, but the idea seemed do-able when you mentioned...scenarios [pause] I could use in class as examples of what was being discussed or taught.

Previous Personal Experiences With Lesbian Issues

In terms of previous experiences with lesbian issues, most indicated not having many experiences with lesbians as clients, students, family, or friends. Some indicated having had a teacher whom they had learned was a lesbian. Two participants indicated having had “out” lesbians in their classes; others indicated that they had suspected a student was lesbian but did nothing to confirm this suspicion. Numerous participants indicated that they had acquaintances and/or friends who were lesbian. Most indicated that they did not engage in conversation about sexual orientation with these friends or acquaintances. Two participants indicated that although they may have talked with lesbian friends about sexual orientation, this was not the basis of the friendships and so they did not see sexual orientation or identity as significant or important.

All participants reported being comfortable to some degree discussing lesbians and lesbian health care, although many indicated not having much knowledge in the area either in their personal or professional lives. However, in conversation many participants searched for words when trying to discuss lesbians. There was a noticeable awkwardness that was rarely discussed, and some softened their voices when saying the word lesbian.

A common report from participants was that, as nurses, they had not cared for anyone they knew to be a lesbian. This was seen as a hindrance to their teaching as they had no personal experience from which to draw examples, or even ask questions, as they did with other areas of nursing practice. About one-third indicated that they had friends who were lesbians and implied that this was comfortable for them. Only one individual spoke about having explicitly talked with her lesbian friends about their experiences of being lesbian in the world and how this impacted their interactions with health care professionals. This had occurred on one occasion when the friend had cause to go to the hospital. She could not recall any details from that conversation although her recollection was it had been stressful for her friends.

Previous Inclusion of Lesbian Content in Teaching

Some of the participants, when first aware that they had not ever included lesbians in their teaching, wondered why that might be. One participant reflected on the topic of inclusion:

I've not previously included lesbians [pause] gay couples [pause] not lesbian people [longer pause] individuals. So I wonder why I haven't. It was the question that was going through my mind when we met initially, back in August, about why haven't I done that. I don't know [pause] Perhaps—? [pause] I can't come up with excuses—

She went on to say:

I've been thinking about it. Because as I told you earlier, I've had to sort of examine...how comfortable am I...going up there [in front of the classroom] and talking about this? And [pause] why would this be different, that a gay issue [pause] um, so, a homosexual issue, you know? I'm sorry [long pause] I'm not using the right words [pause] you know what I mean? [pause], I mean in terms of being a nurse on a floor, I don't honestly know if I've even encountered, I obviously have, but a lesbian couple, that I've had to nurse, I don't know if I can recall that. Now, I have friends who are lesbian. But I don't know if I've ever encountered that as a nurse. So [pause] and that makes you [referring to self] wonder why maybe you have—maybe you didn't [pause] why didn't you notice that or put that in your nursing care [pause] or consider that? So, that [pause] has me thinking about it.

As you can see from the hesitation, this participant was challenged in talking about lesbians, referring to them as a “gay issue” or “homosexual issue” and less frequently using the term lesbian. This was a common observation with many of the participants. They would hesitate or stammer in our discussions. For most, this subsided by the end of our discussions and may be indicative of how rarely we have opportunity to use the terms such as lesbian, lesbian couple, or queer in our everyday conversations. At the same time, participants voiced initial open mindedness regarding the inclusion of lesbian content, even if they were not completely comfortable with the topic in everyday conversation.

Participants were generous in their recounting and sharing of internal processes and specific learning activities they used in bringing the topic of lesbians and lesbian health care content into their teaching. The next section reviews the specific learning activities that participants used.

Learning Activities Participants Used

Participants were asked to include three learning activities during the semester that included lesbian and lesbian health care content. These learning activities were determined by individual participants after discussing possible examples at the project

orientation meeting. In addition to our discussions, participants were given a reference list (see Appendix F) and hard copies of several articles discussing lesbians in general as well as specific content that could be included in their teaching.

As was expected, learning activities varied from participant to participant. All participants were successful in identifying three times during the semester in which lesbian content was discussed. However, the degree to which they developed actual learning activities varied considerably. Learning activities ranged from thoughtfully planned insertion, through a mere mentioning of lesbians, to a hope that it would come up unplanned in spontaneous discussion. The learning activities included: assigned readings, supplemental readings, guest speakers, informal discussion, formal discussion with prepared questions, summary paper, lab scenario, inclusion among a list of marginalized groups, and an exam question.

In the next section, I describe the individual learning activities, analyze the learning activity, and discuss the likelihood that the learning activity advanced understandings of lesbians or lesbian health care.

Classroom Discussion

The most frequently used learning activity was that of classroom discussion, wherein the teacher and students engaged in an exchange of ideas about a given topic or concept. All participants used discussion in one form another within their teaching. Discussion occurred in two ways, spontaneous and planned. Mostly participants reported that the discussions related to this project were more or less spontaneous and that they “tried” to be conscious of including lesbian issues within the ebb and flow of conversations that centred around a focal point for that day’s class. The depth and focus varied depending on the ways in which discussion was used as a learning activity or teaching tool. There were similar patterns of use among the participants.

One pattern was that the inclusion of lesbian content often fell within discussions of diversity, culture, marginalization, and family. Some approached it within an introduction by listing various group characteristics that contribute to diverse populations, such as religious practices, culture, ethnic, nationality, sexual orientation or identity, socioeconomic status, body size, family make-up, and so forth. These inclusions within the learning environment discussions with students were described by participants

as “moments”, and were not expanded on with any specific content or nursing care suggestions or insights.

Another common pattern was that students did not bring the topic up on their own initiative; it was more often initiated by participant educators, either directly by asking about lesbians, or indirectly by including it as a topic within the readings. As mentioned earlier, one participant thought that the topic would naturally arise within conversations with students. She was surprised to discover that that was not the case. In reflecting on this assumption, she was acutely aware that this resulted in the content being missed altogether. She began to wonder if this was because it simply did not come up, or if there was some level of unspoken discomfort about the topic that she had not considered before participating in this study.

One participant described her initial attempt to talk about lesbians under the larger topic of diversity. She wanted the topic to come up “naturally”, “to have it be smooth” and:

where it would be self-evident that it is an issue and not a special occasion. So that the actual course content brings up the issue [pause] and it was interesting because it was there, and no one brought it up. So, then I had to bring it up. I brought it up when students basically said, “Oh, yeah, [diversity’s] no problem.” So, I said, “What are diversity issues?” And they still hemmed and hawed. And finally, I just said, “Well what about the idea that you’re a nurse and will be caring for someone who is a lesbian?” The majority of them [students] remained silent.

On more than one occasion participants commented that the topic of lesbian or lesbian health care “did not just come up” on its own. Participants needed to be prepared in some manner to introduce the topic and help students focus their questions, reflections, or critical thinking.

Many of the relevant conversations among students and faculty members about lesbians happened in the moment and were not directly planned by the participants. To illustrate, one participant had been looking for ways to include lesbian content within discussions with students. She was finding this particularly challenging since she was seldom with a whole group of students and traveled between a number of clinical sites. On one occasion, three students were available at the same time and she decided to have a conversation with them:

I raised the question with them, “What issues do you think a lesbian couple might have in relation to the health care that they could receive?” And I gave them two instances, one a home care instance and the other was a breastfeeding situation. And the comments that came forward...[were] concern[s] about how the individual, how the nurses would respond to them. How were they perceived by the health care personnel and would they receive fair treatment? Or, treatment similar to any other couple requiring care. We discussed along that line, amongst the three of them; one of them was fairly quiet, she didn’t say much. She did, on occasion, make comments that indicated the fact that she recognized the concern that a couple who were lesbian might have.

I found that this group [of students] was harder to get them to articulate. I had to half-say what I wanted them to think. One student picked up quite quickly; the other two, I had to restate and restate in different words. [At] pre- and post-conference...I don’t necessarily write down what it is I want to cover. I have in mind what it is I want to cover and so I’m not sure I was as articulate about it as I could have been. But this would have been true any time I talked with them, and I don’t recall having to be this directional when we’ve talked before.

Analysis of Participants’ Use of Discussion

Faculty members can use discussion effectively as a tool to locate current knowledges, name assumptions, and explore new understandings. These participants used discussion at times more as a superficial engagement with students and course content rather than allowing information and knowledge to lead discussion into areas that challenged both thinking and nursing practice.

As mentioned earlier, even those faculty members who prepared specific questions to help focus discussions were aware, upon reflection, that it was easy to wander off the topic and discuss related but somehow safer or more familiar topics, such as ability or race. Faculty members need to be aware of this and be prepared to address the change of subject as an indicator of discomfort (their own and/or students’), and be willing to redirect the discussions back to the topic at hand, in this case lesbians and lesbian health care concerns.

Teaching beyond experience and comfort. If a faculty member has limited knowledge about an area of practice, this is experienced as “uncomfortable”, and one participant indicated that under those circumstances she decides not to include specific content. This has important implications for many topic areas, not just that of lesbian issues, and suggests two important questions: (a) What other areas of practice may be

overlooked because of faculty members' discomforts? (b) Is discomfort or lack of experience a good reason not to bring up a topic in one's teaching? Nurses and nurse educators draw on a range of experiences to make connections with content areas, clients, students, and families. When fundamental knowledge or first hand experience is not present, some study participants pointed out that they do not include that topic in their teaching. Since many participants voiced having had no experience with lesbians in their practice and most had not included lesbian content within their teaching, there does seem to be a relational connection between the two. One way in which this might be remedied is for faculty members to seek out connections with lesbians. This might be done within their own professional and personal communities, within staff development, through personal reading, or through a focused process of reflection.

Assigned Readings

The second most frequently used learning activity was that of assigned readings. When assigned readings were used as a learning activity, they were primarily required as opposed to optional or recommended readings. One participant included a particular reading as a "supplemental reading" and reported that it was not checked out of the library, and since students were not reading all of the assigned readings she was certain none had read this optional one. Such readings were most often used as a springboard for further discussion in the classroom. Some faculty members prepared specific questions that they felt were relevant and would guide student discussion in certain ways. However, most reported not having prepared questions based on the assigned readings, but having relied on a sense about where they wanted things to go with students during follow-up classroom discussion.

Sometimes participants were able to combine learning activities. One participant had specific assigned readings, followed by an in-class writing/reflection summary page. This participant chose to have the students read two articles, "Lesbian Stereotypes" (Eliason et al., 1992) and "A Nurse Speaks" (Randall, 1994), and respond to them. Rather than having these marked as other papers were for this course, she reported giving the following directions to students:

When I gave out the summary page, I said to them, "I want you to be completely honest. Your opinions are your own. Don't put your name to any of the pages. I

don't want to know who you are. And please be very open and very forthright and give me your honest opinions." And so they did.

When asked what the follow-up was to this, the participant was a bit vague. She reported that no written feedback was given on the summary pages nor were they marked or returned to students as other similar assignments were for this course. The participant reported that she knew she would teach these students in other courses later in the program (this was a first year course), and she thought that there were more appropriate places to address their comments about lesbians on the summary papers than here and now. "I think this would be further along in their education. I think right at the moment they've had the concept of difference, different but equal, given to them."

Other participants reported that the readings were valuable in bringing to light information neither the faculty member nor students were aware of. Participants reported having readings that ensured that students would have to do more than share their opinions and had to locate their comments within a larger context of experience. As might be expected, those teaching in the fourth year reported engaging in discussions among students, in which they addressed complex and challenging issues from their own experiences. They reported that none of the students spoke of lesbian care experiences yet they seemed able to transcend these limitations and imagine different ways of approaching nursing care.

Analysis of Participants' Use of Assigned Readings

For the participant whose students made numerous negative comments within their summary pages after their assigned reading, it would have been timely to capture this as a teachable moment even if the participant had wanted to wait for subsequent semesters when she felt "students would be more ready". Her silence, because of the negative comments within the summary pages, could be perceived as sending a message of acceptance by not, at the very least, interrupting students' opinions and letting them know they would be exploring lesbian health care concerns later in the program.

The fourth-year students' abilities to transcend their limitations of experience and imagine different ways of approaching nursing care probably reflects a developmental stage of being able to see greater complexities since they are near the end of their program of study.

Guest Speaker

Having a guest speaker was a learning activity used by two of the twelve participants, and a third participant reported that students probably would like a guest speaker, and that she would consider one in the future. One participant had a gay man who was a nurse come to class and speak about coming-out issues. The participant described the difference in having a guest speaker rather than bringing up the topic herself:

I think the difference was that he is openly gay and, you know, was able to talk about the whole issue of coming out of the closet and what it's like. But not only that, he's male. So, he is a minority within a minority and all that sort of stuff. He said he's very open about what he does... [very long inaudible section]. So, I think that in of itself, makes it really easy. Umm, they're the individuals taking the risk. You know, it's their experience.

This participant seemed to hold the opinion that having a gay man as a guest speaker addressed lesbian issues. There were no specific examples given by this participant of ways in which similarities and differences between lesbians and gay men were addressed during this session.

Another participant asked me to come to her class and speak about access to health care issues in relationship to lesbians. My speaking occurred within a larger course discussion on access and effects of marginalization within various population groups. The participant described the "most prevalent themes [inherent in learning activities she uses] as social justice, reflection, and gaining insights into one's current position and thinking". In the discussion that followed my presentation, the participant engaged in dialogue with students that helped to link other information they had been exploring within the context of culture and health to lesbians as recipients of health care. She spoke of wanting to have students begin to see the intersections of various concerns or points rather than seeing them as single issues only addressed by one population group at a time. A number of readings were also assigned within this course whereby students could move between various concepts and marginalized groups to gain further understanding of ways in which these concepts impacted the various groups. This participant reported that her tactic had been reasonably effective, as students' papers showed integration and crossover among course topics.

Analysis of Participants' Use of Guest Speakers

Overall, having a guest speaker was a positive learning activity. It allowed participants to bring an “expert” into the classroom to raise awareness, ask questions, and deliver specific content. The participant was then able to follow up with the students, drawing on their shared experience of hearing the speaker and explore their questions while linking this to nursing practice.

It seemed that some participants saw a close connection between gay and lesbian issues, although this was not clearly articulated within the interviews. (Another participant developed a case study addressing a gay male and HIV/AIDS.) While there are numerous similarities among oppressed and marginalized groups, it is important to note that there are remarkable and distinct differences between the experiences of lesbians and gay men, and these differences are as distinct as the differences between men and women (Blumstein & Schwartz, 1983). The use of AIDS as an example of health care issues in the context of lesbians falls short of the health needs of women. It would be like saying research on breast cancer in men tells us all we need to know about breast cancer in women. While there may be overlapping or similar issues, there are also distinct and separate concerns that need to be addressed.

Skills Laboratory Scenarios—Using Case Studies

One participant’s main teaching responsibilities were in the skills laboratory. As was typical of this lab, students practised skills within the context of brief case studies. Before participating in this research, the participant had never used cases that included lesbians. Typically, clients were identified passively as heterosexual by their marital status: “As you well know...a lot of our scenarios are based on heterosexual kinds of relationships”. This participant took steps to develop some case studies where the case client was identified as being lesbian. This took place within the context of including the client’s partner within the scenario in a manner that paralleled how heterosexual clients were addressed. The participant shared two of the scenarios she used:

The first one followed on the heels of the health assessment lab. It was a scenario based on a surgical patient needing pain control following surgery. And it had to do with a hysterectomy. The couple had been trying to have a child. A concern came from one student, “Don’t these people realize they can’t have a child?” Which was quickly followed up by another student in the group saying, “what

planet are you on?” And another student responded saying, “There’s other ways people can have children, just because they’re a same sex relationship doesn’t mean they can’t have children”...So that was the first scenario.

The second scenario had to do with catheterization. It was a lady who was extremely sick with sepsis and was confused. The woman’s partner was present when the nurse came in to insert a Foley cath.

The focus of the lab was to have students learn about psychomotor skills and yet there was room to include lesbians in the scenarios in a way that added a level of complexity and required some critical thinking on the part of the students. The participant reported that this went smoothly with the students and the focus remained on the skill of inserting the Foley catheter. This participant had been worried that there might be “unprofessional or inappropriate comments made such as the term dyke or gay bashing” but this did not happen.

Overall, participants reported few questions or notable comments by students about the inclusion of lesbian content in case studies, although one student, with whom the participant reports having good rapport, questioned her inclusion of lesbian content:

Participant: ...[student asks] “Now, [participant’s name], what’s with all the lesbian scenarios you’re giving us?” (and I’ve given them two). “We’re noticing that this is unusual”. That, in other words, this hasn’t happened before in other classes, “So why have we had a couple, now, and it’s only in your class?” So, they have noticed that and they wanted to know why... Well, they didn’t ask me why, they just made this off the cuff remark.

Researcher: And what kind of a response did you have?

Participant: Well, it was directed to me and the other instructor [there are two lab instructors for this course and they teach together]... I said, “Well, we’ve had other scenarios in class this week, this term too, about [pause] different cultural groups. It’s just another population that we need to consider.” That was my response to them at the end of class. But, they’re beginning to wonder, because they don’t get it in other classes...obviously, it’s been different for them.

This participant reported positive results from the inclusion of lesbians into case studies.

Analysis of Participants’ Use of Case Studies

In the case studies used in the lab skills course, there was little exploration of relationships or the wider meaning of hospitalization, and this would probably be true regardless of whether or not lesbians were identified as the clients. This may be a reflection of how the lab is viewed within this curriculum, as a place of technology rather

than a simulation of clinical experiences in which the whole picture of nursing care may be practised.

It is interesting to note that the inclusion of two case scenarios during the semester led one student to inquire about that inclusion. A student questioning the participant in this way suggests that students are aware of the subtleties present in educational materials used within the learning environments and notice when they change, although the participant did not note similar comments made when ethnicity, religious, or culture had been previously added to case scenarios. Hearing this student question the underlying meaning of including difference in lab scenarios reinforces the importance and value of structuring the lab to reflect various differences that students will probably encounter rather than simply recreating the normative status quo. Using school nursing labs as a means to expose students to the complexity and range of variability within the population can only lead to better prepared nurses.

Exam Question

One participant framed an essay question on an exam that asked students to respond to a hypothetical job interview question, while at the same time exploring ethical decision-making. The students were given the following information to respond to:

You are a recent nursing graduate from [names school] and are being interviewed for a nursing position on a maternity ward. The nurse manager notices your recent graduation and asks about your registration exams. You reply that you took them recently and passed. The nurse manager asks, just in passing, why you want to work on a maternity ward, you reply, "I have a real interest in [the] child bearing area of nursing, it was my favorite course at [names school] and I had further experience with L&D when I was in Belize doing a trans-cultural nursing elective." The nurse manager continues... "I notice your affiliation with [names faith-based school], I want to let you know we don't do abortions here, at this time. Who knows what will come up in the future? We do have, however, more and more lesbian couples, who though artificial insemination, are having families. So I'm wondering how you feel about that. I'm also curious about how you would feel about therapeutic touch that's being used with drug-addicted babies. I know that some [names faith] are leery of these treatment modalities and these practices. Are you up for all of this?" Students were then asked to respond to one of these two questions.

The participant indicated that her reason for asking this question was to have the students look at "places where there might be conflicts between personal beliefs and practices of

patients". She reported wanting them to tell her about what they were thinking and what this would mean in their practice. In terms of responses from students, she said:

It was probably about 10% said they wouldn't take the job and the others said that they would explain themselves and sort of work through the assumptions that were being made because of my association with [names faith-based school] and the values that they hold.

She reported that about half responded to each of the questions and there were no real surprises in their responses:

They spoke of the Canada Health Act, the impact of marginalization on a population, access to health care, and how if they were too challenged personally by aspects of the job, they would have a responsibility to say so and go somewhere else to work.

The participant appeared pleased with the students' responses and thought that they had been thoughtful, reflective, and had pushed their thinking. She said that this is what she wanted to do as a teacher: to have them come to understand themselves better.

Finding Relevant Resources

The concern arose, in both the group and one-on-one interviews, that there is a lack of resource materials such as textbooks, examples, or ideas for learning activities concerning lesbians and lesbian health care concerns. One participant commented on what she used for preparation for teaching and how she did not recall ever coming across material that included lesbian scenarios.

Yes, well, there's always the guidebook for the instructor, ok? They have little handbooks that come [with textbooks] and I don't think I can recall a situation...because I went looking for situations actually, in those handbooks. You know, how you asked me, how I prep...I've got two or three handbooks at home that I go through, looking for some hints...usually orders and meds to make sure the meds fit with the actual condition the person has and stuff like that. And they do have psycho-social pieces in them...and although they're heavy on assessment...I don't think I've ever seen a lesbian scenario. And if I've seen a gay scenario, it's been around AIDS/HIV. So, very very stereotyped.

If this participant had come across examples of how to incorporate lesbian concerns or lesbian health care before participating in this research, she would likely have used them in her teaching since she relies heavily on this assistance in preparing for teaching. This reliance on examples from teacher manuals speaks to the need for greater inclusion of such material within published textbooks and supplemental materials.

Others in the focus group agreed that they could not recall any examples from textbooks or workbooks that included lesbians or lesbian health care concerns. If they had, most participants thought that this might have triggered their inclusion, although some reported that it still would have been challenging since they had not had any experience with lesbians as clients. One participant mentioned that if lesbians and lesbian health care content were included in textbooks and supplemental materials for teachers that it might take away some of the sense of “othering” or singling out of a particular group that she had felt in trying to bring the topic up with students during this project.

Analysis of Finding Relevant Resources

In reviewing the learning activities as a whole, faculty participants relied heavily on discussion and readings as their primary means of inclusion. This reliance, while sometimes engaging and thoughtful, places a burden on faculty members to be well read and reflective regarding the experiences of lesbians and their health care needs. Participants probably would have been more inclusive if there were examples or suggestions for learning activities more conveniently and prominently available which could easily be adapted to various teaching styles and specific courses. Many teachers rely on textbooks for help in preparation for teaching. It will be necessary for textbook authors, publishers, and nurse educators to create a broad, collection of relevant learning activities in the future if faculty members are to begin being more inclusive of lesbians and members of other groups considered “different” from the dominant population.

Indications of Consciousness-Raising

Having started with an overview of who the participants were and what they did to introduce the topics of lesbians and lesbian health care into their teaching, I will now move into a discussion about their experiences during these interventions, and the extent to which it raised their consciousness.

The evidence used to support the conclusion of consciousness-raising having occurred is overt and direct. The interpretations come from things participants told one another or me directly within our conversations. All participants agreed that participation in this study raised their consciousness regarding lesbians and lesbian health care needs. They talked about having not known much about lesbian health care, or of lesbians in general; of having read little about these topics within nursing literature or general

reading prior to their participation in this study; of appreciating the references and articles provided; of having actually read many of the articles they had taken during the orientation meeting; and of the fact they were involved with others in doing something similar.

Most had never previously considered overt inclusion of lesbian health care issues within their teaching practice, and what participants learned varied considerably. All but one of the participants reported having never knowingly taken care of a lesbian during their years of practice and none reported having had students assigned to “out” lesbians in clinical settings. Two participants reported having had an “out” lesbian within a class they taught (though none during this study). We had lengthy discussions as to why this lack of awareness of having cared for a lesbian was so prevalent within the group. Although we did not reach consensus as to why this was, we did gain insights into ways various fears, minimal personal knowledge of lesbians, and limited awareness of specific teaching strategies played a part in previously excluding lesbians and lesbian health care content.

From the first interactions with participants during recruitment, a process of consciousness-raising was evident. They were curious about the topic and reported that they began asking themselves questions about why they had not included any or much lesbian content before. Most indicated that the thought had not occurred to them. This surprised some; others wondered what else they had not thought to include in their teaching. In virtually every interaction, participants shared comments about a range of self-reflective questions, insights, or links they were making about lesbian content and their teaching.

Participants repeatedly shared their reflections and self-questionings as we talked individually and within the group gatherings (both the orientation meeting and focus groups). The primary foci of consciousness-raising centred around awareness and knowledge, reflective questions and personal insights, and a sense of support knowing others were doing something similar within their teaching.

Research, either quantitative or qualitative, documenting the long-term outcomes of consciousness-raising (CR) are limited in number. Research has primarily focused on consciousness-raising as a process within feminist CR groups (Ezekiel, 2002; Freeman,

1975; Lieberman & Bond, 1976). It is not possible to make direct comparisons between the outcome findings of feminist CR groups and this research, as the two were designed quite differently and have different foci. However, since little research has been done regarding consciousness-raising as a critical/emancipatory process, I have drawn on this research in order to gain greater understanding of the process, limited as this might be.

Awareness and Knowledge

Whether we call the initial stage or process of consciousness-raising “enlightenment” as Henderson (1997) does or “insight” as Lieberman and Bond (1976) used, or “information” as Striegel (Nassi & Abramowitz, 1978) called it, there is a place of beginning for those who experience consciousness-raising. Consciousness-raising occurs when individuals gain new knowledge or begin to use their previous knowledge in new ways, whereby insight and awareness are achieved (Ezekiel, 2002, p. 75). While the consciousness-raising process has not had a lot of research attention paid to it, there is agreement that as a result of it, one’s thinking and understanding of events or information shifts (Abarbanell & Perl, 1979; Ezekiel, 2002; Freire, 2000). For the purposes of this research, I call this initial stage “awareness and knowledge”.

Participants (except for one) in this group shared a new awareness that they had each not knowingly cared for a lesbian and had, until now, never given this a thought. In our discussions, most stated that they were aware that somewhere in their practise, they had cared for a gay man and many agreed that they likely had cared for a lesbian and had not known it at the time. This raised further discussion and questions regarding ways in which they met, or more likely had not met, the needs of those lesbian clients. There was some discussion as to why they knew they had cared for gay men but not lesbians. No consensus was reached as to why this might be, and it was variously said that they “figured it out from their [the men’s] behaviours” or “their partner was there and said who he was”, or a “family [member] disclosed it”. None had had such experiences or discussions with lesbian clients and realized that if they had, they would have been more sensitive and inclusive.

Not having experience from which to draw was cited as a critical reason for not including lesbians or lesbian health care content. While this may not always be conscious, one can see from the next example that a certain degree of comfort,

awareness, commitment, and drive is needed to include specific content. If faculty members do not have an awareness or do not see a particular need to be inclusive, inclusion will not happen. This may be due to ignorance, or to wanting to retain a degree of comfort for themselves in the learning environment. One participant said:

I had a great knowledge gap on my part, so when they [students] were saying, we do not get any information, well, it is obvious to me. I don't have the knowledge and have never really thought of the specific issues for lesbians regarding health or regarding substance abuse and different health issues, the elderly, not seeking medical attention, poverty, et cetera. So, I didn't have the facts, information around it, and never really sought it out, but certainly realized through doing this [participating in this project] that there is a lot to learn...I had a lack of knowledge....So my feeling is one of negligence and, you know, the consideration to be more deliberate in discussing it and raising it, in integrating into, certainly this course and others. ...I think we avoid— [pause] I wouldn't talk about— [pause] I don't talk about issues in maternal-child particularly, because I don't feel very well informed anymore about the content, current content. [pause] So, it was an interesting discussion...it was introducing something new for me, it made me stop and think about how I handle different situations, [pause] new things.

All participants commented on being aware that they needed to be more inclusive within their teaching and thought that this experience was helpful in reminding them that inclusion does not just happen within the classroom, it takes effort and focus. For inclusion to happen within learning environments, faculty members need to be aware of the prevalence of the dominant culture, the ability dominant culture has to silence difference and diversity, and ways in which marginalized groups are easily overlooked when the teacher is a member of the dominant culture. (All the research participants were members of various aspects of the dominant culture and therefore had varying degrees of privilege.)

Reflective Questioning and Personal Insights

Reflectivity is at the heart of critical perspectives and ways of knowing. As Willis (1999) asserts, "being reflexive involves considering one's own place in the social world, not as an isolated asocial individual but as a consequence of one's experience in the membership of social groups" (p. 111). Cheek and Rudge (1994) remind us that the application of a critical perspective enables the personal to be political, and in so doing, moves us away from seeing injustices as personal problems and allows for recognition

that injustices have a societal construction. “Consciousness-raising affords the potential for such shared concerns to enter the public domain, to become visible and hence politicized” (p. 60).

This section focuses on the reflective practices and personal insights explored by participants as they shared their experiences within this research. This process becomes important in that it sheds light on ways in which these participants began making visible their personal journeys of understanding, insight, and ultimately what can be called raised consciousness. Cheek and Rudge (1994) explore this process as one in which consciousness-raising “allows for the acknowledgment of otherwise invisible structural constraints and makes visible the power/knowledge axes embedded within contemporary nursing practice” (p. 63).

Although all the participants indicated they felt they had had their own consciousness raised by participating in this project on numerous levels, there was consensus that they would like to do more in the future to include lesbian content in the courses they were teaching. Most admitted that they had not previously given the idea any thought. One participant reported that being a part of this study had her questioning the level of engagement she was having with the fundamental concepts of difference and diversity. Those opportunities for reflection showed her how little was actually being brought to the forefront with students.

Realizing

My assumption is I create the [learning] environment...I don't think I bring [real differences] into the class. I bring myself, which is pretty stereotypical. I'm blond, and I'm married and...I have three kids. And does that prevent me moving beyond there? [pause] This was the question I came away from class thinking. So, how do I live the curriculum in my own beliefs that we need to break down stereotypical ways that we live together so that we challenge one another [pause] challenge one another in how we live and how we embrace how others live differently? I think I can do better than what I'm doing. I think I need to, I think I need to challenge my own way that I, uh, challenge the norms. So, I think about being a radical feminist, I'm always pushing the boundaries but do I only push them when others bring it in? Do I create discomfort? Do I create the dissonance and challenge the students to think beyond what is comfortable, or do I rely on the curriculum to wake me up, to make sure I'm doing that? ...I could provide more opportunities for discussion around racial differences, around sexual differences, and this would provide students the opportunity to work differently within their own thinking. So I really need to address that....What would I do differently...so

that the students have an opportunity to address that very question that you ask me, “So how has your practice changed?” Well, your question makes me think, I don’t think it’s changed much this year. [Students] may know a little more, but if there isn’t something to challenge you, do you really change? Yeah, yeah. You see, that’s what really struck me, it was really quite pronounced, I want them to be exploring fundamental assumptions and challenge them to think about things differently in a way that does change their practice. I’m just not sure I actually am doing that and this project has me really questioning my own actions in the classroom.

The questioning that this participant brought to our discussion is broader than merely looking at the inclusion of lesbian content; she struggles to name the very nature and purpose of her teaching. She came away asking about ways in which her practice has been changed and her teaching has assisted students in exploring fundamental assumptions and challenged them to think differently. This questioning is essential if nursing educators are to bring about conscious and deliberate inclusion of oppressed, excluded, silenced, or marginalized people/ideas/content. Although these examples are about lesbians, this type of questioning would apply no matter which specific topic of difference/diversity/inclusion was focused on.

Another participant shared a realization that arose for her when exploring why she had not previously included any lesbian content in her teaching. She described how typically she draws on her own experiences for examples to share with students and by having none related to being a lesbian or previously working with known lesbians, she felt uncomfortable pretending she knew something.

I thought about my knowledge base [pause] on the whole topic [long pause]. It’s easy for me to talk with students about somebody’s experience with diabetes or a parent caring for a child who’s got asthma [pause] because I’ve done that....But I’ve never really had to [searching for words] nurse, as I’ve said before, or knowingly anyway [a lesbian] [longer pause] so I couldn’t draw on that experience and that makes me uncomfortable.

The articulated realization by this participant, and others, of their lack of pertinent experiences, when asked to make this teaching intervention suggests that there is a strong connection between inclusion of particular content, and faculty members’ previous experiences and their resulting comfort level with the topics at issue. (This was discussed earlier.) This seemed to be pivotal in the consciousness-raising process.

Consistent with the literature about contact and comfort levels with lesbians (Hitchcock & Wilson, 1992; Lance, 1987; Mahoney, 2001; Mathews et al., 1986; Matthews, 1998), one could deduce that with additional awareness, experience, reflection, and engagement with lesbians and their health care concerns, nurse educators would be more knowledgeable, have relevant experiences to draw upon, and be more inclined to include related topics in their teaching. This suggests that if more faculty members were aware of having come into contact with lesbians and knew more about general lesbian health care concerns, they would likely be more comfortable with the topic and bring the discussion forward when working with students.

Maturing

Some participants reflected on changes that had occurred for them over their lifetime that were relevant to this study.

Now, I'm not young anymore; in fact, I'm getting close to retirement, so a lot of this journey has been a long, *long* one. A lot of the changes have been in my later years and I think it has to do with experience and contact with people. Some of it occurred when I started my doctoral program....One of my profs was [pause] [lesbian], although she never said anything about that, it was only other people that told me. But the discussions we had in feminist classes, in qualitative research, in theory...I found all of that sort of helped me, to change the ways in which I was thinking about how things really exist.

All participants spoke of how they have grown and developed over the years. They each reported that there was noticeable growth and development regarding their level of acceptance of others and this was mentioned as having had an important impact on their teaching. Many participants saw themselves as becoming more willing to take risks, to reveal more about themselves as people, and felt more satisfied with the little accomplishments of teaching than in the beginning of their careers.

It Will Just Come Up

One participant reported that she had thought the topic of lesbians or lesbian health care would just come up when having other discussions with students. She had not specifically attempted to develop learning activities to include lesbian content. She had assumed that because she would be looking for specific places to include examples "that it would just happen". In fact, this was not the case and she was quite shocked by the fact

that in regular interactions with students neither she nor the students approached the topic.

I decided...I would pay attention to any openings to talk about, to include lesbian people [pause] lesbians, in my lecture or in the conversation, the discussion, and that I'd just be alert to it....And then I began to realize it wasn't coming up and that really impressed me....Why wasn't it coming up? We're talking about feminism, you know, in one class we talked about feminism and different kinds of feminism and I realized at the end of the day that nobody had mentioned lesbians...now that seems like a huge omission to me...I've never even considered myself to view the world as heterosexual [pause] I just thought that that was just normal [pause] to include lesbians in my life, but I'm not doing it in my teaching and that I find quite shocking!

This participant goes on to ask herself some probing questions about this insight and discovered that unlike her previous understanding and experiences with visible differences, she held the belief that “lesbians were capable individuals”. She came to see that she viewed various types of oppressions quite differently and this led to another opportunity for reflection about why that might be so.

By identifying some of her held beliefs this participant was able to begin exploring some of her assumptions regarding lesbians and came to realize that it was only from personal experiences that she had come to these conclusions and that “different experiences would have brought different conclusions”. After further reflection and reading, this participant reported beginning to realize that she “actually needed to be *more* inclusive and could see that this would take some effort, it just isn't going to automatically come up”.

This participant's insight reveals an assumption that by having an awareness or positive regard for a topic it will surface in the day-to-day activities/discussions in the learning environment. This was shown not to be the case for this participant. Her shock in realizing that she had not done so, even when having made a commitment to do so was a revelation for her. Creating a space for reflection facilitates the examination of our assumptions, intentions, knowledge base, and actual practices, and enables us to check whether they are congruent with one another.

Questioning Personal Responsibility

One participant was quite self-reflective in our interview conversation, summarizing her experience in teaching about women's health;

To me, caring for self is an essential piece of women's health care, and so in terms of the health of lesbians, in terms of how to bring that into the curriculum, like to me, it's that same issue of agency, how to ensure that women who are lesbians have access to health care. That is respected, honoured, supported, you know not...that it's just a recognized part of the health of women and isn't excluded and I need to be more sensitive to that...than I have been. I need to explore the part I'm playing in not engaging with the content. I have to move beyond my comfort zone. I need to be sure to bring up the topic of lesbian[s] in my teaching and not just rely on my colleagues who are lesbian to look after that piece. I have to bring it to students' attention in the same way that I make sure I don't leave race out of discussions. I have to ask myself then, why do I leave lesbian out, why do I not talk about lesbians and health, and race and health? It needs to be there. So, it's just opening my own scope [of thinking] and being more conscious of what I'm including in discussions about health, women's health.

This participant questions her responsibilities to include lesbian health care content within a broader topic of women's health. She sees that a subset of women are lesbians and does not question the inclusion so much as the ways in which to do this. She concludes it is part of her responsibilities and plans on educating herself in the future to include lesbians and lesbian health care concerns in this course.

Making Time to Learn

More than one participant spoke of not having enough time to incorporate new information into their teaching plans. One participant summarized this as:

Oh god, I haven't time to learn anything [she laughs]. Oh, I think it was great [participating in this study], because at the very beginning [of the semester], before I got too busy, I thought about it. And then, it sort of sat in the back of my mind. And I think it made a difference too...when I was teaching...to remember to include lesbian ideas and attitudes...lesbian outlook and that there is another point of view in a lot of things. And I think it did help me that way, but as far as sitting down and reading, I didn't get there [pause] I never got close. So I could have learned a lot more and didn't.

Time was quite valuable to faculty participants and most indicated that it was challenging to keep up on all that they were expected to include within their classes. "So much is changing within health care, it seems as though I get something figured out and it either

changes or something else new happens. I wonder sometimes if it is possible to keep on top of it all.” In spite of voiced concerns about time constraints, busy schedules, and heavy content demands within their teaching, participants reported having their consciousnesses raised throughout their participation in this study.

Improving

One participant, although pleased with her inclusion of lesbian content, reported her reflective process about the need to improve the next time she teaches the on-line course she used for this study’s purposes:

I think where I feel I still have a lot of learning to do or a lot of ways to fine tune the course is to get better at my prompts [pause]. I want to push the students even further in their self-reflection. And so, in prepping for my interview with you today, I was going back to some of our online discussions and just looking at how the discussion had flowed. I think I probably offer prompts in some cases [pause] like what happened in this session we were dealing with gay-lesbian issues is [hesitation] it was gay-lesbian issues and disabled [issues] under the umbrella of access and marginalization. And the conversation started to go down issues of [pause] for the disabled and mental illness. So, disabled and mental illness started to be two hot topics that the students were picking up and going with... When I went back to my notes it doesn’t really look like I pulled them back to say [pause] what about lesbian and gay issues? There’s one student that did a fabulous job of outlining some of the issues for gay populations and a couple of students—two or three students that wrote beautiful case studies about lesbian issues, so it was there in the discussion but we weren’t really taking it further than having a presentation of the case studies. I’d like to do more with our discussions in the future, of keeping the topic in the forefront rather than letting it almost fall through the cracks.

This is a good example of consciousness-raising, reflective practice, and the desire to be a better teacher. This participant is aware through her reflective process that there is even more that she could be doing to facilitate students’ addressing of inclusion issues regarding lesbians and lesbian health care. She was able to review her role in the learning/teaching process and give a specific example of where she might be able to direct students into an even richer discussion.

This same participant goes on to explore her own values that underlie her assumptions regarding students with whom she teaches. This reflective process is significant for two reasons: (a) It explores her personal growth as an educator; and (b) It demonstrates her modeling of behaviour for students and their practice.

I also have this assumption... and what my values are underlying those assumptions would be good to look at. [pause] I have this assumption because these students are studying at [names schools] and most of the students are in urban settings [names different large urban settings within Canada] where there's a high incidence of— [pause]. You know, I think that the whole lesbian/gay issues are much, are more public... So, I have this assumption that the students have already worked through some of the issues and are more aware of them, right? So, [pause] it was interesting when I came to that awareness the other day. I wonder why I am assuming that these students are more comfortable talking about it [pause] are more, are going to be more open [pause] are gonna be able to address it the way I would hope they would address it. So I guess that's one of the points of reflection. I think future rounds of this course I need to be more explicit with the students in offering more prompts, even more prompts to say, what is this content like for you, what was it like for you when you cared for those patients, that kind of thing [pause] just sort of push them more to do the self-reflection.

Reflection was stressed as important among these participants. The internal dialogue that this participant engages in shows a desire to improve her teaching and offer students more meaningful and richer learning opportunities. In order to do this, she questions the assumptions she holds regarding the student population she works with and discovers places where she could probably be more effective in facilitating questions that will help students in their own reflective process.

Relying on Others to Challenge the Boundaries

One participant spoke of leaving our initial meeting and realizing that she never included lesbian content deliberately in any of the classes she taught. What she became aware of is that she had relied on the faculty members who are lesbians to talk about it. She had noted, elsewhere in our conversation, that there are three faculty members who are “out” within this school, not all within the nursing program. “Now, that's very interesting, Carla. Because I really came away thinking about how I expect other faculty that are lesbian to challenge those boundaries and set the tone for what is discussed. I look to them to do that.” When asked if she relies on identified members of other groups to speak on their own behalf, she was vague, responding more with thoughtful hesitations. Her closing comment at the end of the interview was insightful as well as sounding a bit defeated, “I know that I should be talking more about things like race, culture, religion, *et cetera*. I just find it hard to get it all in there [meaning in her teaching]”.

Support

While not well developed in the consciousness-raising research, there is mention of empowerment as an outcome of a consciousness-raising process (Ezekiel, 2002; Henderson, 1995b; Rosenthal, 1984). Most frequently, this is raised about the interactions among individuals as they reflect and question their assumptions, knowledge, and new insights. Often these discussions whereby consciousness was raised were described as not particularly comfortable for members of the group (Ezekiel, 2002; Pharr, 1988). Ezekiel, Pharr, and Henderson all suggest that these discussions do frequently allow for connections and insights whereby women report feeling supported and encouraged to grow and question. People are able to gain an understanding of the patterns that make up why things are the way they are. This occurs when connections are made with others with similar experiences in a way that encourages self-reflection and analysis (Basuray, 1997; Lather, 1991a). These connections are not always smooth or even welcomed in the moment. Often, in reflection with others, individuals come to recognize their own participation in oppression and this can lead to highly charged emotions, sometimes directed outwardly, but often experienced inwardly as anger, rage, guilt, self-doubt, and confusion. Common responses when engaged in this process with others are: "I am not alone", "This isn't about me being a bad person", "If you can make changes, so can I", and "Together we can make a difference".

Henderson (1995a) calls for the use of consciousness-raising both as a method and methodology within nursing research because of the ways it allows for individual and collective discoveries. She found in her research, through the use of consciousness-raising, that change occurred within individuals. These changes lead to new understandings of themselves and others. The process of consciousness-raising, of talking about one's own experiences and having other's share in their exploration of an infrequently discussed topic was rewarding.

Participants in this study addressed this sense of reward as well in their conversations together and one on one with me. A point of consensus occurred within the focus group discussions: that coming together and talking was very helpful.

I think the best part has been this focus group. Really [looked at others in room], because we don't have this kind of conversation [soft comments of agreement

from others in the group]. And it's so inspiring. It's like, 'Hey, there's some people who are having the same struggles, different ideas and it was safe.' Like, here's the trust, right here— [pause].

Another member of the group commented:

And you know, we could share our little anxieties with each other and we could joke about it. And there was that fun aspect....The best part was these rich discussions that we don't give ourselves time to do. And I concur about going into the personal journey [trails off]....You forced me to really look at, 'Do I practice what I preach? Do I? Can I really expand those boundaries? Am I really doing that? How far am I going to take my risk-taking and come to be able to be aware of the boundaries that are there or need to be there, or not?'

Adding to the consensus regarding the shared experience, another said, "You know, it's also made it fun knowing other people are trying to do the same thing. Otherwise you just feel like you're the Lone Ranger with your own little causes." This was followed by murmurs of agreement from others.

Participants found support in sharing their struggles concerning not knowing what lesbian health care content to include at first; the questions they began asking themselves as they questioned their lack of previous inclusion; and what they might do for their three interventions for the study. There was a clear sense that coming together and knowing that others were involved in a similar process was helpful. Some spoke of this as a "sense of comfort" others as "a relief" to know that they were not the only ones looking at their teaching practices in this area. They commented on the usefulness of the focus groups and how they wished there were more opportunities for this kind of dialogue among peers. All participants seemed to value the opportunity for self-reflection and a chance to review their teaching process.

Participants were clear that talking about their experiences was helpful in creating a space for support. This raises questions about use of faculty time together and the need for on-going dialogue and active measures that communicate support rather than just taking care of business or problem-solving student crises. Participants suggested through their comments that they gained something from the opportunity to talk with one another and it would be helpful for more of this to occur. This would enable faculty members to stretch their abilities to move into new, challenging, or unexplored areas with a greater sense of being supported by colleagues. It would also provide a sounding board for newly

explored ideas in confidence that others will be there to assist them through the unknown, if not as a mentor, than at least as another newcomer on the journey.

Another type of support came from connections to others outside the work place. A number of participants spoke of how significant others in their lives had helped them through their questions about what it means to care, about what it means to have someone close to confide in. In most cases, this was a husband, although some spoke of an adult child, parent, or close friend. All reported that this other person helped to keep them on “track, grounded, and focused on a central question rather than letting side thoughts blur their thinking and reflection”.

It really helped to talk this through with someone who just kept asking me about where my beliefs came from, whose interests did they serve, and was that really what I believed when it came to caring about others. It has taken me a while to come to terms with my conservative past and to be willing to explore other possibilities. I think this helps with my teaching, I’ve come a long way, and I still have a long way to go, I’m not completely there yet.

Summary of Consciousness-Raising Processes in this Study

Through the steps of awareness and knowledge, reflection and questioning, and support, participants indicated they had had their consciousness raised. They reported having not thought much about lesbians or lesbian health care concerns previously and now realized a greater need to be more inclusive in their teaching. Each of the participants spoke of being changed in some way and reported that these changes have them thinking differently about what they will include in their future teaching.

Participants shared numerous ways in which participating in this study generated questions they began asking themselves regarding their assumptions and teaching practices overall. Consciousness-raising for the majority of participants was primarily at an initial or informational level. This was expected given their lack of previous thought about, exposure to, or inclusion of the study’s topic before participating in this study. The majority of participants indicated an intention to learn more and continue with the inclusion of lesbian health care content in their teaching although few were forthcoming as to what this would consist of or look like. Those who shared ideas indicated that it would primarily be in the form of reading and thinking about ways to be more inclusive.

Embracing the Challenges of Including Lesbian Health Care Content

In reviewing and re-reviewing the data, it became evident that participants grappled with the inclusion of lesbian content in three ways: (a) through those experiences they had in preparing for inclusion—their hesitations, fears, and knowledge deficits, as well as assumptions and myths regarding lesbians; (b) through their interactions with students and the learning environment; and (c) later through the interactions that occurred when they shared their stories and reflections as part of the participation process of individual interviews and focus groups. Participants spoke about their processes, before, during, and after inclusion of learning activities, and it is through these processes and verbalizing of concerns that I have come to name the specific themes. These themes emerged from the data as substantive pieces and were not specifically located within any one process. That is, participants spoke of curriculum within all three processes. In the next section, I discuss the various themes.

Thematic Summary of Participants' Experiences

A number of themes surfaced from the data related to participants' processes of including lesbian content. These themes included: the role of the curriculum; interactions with colleagues, who needs to be educated regarding lesbians and lesbian health care, lack of inclusion in nursing education, questions of religious objections by students, fear, knowledge deficit, and myths and stereotypes.

Role of the Curriculum

Participants presented an array of ideas regarding the role of the curriculum for them as educators. Depending on the participants' views of teaching, some saw the curriculum as something that was supposed to tell the teacher specifically what to teach. Those who viewed the curriculum this way voiced concerns that it was inadequate and wanted more detail. Others described it as a larger document that set a tone for the overall program of study leaving the specifics of each course open for the teacher to determine. Much to my surprise, there was no consensus about the role of curriculum in assisting these participants with their teaching, even among participants from the same program. Comments clustered into four areas:

- Those who felt strongly the curriculum should be a specific plan that outlines the content to be taught, and when and where it should occur in the program;

- Those who were unclear exactly what the curriculum was supposed to do. This subgroup reported that there was also no consistent understanding among their faculty group about what the curriculum was supposed to do within their program. Most of these participants, however, wanted guidance and felt this was lacking when we spoke together;
- Those who saw the curriculum as a mutable entity that changes according to the whims or trends of the education literature;
- Those that viewed the curriculum as more of a philosophical blueprint for underlying values of the program and larger conceptual ideas of the discipline.

Curriculum that specifies what to teach. All participants spoke of having some level of dissatisfaction regarding how their whole teaching team understood “curriculum”. Many reported that they and others within their school felt similarly confused and yet none reported this to be a topic of discussion within faculty meetings or orientations.

Discussion regarding curriculum raised broader concerns than just those of including lesbian content. More than one participant indicated that she would like to have content areas identified and “assigned” to a course. Some participants felt that having content clearly spelled out and assigned a place within the program would help with concerns about inclusion, repetition, and omission. “Ideally content should have a home within a specific course, ...where the bulk of the teaching would go on and then the other courses support that.” When asked if this was presently true of the program she was teaching in, she responded,

I don’t know [trails off]. Any topic could be a particular instructor’s preference and if somebody else was doing the course, it might not be because [pause] I don’t think we have a clearly defined curriculum in terms of core concepts and secondary concepts that are laid out except in people’s minds and so it might not be consistent. I think it needs to be.

In regards to lesbian content this same participant thought that “it needs to be in the curriculum, whether it’s in the culture course or— but yes, it needs a home base I think. So it doesn’t depend on a particular instructor’s interests, or expertise, or knowledge about it.” This participant desired the curriculum to act as a document that would direct and inform her as to what to include in her teaching of a particular course.

This participant was not alone in her desire to have the curriculum spell out specific content areas for individual courses, although reasons differed. One participant complained of how the curriculum she is working with requires faculty members to weave concept threads across courses.

I think I'm quite old fashioned when it comes to the curriculum and I think there's a lot of dangers in weaving [threads] through the curriculum...in that they don't get well addressed in any course. Well, it turns out everybody addresses it superficially. Instead of, you know, that you are really responsible for this content and there is a clear expectation for the students, you address it in depth. And you know it's been done. I think there are probably a lot of things that never reach the depth that it should. So, I think it's a dangerous road we walk when we weave too many things through, or try to and aren't specific about where and when they happen.

She went on to say that if the curriculum spelled things out, "I would know *what* I'm supposed to be teaching".

A number of participants voiced a desire for the curriculum to specifically include "lesbian" and "lesbian health care content". Those who indicated this did so for two reasons—typically: (a) "There would be less guess work and I wouldn't have to struggle with what to include or not, it would be right there in the curriculum and I would know what to include" and (b) "I wouldn't have to worry about negative feedback, because I could always say, 'It's in the curriculum'." This notion of having the curriculum "to blame" for including certain topics was voiced by some participants. They were interested in doing a good job in their teaching and saw what they understood to be vagueness within the curriculum as being problematic. At the same time, they did not want to take risks that might have people questioning their ability to teach. They felt that by having what was to be included in the curriculum specified they would not have to worry about introducing controversial subject matter into their teaching, and would likely do more of this if they felt "protected".

Others felt similarly, reporting that if the curriculum did not specify content explicitly, it would be easy to leave out topics like lesbian health care.

I know it'd be easy to leave out, [pause] if it's not explicitly addressed. So even when you talk about social determinants and stigma or [pause] you can still leave it out if it's not explicitly addressed in the curriculum. So I think it probably does need to be explicitly identified within the curriculum.

This participant summarized what she wanted:

I would prefer to see a curriculum more well-defined. So you'd know what else had been dealt with in other courses. You'd know how to fit in what you were teaching. So I think that would be the biggest advantage. Overall, for the curriculum it means that people couldn't exclude the content just because of lack of experience or interest or [pause] something [trails off].

Curriculum as more than trendy topics. One participant had a slightly different approach to curriculum. She spoke of the trend for faculty to have a “topic du jour” that seemed to break down into some colleagues telling others what to do. By the conclusion of our interview, she had returned to the topic of curriculum and concluded it was the process of talking together about the work we are doing as nurse educators. This participant responded quite passionately to both of these ideas:

And if it [lesbians] was the “topic du jour” you see—I would hate to see this... because that's exactly what we always do. ... What that does is it shuts our mind down to other topics. ... And it's the repeated pattern of trying to be in a position of prima donna, or “I'm right”, and I know the answer, and this is the “right” thing. And, so, the reason I'd never want to introduce this, or any topic like this as a curriculum topic, “Oh-oh, now we're on another high horse”. And that's not what we need to be on. ... What we need to be on is learning to listen to each other [rather than going off on a tangent], learning to appreciate each other, learning to respect each other and give each other dignity in every kind of interaction that we have. And that's hard when you're all tired and stretched.

The importance of our discussion about curriculum came up later in our conversation when this participant brought the topic up again:

Yeah. I'm surprised we got into the bigger issue and I hadn't made that line between content and some of the bigger issues, so I think your question about the curriculum forced me to begin to look at that. You know, I thought as soon as you said, “introduce it into the curriculum”, I go, “oh no, no, no.” But then what I became aware of is the process of talking, [pause] you raised my consciousness about, about what some of the issues are around how we approach our curriculum work. And the fact that I think we have a lot of growing to do if we're going to have a really healthy process. So that was interesting. It isn't the topic so much as it is the process we use, or not, in talking about things.

An insight was sparked for this participant about separating the content aspect of curriculum from the more complex work of having a group of faculty members communicate their shared understandings of what they are doing as a collective whole—which she would call the curriculum.

Curriculum as a guide. Others spoke about the curriculum more as a blueprint of underlying values and felt that the specific examples used to communicate these were the responsibility of the individual faculty member given the context of the area being explored. Those who felt that the curriculum was a broader guide were able to see how the inclusion of lesbian examples could be used to illustrate broader values of caring. They saw a fit within these broad curriculum concepts without having to spell out lesbian, or any specific content for that matter.

One participant was explicit about the role the curriculum played in her teaching. She was passionate about her resolve in seeing the curriculum as a document critical to a school of nursing. She came back to the importance numerous times throughout our discussions. In deciding where to work, she had deliberately sought a position in a specific school because of the curriculum—the philosophy and values it supported:

That ability to be reflective, thoughtful [pause] critical and all of those processes and trying to emphasize being authentic. It's like a fertile field for this kind of content [referring to diversity]. And that's why I came to this school, because to me, it's the philosophical underpinnings of the curriculum that are the strength of it; they're what makes it work, what makes our graduates strong. And so that explicit commitment to a values orientation means that we've taken it as a given, that we're prepared to engage in this kind of a content area.

No other participant spoke of curriculum in quite this manner and yet her ideas resonated strongly with my own values and experiences teaching. In Chapter Five, I discuss some of the broader pedagogical issues that were revealed in the course of this research, and in Chapter Six there is a discussion of some of the meanings and questions that arose from the study which I feel require further exploration.

Given the level of dissatisfaction and confusion regarding how curricula informed nursing faculty members about their teaching, there was surprising little discussion from participants about how they consciously and consistently were working to clarify the purpose of curriculum. Perhaps this was from an understanding that changes take time and work which most said they had little extra energy to follow through on. Or perhaps it stems from a lack of understanding about what a curriculum could offer a teacher. Or perhaps a focus on curricula merely gets lost in the day-to-day business of the average teacher. No matter the reason for the lack of engagement, there seemed to be a sense of

submission among most—a feeling that the curriculum is fixed and they could do little in the short term to amend it.

Where in the curriculum should this topic go? There were some discussions regarding where lesbian content might best fit into a school's curriculum. There was no consensus about the placement. Many spoke of it being mentioned in definitions and discussions of “family”, “feminism”, and “diversity”. When asked to identify the ideal placement in the curriculum where lesbian lives and lesbian health care might best be explored, many participants readily identified courses other than their own where it could be incorporated.

There was some discussion about the importance of encouraging personal reflection among students when it came to understanding difference and comfort. Participants suggested that this type of reflection belongs in discussions of clinical practice although most did not have experience doing this, nor did they offer any concrete ways of bringing that discussion into clinical practice. Some could see where a discussion regarding lesbian health issues “could fit into larger group discussions on social determinants of health”, or “maybe legal issues...although, I don't know what all of them [issues] are.”

In summary, participants discussed many ideas about what might work best for their program. All hinged on there needing to be more discussion among fellow nurse educators and a commitment for such inclusion, which most felt was not present among their entire faculty. They felt that until there was a voiced need to explore the topic of lesbians and lesbian health care concerns in depth, it would likely remain absent or at best superficial. While all participants did not share this thinking, the majority voiced awareness that this would probably be so.

Participants' Interactions With Colleagues

Almost all of the participants commented, unprompted, about liking the opportunity to come together with colleagues and discuss their experiences and ideas regarding inclusion of lesbian content within their courses. They saw the conversations as helpful in terms of including challenging topics, listening to others' processes, types of questions others were exploring, personal challenges, and student struggles.

When directly asked if they had engaged in such conversations with other colleagues, all responded that they had not done so outside of this research project. They gave numerous reasons why this was so: “too busy”; “we only talk about problems when we get together for meetings”; “not enough time”; “everybody does their own thing”; and “not sure who might be interested”. Having the support of colleagues and superiors was deemed important although few participants sought out assistance from either colleagues or superiors.

Participants described much of their teaching as occurring in isolation from their peers, spending the majority of their time in contact with students. Participants described that the majority of their meeting time was spent “chasing their tails” or “solving problems regarding specific students”. None described having meaningful conversations or dialogue with their colleagues at meetings regarding teaching topics, pedagogy, teaching challenges, or faculty development.

One participant spoke of seeking out a level of support from the nursing faculty members that she works with prior to participating in this research project. This was done because of the challenge she felt I would have in maintaining the anonymity of her school, as it is the only religion-affiliated nursing program in BC. She felt an ethical responsibility to notify the nursing faculty members of her participation in this study. She did so, not as a means of seeking their permission, but of informing them and moving the conversation of inclusion into the nursing faculty group. She handed out copies of two articles (Harrison, 1996; Randall, 1994) that she thought might significantly inform faculty colleagues about lesbian health and her desire to include the topic within classes for the semester. The response from faculty colleagues was quite positive: “Oh, this is great. Go for it. Yes, definitely, we need to be more thoughtful about how we do this in our curriculum”, although there was no sustained discussion and no one inquired about the research after this initial information was provided.

Only one participant spoke of any negative responses from colleagues and this was from an individual with whom the participant works. When asked about these comments the participant responded:

It hasn't been real negative. It's just been how... any discriminatory remark usually comes around [to] a joke. ...I sort of just brushed it off and just kept going.

And that's what I mean by uncomfortable— [pause]. I keep coming back to uncomfortable, don't I? It's that place in nursing we've all had, where you run up against somebody [hesitation] a colleague, that has a different world view than you do.

After I pressed her to say more about the jokes, she said: "Comments have usually been trying to be humorous about it [pause] like, 'they're going to think you're gay' or something". The participant was obviously uncomfortable. Later in the conversation, she came back to the topic of others' comments and said that they were noteworthy. "I get comments like this all the time [pause] racist comments [longer pause] like from faculty members. Not all the time, but [pause] enough. Of course you remember them, because they're startling". The participant went on to ask questions about her role as an educator and peer: "Do I want to pick a battle with somebody over their beliefs or values? Is that something I should do?" She questioned her relationship with a specific colleague and wondered about her role regarding interrupting this sort of interaction.

Interactions with others outside the study, in their work environments in general were reported as unhelpful regarding the inclusion of lesbian content. Overall, the consensus was that faculty members actually "interact very little with one another in regards to teaching". Participants shared little about ways in which they interact with colleagues that directly supported, challenged, or improved their teaching.

Student Readiness and Attitudes

Many participants' conversations and reports were concerned with their interactions with students in the context of introducing this particular material into their courses. Two significant themes that surfaced were: which students needed such course content; and how to deal with students' biases and religion-based concerns in light of the recognition and mandate that nurses care for all people, no matter how they identify or are identified by others.

Who needs to be taught about lesbians? A number of participants spoke to the idea that there were different groups of students; some in greater need than others of having the topic of lesbians brought into the classroom. However, there was no consensus among the participants as to which student groups this might include. Even when a participant thought that a certain group of students might be more informed or accepting,

they were unable to show through their examples in our interviews that this was clearly so.

Groups of students that were mentioned by participants as specifically needing to have lesbian content spelled out included: returning RNs, foreign students, those taking refresher courses “because of their being older”, “culturally different”, or “not having had this content within their original program”. There was by no means consensus about this, nor were there commonalities among participants from the same types of programs or within programs themselves. None of the programs represented by participants specifically include lesbian content within their curriculum, so it is difficult to understand how it is that some participants teaching various types of students felt that one group needed more or less content. Only two participants were able to give multiple examples that covered a range of topics to demonstrate that students were adequately prepared to assist lesbian clients in their day-to-day health care needs or challenges.

A participant teaching in the first year, first semester of her program, described how she thought inclusion of lesbian content might fit best later in the program, although she reported covering foundational concepts during the first semester.

As an educator, I could introduce [the topic] into the classroom but that [any real discussion] would possibly be a bit further on than the first semester. Right at the moment, I’m trying to give them the foundational concepts and to get them to consider that not everybody lives in a nuclear family (even have them recognize that not all of them live in nuclear families. I mean, some of them come from blended families, extended families, et cetera). I try to get them to realize that there are different types of family units. ...Probably by the second year this [lesbian content] would be more appropriate. See, they haven’t even been into a hospital setting yet and given basic care.

It is clear from this statement that this participant feels she has her work cut out for her just getting students to understand what she called “foundational concepts”. She saw there being a need to have students in a hospital setting and providing basic care before they could really come to appreciate her including lesbian content in the course. It is unclear from our conversation to what she attributed the need to delay information about lesbians.

Other participants indicated that they thought generic students might need less exploration of lesbians and lesbian health concerns. “Generic students may not need to

have this addressed because of their youth, the overall acceptance that is out there today.” Yet, from the stories shared by faculty members regarding generic students, this assumption could not be confirmed.

One participant reported that some students were in fact not well informed, nor accepting of lesbians. She based this conclusion on responses she observed to an in-class exercise where students read an article and were asked to respond with their thoughts and feelings about the information presented. It is important to note that the teacher did not utilize this learning opportunity to interrupt students’ opinions, reporting in our one-on-one interview that she thought it best to wait until later in the program. She knew she would likely teach them in subsequent semesters and did not see a delay in addressing this as a problem. She reports having other more pressing details to pay attention to and felt that as students came to understand the curriculum they would think differently about such areas as difference and marginalization. This is an interesting idea since the participant was unable to provide any details about how it is that students learn this. The participant reported that she has worked with enough students to know that in the end they do not hold such negative ideas any longer. It was unclear from our discussion whether the participant knew that they have actually changed their thinking, or that they may have merely learned not to share such thinking aloud with the teacher.

It is interesting to note that some faculty participants saw younger students as tolerant compared to their own generation, even though little actual discussion was explored regarding what it means to be tolerant or accepting. When asked about this, one participant responded,

I’m finding that this generation of potential caregivers, and I use the term loosely, “baby nurses”, Semester One students are very, very tolerant. Very tolerant. They don’t see the difference [in people]. Their attitude is equality, that irrespective of creed, color, race, belief, lifestyle. They’re very tolerant. And I’m sort of looking around—is there more of a tolerance permeating the school system? Because most of these students are newly out of school; they’re directly from high school.

Yet, later in the conversation she told me “students don’t know very much about lesbianism. They hear a lot about gay men but lesbianism, they’re not very sure of the ground under their feet.” It was not clear from our discussions what she sees as “tolerant”

and how this relates to students “not knowing very much”. She did not give any examples of students being tolerant, accepting, or particularly insightful.

Students’ religious concerns, cultural biases, and refusal to care. Refusal to care for clients who were believed to be lesbian was addressed in a hypothetical setting within a number of conversations with participants, primarily in our face-to-face interviews. Not all participants talked about this, or questioned a student’s right to refuse to care, and those that did, generally took the position that students did not have a right, as a nurse, to refuse to care for anyone. One participant said,

I also teach refresher students and we certainly do broach that subject because that’s a real issue with nurses coming from other countries. ...[A student] announced that she couldn’t work with anyone who was homosexual because in her country that was against the law, and I just said, “Well, if you want to work in this country you will, because it’s against the law to discriminate.” And so we do have to include it [pause] you know, we do include that kind of content.

There was no reflection by this participant about how declaring rules of conduct might not actually bring about cognitive or behavioural changes in the students’ approaches to lesbians with whom they come in contact in practice. Nor was there any exploration about how this student’s background, culture, nationality, religious practices, beliefs, and values might have directly led her to make the comment that she did.

One of the participants spoke of an experience she had while teaching in a different discipline. She reports having a student teacher declare quite forcefully that she would not be able to tell a student that it was all right to be lesbian. The participant reports being challenged by this and modeled for her students, in the moment, how to take the individual’s negative response and use it to find common ground. She began by asking what the student teacher could do. “Could you give the student respect?” Following each positive affirmation that the student teacher could do this, she presented another question, which finally led her to ask:

“Could you take her to a counsellor if she wants some help, if she wants to talk to someone?” She [the student teacher] said, “Oh yeah, I could do that. I’d be glad to take her to a counsellor.” And I said, “Then I think you’ll help her.” ...And I thought, where did that [comment] come from, you know? So you never know when you’re going to meet it or not.

Surprisingly, after having related this teaching experience the same participant reported that she could not “dream of a nursing student saying, ‘I could not provide care to someone’”. She stated that she believes that anyone who wanted to be a nurse would not set those kinds of boundaries, where they would say they would not take care of someone. What she can imagine is that a student might present with an attitude of superiority and condescension.

The problem with a nurse would not be, “I would never take care of a lesbian”. The problem with a nurse’s attitude would be, “I can take care of the worst people in the world, including—” [pause], that would be kind of [the] attitude I’d be more likely to get...that, you know, drug addicts, pedophiles, and lesbians—they’d put them like that— That would be the kind of attitude I’d get— Not that I wouldn’t take care of a lesbian. Because I can’t see anyone in nursing saying that, because that’s not how they think about nursing.

She went on to illustrate her position on the refusal to care for someone by bringing up the topic of abortion.

[A student] might say “I won’t look after someone who’s had an abortion”, but I even think that— that they’re not going to say that either— even if they’re fundamentalist, or Catholic— I don’t think they’re going to say that. I think they’re going to say, “I would like to be in a different ward” or something. Their problem would be one of condescension, I think, to the client, not refusal. I can’t imagine— I mean, they cannot refuse, right? They’ve got— they can’t refuse to take care of anybody. Is that right? Eh? That is not a question for a nurse. ...You have an oath that you’ll take care of anybody. So this is not open to negotiation here...You can choose to work in situations where you don’t have people you don’t want to work with, but you can’t refuse to care for someone....You cannot refuse to care for someone!

Although this participant stated that it is unimaginable for a student to refuse to care for someone, she could imagine someone refusing to care for a client “who’s had an abortion” with the rationale that it would be for religious reasons that the student might object. And yet, this was directly contradicted by the comment made by the participant quoted above who reported a student’s refusal to care for a lesbian on religious grounds.

From the discussions with participants, details of how one would interrupt or even question negative or biased student responses to the question of caring for all clients were not given. Participants did refer to the Registered Nurses Association of British Columbia (RNABC) and the Canadian Nurses Association Code of Ethics as reasons that students would not be able to refuse to care for someone. Here again though, the anxiety, tension,

and questions, which might arise for a student thinking about refusing to care for a client were not explored. Faculty who mentioned this kind of a scenario, tended to give pat answers of conforming to a standard of practice rather than helping the students explore their objection and then their legal responsibilities.

Lack of Inclusion in Nursing Education Materials

The lack of inclusion regarding lesbians and lesbian health care needs in undergraduate education goes beyond the individual educator's awareness and sense of comfort. A consistent theme among participants was that there was very little information readily available for them to use in preparation for classes. As was mentioned earlier, textbooks and preparation guides provide no examples or directions for learning activities that would include lesbian health care concerns or didactic information about lesbians. This was viewed as problematic as some participants mentioned they typically did not have time to read lots of literature and figure out learning activities. They reported relying heavily on learning activities prepared by textbook authors. Most participants felt that they had no real knowledge or experiences from which to draw regarding lesbians and lesbian health care, and time constraints were always a concern in their preparation for class. Therefore, they felt as though inclusion would remain minimal until they came across developed learning activities or had release time in which they could develop their own approach and learning activities.

Another set of related comments among all participants dealt with the lack of teaching within nursing education regarding both lesbians and gay men. The general stance was that little was presented anywhere in nursing education. All indicated that there was little presented in their own education and "about the only time homosexuality is discussed is in regards to HIV risk behaviours, and then we don't talk about the people, we talk about the behaviours and the disease". Most commented on "just not knowing enough" and not having information readily available, "like most of the other content I teach".

One participant brought up an important observation about her teaching experience, she pointed out that "within discussions of any 'ism' we actually don't do well at addressing the complexity of the issues". She went on to say:

I think there's just discomfort in all of them [isms]. ...and that we have criticism in student evaluations that we don't [pause] we don't deal with any of the isms [pause] like racism, feminism— [pause]. There's all sorts of moving away from anything that creates any sort of conflict or controversy. Somehow everything's to be sort of happy, harmonious. If there's conflict that comes up, people just sort of, don't [pause] don't go there.

This was spoken in one of the focus groups and the laughter seemed to be in recognition of their agreement with the statement. As explored later, many participants shared a sense of fear regarding the inclusion of lesbianism as a topic within their courses. One participant suggested that there was a connection between general societal acceptance and each educator's personal comfort level with what she/he addresses in class.

Participants' Religious Beliefs

Not everyone commented on religious beliefs/practices and personal challenges brought on by issues of lesbianism and gayness within their spiritual practices. Those that did commented about their personal journeys, challenges, and growth that had occurred over the years. None indicated a particular concern or challenge during the semester they were involved with this research project. Of those participants who did comment on religion, their comments fell into three areas: those of their own religious practices, a curiosity regarding one member of the group who teaches at a religious-based school, and concerns about how to respond to religious objections from others. The latter will be discussed within the topic of fear below.

When focused on their own religious beliefs, there was a reflection about how one was raised and the impact of either a significant life event or the influences that others had had on their thinking and beliefs. One participant spoke of how her life changed when asked to reevaluate her basic belief system. "I was raised pretty fundamentalist...my husband challenged me to look at what it means to care". These beliefs often differed from the dogma of their specific religion and their stories centred around the processes they had undergone to incorporate the "essence of Christianity" and acceptance of others with regard to homosexuality. It was evident that those who believed themselves to have a personal connection to a Higher Being had struggled with the rightness and wrongness of homosexuality and the mixed messages they had received over a lifetime of membership in a religious group. All of those raising religious practices

within our discussions had as one participant put it “arrived at a place of acceptance regarding sexual practices between two consenting adults”.

There was a strong curiosity regarding one participant’s participation in this research because of her working at a university with an official statement in policy regarding religious beliefs.

I guess I had this preconceived notion, you know, [names school]. Perhaps the curriculum being guided by the *Bible*...and I thought maybe the constraints would be there on them for what they speak about and talk about, but obviously not. [long pause] I remember that meeting [orientation meeting] and thinking that, that I had this preconceived notion that this woman from [names school] would be so different from us. I know, it’s just that I remember that [long pause], I remember thinking about that driving home.

Regarding the “novelty” of being from a faith-based university, the participant had this to say about her experience of being singled out and at times feeling like the position of the school she is associated with was misunderstood:

It’s very interesting because I think students, and certainly myself, and my association with [names school], there are all kinds [of] social assumptions and stereotypes about who we are...all the time. Thinking back to the first focus group I was in with your research study, ...when the people around the table heard I was from [names school]— “You can’t possibly be teaching this stuff there, can you? Does your administration know you’re doing this? Is this OK?”. So I know what it feels like to have assumptions made about me based on being put in a certain category— based on my affiliation— I know what that piece feels like.

She went on to say that there may actually be a certain level of safety for students to have challenging dialogue about “hot topics” among their peers:

We have this fairly homogenous group, ...young students, mostly women, mostly white, obviously heterosexual, if they’re here. And maybe we can hold up these really tough questions, hold them up for scrutiny in ways others can’t, because who else would understand their perspective better, than those sharing a similar perspective? There wasn’t [*sic*] issues of defensiveness— or something, that the others have talked about.

This participant made a strong case for having students with a shared belief system explore controversial topics in greater depth. She concluded that this “might allow for greater discussion and understanding of any personal struggle since they likely all have experienced some of this”. Interconnected with this exploration is a critical component that the participant inserts, and that is the role of the teacher. She firmly believed that part

of her role as teacher and more specifically as a faith-based teacher is to help students grapple with such issues and struggle to find personal meaning out of their experiences, to help them reflect on their beliefs and practices as both a religious individual and as a nurse.

Participants' Fear

While fear may seem a strong word to use, I do think that it captures a sense of the emotion beneath the surface for faculty members who included lesbian content in their teaching for this project. The American Heritage Dictionary (Pickett, 2000) defines fear as “an unpleasant often strong emotion caused by anticipation or awareness of danger; anxious concern; to be afraid of or apprehensive” (p. 646). Much of what was discussed by participants held a sense of anxious concern, although most of this lay just below the surface. The expressions of fear varied from participant to participant and there was no consensus regarding a specific fear. However, it was clear that there were concerns and caution being expressed by the participants, about taking this deliberate step to consciously include the topic of lesbianism and lesbians' experiences in health care more than once during the term.

Participants spoke of their fear in terms of the unknown, fear of being in situations that they would not know how to move through, fear of conflict, fear of not having support from colleagues and administrators should something “erupt”, and fear of being offensive. Two participants voiced concerns about offending me and sought my reassurance regarding this. One participant reported an awareness that in talking about the subject she might offend students who identified as being lesbian, or who had a close association with a lesbian. At the other end of the continuum, some voiced concerns of offending students who might have religious beliefs that limited their ability and willingness to engage meaningfully with exploration of the experiences of lesbians and health care. Still others initially had noticeable difficulty using the word lesbian, speaking awkwardly and at times in a whisper or lowered voice when saying the word. This seemed unintentional and unconscious on their part and became less frequent throughout our conversations.

One participant spoke of her concerns that students might use street language when talking about lesbians. She would find the use of the term “dyke” to be

unprofessional. This concern seems warranted in her mind because “I had had some problems with racist comments last year in class, so I was worried about gay-bashing comments that might come up from one or two individuals that maybe another 14 people would hear”. The focus of her concern became evident as she talked, which was that if inappropriate comments were made she would need to interrupt this behaviour:

I’m not sure how comfortable I would be in responding to that, in all honesty....I don’t like to think of myself as having issues with [pause] with lesbians [pause] gay couples....But you don’t know how well you’ll respond to the whole group if something like that comes out of left field at me. So, that was my concern, to come off professionally. And not to be angered [long pause] and come across as being angry, rather than coming from...more of a professional place.

This participant spoke of her surprise at how well students responded within this situation, in light of her concerns that they might be unprofessional:

I thought about it. I tried to think about that ahead of time, what the students’ responses might be and I worried about...what I would characterize as unprofessional responses, gay-bashing, et cetera. And have been very, very pleased that they’ve been very professional. The majority of them have approached it as they would have approached anything else: in terms of stepping back, trying to ask the right questions regarding what is the nature of the concern; coming from a place of caring, that this is a loved one; this is a concern that is natural when people go through stressors related to health care experiences. So actually I’ve been quite, [pause] it took me by surprise. I guess I was, well, I was anticipating the worst and that didn’t happen.

Another participant spoke of her surprise and relief following a faculty meeting where she had informed her colleagues she would be participating in this study. “And I was quite relieved no one was going to be surprised or upset”. While she had not voiced concerns regarding their support, her sense of relief suggests she had been worried to some degree and was relieved they had not objected.

Many participants spoke of not having enough experience in addressing issues of conflict to feel comfortable about knowing what to do should it arise in the learning environment. Many also thought that conflict might arise since there were a number of students who were seen to “practise their faith strongly”. Participants voiced repeated concern that they would not want to put students in a place that challenged them, nor did they want to put themselves at risk of not knowing how to answer a question or what to do or say.

While not a prevalent theme, there were some reports of a level of fear regarding retaliation for taking risks in the classroom; of possible consequences in terms of negative student evaluations.

You just don't know what people are thinking, you don't know whether it will show up in the evaluations or if they're [students] sitting there thinking that you're being inappropriate. So, yea, those would be some of the things I'd be thinking about.

Others mentioned being concerned about changes to teaching assignments, and poor recommendations for continued employment or tenure from superiors. Some participants hinted that long-term consequences could result and this impacted how far they were willing to take the discussion of lesbians and lesbian health care needs into the classroom.

One participant commented about her fears of possibly being mistaken as a lesbian. Her personal history of being an athlete had informed her that there were frequent assumptions and associations made regarding lesbianism and athleticism.

Well, you wonder if the students are going to think you're a lesbian and I suppose there's nothing wrong with that but I don't like to be misrepresented. ... If I was lesbian that would be fine, but I'm not.

This participant was the only one who spoke of concerns about being mistaken for a lesbian by bringing the topic up in class, although another had brought it up as a comment made by someone not involved in the study. Interestingly, all of the participants spoke of ex-husbands or current husbands during the recruitment phase of the research process, making it clear that they were heterosexual. It is not known if other participants had similar concerns of being mistaken for a lesbian and did not voice them or if they did not have such worries. However, it is important to note that participants clearly stated their heterosexual identity and that they made their heterosexual status clear before participating in the research.

Another way fear surfaced was in the form of concerns regarding a lack of support from others and the possible consequences that might arise from this. Even participants from the same school indicated that they did not talk much with one another regarding their teaching. An exception to this would be when there was a problem with a student. On one occasion, a participant did recall an exchange and even though she

recalls being excited about bringing diversity issues into the classroom, when it came right down to it, there was hesitation and fear:

I really want to say that I got really stoked after our orientation [research] group meeting. It was so exciting, you know, hearing what everyone was teaching and what we're going to do and all that sort of stuff. And then when it got closer to doing it, I thought, "Oh god [loud laughter] do I really want to be doing this? [long pause] Oh, no, I made a commitment, I'm going to do it." But I think that there's something you have to consider is [pause] support. You know, I remember coming down the hall and seeing my colleague, "Oh", I said, "What are you doing?" And she'd say, "You know, I've got to bring up our diversity discussion [starts laughing as she's talking] today in practice." She didn't look too happy about it. I'm [saying] "That's okay." She says, "Yeah, well." You know, just in that short interaction, I could relate with her. You do feel a little anxious because you do feel like you're being on the frontier; you're doing something different. And these days, there's a pattern here, if you don't like something, they [students] go running to the Dean. So, it's not like you're really getting support because of how communication is here. So, yeah, and I think that's important. It's like, how much support do you have from your superiors in doing something different, even controversial?

This participant reports feeling that there is not much support within her administration for any sort of change or risk taking. "We are really expected to just teach and not make waves; when you do, you are told in subtle ways that you don't have time to go there, you are reminded that you shouldn't rock the boat". When asked to elaborate on this, the participant became quiet and needed to be encouraged to say more. "It's mostly unspoken; it's a look, a brief comment, a tone, that says, that tells me don't go there." It should be noted that these comments were not directly in relationship to the topic of lesbian inclusion but spoken about the general messages she received about taking any sort of risk or wanting to move outside the status quo. She clearly indicated in our discussion that inclusion of lesbian content in her course would be viewed by some students, faculty members, and administrators as taking such a risk. This gave her pause in the actual inclusion of much content because she did not feel as though there was real support. There was, perhaps some lip service, but when it came to the bottom line it had been her experience that people were not supported in really questioning or doing things differently. This awareness held her back in taking risks and challenging her teaching in the areas of diversity and difference, except to give lip service to it. "No one is really

wanting to look at this, it would require that we would have to change ourselves, and few of us are interested in doing much of that”.

Participants' Knowledge

A frequent comment among the participants was just how little knowledge they actually had about lesbians and lesbian health care needs. One participant summarized her awareness of this during our first meeting:

I really appreciated the articles. And I had an opportunity at the front end of the semester to read them and my perception is how ill-informed I am. And so I learnt a lot, reading the articles. And then it was a case of how to introduce them into my courses. And what to introduce. I'm still figuring that out but having the articles up-front helped me to realize how little I knew and has given me some direction.

Another participant thought that she would continue including lesbian content in her teaching.

And I'm certainly going to use it [Randall, 1994] again because, not only did it give the students food for thought, it gave me food for thought. I'd never stopped to really examine or reflect on my thoughts with the questions “Are you sexually active? Do you practice birth control?” Those two were sort of like a baseball bat between the eyes to me. ... And so, when partners come in, I'm missing it. I'm missing that this person *is* the significant other. This person *is* the person that [the] client— is in love with. This sort of thing should be included into *every* assessment.

These two examples show how faculty members, with opportunity and learning materials, are willing to incorporate lesbian content into their teaching. Participants in general reported a lack of knowledge and awareness regarding lesbian health concerns and most reported little reason to look at this—“It hasn't ever come up”; “I hadn't thought about this”; “I don't know any lesbians”.

Another participant said that she brought up the topic of planning to talk with students about the possibility of having lesbian clients in a community agency.

I talked with the [community health] nurses... telling them what I was doing with the students...and the nurses said the family unit is no longer the traditional family and we really have to be very aware of this when we go out and we make home visits; that, in fact, that the couple may be a lesbian couple with a baby, that they have questions about something, *et cetera*, and that when you do breast feeding counseling, the same sorts of things come up. So, I thought, wow, I hadn't even thought of that, so I learned a lot from the nurses...they were just very open to it and very accepting.

This participant, who had been teaching at this agency with students for a number of years, found the nurses to be a wealth of information once she brought the topic forward for discussion. She was surprised to learn how much information they had regarding same-sex-parenting and wished she had talked with them sooner as they “could have helped inform the students much better than I could”. Once the participant had brought the topic forward for discussion, the nurses shared their knowledge. She could use the relevant resources and knowledge available from colleagues in practice. Acquired knowledge did not need to come solely from textbooks or current research literature.

One participant brought up the fact that while she did not have much knowledge about lesbians and lesbian health care concerns she was stretched beyond her limits being in a new position and teaching all new courses. She reported:

I simply didn't have time to educate myself about all topics I'm supposed to teach. There's just too much for the first time. I was thoughtful but not focused. What it means is I didn't bring up very meaningful discussions with students, I'm really just barely getting through what's expected of me, there's not time for anything else.

A hindrance to acquiring knowledge was articulated by this participant who felt she was over-extended already.

While participants spoke of their lack of knowledge in regards to knowing lesbians or what lesbian health care concerns would be significant to discuss in learning environments there may be a connection to a greater lack of knowledge regarding sex in general. McKelvey, Webb, Baldassar, Robinson, and Riley (1999) found

Doctors and nurses must not only know what to ask patients, and how to do so in a sensitive, caring manner, they must also convey to patients a supportive, non-judgmental attitude. However, there is evidence to suggest that many doctors and nurses, as well as medical and nursing students, have deficient sex knowledge, lack adequate sexual history-taking and sex counselling skills, and have negative attitudes toward the sexual behaviours of some of their patients. (p. 261)

The relationship between lack of knowledge and negative attitudes does not guarantee that poor quality of care will be provided. However it does suggest that if nurse educators are to meet the needs of nursing students to develop adequate assessment skills nurse educators must be willing to address the issues of lesbianism both as a way of living and as sexual behaviour/practices.

Implications of Participants Sharing Themselves, or Not, with Students

Sharing any part of one's personal journey is just that: personal. Participants differed in how much, or little, they share with students in general about their own struggles and success within their teaching and nursing practice. This was revealed as they spoke about sharing their own learning needs and process with students. Few of the participants disclosed to students that they were learning about lesbian health care issues or that this was an area about which they did not have much knowledge, awareness, or insight. A line was drawn about not being too vulnerable in the presence of students and wanting them to have the space to do their own reflecting. Participants said they introduced their inclusion of lesbian content like the following:

When I introduced it [lesbian content], I said—well I didn't mention your name or your study or anything. I introduced it as an article or several articles I had been reading and this was one that might be of interest because it was of interest to me and a different way of looking at things. [pause] I was talking about looking at things differently and thinking outside the box, so I said I wanted to explore their views and reflections.

I sensed from participants that their personal processes were not for public review, which seemed to limit the role modeling necessary to foster students' abilities to discover and experience their own process. It was unclear from participants just how they thought that students are to learn a process if they never actually hear about it, see it, or gain insights from other's experiences.

One participant talked about wanting to share more of her own journey with students:

I'm revealing more of myself in my teaching and I think [long pause] I was thinking about that the other day and, actually, discussed with my daughter [pause] that I think I do share more about me. It's tricky in this course, because you want them to explore their ideas and I try not to present a bias [pause] ahead of group discussions. But I did try to reveal a bit more about myself and my views without bias, as much as I can.

In contrast to this, one participant commented that “any topic brought up in class held a bias of some sort”, in that she chose to bring one topic to the forefront over another. This was not seen as problematic; it was viewed as a responsibility of the teacher to bring a wide variety of examples to the forefront for consideration.

Another participant thought that sharing with students was important but worried about keeping the focus on the students and their learning, not hers.

There needs to be a balance of sharing enough to be authentic but not placing the emphasis on your journey, it is also the students' journey and it is important to model for them ways of reflection and disclosure. And then you need to give them space to share their journey. So, yeah, I did talk about my journey. Not extensively but I did share. For me, there's always a balance.

More than one participant used the word balance within our discussions and it was not always clear what the participants were trying to balance. At times, I wondered if the mention of work balance was meant to say, "I won't take this discussion into the classroom" or "this isn't the place for that" or perhaps, "I am feeling uncomfortable". One participant had been referring to the need to "keep a balance" and she followed this need with "not wanting to sound as though I'm on a soap box". No one mentioned a similar concern of a 'soapbox' in regards to the overwhelming presence and assumption of heterosexuality within nursing education or society in general. There seemed to be an underlying, unspoken sense of fear or worry. (See previous section about Participants' Fear.)

Other participants felt that it was not important to share with students their personal journeys. They described their teaching as something separate from their personal lives and did not feel comfortable being vulnerable with students. They saw their role as teacher as providing students with opportunities to learn and that this was about the student not the teacher. Others were less direct but maintained the sentiment that this was not "their stage but a place where students were the focus".

Regarding who learns and who teaches, judging from the comments made about sharing with students it would seem as though most participants regard teaching and learning as a one-way street in which they teach and students learn. Little to no discussion occurred about modeling their own exploration processes for students to help them develop their own approach to examining more volatile or controversial topics within the profession.

Participants' Myths and Stereotypes

During conversations with some of the participants, it was noted that their attitudes and beliefs about lesbians included myths and stereotypes. Phrases used that

were illustrative of this included: “They [lesbians] live in...[names urban poverty area],” “Students have to be prepared to be ‘hit on’ and know how to respond,” “I don’t know any lesbians,” and “It really is a bedroom issue and not something that I think has a great impact on nursing practice; it really doesn’t matter what people do together”.

A distinction was made between the supposed visibility of lesbians and gay men:

They [students] were less likely to think about lesbians because they’re less visible than most gay men. You can generally tell if someone’s gay, you can’t necessarily tell if somebody’s lesbian. But perhaps they looked around the room a bit and wondered. ...It may have made them stop and think. I don’t know, there was a comment from one [student], I remember thinking, she doesn’t know if she’s ever cared for a lesbian and it was almost a bit of a surprise to think, well, gee, perhaps I have and I didn’t know it.

This awareness was shared by many of the participants, as was noted earlier in their collective awareness of having not knowingly cared for a lesbian within their own practice.

As mentioned in a previous section, one participant reported including lesbian content through a guest speaker, a gay man, she had invited to speak about gay issues. In discussing her inclusion of inviting him to speak, the participant gave no information about how this directly addressed lesbians or lesbian health care issues either generally or specifically, nor was there any recognition that using a male “expert” to illuminate a woman’s issue might not be relevant. This is another example of failure to distinguish between lesbian and gay health care issues by assuming that in discussing one you have discussed the other.

Heterosexism

Much to my surprise, there was little reporting of exploration around the topic of heterosexism or heterosexual privilege. Discussions on the topic of heterosexism or the exploration of it in ways that paralleled any other “ism” were rare; only two participants reported attempts to draw parallels, or to discuss the intersections of various other “isms” and/or heterosexism. Both of these faculty members mentioned feeling inadequate in addressing this and wanted to make greater efforts in the future. When asked directly, one participant indicated that she did not think that others (students or faculty members) were really concerned about or aware of their participation in heterosexism.

No, I don't think they are aware! No, that's a really good question. I don't think they are [aware]. And I don't think—I mean, I look at saying, “Hey wait a minute this is what's going on here?” And I don't think students really want to have it pointed out. I think that they are involved in their own lives, and they don't think of themselves as excluding anyone for any reason and yet they don't realize that they are.

When asked about the responsibility of the nurse educator to address this directly the participant was fast to respond,

I think it's within the responsibility, but I would be very careful—these students are overloaded with stress—and in no way do I want to make them feel inadequate. So I wouldn't challenge them—I just wouldn't do that to them.

Others felt somewhat differently about their role as educator indicating that it was clearly their responsibility to help students see the assumptions that they were making.

You know you have hit on something important when they come back to class reporting on a conversation they'd had over dinner about the “isms” and politics. And so, it was very much a lived experience and I think that's an important part for evaluating how it [the course] is going.

This participant talked about her commitment being more than just a way of teaching. She spoke of it as a “moral commitment” and

just part of who I am as a person. Who I am as a nurse and who I am as somebody who does work in [names area]. That, for me, the unpacking of issues about diversity and social justice is just at the foundation of what I try to do everywhere, in my writing, in my research, and so forth. And it doesn't always get foregrounded in a way but it underpins everything I do about the context of nurses' work— Who gets heard? Who doesn't? It is about trying to understand meaning. Coming from a place of understanding the meaning of people's experiences first. Heterosexual assumptions are a part of this and something that I haven't really focused on enough. I mean, I know it is a part of me and it is only recently that I've begun to take a look at my own assumptions and how it impacts what I see, the questions I ask. I've done more of that work around race and I'm seeing the importance of reflecting on heterosexism and how it impacts my own experiences.

This clarity and self-reflection was somewhat unusual for the group as a whole. Most were not this reflective about their own process and thinking.

Those who spoke of coming from a place of inclusion did so from the perspective of social justice and critical theories (critical social theory, feminism, emancipatory theories). They spoke of their own personal struggles regarding their membership in the dominant culture and how they were challenged to frequently interrupt this basic

thinking. They were able to speak to ways in which they held heterosexual privileges and how challenging it was for them to reflect on this location of unearned privileges (McIntosh, 1992, 1998). None of the other participants referred to these kinds of awareness or insights.

This section has addressed both intrinsic and extrinsic factors raised by participants regarding inclusion of lesbian health care content in their courses. These are areas that, through self-reflection and consciousness-raising nursing faculty could, and within an emancipatory framework, should, do more to include within general undergraduate nursing education. The next section focuses on the reported intersections of that content with the students and learning environments.

Intersections with Students, Learning Environments, and Lesbian Content

In addition to their discussions of their own processes and difficulties in introducing lesbian health care concerns into their course content, participants spoke of what happened and how students responded. The data being viewed within this next section come from the participants reporting what happened, rather than directly from the students themselves. It is through the participants' expressed views and possible censorship that we seek to understand some of what was happening within their experience. These reports were not verified by other means, such as observation of participants' interactions or directly asking students.

Worries Regarding Anticipated Responses From Students

This section looks at the interactions of the participants with students and learning environments. Input from over half of the participants focused on anticipated responses that students might have to the inclusion of lesbian content rather than the actual responses that occurred. Of course, some of these conversations occurred at the beginning of the study before the introduction of the new material into the course; however, more of these remarks occurred at the individual interviews that were scheduled after at least two interventions had been made. Comments primarily clustered around stories that focused on participants' anticipated concerns regarding what might happen when lesbian content was introduced. This seems to be related to their reflection on inclusion of content and their own slight discomfort in having to make three interventions in one semester.

All comments regarding anticipated concerns were located within hypothetical examples and demonstrate very real concerns for these participants. They primarily focused on safety in the classroom and the implied responsibility of the teacher to ensure that the learning environments “did not get out of control”. The next two examples speak to the concerns participants had of how far teachers saw themselves taking conversations within the learning environments. One participant said:

Now what I found most interesting was that I didn't even push it [lesbian content], because of my previous experience that students have accused me of harassing them. ...[It's] important to note...I have tried to raise diversity issues in the classroom, and unbeknownst to me, some students were offended by it, and reported my behaviour to the Dean. The majority were not offended. So I thought, I'm not going to push the boundary here when it comes to the whole issue of lesbians because I don't need this riff raff. I'm tired of these complaints about how I teach and stuff. So I would say that's probably the major thing that prevented me from getting any further.

Another participant questioned her “right” as a teacher to push students in light of their “right to privacy”, asking:

How can I safely bring forward topics that are controversial when I also want to respect other people's privacy? How do you enable other people to be comfortable? And do I have the right to really push it in the classroom? Where I see that some students become quiet, others are hurtful, and some students can be left out all together for any number of reasons. Ideally, I would like my students to talk about [lesbian health care]. But in the process of talking about other people's lives, you just can't always keep it safe for everyone. You put yourself, as teacher, in a vulnerable position— Is it worth that risk?— In light of how mean the students can be with one another?

These last two quotations illustrate two concerns about job security and questioning whether it was necessary to push students into areas that might have a level of discomfort for them. They identified possible adverse consequences such as: “lower evaluations from students”; “lack of support from peers and administration”; and “reactionary students” who are viewed as “too much work [for teachers]”. Participants were concerned about negative outcomes either personally or in the classroom, and this fear has diminished their willingness to confront controversial topics or inappropriate responses from either co-workers or students. This tended to limit what their students were exposed to or challenged by.

Safety and Need to Protect Some Students

There were various ways in which participants spoke of wanting to provide a level of protection or safety for students that extended beyond the previous examples of maintaining a level of safety within learning environments for all students. As a general observation, participants spoke of being aware that students were quite stressed. Numerous participants spoke of not wanting to add further stress to students' loads, this included not confronting them or challenging their thinking. They were also aware that they consciously moved conversations back to topics that were "safer" when they felt the need to do so. The reasons faculty participants gave for this careful avoidance of additional stress or conflict in students' lives were articulated as: "They are only First Semester, I'll have another chance to look at this in Semester Two or Three"; or as "Single mothers they have enough going on for them"; or "Many of our students have families and work part or even full-time". Thus, there was a level of protection being provided by the participants toward certain identifiable groups of students (those that are just beginning nursing, those who are single parents, those who have families and are working for pay) and who represented a large portion of the student body.

However, only one participant commented directly about having concern for lesbians within her class. She voiced concerns about not knowing how she might go about helping a lesbian student in her class feel safe or comfortable, "especially if anything unsettling came up" in class. She reported having this concern since she had been reading more about the topic. No one had ever come out in one of her classes and she felt that coming out was a personal decision, "It is up to them". There was, however, an unspoken expectation that safety could only be ensured if those of the minority group declared their status. She made no mention of understanding that the creation of a "safer" space was within the responsibility of the teacher or as a modeling example of inclusion for students in general. This type of expectation of revealing one's status did not occur for other categories of students within the group, such as men, those with families, those working outside jobs, single parents, or those with ill relatives. There was little discussion from the participants about the protection or safety of students who might belong to a less readily identifiable subgroup or minority. There was neither real discussion about, nor much acknowledgment of, the safety or inclusivity of the learning environments for

either an “out”, “closeted”, or “questioning” lesbian, as a client, student or teacher. There was a sense that students would need to be responsible for sharing this information with faculty members and or other students if it were to be addressed in the classroom. This seemed applicable to discussions about clients as well. If a student had cared knowingly for someone of a subgroup or minority, then the topic might be addressed, especially if the student raised a question or concern. There was little dialogue about how faculty members would or could direct student discussions to allow exploration of the topic if it did not come up “naturally”.

As a means of increasing a sense of safety for students, there was discussion among participants about talking in class within small and large groups. One participant deliberately used small group discussion to try to create a space where students might feel safe to talk openly with one another.

They also work in small groups where the quieter ones can discuss things among themselves, so I think I give them a fair amount of time doing that...So that's safer [talking in small groups] than with a lot of people. I just try and set it up so that they will talk about things but you're never really sure if they feel that's safe or not.

Participants report mixed results from the large and small group discussions. Some reported that their group discussions were “awesome” and that students got a lot out of them when they were prepared. Others reported that they were challenged to keep some small groups focused. “Some always seem to get off topic and I can't keep track of all the groups. I just have to trust they are getting something out of it.”

No one questioned whether or not learning environments can actually be made safe for everyone. hooks (1994) challenges the idea that classroom can or should be considered safe space for everyone at all times. It simply is not possible for this to happen, especially if one's preconceptions of marginalized groups are being explored and seen as challenged. There was an implied assumption within most participants' comments that the teacher is responsible for overseeing the safety of the classroom, although one participant did comment that “the safety of the group was co-created by the group” and was not her sole responsibility. As was mentioned earlier when participants were uncomfortable or scared about something being discussed in the classroom, there seemed

to be a strong desire and action to change the direction of the classroom conversation and return to a “safer place”.

I remember when it got uncomfortable with students talking about lesbianism, the context we were talking about was issues of marginalization and— different population groups and stuff. So, I went back to that safe area and made it a little more general, but at the same time saying, the tendency is, is to stress the difference, rather than saying, how can we learn? I can't remember what example, but I was just trying to say, the issues for a person that's lesbian really aren't that different from anyone else.

This participant wanted students to view people as more similar than different.

Differences were understood to lead to discomfort and she felt it necessary to bring the group back to a common ground rather than exploring the uncomfortable moment. When asked about this, she shrugged it off as “just being how I am with conflict”. There was no follow-up discussion regarding how the difference of being lesbian might lead to different ways of addressing concerns. For example, rather than asking if a woman client is married, ask whether she has a partner; or, to consider the possibility that a second woman attending to a sick child may be a second parent rather than assuming she is simply a friend. Another participant reflected a similar sentiment:

I think there may be some issues that a lot of faculty are not comfortable with talking about. And part of that, I think, is from their own personal perspective, but part of it too, I think, is because of what, you know [pause] we work in [names area] and in [names area] there is all this controversy about homosexual content in the readings, in books in the classroom. And I think that some of us are aware of that and how, you know, you've always got to be careful, just in case students find things very objectionable. I can remember teaching in [names a different school of nursing] and I offended some students because I talked about amniocentesis and abortion as a result of amniocentesis. I think that parents have the right to make decisions but I clearly got the message that I needed to state when things were my opinion. I think about what if the student had gone further and reported me to the Dean and I would have been reprimanded for that or something like that as a result, I think it probably would curtail my actions. Maybe it does and I'm just not aware of it.

This participant referred to a lawsuit (*Chamberlain, et al. v. The Board of Trustees of School District # 36, Surrey, B.C.*) which was in progress while data were being collected for this research. The participant's comments speak to the influence current events have on what is brought into the learning environments. She even commented that these possibly curtail her actions.

Regarding other concerns of privacy, participants did not bring up similar issues of privacy with regard to such things as heart conditions, sexually transmitted diseases (STDs), or alcohol and drug abuse. There was no discussion among the participants either in focus groups or individual interviews that indicated that this private/public domain divide was addressed enabling students to be better equipped to sort through the complexities of their lives or the lives of clients. Somehow it was taken up by instructors to “do” this for students rather than helping them explore different processes themselves that might better enable them to cope with unusual experiences or manage challenging personal triggers as they work with clients in complex and challenging situations. I asked participants how, as a teacher, they saw students responding to being asked to think beyond their place of comfort and experience—was this something they felt was part of the nursing education experience and what was the role of the teacher in providing this experience? One participant said:

I don't know how far they're [students] thinking...or where they're going to take that thinking, but all I want them to do is start— I think they'll think of something they hadn't thought of before— They're pretty smart— They'll read. They'll start picking up— I think what it'll do is they'll pay more attention when they're reading something, and they'll just notice more and so I don't take it on as my responsibility to develop it in them.

While this participant was able to muse about the movement of students in their thinking, there was nothing that suggested a clear role for the instructor and how the instructor could play an active part in facilitating critical thinking and mental stretching. There was an assumption that by reading, students will pay attention and notice more and that by so doing this alone will stimulate their critical reflection skills and move them to think differently. While participants in this study did not give evidence of this happening, the literature that deals with critical reflection within nursing education suggests that there is a difference between first and fourth year students (Angel, Duffey, & Belyea, 2000).

Two participants indicated that they saw their role as helping to facilitate students' learning and that this required them to engage students' critical thinking and to challenge them. The challenges were not about being right or wrong but about asking the students to challenge their own thinking, to explore their assumptions in light of material they were reading for class and to see if they could come to an understanding about the

experience clients might have. These participants felt strongly that their role as teacher was to help students reflect on their understandings of how they came to know something to be a certain way and to help them question and gain awareness.

Responding to Students' Religious Objections to Lesbians

Martsolf and Mickley (1998) and Schlub and Martsolf (1999) indicated that there are reasons for nursing faculty members' concern about religious beliefs and expressed homophobia. Martsolf and Mickley's study reported a relationship between religious beliefs and how nurses approached nursing practice. Schlub and Martsolf's study indicated, "that the Christian religious belief system is linked to homophobia" and when asked, "58% of the nursing students were intrinsically motivated by religious beliefs" (p. 20). Not surprising, these same authors found that for those students who attended church frequently there was a higher level of reported homophobia.

All participants brought up the topic of how the inclusion of lesbian content might challenge students' religious values and beliefs. The tension of uncertainty created turmoil for the participants who were uncertain how to address within their teaching resistance or declarations of intolerance based on religious doctrine. Concerns ranged from general awareness that this could be a problem, to an example of a specific experience. In this example, a student had indicated that because of his fundamental Christian beliefs, he would not be able to care for anyone exploring abortion options; this included caring for or even referring the client to someone else. Within this same conversation the participant shared, "He would have a problem caring for anyone within a gay relationship, period. These were two things his Christian beliefs required him to speak out against." When asked about how she dealt with that, her response was quite guarded:

I tried not to have conversations with him in class regarding his beliefs. I tried to bring everything back to the curriculum and [a] nurse's responsibility in caring for people, both professionally and ethically. At the end, I tried to fail him based on safety issues, interpersonal issues and the like. I wasn't successful. I couldn't in all consciousness, not do anything with that student, because he was scary, very, very scary. Almost Nazi kinds of views. He was trying to convert people and influence their way of thinking. ...I really didn't know how to manage him. It was an impossible situation. This happened a couple of years ago, not for this project. Right now, now, I have someone who has some similar views and who is vocal but she doesn't try to convert people. She will say, these are my values, these are

my beliefs, this is where I come from, but doesn't try to make it everyone's way of being in the world. ...I don't think she would do anything harmful to anybody. ...These situations leave me wondering about what I'm supposed to do as an instructor.

While no other participants spoke of such a clear example of students' responses to things that were upsetting to them, a number of participants were concerned that this sort of experience might happen and that they would want to avoid it if possible. They voiced concerns about being ill-prepared, not being clear how to challenge such fundamental beliefs and values in ways that allowed the student to be respected and yet wanting to move them to rethink how their strong beliefs (mostly religious) might actually impact the care they were able to provide.

Most participants felt that students were not open to discussions of religious beliefs and many wondered if it was within their responsibility as teachers to really explore or push students regarding something so fundamental, even when it related to client care. When asked if there were other areas where they felt this strongly there was no clear response. Although most thought that there were other topics, none were named other than the examples provided previously, including abortion. Although others felt that it was their responsibility as teachers to broach the topic, they were not able to articulate how they would actually go about it, and frequently commented that they just hoped it did not happen in their class. Participants reported being ill-prepared to deal with conflict in general and this seemed heightened when the conflict had a religious basis. There was little discussion regarding how teachers might locate these challenges within practice setting scenarios (case studies) as a way to explore possibilities with the students. None had had in-service or faculty development opportunities to help with these concerns or fears.

Responding to Students in the Learning Environment

While none of the participants' worst worries or fears happened, responses from participants were mixed regarding how they handled actual comments or questions from students within this research study. A number of participants indicated they just did not want anything to come up in class that they did not know how to handle. They spoke of "hoping nothing would happen" in an anxious tone that indicated they were concerned

and not prepared to confront what they most feared might happen. This “hope” that conflict would not arise could only help to foster a climate whereby discussions would probably be limited or redirected to “safer” topics. This redirecting while spoken about by two of the participants also went unnamed by others who changed the topic or redirected conversation with students in some manner. When asked directly about this behaviour, most commented that there was so much content to cover they could not focus on one aspect for any length of time.

Not all participants felt similar time or content constraints. One participant spoke of using the beginning of class for check-in (Chinn, 2001) and found that by the end of the course students were using most of class time for this activity. This was not seen as problematic, as she goes on to share that most of the students used this time to talk about how the course material related to, not only their nursing practice, but their lives in general. She saw their use of the check-in time to be a measurement of success, as the students were actively engaged with the key elements of the course. This discussion was welcomed and viewed as a learning activity whereby students were directing their learning and sharing the application of course material with one another. This is discussed in more detail within the Learning Activities section.

Increasing students’ awareness. In terms of participants helping to raise students’ levels of awareness regarding lesbians and lesbian health care, the outcomes varied. Participants struggled to some degree or other, although they reported being pleased overall with the outcomes afterward. One participant told about a role-play exercise she had used:

That’s what was neat. They [students] were pleased with being challenged and rising to it. So, I think any kind of situation like that they would have appreciated rather than just going through a mundane role situation. But I think they also appreciated it because they said, “It never occurred to me to ask that question and I realize the assumptions I was making.” And they said that without having the background, I mean they both,...they were both mature students but they both identified as being open. You know, I came in with these assumptions and they were really blown away that here they thought they’d been taught to be really sensitive— And so, that was a part of having their own assumptions brought to the surface.

This participant could not recall what exactly had been the particular assumptions of these students, but thought that it was probably around assuming that everyone is heterosexual.

At times participants did seem to overstate that students were challenged within the learning environments regarding lesbians and lesbian health care. Few specific stories were shared that showed students were challenged much beyond a superficial acknowledgment that lesbians might be in the population of clients that nurses will be caring for. Few examples were provided of very specific information on how to best to support, encourage, interact, or help lesbian clients with specific concerns, health care issues, or health promotion. Participants shared general stories of inclusion that seemed to them to be sufficient in posing the topic. Four participants felt strongly about their previous lack of inclusion and clearly stated that they planned to read more of the literature and include something in future classes. What this might be specifically was undetermined.

Another participant spoke of a student raising the concern that in nursing classes there is seldom a space created for what Hartrick (1997) calls authentic dialogue:

Some of that discussion came up because one of the students introduced it, “You know, if I was a lesbian, I would want to be able to tell you what a ‘rad’” (she used some word, ‘rad’) ...” I had this ‘rad’ night with the woman I’m in love with. Like, I’d want to be able to tell you that.” Everybody talks about their boyfriends, like you’d want to be able to share that. ...or what you’d done, and share that if you were really friends and supportive. Nobody disclosed. We’re not in environments where we have an opportunity to see how to make life good for everybody, not just for ourselves, so that it’s a rich sharing environment. You know it’s about the freedom to disclose or not to disclose and I think people won’t disclose, they don’t feel safe to talk openly and freely. We can’t talk about a lot of things even though you try [referring to self]. We don’t talk about race, racism— affects a lot of students and we just scratch the surface and never really say much. So why would anybody talk about something if you can’t see it? Like you can see race and we can’t talk about that.

Here we have an example of a teacher being aware that students are able to begin creating a space that allows for difference. However, there was no real follow-up regarding how this might be done either in the classroom or in a clinical setting.

One participant spoke surprisingly of a student’s experience with friends when she decided to enter nursing:

“Oh yeah”, as soon as I went to go into nursing, they said, “What are you [pause] a lesbian?” And there echoed throughout the classroom, “oh yeah...yeah...that was talked about me too.” That sort of comment...when they entered nursing. And I thought, wow, that’s really different...you know, this is none of their bloody business and all that sort of stuff. Students used some very strong language as they talked and it was extreme language, it wasn’t neutral language.

The participant was unable to recall the specifics of what she called “extreme language”. She did summarize by adding comments students made, “It was like... ‘It’s none of their business’ and ‘If someone is a lesbian, that is their choice’ They were really stating [that], they’re clear about someone’s rights and right of privacy”. She goes on to say, however:

At that point, I didn’t want to push the envelope, so to speak, to say, “Is it important for someone to come out?” And I didn’t go to that question, because I had a sense they didn’t want to deal with it— that there was a possibility amongst their classmates— someone was of that particular orientation, but I don’t know for sure, it never was mentioned.

This participant was at a complete loss as to how to move the conversation forward if no one came out in the class. She was concerned about not wanting to offend the students who talked about being bothered that someone might assume they were lesbian. She had not thought of reflecting for them what it might mean in our society to call a woman a lesbian. Nor did she reflect upon the idea that questioning a woman’s sexual orientation might provide message that she is beginning to behave outside an acceptable norm—a not-so-subtle means of policing her behaviors or speech (Cottingham, 1996). What this has to do with choosing nursing as a career is puzzling and this question was not explored further by either the instructor or students. The participant had no additional insights into this as she had not heard of equating nursing to lesbianism before and reported that the topic of discussion moved to something else right after it was declared by students to be no one’s business.

Throughout the stories shared by participants regarding interactions with students, there were few discussions or examples of how faculty members moved the opportunities for learning forward. There were no reported discussions of related broader areas such as coming out, social stigma, bullying, what is “normal”, or appropriate means of showing affection in public. Most participants spoke as if they assumed that as long as students are not overtly homophobic, they would be able to address the needs of lesbian clients that

they knowingly or unknowingly meet. Yet, no specific content or examples were given to support this assumption. For the most part (possibly because faculty members have only recently begun to raise their own consciousness) the examples used in their teaching showed minimal critical reflection or questioning of these assumptions.

The Experience of Including Lesbians and Lesbian Health Care Content

In conclusion, the data collection and analysis revealed that the participating educators had differing levels of comfort and concerns about including lesbians and lesbian health care content in their teaching. They had little previous personal knowledge of course content about lesbians and lesbian health care, and had no previous nursing experience working knowingly with the population. They had had little to no exposure within their own education, and had not given the topic of lesbian health care concerns much thought within their teaching practices. They did not have readily available experiences with which to share or normalize lesbians and lesbian health care experiences. Participants discussed numerous aspects of their experiences in introducing such course content.

The process of participating in this study provided a substantial opportunity for these participants to review their personal thinking about lesbians and lesbian health care. In having the opportunity to directly engage with the inclusion of a marginalized group, these participants indicated that it was a positive experience and stretched them in ways that were challenging and educational. Through the steps of awareness and knowledge, reflection and questioning, and support, participants indicated they had had their consciousness raised. Each participant spoke of being changed in some way and these changes were reported to have them thinking differently about inclusion of lesbians and lesbian health care concerns in the future.

Research participants shared numerous accounts of interacting with students, yet participants saw few of these interactions as examples of missed teachable moments. Seldom did participants speak of challenging students to engage in critical reflection or to question their assumptions regarding lesbians and lesbian health care concerns. There seemed to be an unsupported assumption among most participants that if students were not overtly homophobic, everything was fine, and those students would be able to address the health care needs of lesbian clients.

An Unexpected Finding

While examining data from this research project, an interesting and unexpected conceptualization surfaced. As participants spoke about including lesbian health care content, they revealed that the methods they chose were examples of ways in which they engage with their teaching in general. I detected fundamental differences in the ways various participants spoke about their teaching, and how they went about teaching what was primarily new and unexplored content. This conceptualization is broader than merely the inclusion of lesbian content within nursing courses. Four clusters of recurring concepts or styles of teaching used by study participants became evident through the process of reviewing and re-reviewing the data and their recurring patterns. These four approaches to teaching have been termed: “fill them up”, “learner centred”, “co-creation”, and “survival”, and they will be expanded in the next chapter.

CHAPTER FIVE: TEACHING APPROACHES

In this section, I focus my attention on four clusters of behaviours that participants reported engaging in while discussing their teaching/learning associated with including lesbian health-care content during a semester of teaching. In the previous chapter, I focused on participants' experiences with content; here I will focus on their patterns of teaching. From the focus group discussions and individual conversations, how participants spoke of their teaching revealed more about their teaching than about their inclusion of lesbians and lesbian health-care content. While it must be clearly stated that the context participants were talking about was their teaching of lesbian content, they repeatedly spoke about teaching and ways in which they taught. How they addressed lesbian content appeared to be how they would teach in general and, perhaps more specifically, how they would approach any new content since most had not previously included lesbians or lesbian health-care content.

Data from the 12 participants revealed patterns of teaching that clustered into four dominant sets of behaviours and underlying philosophy or set of values. I have labeled each of these patterns according to a predominant term or phrase that was used within our discussions. The terms are meant to illustrate ways in which the participants described and recalled their teaching process. The four patterns have been labeled: "fill them up", "learner centred", "co-creation", and "survival".

Fundamental to this discussion of teaching is the exploration of nursing pedagogy as foundational to nursing education. While not the intended focus of this research project, uncovering these four clusters or patterns of teaching is an unexpected yet important outcome from the data. In attempting to understand the experiences of faculty members who agreed to include lesbian content, what I have come to understand is that I was also asking them to tell me about the ways in which they engage in teaching. At the time of designing this research project, I was completely unaware of this implicit, related research question. In retrospect, I wonder how it is that I missed it from the beginning. My view of nursing education has been impacted and reorganized because of this analysis in such a way that I now see dominant patterns when talking with others about

their approaches to teaching nursing. That is, my own conceptualization of teaching within nursing has shifted in what Kuhn (1991) calls a paradigm shift. It is impossible now for me not to see the teaching examples provided by participants outside of these four patterns. In this chapter I explain these four patterns of teaching, explore reasons given for participating in the study, underlying assumptions regarding teaching, how the participants taught content, and how descriptions of time were used as a style indicator. Finally, I will provide an analysis of this aspect of the findings and what this could mean for nursing education and practice.

Pedagogy

The National Board for Professional Teaching Standards (2004) defines pedagogy as the “skills teachers use to impart the specialized knowledge/content of their subject area(s)”. McKenzie (2003) understands pedagogy to be a wide range of skills and abilities that lead teachers to create a learning environment where all students feel comfortable and are sure that they can succeed both academically and personally. This complex combination of skills and abilities is integrated into the ways in which essential knowledge, dispositions, and commitments are explored and enacted. More simply, the American Heritage Electronic Dictionary (Bankston et al., 1992), defines pedagogy as: “1. The art or profession of teaching. 2. Preparatory training or instruction”. These definitions suggest that a review of the nursing education literature would reveal various ways in which faculty explore their teaching practices, underlying values and philosophy, beliefs about teaching nursing, and various choices or options of teaching nursing content, within a larger context of what it means to teach nursing.

The published works of nursing scholars and educators show little evidence of this type of discussion. Current nursing literature reflects a primary exploration of specific methods of teaching as applied within nursing education and nursing practice rather than a dialogue about a more general or broad understanding of pedagogy and subsequent outcomes within nursing education and professional practice. There are discussions within nursing education regarding the combination of other philosophical underpinnings with the practice of nursing, such as the use of problem-based learning (Andrews & Jones, 1996; Becker, Viljoen, Botma, & Bester, 2003; Tanner, 1999), story telling (Irvin, 1996), feminism (Beck, 1995; Chinn, 1989; Crowley, 1989; Hezekiah,

1993; Tanner, 1993; Weyenberg, 1998), case-based instruction (DeMarco, Hayward, & Lynch, 2002; Thomas, O'Connor, Albert, Boutain, & Brandt, 2001), and learning styles (Brown, 2001; Knoedler & Shea, 1992; Linares, 1999). While all valuable, there seems to be an underlying assumption shared among these authors that nurse educators have a common perspective on teaching and its meaning, albeit enacted differently in various learning environments.

Data from the group of faculty who participated in my research do not support a common underlying shared perspective, at least not from what they spoke about during our interviews and discussions. While an exploration of pedagogy was not the intended or expected outcome from this research and research questions were not directly focused on this aspect, compelling data were divulged. Thus, in the remainder of this chapter I will explore what these participants revealed as their patterns of teaching and the importance of looking at these patterns in relationship to a broader discussion of nursing pedagogy.

Nursing Pedagogy

Teaching is an intentional activity that entails fostering students' learning (Okech, 1997). Pedagogy refers to central aspects of teaching that do not relate directly to or address a specific subject or content matter. Pedagogy is not a new concept to nursing education. There are numerous articles within the nursing literature addressing selected aspects and implementation of different types of pedagogy within nursing education and practice (see previously listed examples). However, a general discussion regarding the art and the science of teaching nursing is critical in understanding the location of teacher, learner (student), and content within learning environments. Yet, in the literature, there is little discussion regarding the various underpinnings of nursing education and how one might go about being a teacher of nursing knowledge. An assumption lingers from the apprenticeship model of nursing that anyone can teach if they have an area of expert knowledge. Diekelmann and Schulte (2000) suggest that nurse educators are frequently under-prepared to teach and that when they do teach, they often teach as they were taught.

As noted earlier, there are scholarly explorations of the implementation of various types of pedagogies within nursing education. These types include: feminist pedagogy in nursing; use of problem-based learning; emancipatory pedagogy (Romyn, 2000); and

critical pedagogy (Duchscher, 2000; Ekstrom & Sigurdsson, 2002). These discussions, however, assume a common denominator or core within nursing that is not explicitly explored. There has been discussion regarding emancipatory education and curriculum revolution within nursing as a pedagogy for nursing education, primarily in the late 1980s and early 1990s. Bevis and Watson's 1989 book, *Toward a Caring Curriculum*, was considered revolutionary in its day, but, there has been little advancement of this pedagogy beyond isolated schools of nursing implementing it. These schools include the University of Victoria, colleges and university colleges within the Collaborative Nursing Program of BC, the Oregon Health & Sciences University, and the University of Colorado. There has been discussion about the intent and practice of the curriculum revolution (Allen, 1990; Bevis, 1988, 1989a, 1993b; Bevis & Murray, 1990; Chopoorian, 1990; Danner, 1990; de Tornyay, 1991; Gould & Bevis, 1992; Gunby et al., 1991; Lindeman, 1989; Mayo, 1996; Moccia, 1988; Moccia, 1989; National League for Nursing, 1988, 1989, 1990, 1991; Pitts, 1985; Waters, 1991). But there has been very little discussion about how one transforms the practices of individuals or schools of nursing that continue to embrace content-driven curricula (Bevis, 1993a; Bevis & Clayton, 1988; Gould & Bevis, 1992). Lately, questions have been raised about whether or not nurse educators should unseat the behaviourist paradigm that is prevalent in nursing education (Romyn, 2001) while others are calling on the need for reform beyond that of the curriculum revolution (National League for Nursing Board of Governors, 2004).

There has been minimal exploration regarding the intent of nurse educators, as a teaching group, as they engage in the practice of teaching nursing. What is it that nurse educators want students to learn, beyond specific content information? What are nurse educators actually teaching? Who is empowered or disempowered, included or ignored through our patterns of teaching? What content is privileged or systemically silenced or excluded? The history of formal nursing education is relatively new, spanning only 100 years. And, it has been approximately 50 years since the American Nurses' Association recommended entry into practice at the baccalaureate level and formally moving nursing education out of apprenticeship in hospital-based settings and into institutions of higher

education (Ashley, 1976; Reverby, 1987). It is within the university/college educational environment that such a discussion about pedagogy can and should occur.

Abridged History of Nursing Education

Nursing education has existed in some form or other since the dawn of the profession, whether it was explicitly stated or not. Whether we start with the monks of the 11th Century, or the more formal beginning of nursing in the late 1850s, there has been an implicit attempt to teach nursing through pedagogy pertinent to nursing practice. Through the establishment of schools of nursing, Florence Nightingale laid a formal foundation for a pedagogy of nursing. In writing her book, *Notes on Nursing* (1969), she attempted to capture the essence of what it means to be a nurse and what would be entailed in the education of someone entering the profession. While the pedagogy of nursing education reflected the historical context in which learning was predominantly acquired through memorization and “regurgitation”, foundations were laid that continue within nursing education today. These remain observable in the ways in which faculty members speak about their practices of teaching. We can also see evidence of changes. As the curriculum revolution (Bevis & Watson, 1989) began in the late 1980s, efforts were made by some nurse educators to focus on learning as a process rather than a collection of facts. The curriculum revolution began to shift the focus of teaching and learning away from fact acquisition to one of relational connection (Bevis & Watson). Efforts by nursing education leaders, such as David Allen, Em Bevis, Peggy Chinn, Christine Tanner, Joanne Thompson, and Jean Watson, sought to challenge the scope of nursing education and to expand what was considered nursing knowledge and nursing practice.

The history of formal nursing education is relatively new. *Nursing Schools Today and Tomorrow*, published in 1934, reported, “In 1932, 23% of the schools did not have even one full-time instructor, and only 25% had two or more” (Ashley, 1976, p. 30). The level of educational preparation of employable instructors in the field was just as deplorable as the scantiness of supply. In the mid 1930s, just under 30% of the salaried teaching staff had not finished high school; of those who had, more than half had no college education. Only 20% of the total number of training-school staff members across the country “had as much as one full year of college” (Ashley, p. 30). Few institutions

went to the expense of hiring separate faculty. In most, the regular staff of head nurses, supervisors, dietitians, and physicians served in the capacity of teachers, both by example and by giving meagre classroom instruction. Learning was primarily achieved by associating with individuals on the staff, which constituted a process of education by informal socialization into the system (Ashley, p. 30). Not until 1965 did the American Nurses Association formulate its first position paper on nursing education. The Association took the position that “minimum preparation for beginning professional nursing practice” should be a baccalaureate degree education (Ashley, p. 126). Even today, we see the results of an apprenticeship model of nursing education, as minimum education for nurses is not universally at the baccalaureate level and baccalaureate education is not yet widely practiced as minimal entry into the profession even through the ANA continues to endorse this position.⁴ The primary preparation of nurses is within higher education but the majority of practicing nurses today are not baccalaureate (BSN) prepared (Gosnell, 2002). Many current nurse educators’ initial preparation for nursing practice was based within hospital school apprenticeship experiences (Gosnell). Exploration of nursing pedagogy, then, is rather new and the literature focuses on specific methods of teaching rather than exploring various possible ways of being as a teacher, and the effect these patterns of being have on student learning. This research begins an exploratory dialogue on the ways nursing educators practise teaching.

Four Teaching Approaches Uncovered

In working with the data from this study, I found that the 12 participants reported different ways of teaching nursing content. Many, but not all, of the examples given by participants about their teaching focused on the inclusion of lesbian content. This has led me to think about these data in relationship to general patterns of teaching and ways of being as educators. What follows is an exploration of the four ways in which participants discussed nursing education in the context of including lesbian content. A summary of the four approaches can be found in Table 1 (pp. 176-177). While these four patterns of teaching are likely not exhaustive they do represent a naming of what it is that nursing

⁴ In Canada, the Province of BC in September 2002 announced that in 2005, baccalaureate level preparation would be considered required for entry into the profession. In the United States, no state currently has BSN as entry into practice. In 2003, North Dakota, USA repealed its law of BSN entry.

educators do when they teach. Further exploration is warranted to determine ways other groups of nursing faculty use these and/or other patterns to engage with nursing pedagogy.

In his book, *The Courage to Teach*, Palmer (1998) speaks of teachers having more power than they either realize or want. Gregory (2001) says of this power:

Although everyone pays lip service to the value of “good teaching,” few teachers take time to think deeply about this power, about the special opportunities it offers or the special responsibilities it imposes, but I think our avoidance has less to do with time than with the fact that we are not sure what to do with this power.
(p. 70)

This research represents a beginning attempt to understand issues of power and as such, ways in which these participants focused their efforts in teaching.

In much of the research and literature on nursing education, there is an assumption that nurse educators share perspectives and meanings about teaching. While nurse educators may teach using different methods (for example, problem-based, story telling, case studies) there is little discussion within nursing literature regarding the pedagogy of nursing and what specific shared perspectives, values and beliefs are shared—or not—among nursing educators. This is problematic when reviewing the data presented here because, as noted, the literature within nursing education does not directly address ways of interpreting or making meaning of the data regarding patterns of teaching. Much of the literature that has informed this section of the report comes from the discipline of education rather than nursing.

Discussions with participants suggest that there is no basis for assuming a single, universal perspective on teaching nursing. Four different patterns of teaching did emerge and, although there was some overlap between them, participants spoke about their teaching in four distinct ways. I have labeled these perspectives “fill them up” or “empty vessel approach”, “learner centred approach”, “co-creation approach”, and “survival mode”. These terms are not specifically found in nursing literature and have been selected purposefully as terms not apparent in educational pedagogical literature. I link the four approaches I have named to education literature as a means of beginning an exploration of these patterns and suggesting the need for further study in this area of nursing education.

In examining the data, I strove to see the patterns within the stories that participants shared rather than trying to label an individual as being one pattern over another. Participants did not engage solely with a singular pattern; they did, however, provide enough examples of their teaching to lead me to see a dominant pattern to their understanding of teaching and learning. Each participant provided numerous stories that led me to see them falling primarily within one pattern rather than another; however, they each gave at least one example of another pattern or patterns. The majority of the participant group could be described as falling within a “fill them up” pattern, but each of the other patterns had at least two participants predominantly using that pattern. It would be important to develop further research questions to explore these patterns in greater depth and to see if there are other patterns not identified within this data set that nurse educators use. For the remainder of the discussion about teaching patterns I will focus more on the context of the stories than on the individual participants. These findings are an initial attempt to make sense of embedded information and further research is needed to advance these first impressions of the data regarding nurse educators’ teaching patterns. The fact that the majority of the nurse educators told stories that fell into the “fill them up” approach, likely reflects the way in which these nurses have been taught historically rather than a deliberate exploration of what it means to teach (Diekelmann, 2002a; Diekelmann, 2002b).

Fill Them Up—Subject Centred, Empty Vessel Approach

To describe or conceptualize some aspects of what I call “fill them up, subject centred” teaching, education researchers have used various labels. Pratt (1998) calls this process of teaching “transmission teaching” whereby the focus is on the effective delivery of the content. Fenstermacher and Soltis (1986) describe it as an “executive approach”, whereby the focus is on the teacher to impart knowledge to the student in a skilled and controlled delivery of that knowledge. Samuelowica and Bain (1992) described similar teaching perspectives in what they called “imparting information” and “transmitting knowledge”. The main assumption within this pattern of teaching is that learners are deficient in knowledge and “need” to have it “given” to them, because they are “empty” of it. The process of teaching within this pattern keeps the central foci on the

relationship of teacher to content and the delivery of that content to students who are perceived to need the identified elements that the teacher is imparting to them.

Participants

Participants who used the “fill them up” approach had been teaching nursing for a number of years, 4 to 15. They all taught in the first two years of nursing programs and primarily in the first year. It is difficult to tell from the data gathered if this is important information or a coincidence. There was a strong sense from these faculty members that they needed to provide students with a knowledge base from which they could subsequently engage with nursing theory and practice information later in their programs. Further research could be conducted to learn if the same instructors would change their pedagogical approaches when teaching different levels of nursing students, or if their approaches are basically the same regardless of level or content.

Underlying Assumptions

Some underlying assumptions of this approach include an objectivist orientation to knowledge. There are expectations within this pattern of teaching that teachers “know” a certain body of knowledge that is needed within the profession and it is the teacher’s responsibility to focus the attention of the student on this information. Teachers are expected to have the knowledge and impart it to students with a high degree of understanding and expertise. Within this pattern of teaching, specific content drives the knowledge/learning in light of the teacher’s beliefs and values. The focus of learning is on specific and predetermined knowledge acquisition understood by the teacher and presented to the learner. The student is seen as a receptacle for the knowledge imparted by the teacher. Questions asked by the teacher are in regards to understanding the specific content presented. Within this focus, Bolt (1998) points out that the learner is expected to adjust to the delivery of content rather than the teacher altering her or his approach to teaching. After all, it is the content, as dispensed through the teacher that is being presented for the student to learn. Limitations are viewed as coming from the learner not the “expert” (teacher). The teacher is seen as someone who has deep respect for the content and sets about to present it in an accurate and stable fashion.

These expectations can be seen in comments made by participants in the current study that indicate there are specific things students are to learn, right now, as well as

content or ideas that will be explored later in the learners' program of study. Participants who used this approach used phrases such as, "I have to cut discussion short, there is so much to be covered"; "I have to get through so much material each class, I can't just let things get off topic or we will never get through it, I'll always be trying to catch up"; and "I can't linger on any one topic for too long". One participant spoke of knowing that she could address some of the concerns she had with students' thinking in a later semester because she would have them again. It was clear from how these participants spoke about their teaching that they had specific ideas about what content needed to be covered in a certain amount of time and that other information or questions that led them away from their intended content agenda were not particularly welcomed or valued.

The participants in the "fill them up" group focused on knowledge acquisition as their primary goal. They spoke of students as needing to learn specific content and viewed their primary job as providing this information to students by means of readings, discussions, lectures, and examples. While not always obvious to the participants, there was some indication that even the selection of the information was something they determined to be significant to the students' understanding of what it means to be a nurse and that reflects their own (teachers') underlying assumptions of teaching and learning.

When asked about responding to the students' desire for more information regarding lesbians, one participant thought she might "bring in guest speakers from the gay community". She wanted to have an expert come and talk with the students, "since I would be unable to provide first-hand information". There was some hesitation on her part about whether this first year first semester course was the best place for inclusion of lesbian content:

Right at the moment, I'm trying to *give* them the foundational concepts and to *get them* to consider difference. And I need to *get* those foundational concepts *into them* [emphasis mine]. Now when they have had a chance to review and reflect on that a little bit more and probably by the second year, this [lesbian health care] would be more appropriate to look at.

Participants in this group included lesbian content within discussions of diversity and culture, definition of family, and basic assessment. One participant pointed out that there are heterosexual assumptions associated with many agency forms. Another participant, who was teaching in the skills lab, included scenarios that had lesbian clients

rather than the typical female client who is identified as heterosexual through the use of information like “Mrs.,” “married,” “widowed” or “divorced”. Another participant spoke of the need to prepare students for the possibility of being “hit on” by female psychiatric clients because it “could happen”. The participant, seen as an authority and having experience, presented this information as being a matter of fact and relied on the students believing her that it happens.

Another participant used, and reported enthusiastically about, an essay I wrote a number of years ago (Randall, 1994) where students are challenged to think about the outcomes to their typical lines of questioning in an initial assessment. This participant had students write their responses to their reading, although minimal discussion followed regarding ways in which students might be encouraged to think about the inclusion of different ways of interacting and the underlying assumptions that one holds and how these assumptions direct assessment, interventions, and evaluation. The participant felt that it was sufficient, “at this time in the curriculum” to “expose them to knowing there are lesbians” but also to “limit the discussion by not challenging” them any further; she plans to bring it up in a future course that she will teach with them (although no specific plan was articulated). This was a bit surprising since she also indicated that there were a number of students who reported having never thought much about lesbians within health care or who reported having had negative responses. She spoke of thinking that “this initial exposure was enough” and would “give them something to think about”. Note how power is used by the teacher to decide on topics and when, how, and how much a topic each will be explored or discussed. Her primary concern for not going any further focused on “a need to move on to other specific content that [had] to be covered within the semester”. This emphasis on not having enough time was shared by others coming from this approach.

Time

Time seemed to be addressed differently amongst those espousing the four teaching styles or approaches. Within the “fill them up” approach, time was seen as needing to be managed.

I find, sometimes you’re on such a schedule that you can’t let discussion happen. That sometimes you would like to go off in this direction, but you know you don’t

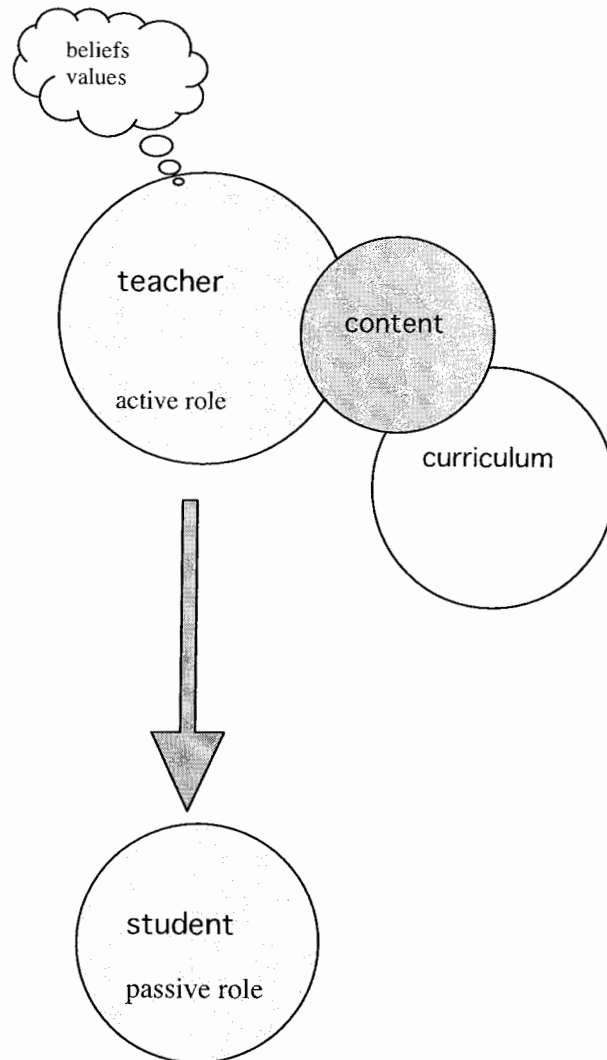
have the time to do it. Um, so I would sort of take control if I feel like we're running out of time and we haven't gotten through...or I don't even think we can get to it for the next class...sometimes I'll let, [pause] if we're having a good discussion, I would let it go if it involved a lot of people... and then maybe push—change my class the next time to incorporate what we didn't get through today. But I find I usually don't have the luxury of that time, [pause] like, it's so tight, as it is—and that's what I felt with this project...that I just didn't give it [pause] you couldn't give it the time that you would like to have with students, as you try and get through all the other material. You're trying to keep people on task.

We can see from the explanation that this participant felt compelled to direct, redirect and limit what content was covered within the course. She had an agenda and was trying to keep the focus on predetermined course content.

On the following page is a diagram envisioning the relationship of how learning and teaching unfold within a “fill them up” approach. There are strong ties between the teacher, content, and curriculum. The teacher is the driving force and students are rather passive within this model, consuming or taking in what the teacher has to offer them. There is minimal feedback from students into the content or curriculum. The teacher is seen both as the gatekeeper, interpreter, and knower of what needs to be learned by the student.

In this model, the instructor herself is “filled up” with previous learning and uses the role of teacher to “dump” her knowledge out on the students.

Figure 1. The “fill them up” or empty vessel approach.



Learner-Centred Approach

Participants

The participants who were identified as embracing a learner-centred approach to teaching identified themselves as self-learners and spoke about the value of being self-directed in learning. These participants expressed an interest in participating in this study because they were aware that it was important, but had never included lesbian content in their teaching before participating in this study. They revealed that being asked to participate in the study “provided permission to go down that path”. One participant described it as:

You gave me permission, and then I took that to the classroom and gave them permission by suggesting it as one of the group topics. The students actually then brought that topic forward, the topic of...I believe it wasn't lesbian but ah, [stumbles with words] gay male, that they brought into a classroom activity by their choice. So, I'd opened the door, or you'd opened the door to us including that as a topic, and then we talked about family diversity. That's the route they went with it and then, um, the content that I introduced was around a case analysis for group work. And the students then developed a case story that was a lesbian woman with irritable bowel syndrome. So, we brought that into the classroom [pause] and the experience of that. I guess, um, it just gave permission for me to introduce it. And that in turn gave me permission to the students to discuss it.

This same participant described the difference between inclusion of lesbian health care as a topic this time in her teaching, but not before: “Yeah, it's never happened before. Never. This time it happened. And I think if you hadn't done your intervention, (which is what you've done), it still wouldn't have happened”.

One particular participant in this group uses story-based learning as a model that directs her teaching. In response to inclusion of lesbian content in her teaching, she said:

So, yeah...so I think the story-based learning model allowed it...it provided a bit of a pathway to integrating those ideas. And it's designed to do that. But I'm not taking credit for it. I give the students credit for it because they're the ones that put it all together and brought it forward in the small group activities...And so I think that using the stories, and using it as student-centred, worked really well because it allowed for that more fluid process in the classroom. I wasn't directing it, the students could pick it up as they wished and they could bring the fluidity to it and they did.

This way of teaching parallels constructivist teaching pedagogy, whereby teachers encourage students “to become active learners and to discover meaning in their own

world” (Strauss, 1994). This teacher brought the topic of lesbian and lesbian health care into the classroom, although she credits the students for furthering the discussion by developing it as a topic for their assignment. We did not discuss in depth what would have happened if the students had not chosen to further explore the topic of lesbian health care. However, it did appear that the topic would have been dropped if the students had not shown any additional interest.

Underlying Assumptions

Participants frequently referred to the importance of students finding meaning within what was being learned. Participants spoke about their teaching in ways that were similar to those of constructivist teaching models (Baxter Magolda, 1999). Strauss (1994) speaks of a constructivist teaching pedagogy whereby attempts are made to help learners make more meaningful connections to what is being learned. The focus of teaching is on how teaching/learning models are developed; how one encourages a learner to become active rather than passive; how to assist them to discover meaning in their own world rather than in preformed ideas or definitions from the teacher, counselor, or text. Participants using this approach spoke of wanting students to take the lead in their learning, to be excited about something and follow up on it. Their assignments were designed for students to learn individually and in small groups, followed by large group presentations in which they shared their learning with the entire class.

In listening to the various stories told by participants, I was struck by the shift in thinking required by these teachers. While not discussed directly in our interviews, I wondered how teachers encouraged active rather than passive learning. Clearly, this approach was philosophically embraced, but examples were quite limited as to how they were actually operationalized. It would be interesting to work more closely with teachers employing this pedagogical approach and directly observe how they engage both with learners and specific course content that would be needed to practice safely within nursing. This is not to say that this was not done by these participants, but rather that their specific examples focused more on outcomes of students’ learning, rather than on the process by which the teacher engaged in assisting students to discover meaning in their own world.

In returning to the literature following my conceptualization of the four teaching approaches, I was struck by the lack of discussion from the participants regarding any of the concerns mentioned by various authors. A noticeable segment of educational literature warns of potential problems inherent within a student-driven teaching approach. Gregory (1997), Hirsch (1998), and Hansen and Stephens (2000) all question the efficacy of what they termed “student-centered learning”, within the current educational climate. Hirsch cites several studies in which a significant number of students were more receptive to traditional methods of teaching than to student-centered approaches. Gregory and Hansen and Stephens cite a number of factors that contribute to students’ resistance to the intellectual and practical work of student-centered learning. They suggest that society’s emphasis on success, instant gratification, competition, and a consumer model of education led students to look for easy answers and to count on high grades. Gregory warns that teaching to students’ comfort levels “has become so much the norm that students expect it” (p. 66). Strauss (1994) warns that “engaging them [students] in active learning takes more time, may lead in unforeseen directions, and often generates more questions than answers” (p.). Participants in this study who were identified as primarily teaching with this approach did not explore specific drawbacks or problems arising from their engagement with learning in this approach. They were not critically self reflective of their disclosure of changing the subject when they sensed discomfort from either the students or themselves. I am uncertain if this is because they did not recognize these concerns as concerns, or if they were not viewed as significant problems. Perhaps this information was not offered simply because these concerns were not the focus of my research or the questions being asked.

In contrast to the previously described participant’s experience with letting students drive their learning, another participant tells a different story: Her students were not interested in exploring the topic of lesbians or lesbian health care any further and so the topic was dropped.

This was the “official” class where I was deliberately bringing in the lesbian content...I photocopied the newspaper interview with the picture of [names a local public nursing figure], and you know, the comments associated with her being a lesbian. And, uh, we were looking at images of nursing and uh, again students skirted around the issue. They didn’t want to talk about it. ...I brought up

...”What about the issue of diversity? And they go, “Well, what do you mean?” So, that’s when I brought up about sexuality and things like that. And they wouldn’t go any further than to say, yeah...I’ve been accused of being a lesbian, that nurses are lesbians in general...One or two say, “Yeah, you must be a lesbian to be in nursing” “So, how’d you feel about it?” And they said, “It’s none of your goddamn business.” And I said, “ok”...and then [student] said, “Of course, I’m not a lesbian.”...What was interesting, I said, “What if you were a lesbian and you were in the nursing program...how can you be more supportive of each other in recognition of diversity?” And they said, “Well, your sexuality is your own business, you don’t have to make it public”. And...that’s it. Hm...they didn’t want to talk about it any further.

The participant goes on to talk about why it is that she did not take the discussion any further. “Now, what I found most interesting was that I didn’t even push it, because my previous experience has been that students get upset and run to the Dean.” While she reports being surprised, her comments demonstrate the concerns around risk-taking for herself when students are viewed as directing their learning.

Participants in this approach reported that if there were topics that students did not want to talk about, that those limits needed to be honoured. There was hesitation on the part of participants to confirm that these limitations might be related to social norms rather than the topic being beyond the scope of current learning interests or needs as suggested by one participant. There was some discussion about how other topics might have similar limitations but no specific examples were forthcoming, although in principle participants felt the idea of social norms seemed quite valid and yet these participants were not at all interested in pushing into uncomfortable areas with students.

Time

For those who saw their teaching within the context of student-centred learning, time was talked about within a very different context from other participants.

Because I teach using case stories, time is a little bit different. The time is always a factor...time really does shape what you can do in the classroom...for sure. Some of the discussions, though, occurred between the student and yourself when you’re doing the marking. And so, when the student...submitted her own case and she had written the story and there was lesbian content...she missed a big piece of literature in the area...then my feedback to her was textual and you know, you missed this and here are some references in here on your topic. So...you know I guess written feedback and evaluative feedback is another opportunity for discussion and has me using time differently than seeing it being limited within the classroom.

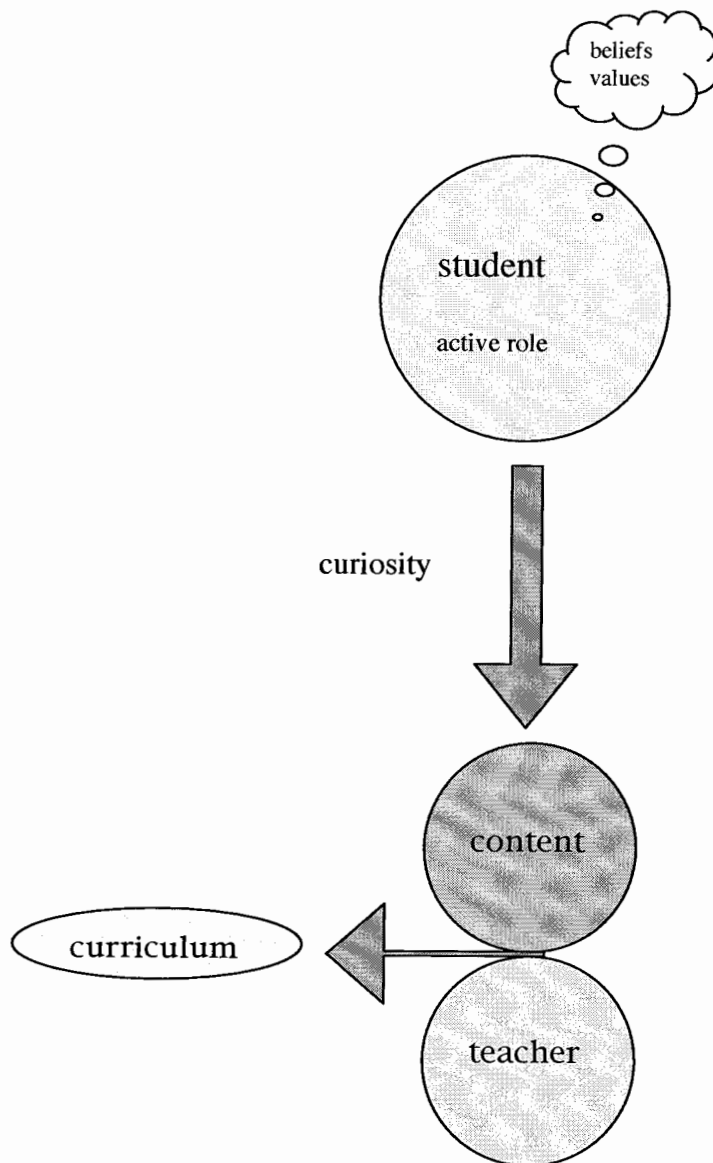
Another contribution to this notion of time was participants' mention of looking at learning activities outside of the classroom.

I think if you had a class that was half online and half in class...those online discussions, those chat room discussions, whatever you want to call them...would provide for more student-led kind of—kind of input. Without you [the teacher] being in control.

This participant was not currently using much online discussion, although she encouraged students to communicate with one another via email exchanges. She was beginning to explore online possibilities and saw the use of this medium as another way that students could engage in self-directed learning. This participant was looking for ways to expand time outside the classroom in which students could continue their learning.

The diagram below depicts the various relationships in a learner centred approach among student, teacher, content, and curriculum. Within this approach students are seen to be a driving force in establishing what content will be explored and this is primarily based on what curiosities they have regarding the course content. The curriculum and teacher are not front and centre within this approach.

Figure 2. The learner centred approach.



Co-creation Approach

The focus of the co-creation teaching approach is remarkably different from the others already explored. At the centre of this teaching approach is the desire to create a better society, not just the acquisition of skills necessary to practise the profession of nursing. This desire for a better society is evidenced by the participants' focus on social justice as a key underpinning of their teaching. Co-creation teaching involves looking both within and outside the profession to understand what is going on and in the asking of questions that explore the social construction of such institutions as health care, education, and so forth. Pratt (1998) indicated that "social reform approaches to teaching viewed teaching as a vehicle for empowering individuals and reshaping society" (p. 195). Inherent within the co-creation approach is a desire to help facilitate the learners to come to ask their own questions and find their own answers rather than accept the questions and answers that others, including the teacher, may provide.

Participants

The participants identified as teaching from a co-creation perspective reported the highest satisfaction regarding their inclusion of lesbian content. These participants were teaching senior level courses, in fourth year, at different schools of nursing. It is unclear from the data presented whether the format they used is how these women would teach regardless of the level of nursing education they were involved with, or if there is significance in their students being at the end of a BSN program. From my personal knowledge of these participants, I would argue that they would teach this way regardless of the student level; however, it is important to be aware that it would require further exploration to substantiate this claim.

Participants teaching with a co-creation perspective located the inclusion of lesbian and lesbian health care concerns within a social justice paradigm. Each credited their thinking about and performance of teaching from this perspective to their work with a particular faculty mentor during their PhD programs. One said:

I've been working with my mentor, [names professor], for 15 years; this brilliant, beautiful woman who is a woman of colour. We've been many places together and I've learned that her experience makes her see things sometimes differently than I would. And I've learned to respect that because I'm not walking in her skin.

This ability to listen to another, to be aware of differences, and to pause within this place of awareness while at the same time being conscious of one's own privileges was repeated throughout our discussions. This was not mentioned within any of the other teaching approaches.

One of these participants had previously included lesbian content within her teaching and another had been seriously thinking about it and used her participation in this study to begin. Both were able to clearly articulate a connection and link with other "isms".

I've learned a lot from [names a professor], for instance, about immigration issues, issues with refugees. I've learned about not stereotyping ethnic groups. I've learned about the interface...some of the intersectionality of gender, race, class, and so forth. And in my own dissertation research, I certainly learned...that I probably didn't have my eyes opened as much as I ought to with racism. But I saw a lot of ageism, and a lot of substance-use-ism, if we can give that a word. You know...it needs a name because it's a huge, it's a huge bias and prejudice actually in health care. So, all of that has kind of driven me to try to be more attentive about all the diverse meanings that people have. And that is informed, for me, by a notion of social justice, or grappling with whatever that is. But it's not a level playing field. That being fair means attending to the circumstances of people's lives.

This same participant commented:

But the reason that I was really interested in your project and wanted to make sure to weave it into the [names course], is that I've spent very little time understanding heterosexism and probably have my own, having grown up with heterosexist biases that I haven't really unpacked. The same way I probably have my own ageist and other kinds of biases. So, I thought that if we were going to do a course on culture and health, it was very important that students not see culture as only ethnicity. So, even having guest speakers in who represented some of the different ways that we can understand culture, so...there's yourself coming to speak to lesbian and gay issues, [name] coming to talk from an Aboriginal perspective, and then [name] I wanted to talk about culture of violence. I'm trying to help students see some of the complexity and some of the layeredness of culture. And some of the isms, including racisms, and stereotyping, that get in the way of health care delivery. So, that meant bringing in experts in different ways, which is why I wanted to participate in this study, because it's a new journey for me, to really focus on this as a particular area of inquiry and also for the students.

In talking about differences, this participant spoke of intersectionality in ways that helped link discussions between and across various differences. She was deliberate in sequencing class discussions "beginning with race, since there is much written about it

and a general understanding and acceptance of being stretched” to see ways in which one can improve understanding of racial differences. Race as a topic was followed by my being invited to talk about heterosexism, and then another speaker to discuss the culture of violence.

Helping students to make connections among and between “isms” is most challenging for educators (Blaisure & Koivunen, 2003; Fisher, 2001; hooks, 1994; McLaughlin & Tierney, 1993). While there are significant differences across various isms there are also numerous connections between and among differences that lead us to talking more about other isms in new and insightful ways rather than isolating one after another. In talking about her class and intentions of her teaching, one participant stressed the importance of the concept of intersectionality:

We talked about traditional discussions/writing around intersectionality, which tends to be gender, race, and class but doesn’t necessarily include many other intersections. One of the pieces they have, the Mandel article, included disability and poverty, so it unpacked more. But it doesn’t necessarily include issues about gender, sexual orientation, or age or, well, there’s lots of them obviously...so that intersectionality was clearly an important concept for them to interact with. I think, I hope, we wove a little deeper than just the superficial ideas. I hope we were able to put more layers on than we might have just reading about it.

Participants in this approach were able to embrace the notion of diversity and saw their teaching as directly linked to a form of social justice, and as such, felt compelled to stretch themselves and their students in areas that could be challenging both professionally and personally.

Underlying Assumptions

Participants articulated a desire that students be stretched to look at their comfort zones and to explore their own thinking and actions regarding intersections of various “isms”. Participants were able to give clear examples of ways students and they themselves interacted with lesbian content and other isms as they applied their learning of details to the lived experiences of clients and health care providers. These participants were up-front about wanting to have done more work on inclusion within their classes and had a number of ideas as to what they might do the next time they teach this same general content. Participants teaching within this perspective thought that specific examples and different case studies would have helped keep the student group coming

back to a focus. They felt this would have aided in going even deeper in their conversations with students.

Within nursing education, these ideas of co-creation in teaching and learning are reflected in the transformative caring pedagogy for nursing education as conceptualized by Bevis and Watson (1989). Education is described by these authors as having the goal of graduating students who are independent, self-directed, self-motivated, and life-long learners who are inquisitive and familiar with inquiry approaches to learning. Participants who used the co-creative approach not only verbalized the importance of nursing education bringing about transformative results, they continually looked for ways in which their teaching could assist in bringing this about.

Participants using this approach saw themselves as having a number of resources available to them in the form of personal experience, guest speakers, colleagues, a depth of scholarship and a sense of self-confidence not described by participants employing other approaches. One participant said:

so I think, yeah, knowing that I had resources, like I wasn't there alone in the classroom, we had three guests...so I was able to draw on expertise of other people, that helped. And then, having done that cross-cultural ethics project gave me some confidence, because I'd been part of a lot of...there [were] some discussions about cultural relativism versus imperialism and I had the confidence to be able to feel comfortable with that. And sort of argued for a notion of moral horizon, a middle ground, talked about by Charles Taylor. So the fact that I had some substantial theoretical background in it, by no means all of it, but in terms of...at least a standpoint, it gave me confidence as well. Confidence I think is important and not arrogance, I mean, what I tried to do was have a level of self-reflection so that so that it...was an example rather than a telling them how they were to think or be with this information.

Time

Time was not discussed as a negative issue for these participants. In contrast to the “fill them up” approach and the “survival” approach (to be discussed in the next section) there was no mention of not having enough time or having to move discussions on before they were finished, or needing to control or limit what happened in the classroom. Quite the contrary, discussions were encouraged and welcomed. One participant used a check-in format (Chinn, 2001) and found that by the end of the semester check-in took most of the class time. There was no concern about this; as a

matter of fact, the participant welcomed it and reported it as demonstration of real engagement of the group with the course material. Students were sharing stories of how their reading, thinking, and interaction with others was impacting their lives. As the participant talked about this, there was a sense of passion, accomplishment, and pride that students had been touched in significant and profound ways, not so much by her presence but more by their engagement with the course material, learning environment, and classroom community that had been created throughout the learning experience. Again, this was not something those using other approaches brought up as a significant outcome of student learning/experiences.

Participants coming from a co-creation approach valued critical reflection and aligned themselves within a critical paradigm. In education theory, Pratt (1998) identified these ideas as a social reform perspective. “Their [teachers’] perspective is unique in that it is based upon an explicitly stated ideal or set of principles linked to a vision of a better social order” (p. 173). The desire for critical reflection can be seen in the following example where the participant recounts what she wanted a group of students to understand about culture:

Like, there’s this constant trying to deconstruct what culture is all the way through the course. And looking at...the two main messages being, or three I suppose. Don’t essentialize culture. See, culture as more than just ethnicity; hence including the lesbian content and issues about violence as well, and also that self-reflective move of understanding where we’re coming from as individuals but also our own health care culture.

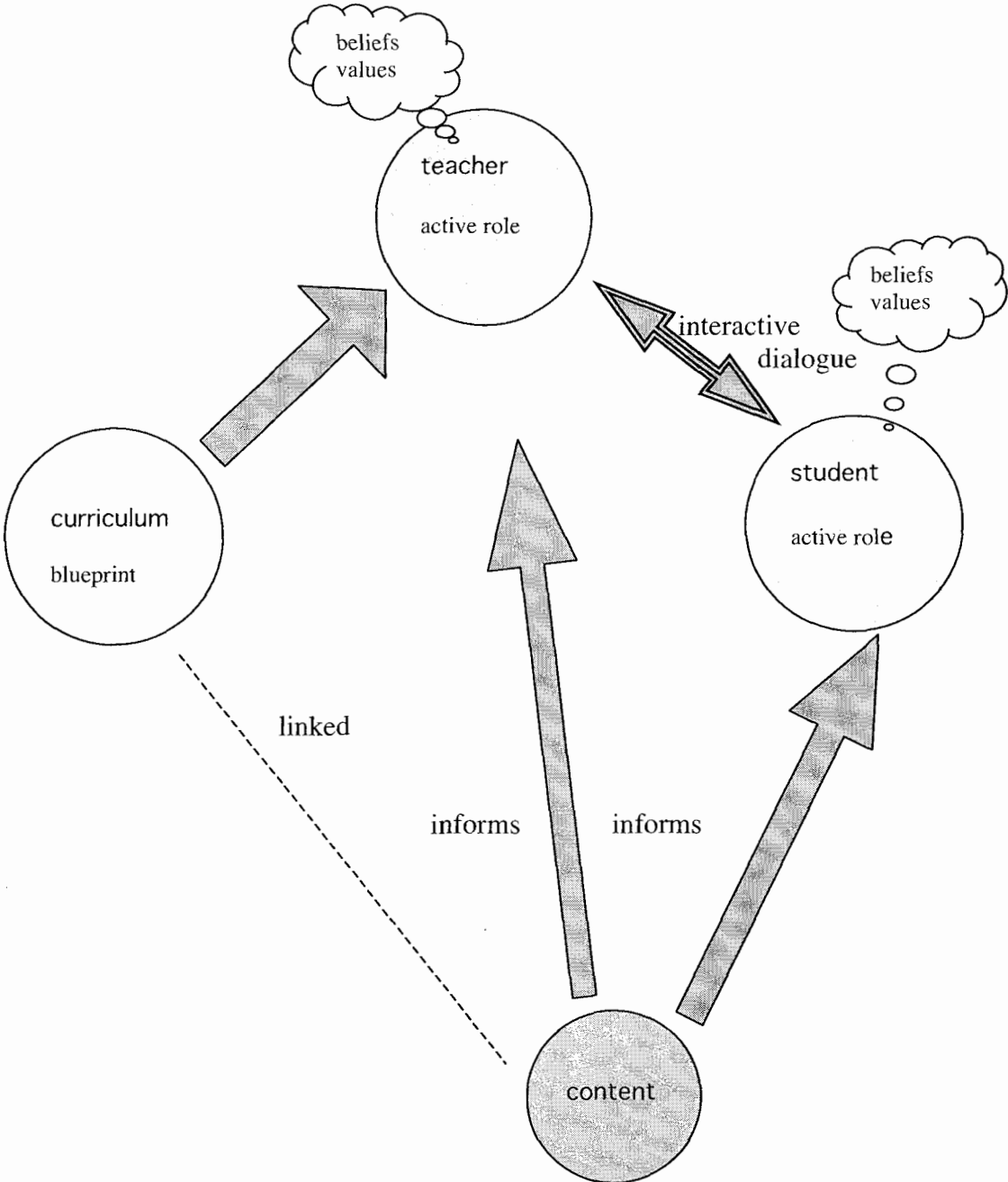
Another reaction specific to addressing lesbians and lesbians’ health care concerns within their courses was illustrated by the following statement:

That there was an “aha”...similarly to what we’d discussed...We underestimate racism, well some of the homophobia, the fear, the biases, the prejudices...The fear, you know you put “fear” up on the board. That twigged a connection for them, and I think it did for me that it’s easy to underestimate the level of fear that people who are lesbian or gay probably have to live with in all kinds of ways. And the different choices about “out” and, as you described it so well, about having to make choices in different circumstances. So that, um, my sense was that it got taken up and worked with in the kind of way that I would have hoped. By no means being an expert in it, but it seemed to me my goal had been that we do that self-reflective move for all issues around diversity. And we couldn’t hit them all but we hit a fair number of them.

Participants repeatedly engaged with concepts and principles associated with emancipatory education. They spoke of learning and teaching as being socially constructed and said that part of their responsibility as a teacher was to help students explore various social and cultural meanings attached to or communicated within their learning/teaching. None specifically spoke of a theorist whom they modeled their teaching after although they did speak about empowerment, emancipation, power, and privilege as contributing to how they go about exploring their teaching and learning opportunities. Participants were well read, both having PhDs, and mentioned the influences of scholars such as: Freire, McLaren, Marx, Brookfield, and Dewey on their understanding of the world. While not laying claim to the title of “radical education”, these participants often seemed to describe their teaching practices in much the same way that Pratt (1998) does under that title. Participants frequently used a “problem-posing” approach to learning, asking students to explore not only the direct questions posed, but also the associated question, where does this information/question come from? Participants echoed Pratt’s understanding of problem-posing within a critical theory approach whereby, “learners come to ask their own questions and find their own answers rather than accept the questions and answers that others provide. They experience education as an active process rather than as something that just happens to them” (Pratt, 1998, p.175).

The diagram on the next page draws attention to the co-created or co-constructed nature of learning in this teaching model. Teacher, student, curriculum, and content are all engaged with one another in various relationships and challenges. Curriculum is more within the domain of the educator since faculty members have the primary responsibility for developing and modifying it. However, students do engage with the curriculum as seen through its implementation of the specific program.

Figure 3. The co-creation approach.



Survival Approach

Participants

This last approach took some time for me to grasp and be able to explicate. This approach was taken by participants who were so stressed within their teaching during the semester in which they were asked to include lesbian content, that they were challenged in ways that made them behave quite differently than how they would like to see themselves as teachers. These challenges and stresses were not specifically due to inclusion of lesbian content; rather, they arose from being pushed to their limits as teachers. It should be noted that participants within this group did not teach within the same program. The patterns of behaviour revealed by these participants were associated with being either new teachers (less than three years) or new to their particular teaching positions so that all of the courses and work environment were new to them. They reported a sense of being overwhelmed within their role as teacher.

Underlying Assumptions

These participants spoke of “hoping” that the students would “just bring the topic up in class as a matter of course”. Much to one participant’s surprise, this did not happen. When participants who took what I have called the “survival approach” did bring up the topic of lesbians within their classes, the way they spoke of their inclusion did not seem to be directly connected to the course material. One participant engaged students in a discussion that explored what they had already learned about this population group. That participant reported being pleased that the students had had previous exposure and spoke with pride that this had occurred within the program although seemed at a loss as to how to further the discussion with them:

They [students] thought they had had a wonderful learning experience in their family course. They absolutely raved about it. They said... basically a pro-lesbian or non-heterosexist perspective had been a critical part of their family course. They talked about an older lesbian couple coming in who talked about their family from their perspective and their experiences. And, I mean, I’d say that 80% of them absolutely raved about what a wonderful experience this was. How much they learned, etc. And they thought that the topic had been well covered. So, at that point, I’m thinking, “Well, how do I do a follow-up to that?”

Not only did this participant seem puzzled as to how to move the topic forward within her course, there seemed to be a competitive edge to her last statement regarding how to

follow-up after students had such a positive experience elsewhere in the curriculum. She also seemed to be saying that she was satisfied that the topic had been sufficiently covered, as students were able to recount a previous learning experience regarding lesbians that was quite positive. She was unable to see ways in which she could contribute further to their learning about lesbians and lesbian health care needs within the current course. When asked if she understood the students to be saying, “we’ve been there, done that”, she said no. Yet she did not expand on the topic or offer students additional learning opportunities after she had assessed they knew something positive about lesbians.

Even though agreeing to participate in the study, one participant was challenged in a number of ways that she reported were not directly related to lesbian content but to numerous other factors that complicated her teaching experience, saying:

Okay, I think when I first thought about participating, originally, I was thinking that there would be something of a substantive intervention that I could integrate into my teaching. And that wasn’t so. But I think most of the problems, or challenges, is because the course...it’s not my course. I’m not course leader, the course is already fully developed. And really...there wasn’t the room to integrate anything new, say in terms of readings or...So I think that was a major barrier first of all, not being my course. But the other being, the kind of course it was, that it didn’t really relate to patient care or the kinds of patient issues, or client issues, or even societal issues that we would normally find in most nursing courses.

As a means of ensuring anonymity for herself and the lead teacher, this participant was particularly vague regarding the course content and what was included in the course.

More important than the content of the course was how she spoke of her experience teaching:

It was horrible. It was truly, truly an awful teaching experience. So, there wasn’t a sense of connection with the course leader. What we didn’t do, was to really, to get around to a lot of application related to, to the substantive areas...not as much as I would have expected. It didn’t reach that level because they were not getting basic theoretical parts. Certainly, I used cases and examples and we tried to do that, but it was a difficult course. So, that’s a part of the situation that made it very difficult.

Participants whose patterns of experiences placed them primarily in this approach were relatively new to teaching nursing, although one had taught previously, outside the discipline. They were new to their current positions and expressed a level of frustration

regarding their teaching experiences that suggested this was less than an optimal teaching experience for them. Another participant said:

It's basically, a sink or swim situation. Supposedly, the course material was to be available in a common resource room but nothing was there. And what I learned was that people are tired of their ideas being stolen and not acknowledged. So, there's a lot of distrust...And if I question someone, it's like, "what do you know?" so I just shut up. From my perspective, there was not support for new faculty.

Participants using a survival approach expressed a lack of power within their situations. They seemed to be just getting through on a day-to-day basis. They spoke of numerous frustrations that they were aware of through the semester that had little to do with the focus of this research project. And yet, as I listened to their stories their sense of frustration and sadness in not having done a better job teaching came through. They spoke of wishing they had done a better job, both in their teaching in general and more specifically in this research project. They seemed as though they were looking for something to go well for the semester and it had not. When asked about the curriculum each participant was able to describe the connection between their teaching and the course expectations. Their disappointment came in not having a sense of control to shape the course in certain ways that might have made them feel better about the experience. Their reaction to being asked to participate in this research was to express a sense of inadequacy. They connected this to being overwhelmed and having too much to try to accomplish without having more tasks added.

None of the participants spoke of ways this might have been different for them when asked about what they had expected. There was little evaluation of the lesbian content presented. They did think that they had a better sense of what to expect from the students and this was seen as helpful in some way. They seemed to have a sense of needing to endure this experience. Throughout our discussions, participants were focused on having survived the semester and hoping that their future teaching experiences would improve, although no plan for this to happen was discussed. Participants appeared to have little or no sense of control of their situation. Their focus was primarily on a sense of being overwhelmed in general, barely getting through the semester, and their strong

disappointment about themselves as teachers, although each blamed their situation for the results and not themselves.

Time

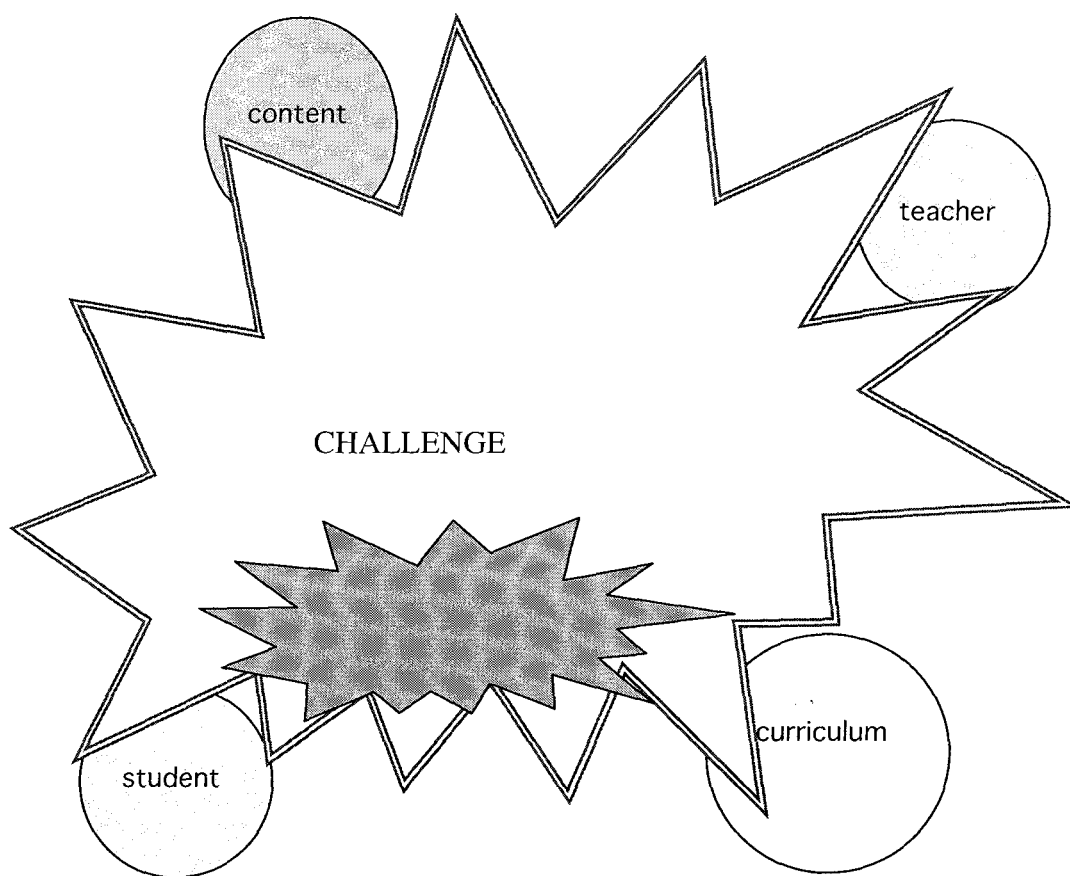
Time was a commodity of which this group felt they had precious little. They spoke in terms of not having enough time to get done what was expected of them, whether that was in preparation of the course material, their day-to-day existence, or in the classroom. They described their experiences as being overwhelming and stressful. Those who came primarily from this perspective indicated that they wished they had had more time to think about how to incorporate lesbian content into their teaching as well as wanting to have more time in general to read, think, and prepare. They spoke of always being on the run and hoped that things would get better the next semester. They each spoke of thinking subsequent semesters might be better although they would be teaching different courses and would not have any additional preparation time.

When looking at the data regarding these participants, I suspect that under different circumstances these participants would likely have “fit” into one of the other categories in terms of their pattern of teaching. However, due to the impact of their newness in their current job, their stress levels, and their sense of lack of control within the present environment, their underlying motivations, philosophies, and values about teaching and learning were obscured. Perhaps with the development of a specific research study to look at teaching approaches, direct questions could be constructed that would help identify enough variables to locate such participants into another specific teaching approach.

The diagram below attempts to capture the sense of disconnect among all the various aspects involved, teacher, student, curriculum, and content. There was little direct connection of curriculum to the teacher’s teaching and participants spoke of disappointments since they had wanted more direction from the actual curriculum. They wanted the curriculum to inform them about the specifics they were to teach and felt that there was not enough detail to actually guide them. It is difficult to get a clear sense of the relationships among various aspects of this survival approach. Participants did not talk about students, content, or the curriculum in ways that were similar to others in the study. In terms of the schematic diagram of this approach, I am uncertain about the

connections between content, curriculum, student, and/or teacher. I think the disconnection among the parts is what stands out the most. Further research would need to be done to examine this approach and be able to describe it in greater depth.

Figure 4. The survival approach.



Summary

To summarize the four teaching approaches used by participants in this study I have created a quick reference guide (see Table 1 on the following two pages) of the key variables and how they were expressed within each of the four teaching approaches. These variables emerged from the data as a topic discussed or expressed similarly or differently among participants and which appeared to cluster by teaching approaches, for example, time was discussed differently among the participants. Other variables included role of the curriculum, teaching assumptions, role of teacher, and so on. Each variable added to the overall conclusion that there were distinct and different ways in which participants approached their teaching. Further research would need to be done in this area to see if there might be other approaches that nurse educators use in their teaching.

While there were similarities within these teaching approaches I have listed areas that stood out as significantly different to highlight for the reader the distinctions among the four approaches. These differences and similarities, of course, warrant further exploration to see whether significant differences appear when the research is deliberately designed to understand the specific teaching approaches used within nursing education.

Within this chapter I have explored four dominant teaching approaches that surfaced from the interviews with twelve participants discussing their experiences of including lesbian content in their teaching. These actually came as a surprise to me since I had gone into this research expecting to come away with various concrete teaching and learning activities that included lesbians and lesbian health care content. I found little of what I thought I would find. The data revealed patterns of teaching styles and of how nursing faculty approach learning within the context of the nursing pedagogy they embrace, consciously or unconsciously.

In thinking about these four approaches to nursing pedagogy, questions arise that this research did not address: Do faculty use different approaches based on specific content, level of nursing education teaching, length of time teaching, students' previous exposure to content, and specific learning goals and objectives for specific courses? Do their teaching practices reflect a form of formal teacher education (in contrast to teaching as one was taught)? What philosophical approaches have influenced their approach to

teaching? What are their values and beliefs about teaching, learning, nursing, or life in general? Questions such as these need further investigation through research specifically designed to explore them. Further research and discussions need to take place within nursing education regarding our individual and collective approaches to nursing pedagogy(ies). These findings act as an interesting starting point and speak to the need for faculties of nursing to explore our teaching ideologies and how they are linked to our teaching practices and to student learning, both overt and covert.

Table 1
Four Clusters/Approaches of Teaching

Topic/Variable	Approaches to Teaching			
	Fill Them Up/Empty Vessel	Learner Centred	Co-Creation/Shared Learning	Survival
Years teaching	5-20+	2-4	5-20+	<3
Level/year	1, 2, 3, 4	3, 4	4	2, 3, 4
Indicated mentor	no	no	yes	no
Satisfied with teaching overall	yes	yes	yes	no
Role of curriculum	“tells me what to do (teach)”	directive—have to include	informs—acts as blueprint	structure
Assumptions regarding learning	fill with content; tolerance; non-judgment	students take up when needed	self reflection; aware of position/beliefs	unknown
View of time	not enough of it, limited	expandable outside classroom	quality, sharable	added stress
Role of teacher	tell them	invite/suggest	engage expectations	unclear in struggle
Student responses	state opinions, listen, “told”	few explored in assignment	engaged, stretched	“done that”
See lesbian health care as content	yes	yes	yes	yes-but
Consciousness-raising occurred for participant	assessment. inclusion	permission with results	opportunity	yes but other focus

Table 1
Four Clusters/Approaches of Teaching (Continued)

Topic/Variable	Approaches to Teaching			
	Fill Them Up/Empty Vessel	Learner Centred	Co-Creation/Shared Learning	Survival
Self reflection re their inclusion of lesbian content	viewed as adequate “ok”, would do again	“in their [students’] ball park”, will continue to include	thoughtful, critical, pushed self to improve, new ideas surfaced	limited reflection- “relived semester over”, rushed
Missed opportunities	unchallenged status quo	dependent on student interest	no-sees opportunity for greater integration	waiting
Talked with colleagues regarding lesbians and health care content	no	no	yes	no
Links with other - isms	little	no	yes	race
Discussed privilege	no	no	yes	no
How included	reading, discussion, opinion writing	invitation, self disclosure	readings, discussion, essay exam, guest speaker	add on reading, discussion regarding past experience
Specific content/format used	lab case, forms family, culture assessment, being “hit on”, diversity	case study, library search	access, -isms, social justice, understanding self/other	asses prior knowledge, wait to see
Concerns for further inclusion	touched surface; “too much” content	fearful, limited challenges with students	critical; wants more intersectionality examples	other content

CHAPTER SIX:

NURSE EDUCATORS' EXPERIENCES OF INCLUDING LESBIAN CONTENT IN
TEACHING: IMPACTS, RECOMMENDATIONS, AND MOVING FORWARD

In this final chapter, I recap the use of an eclectic research design; summarize my findings; and explore their implications and applications for nurse educators and nursing education; discuss questions about nursing pedagogy concerning the inclusion of lesbians and lesbian health care in undergraduate nursing education, curriculum, and faculty development. I also describe the limitations of this study; and make recommendations for further inquiry in the areas of research and educational practices.

Summary of the Main Findings

In this study, I explored the experiences of 12 nurse educators as they deliberately set out to include three learning activities focused on lesbians and lesbian health care concerns within an undergraduate nursing course that they were teaching over one semester. This study revealed a willingness of participants to include lesbians and lesbian health care content, although most had never done so and all admitted to being challenged by the request. Each participant reported that her consciousness had been raised regarding lesbians and lesbian health care concerns. This consciousness-raising occurred primarily due to participants becoming aware of their lack of knowledge and awareness regarding lesbians as a cultural group and as a minority group with unique health care considerations and unmet health care needs.

Learning activities chosen by participants were standard educational activities and included such things as an assigned or additional reading, group discussion, inviting a guest speaker, using a case-study scenario involving lesbians, and setting an essay exam question. One desire of the researcher had been to gather new and innovative learning activities for future distribution among nurse educators; however, no new approaches or activities were revealed. Participants' overall knowledge base regarding lesbians and lesbian health care concerns seriously limited the depth and range of their learning strategies.

Although most participants approached inclusion of lesbians and lesbian health care concerns by adding information to already established course content, one

participant had assumed that the topics of lesbians and lesbian health care concerns would naturally arise during discussions about feminism and women's health. Much to her surprise, this did not happen either from her just bringing it up or from students initiating the topic. This strongly suggests that faculty members need to plan specific means of including the topics of lesbians and lesbian health care content within undergraduate nursing courses rather than leaving it to chance or assuming it will automatically occur. On the other end of the inclusion spectrum, two participants viewed the inclusion of lesbians and lesbian health care concerns within undergraduate nursing education as a professional obligation and a component of social justice work. These participants were much more successful in incorporating lesbian health care concerns into focused discussions and were reflective about ways to improve the process for future courses. Other factors described by participants as contributing to their not having included lesbians or their health care concerns before were: not having enough time to learn about the topic in detail; and relying on "out" lesbians within the faculty to inform students about lesbians and lesbian health care concerns, and to find ways to challenge the limitations of heterosexism.

Numerous themes came to light as participants spoke about their experiences with including lesbians and lesbian health care concerns in their teaching. The most notable themes were:

- Uncertainty and confusion regarding the role curriculum plays in informing educators regarding the content and timing for introducing particular topics in the program of study.
- Participants' fears of the unfamiliar, including: awkward or sensitive situations arising in the learning environments; not knowing answers to questions that might be asked; the possibility of offending someone; uncertainty of how to deal with religious objections to the topic; and perceived lack of support from administration regarding possibly controversial topics.
- Lack of inclusion of lesbians and lesbian health care concerns in available nursing education materials.
- Minimal direct exploration of homophobia, heterosexism, and heterosexual privilege within society, nursing, or nursing practices.

Participants were extremely generous in revealing details of how they teach and how they think about teaching and learning within undergraduate nursing education. During analysis of the data an unexpected and interesting finding was revealed regarding patterns of teaching. Four different teaching approaches were identified, and have been descriptively labeled: “fill them up”, “learner centred”, “co-creation” and “survival”. As might be expected, participants who used the *fill them up* approach described a focus on providing factual information to students in areas that were important and linked to students’ future practice as nurses. In the *learning centred* approach, participants were focused on providing students with opportunities to pursue their curiosities and interests in areas that students wanted to learn more about. The *co-creation* group was the only group that held issues of social justice at the core of their reasoning for inclusion of lesbians and lesbian health care concerns. The focus encouraged students to engage with their own biases and comfort levels and to stretch their ideas of what it meant to practise nursing from a caring perspective. Lastly, those in the *survival group* focused on getting themselves through the semester. In this group there was little direct focus on including lesbian health care concerns although these participants offered valuable insight on what it means to be asked to include additional content when feeling overwhelmed within a teaching position.

The identification of different teaching patterns and the exploration of underlying assumptions about curriculum, knowledge, learning, content, time, and teaching are critical to the exploration and discussion of nursing education. At the centre of these discussions are ways in which they are linked to a central concept of nursing pedagogy. Before addressing the pedagogical implications of these findings, I want to look at the need for inclusion of diversity within nursing education.

Inclusion of Diversity

The implications of this research for nursing education are numerous and some are far reaching. There is a connection to what happens within society and what the teacher brings into the learning environment. It is important for the teacher to be critically aware and reflective regarding topics that are brought forward, or not, within the learning environment (hooks, 1994). Therefore, it matters within nursing education that there is conflict, apathy, reticence, resistance, or balking, in society regarding the acceptance of

various marginalized groups and this resistance needs to be part of the discussion as it relates to health care needs of individuals and groups within society (Young, 2004).

This study calls into question the ways in which faculty members include issues of diversity and related health care concerns for groups that are marginalized. Specifically, there was a lack of systematic and informed inclusion of lesbians and lesbian health care concerns by most of the participants. Few participants reported discussions exploring the challenges of marginalization, stigmatization, and harm that this population might experience, whether deliberately or inadvertently, within the health care system or society in general. No one reported including lesbians as examples while teaching other content pertinent to nursing knowledge such as growth and development, aging, death and dying, adolescence, parenting, or participating in healthy relationships. Only two participants engaged with lesbians and lesbian health care concerns in a way that directly challenged students beyond the superficial or encouraged them to think beyond their comfort zones by asking how their nursing practice would be different when caring for this identified population group. When discussed, the topic was about access to health care, ethical obligations to care, and different types of diversity. For the most part these concerns focused on lesbians and lesbian health care as problems or topics that lay outside normal human experiences rather than broadening the definition of what is 'normal' to include a variety of groups.

Another outcome of this research was an awareness that there is a need for deliberate inclusion of content that is not incorporated or even welcomed within the practice of nursing (Thompson, 1992). In the case of lesbians and lesbian health care content, silence and silencing have been the common practices for nurse educators. One way this surfaces within learning environments is through an assumption that everyone is heterosexual (Gray et al., 1996). This assumption perpetuates a common set of social norms that wrongfully subsume and embrace heterosexuality as the only way of being (Pharr, 1988). Overall, nurse educators in this study fostered limited inclusion of lesbians and lesbian health care concerns through discussions or challenges to students' thinking. As a group, they did not ask students to deliberately and critically reflect on current social norms about what is acceptable or common practice within nursing and the health care system. To do this, they would have had to include an opening to discuss broader topics

and their effects on everyone (not just lesbians) such as, heterosexism, heteronormativity, homophobia, and the discomfort we have as a society discussing such topics. The point would not be to have students sharing intimate details of their lives with one another; the point would be to explore how, as nurses, these students will engage in conversations about intimate details with clients and families. Nurses need to be prepared to accept the fact that not all people are heterosexual. They need to understand the health and health care implications of information on their clients who are lesbian, and to respect their relationships by granting loved ones access to, information about, and rights routinely granted to heterosexual couples and their families. There needs to be some basic guidance within nursing students' education for ways to approach this set of issues, and cultivate an environment that supports all clients and their family members through a wide range of human experiences (Thompson).

Participants demonstrated a lack of awareness regarding lesbians, had not included the topic of lesbians prior to this study, and some just "assumed" that the topic would come up. Looking at these factors, and at the lack of identified teaching resources, questions can be raised regarding why these areas have not been previously addressed within nursing education. The implication is that, because of nurse educators' lack of knowledge, lack of awareness, and living within a heterosexist social structure, nurses could conceivably treat everyone the same, as heterosexual. Treating everyone the same may result in a silencing of lesbians when they realize that the nurse is not prepared to address their legitimate issues, due to lack of knowledge, not realizing that not everyone is heterosexual. If a lesbian client does not feel safe she may choose to close down communication with the nurse. The danger in this kind of silencing is that faculty members do not have to think about differences or move outside their own ethnocentric biases and assumptions, nor do they have to challenge students' behaviours or thinking in any fundamental way. This also leaves the nurse educators' ethnocentric biases firmly in place and more tenacious by having been reinforced.

Becoming aware of one's privileged location within society can be a daunting task. It requires individuals to explore their own experiences and situations and come to terms with what it means to benefit from one's location in society (Thompson, 1992). This usually occurs through painstaking reflection that often means overcoming a

lifetime of falsely held assumptions, working through guilt, and deliberately letting go of some of the benefits within one's privileges (McIntosh, 1988). It would seem that this process of self reflection and action would be necessary for faculty members to be able to be supportive of students who may feel challenged, and vulnerable, perhaps by information intended to expand their understanding of the world (hooks, 1984; Palmer, 1998). This would apply to any "ism" (such as racism, sexism, ablism, classism, lookism) not just specifically to heterosexism.

All participants were clear that they had very limited knowledge regarding lesbians or lesbian health care concerns and because of this, were unable to draw on personal experiences for examples in their learning environments, as they frequently did for other course content. It is important to recognize and address this need for specific examples that may be used to communicate with students about topics outside the teacher's and most students' personal experiences. Some participants indicated a desire to learn more about lesbians and lesbian health care concerns and reported having read at least some of the materials provided at the beginning of the project. Only one participant reported seeking additional information beyond that which I provided. Participants indicated limitations in their abilities to learn about lesbians because of time constraints and the expectations of teaching other content within their teaching responsibilities. The need for consciousness-raising amongst nurse educators is shown because the topic of lesbians and lesbian health care concerns had not entered into their thinking before participating in this study. For this significant knowledge deficit to be remedied would require faculty members to make a concerted effort to educate themselves about lesbians and lesbian health care concerns. They would also need to have a sense of support from their colleagues and administration regarding the importance of being more inclusive, and to be assured that there would not be negative consequences due to any objection from students because of having taken these steps (Fisher, 2001; Governor's Commission on Gay and Lesbian Youth, 1993).

Nurse educators need to have basic information, or a knowledge base from which to draw, and need to have worked through their own personal fears and hesitations. This could be accomplished through reading about lesbian health, talking directly with lesbians regarding their health care needs, or reading literature by and about lesbians in

general. There are numerous web sites that would provide information about lesbians and legal concerns, parenting, current events, homophobia, heterosexism, and specific health care content (see Appendix K for examples). These include: The Mautner Project [Breast Cancer] (Biren, 1998; Messina & Zurn, 1998); support organizations such as Parents, Family, and Friends of Lesbians and Gays (PFLAG); and a number of national and local organizations.

Until faculty members see the need for specific inclusion within undergraduate nursing courses of health care content pertinent to lesbians, gain knowledge of these issues themselves, and develop a sense of personal comfort (overcoming their fears), it is unlikely there will be much if any forward movement and innovation on these topics. It seems unconscionable that personal fears, ignorance, lack of time, or fears of retaliation by academic administrators or students might determine the scope of exploration within an institution of higher education and within a profession that engages with people on very personal levels during crises. In addition to the individual shifts necessary to bring about change, there are institutional policy changes that can be considered such as: non-discrimination clauses, safety zone campaigns, changes in forms (intake/survey questionnaires), and general educational programs for students and the general public.

Nurses are called upon to act outside of heterosexist thinking on a daily basis if they are to meet the needs of a diverse and ever changing client population. Until individual faculty members perceive their role in disrupting common misunderstandings about any group of people, and do the personal work necessary to interrupt their own thinking, habits, and assumptions, they will continue to contribute to the misrepresentation and invisibility of minority groups such as lesbians. There is a high probability that failure to note the differences among people reinforces existing assumptions of what is considered normal, without critically questioning who might be excluded from this norm. By not directly challenging the assumption of sameness, nurses reinforce the invisibility of lesbians and the status quo of heteronormativity, both of which fall short of meeting the health care needs of lesbian clients. This reinforces the status quo, thus further entrenching the assumptions of heteronormativity and promoting the silence and invisibility of lesbians. Nurses may thus overlook or inaccurately assess

lesbians' health challenges, health risks, or their particular needs within the health care system.

Stevens (1989) argues, "the more actively and extensively nurses are able to perceive and reflect upon their social, political, and economic environment, the more effective they become in their interactions, a condition that is the essence of health" (p. 63). Faculty members need greater support from within the discipline to understand what it means to embrace inclusiveness and diversity; to teach from an emancipatory and empowering position that values critical thinking and liberal education. They need to believe that these ways of knowing are critical for transforming a health care system that is to serve numerous communities with dignity, moral consciousness, caring, and compassion.

Recommendations to Nurse Educators for Inclusion of Diversity

As nurses, and especially as nurse educators, it is important to recognize the need for ongoing learning and incorporation of this learning into our teaching. Based on the concerns seen in this study the following suggested activities and support systems provide direction to nurse educators for the inclusion of diversity in their teaching:

- Personal exploration and willingness to confront one's own biases, assumptions, stereotyping, and prejudices about marginalized groups (Pharr, 1988).
- Experiential learning activities in regards to understanding and teaching about heterosexism, homophobia, and critical reflection in conjunction with a social justice orientation (Thompson, 1992).
- Library resources that provide information regarding lesbians and lesbian health care concerns as well as other forms of marginalization and their intersection with nursing and the health care system.
- Support from administration for faculty developing changes in curriculum, policy, student-faculty and faculty-faculty interactions.

Undergraduate Nursing Education

Another area of concern in this study was the varied understanding of what it means to teach within an undergraduate nursing program. Three areas readily come to mind for this topic and while they are inevitably linked to one another, each will be

discussed under a separate subheading: Teaching Approaches and Nursing Pedagogy, Nursing Curriculum, and Faculty Development.

Teaching Approaches and Nursing Pedagogy

Serendipitous yet major findings from this research have led to a conceptualization of teaching styles or approaches and nursing pedagogy. While completely unexpected, this is an area of profound interest, as it ties together much of the data that participants provided regarding their inclusion of lesbians and lesbian health care content and locates the findings within a larger discussion of nursing pedagogy. As discussed earlier, the four teaching approaches are likely to be patterns of teaching that these participants use regardless of the specific topic being taught, course description, or where the student is in the undergraduate program. By identifying teaching patterns and coming to understand ways in which these patterns serve as, or are based on, the faculty members' philosophical approach to teaching, these findings introduce an opportunity to better understand the process of teaching in nursing and to re-envision nursing education. Clearly, additional research needs to be developed to explore this in greater depth.

Some questions that come to mind regarding pedagogy include the following: How does an educational process that is based primarily on the "fill them up" model affect ways in which students learn to be nurses? In what ways does a "learner centred" model influence the way in which students approach nursing care? And in what ways does a "co-creation" model foster specific ways of being for a student and eventually a nurse? These questions are intended to spark further investigation into how nurses become educators, and to look at the education they receive about what it means to teach both the art and science of nursing within an educational process that is not well understood and has a long history of primarily teaching as we were taught (Diekelmann, 2002a). Continuing theoretical discussions linking nursing education and nursing pedagogy is warranted and further research to examine nursing pedagogies and their impact on nursing education is recommended.

By determining that there is merit in the overt naming of nursing pedagogies, and subsequent dialogue about them, we open up further discussion within the discipline of nursing. We begin to see ways in which particular nursing pedagogies can inform our teaching and how we prepare nurses to teach (French & Cross, 1992; Harden, 1996;

Romyn, 2000). The way in which the knowledge, the art, the essence of nursing is learned matters. Pedagogical discussions can help in understanding the content and methods by which nursing knowledge is conveyed, beyond the transfer of accumulated information and a set of psychomotor skills.

Nursing Curriculum

There was significant confusion among participants with regard to the concept of nursing curriculum. Participants had varied understandings of what was meant by the term “curriculum” and the ways in which curriculum played a part in their everyday teaching. Participants did not agree about the purpose, function, or format of the curriculum. Each had a quite different understanding about the ways in which curriculum informed their teaching. In some cases, participants indicated that it did not inform them at all. Most thought the curriculum directed them (or should direct them) to the specific content they were to teach and where in the program that content was to be taught. This approach to curriculum offers limited creativity and interpretation of what can be included within the process of nursing education. In contrast, a few participants understood curriculum to be similar to what Bevis (1989b) describes:

The curriculum is not a plan. ...The curriculum is what happens, what actually takes place among teachers and students, students and students, so that learning occurs. ...What occurs can be quite spontaneous, or it can happen to a student alone when pursuing some meaningful idea triggered by something read, discussed, or investigated that is quite different from where the train of thought was supposed to lead. In fact, a good curriculum should be full of such gates of stimulation and inspiration. It cannot and should not be entirely preplanned and prescribed. (p. 72)

I am left wondering how and to what extent teachers’ understanding of the role of curriculum forms a pedagogical perspective and how this informs their teaching practices. What does it mean to nurse educators to have the curriculum drive the teaching of specific content? What does it mean to students to have the curriculum create an environment in which ideas are explored and learning occurs through conceptual understanding, with examples that provide specific content within a larger context of learning and critical thinking? There would seem to be remarkable differences among these four teaching approaches in how teachers would engage with learning and teaching and their evaluation of students’ growing knowledge base.

In listening to participants' stories, and being aware of my own experiences as a nursing faculty member, I have come to understand much of what faculty members do as educators happens in isolation rather than with colleagues. I have begun to wonder if this isolation keeps us from looking at our own practices and challenging or changing them. In our isolation, we become couriers of the curriculum content rather than being actively engaged in explorations of nursing knowledge.

Recommendations for Curriculum Changes

Curriculum acts as a foundation and gives direction for nurse educators as they plan their teaching. As nurse educators it is essential that we have an understanding of the ways in which a curriculum brings substance to the mission of a program, as well as the philosophical underpinnings of students who will come to understand the complexities of the profession of nursing. In order to assist in enhancing this understanding and have curriculum serve to expand what it means to nurse, the following recommendations are made:

- Envision and enact a change in how curriculum is understood, implemented, and evaluated within faculties of nursing whereby it is seen as the total experience of students during their program of study.
- Explore with colleagues the necessary specific changes required to bring about such emancipatory changes.
- Lobby accrediting bodies of nursing education to specify guidelines and expectations that demonstrate social justice within teaching and practising ways of knowing, being, and doing.
- Examine and revise expected competencies in undergraduate programs to include emancipatory education, critical social theory, feminism, and critical thinking.
- Mentor graduate students who are becoming the next generation of nurse educators to ensure these knowledge areas are part of nursing education preparation.
- Provide opportunities for discussion of the tensions and disjunctions that arise with regard to the vocational aspect of nursing education and the philosophical underpinnings of the profession, with the aim of bringing about change within the

health care system to create a bridge between those in practice and those in education.

- Revisit the classic works of the curriculum revolution such as: Bevis and Watson (1989); Allen (1985; 1990); Ashley (1976); Chinn (2001); Tanner (1988; 1990a; 1990b); Thompson, Allen, and Rodrigues-Fisher (1992) and seek means of implementing their findings or re-envisioning how this knowledge can be used to educate nurse educators differently.
- Explore ways in which nursing education can transform the lingering paternalistic model of apprenticeship within nursing education as the primary method of learning what it means to be a nurse and a nurse educator.

Nursing Faculty Development

Without tools or strategies for thinking critically about issues of teaching and learning, the practices of teaching in nursing education will continue to be much the same as they have been for years. Diekelmann (2002a) predicts that unless nurse educators are challenged in some fundamental way, they will teach in the same ways they were taught. This kind of passive approach to nursing education will not serve the profession well in the years to come in light of the challenges and needed changes in both the health care and educational systems. In this study there was overwhelming evidence that nurse educators were under-prepared to teach about matters that were viewed as controversial or having potential to cause direct confrontation and conflict. Our discussing the topic of including lesbians and lesbian health care concerns in their teaching usually shifted our conversations to areas of uncertainty, unknowns, distress, fear, religious objection, and misunderstandings. Participants reported that these fears restrained their teaching in numerous ways. Palmer (1998) addresses this type of fear in his book, *The Courage to Teach*. He says of fear:

My fear that a topic will explode in the classroom may be not a warning to flee from it but a signal that the topic must be addressed. My fear of teaching at the dangerous intersection of the personal and the public may be not cowardice but confirmation that I am taking the risks that good teaching requires. (p. 39)

Fear then, ought to be viewed as a welcomed sign rather than as cause for shutting down discussion or explorations.

Questioning what is moral and just within our teaching practices prompts us to reflect on those practices and interrogate the assumptions that underpin them. In this research, heterosexism and heteronormativity, while present in these participants' teaching practices, went for the most part unexamined either individually or as part of discussion within the learning environments. None of the participants reported having had sustained conversations with colleagues or experts in these areas. Those who participated in the orientation meeting and focus groups that were part of this project reported that their interactions with each other were helpful and enlightening, and as a result, they reflected more about their teaching. They welcomed the opportunity and questioned why it did not happen more often within their own faculty group.

Reflective practice about teaching is key to the concept of faculty development (Bradshaw, 2004). Faculty development can be described as an extended conversation among faculty members whereby critical reflection is invited, supported, and sustained. Key to these discussions is the insight gained through consciousness-raising. This occurs through the telling of stories in which one hears the connections, resonances, and dissonances with one's own experiences. Central to this critical reflection is the exploration of issues such as power, stereotyping, marginalization, difference, relationships, and what has been taken to be "normal". These concepts can be explored in a number of ways through the incorporation of inclusion. This might take the form of a discussion of the health care concerns of lesbians, persons of color, persons with disabilities, and ways in which these differences or sameness impact our perspectives and perceptions of nursing care and education.

Faculty development has frequently been experienced as program development that expands educators' knowledge about a particular topic. This often takes the form of imparting specific information about a particular subject. And while this can be beneficial in providing facts to faculty members, it inadequately defines faculty development. In this study, it was obvious that faculty members needed not only information about lesbians and their health care concerns, but also opportunities to explore what it meant for them to be inclusive within their teaching. Underlying the notion of faculty development is the need to develop a critical consciousness (Thompson et al., 1992). Among these study participants, numerous questions or issues arose that were beyond the need for

mere facts, they needed opportunities and support from each other to reflect critically on larger issues such as what it means to not be an expert on a topic of discussion within the learning environment. They also needed opportunities to explore their strengths and insecurities about how to facilitate learning and mediate possible conflict and misunderstandings among those in the learning environment, including students, peers, administrators, and colleagues in other disciplines. They needed to ponder the implications of stereotyping, and possible moral objections to the topic of lesbians and lesbian health care concerns.

Faculty development consists of those activities that engage teachers in meeting what Bevis (1989b) has called, “the primary duty of developing the self” (p. 164). Bevis stressed the importance of faculty development as part of this primary duty. This critical self-reflection, in turn, leads to a critical exploration and synthesis of such things as curriculum, learning, teaching, liberal education, and ways in which we engage with praxis (Coverston, 1993). In developing the self, Bevis purports that this will yield “teachers who are no longer lecturers who are merely knowledge and information brokers” (p. 164, 1989b). Bevis locates the need for faculty development around the principle idea of teachers learning to be liberating educators.

Liberating education requires educational strategies and frameworks that focus on the responsibilities and implications of practising nursing education from a critical perspective, an emancipatory underpinning, and cultural safety. Special attention must be directed toward fostering critical consciousness among nurse educators. Critical consciousness is characterized by self-awareness, and by insight into societal ideologies, mainstream stereotypes, and social agency. In order to develop the self and bring about emancipatory changes and understanding, educators must learn to see ways in which society influences one’s social identity and interpretive lens. In doing so, educators are able to challenge sustaining ideologies, institutional discourses, and predominating practices (Reimer Kirkham, 2000).

The context within which faculty development occurs will vary from faculty to faculty. Fundamental to the details of faculty development will be the concept of consciousness-raising, in this case about the lived experiences of lesbians and their interactions with the health care system. The key links of creating a space whereby there

is the opportunity for meaningful and competent nursing care will be in hearing stories of difference, linking understandings of cultural awareness to other concepts such as cultural safety (Polaschek, 1998; Ramsden, 2000), and the notion of a moral horizon (Rodney et al., 2002). The concept of cultural safety links well with an underlying intention of this research which was to have nurse educators move outside their privileged location within heterosexism and deliberately include lesbian health care concerns within their teaching. In so doing, these participants took an initial step in practicing and modeling for students what Ramsden (2000) has called culturally safe nursing practice. While cultural safety is a concept developed to speak to the experiences of the Maori peoples of New Zealand, at the hands of Pakeha [white people] (Polashek, 1998), the basic concepts can be explicated within this discussion of lesbians and undergraduate nurse educators. The basic concepts of cultural safety include: (a) consequences of negative attitudes and stereotyping; (b) ramifications of inadequate health care services; and (c) the need to foster changes in attitudes that contribute to the continuation of unsafe nursing practice (Polashek). Cultural safety in this context of inclusion of lesbians and their health care needs involves recognizing negative attitudes and stereotyping of lesbians, or those labeled lesbians, understanding the inadequacy of health care services for lesbians, and raising the awareness of institutional heterosexism and the nature of social structures that alienate lesbians within nursing and the health care system. Cultural safety would seek to changing nurses' attitudes from those that contribute to ignorance, injustices, and misunderstandings, to those that allow for the full potential of the individual to be present, free from the consequences of heterosexism and homophobia.

The link to navigating moral horizons as discussed by Rodney and colleagues (2002) explores various processes by which ethics are addressed within the nursing profession. These authors focus on the moral agency of nurses and the need for improvement in three areas: the quality of the relationship between nurses, clients, families, co-workers, and other disciplines; the language of ethics and the ways in which this supports the practice of nursing; and the need to improve the moral foundations of health care policies. This linkage of cultural safety and moral horizon needs to be understood in the context of establishing nursing standards, paying attention to specific cultural practices and recognizing the social, economic, and political position of certain

groups (such as lesbians) within society, and the positive impact this will have on the health care provided. The inclusion of concepts such as cultural safety and moral horizon give direction to the conceptual changes that need to occur if nurse educators are to teach from an emancipatory foundation.

Recommendations for Faculty Development

Learning to teach while teaching to learn is demanding, time-consuming, and a life long process for exemplary teaching (Scheetz, 2000). Faculty development is pivotal in assisting faculty members to visualize the potential learning opportunities within their learning environments. It becomes essential that faculty members do more than recreate the kind of learning that they themselves experienced. Learning from one another, challenging one another, stretching one another serves to empower and prevent us from settling on the familiar, settling into our comfort zones, and becoming stagnant. The following are recommendations for faculty development:

- Create a forum for sustained conversation among nursing faculty members regarding what it means to teach from an emancipatory perspective.
- Facilitate practices that support a process of engagement and exploration of teaching patterns and their pedagogical implications to nursing practice.
- Provide resources and educational opportunities for nursing faculty members to focus on assisting students in the exploration of their beliefs, values, stereotypes, and in the case of this study, their assumptions about lesbians.
- Provide resources and educational opportunities for nursing faculty members to be aware of and accept their fears and uncertainties within the learning environments and to encourage curiosity and exploration rather than resistance.
- Provide tools for nursing faculty members to address the challenging issues of social justice education so that the learning environments may become places of empowerment and real learning (Giroux, Lankshear, McLaren, & Peters, 1996; hooks, 1994)

Nursing Research

Within an eclectic form of a participatory action research design that embraced feminism and emancipatory inquiry, success occurred the moment participants engaged with learning activities that included lesbians and lesbian health care concerns within

courses they were teaching. Through this research, participants were challenged to rethink their teaching practices and to explore their lived experiences of what it means to include lesbians and their health care needs within learning environments. For most, this was a new experience and one in which each participant reported a positive response to the process.

Emergent Eclectic Research Design

A unique aspect of this research design was to incorporate the intent to hold the privileged group, nurse educators, accountable for the creation of change within their teaching. Participants were asked to include three incidents where lesbians and their health care concerns were brought into the learning environments. Following these experiences, participants explored with each other and me what it was like to include lesbians and lesbian health care concerns in their teaching.

In this study I used an emergent qualitative design (Marshall & Rossman, 1995; Tom, 1996) incorporating underpinnings of feminism (Bricker-Jenkins & Hooyman, 1986; Fonow & Cook, 1991; Lather, 1991a) and emancipatory philosophies (Harden, 1996; Heron & Reason, 1997; McLaren, 1996; Reason, 1994c). Three qualitative methods comprised the design: 1) group interviews (Fontana & Frey, 1997; Marshall & Rossman, 1995); 2) individual interviews (Fontana & Frey; Marshall & Rossman); and 3) limited participatory observation (Marshall & Rossman). In addition, derivations of feminist participatory action research (Reinharz, 1992; Reinharz & Davidman, 1992) and emancipatory research (Hart & Bond, 1995; Reason, 1994c; Streubert & Carpenter, 1999) were used. The effectiveness of this research design can be seen in the rich data, and in the willingness of participants to include lesbian health care concerns in their teaching and to share their experiences with each other and me. All participants reported thinking about lesbians and their health care concerns differently following this action research.

Limitations of This Study

The results of this study are limited to the reported experiences of the 12 nurse educators who participated in this research and to some degree other nurse educators who are similarly situated, that is, those who are teaching in undergraduate nursing programs within an urban setting and who are: between the ages of 40 and 60 years; identify as heterosexual; and have a minimum of a master's degree. Although these findings are not

generalizable to all nursing faculty members, given the high degree of homogeneity among other nurse educators in North America, there are probably similarities across many other settings and faculties (American Association of Colleges of Nursing [AACN], 2003; Hinshaw, 2001). Identifying these similarities, as well as the differences among nursing faculty members' teaching approaches would be helpful in better understanding what it means to teach professional nursing at the undergraduate level and ways of including the concept of difference, of which lesbians and lesbian health care concerns are but one example.

In order to broaden the applicability of similar research, I would recommend that a future study use a more purposive recruitment of nursing faculty members to increase diversity in terms of race, gender, ability, ethnicity, and sexual orientation. Having a greater representation of diversity within the pool of participants would have contributed to the deepening of the understanding of what it is like for nursing faculty members to include lesbians and lesbian health care content within their teaching of undergraduate nursing courses. Also in future research, interviews conducted by a heterosexual investigator might create a different investigative environment and reveal additional data that will further enrich our understanding of what it means for nursing faculty members to include lesbians and lesbian health care concerns within their teaching.

Another way of expanding the applicability of this study for future research would be to expand the geographic locations of schools of nursing used for the study. This would help to reveal any local bias or generally understood regional practices among nurse educators. An international study would reveal differences and similarities among different nursing faculties, and any differences that may result from lesbians having a favorable legal and social status (or not) within wider societal contexts. For example, a single study might include faculty representation from other Canadian provinces, the United States, Japan, United Kingdom, New Zealand, Taiwan, and so forth, as well as from different types of programs (college/university, associate degree, and graduate). There have been recent changes in Canadian federal law, extending equal Charter rights to lesbians and gay men within the contexts of marriage, immigration, health care, survivor benefits, and equal protection laws in other areas of daily living. Given the widespread resistance within United States federal and state laws regarding similar

inclusions, it would be interesting to see what the differences and similarities are between these two jurisdictions (Canada and the United States).

Other limitations of the research include my use of single rather than repeated interviews or focus groups with participants, which captured their teaching stories at only two different points during one semester of teaching. Subsequent interviews, along with participant observations within the learning environments, might have revealed further relevant material, possibly augmented by more reflection on the part of participants. Interviewing as a data gathering strategy necessarily limits what is known, because the information is filtered through the participants and reflects those ideas that they recalled and shared only when I was present and collecting data. Additionally, the fact that I am a nurse educator and an “out” lesbian probably limited, to some degree, what was shared with me by participants, who all identified as being heterosexual. Lastly, no matter how reflective I have tried to be as researcher, I retain the privileged voice of the author in the dissertation text. Although the voices of the participants dominate the report, the excerpts were selected, organized, analyzed, constructed, and presented by me (Acker, Berry, & Esseveld, 1991).

Because I had chosen an eclectic research design, participants were enabled to take steps to include lesbians and lesbian health care content into their teaching, which had not previously been done. Yet, this research occurred within a brief time span and did not address the sustainability of the described changes following participants’ self-reported consciousness-raising. It is significant that I have been unable to locate any research reports that address the longevity of changes following consciousness-raising. Freire (1994) demonstrated that change occurs slowly and the long-term effects are likely to be known only generations later. The brevity of this study (limited by funding and the period designated for the dissertation research) precluded the determination of the sustainability of the initial changes articulated by these participants. Further research in this area is warranted.

Recommendations for Further Research

Although the intent of this study had been to look at experiences of nurse educators when they included lesbians and lesbian health care concerns, it is the process by which these participants chose to include the information that is most interesting and

noteworthy. These discoveries open up a more complex discussion regarding nursing pedagogy that has not been explored in depth within the discipline. There are numerous areas where philosophical approaches and practical applications to learning could be explored in greater depth.

The results of this research suggest the need for nursing investigation in the following areas:

- Exploration of nursing pedagogies and the impact these have on the development of students as nurses and nurses as educators.
- Identification of teaching approaches and the contribution these approaches have on nursing practice.
- Faculty development strategies and tools that focus on a shift away from curriculum being a detailed blueprint of what is taught in a program of nursing education to one in which there is a broadening of the understanding of curriculum as being about the total experience of students within a program of nursing education (Bevis & Watson, 1989).
- Development of teaching methods that create teaching strategies grounded within pedagogical reasoning that contribute to critical thinking and emancipatory education for nurse educators.
- Investigation of the sustainability of change through faculty engagement in pedagogical conversations that seek direct implementation of learning activities formulated around emancipatory change within nursing education.

Summary

In this research, I examine various aspects of the theoretical and methodological underpinnings of an evolving research study on nurse educators' experiences when including lesbians and lesbian health care concerns into their learning environments. I have explored how feminism, emancipatory inquiry, and consciousness-raising impact various aspects of and decisions in the research process. In so doing I have discussed decisions about specific aspects of the research process, including: sampling, data collection, analysis, and ethical considerations.

One specific challenge of feminism, emancipatory inquiry, and consciousness-raising is to create positive, constructive, liberating change in one's world that highlights

the interruption of oppression and privilege. I sought to explore ways in which nursing faculty members can gain greater understanding of the ways that heterosexual privilege limit what is taught and learned. Livingston (1996) suggests that individually we can act deliberately in creating a future free of heterosexism. Braun (2000) locates this challenge within our research and claims it is the responsibility of all researchers to be ever vigilant not only for the blatant heterosexism and homophobia in our work but, even more significantly, for the insidious and subtle forms. Therefore, I strive to discover ways to create practical teaching opportunities to bring these discussions into nursing learning environments. Here, their impact will help to direct nursing students to find ways to be more inclusive and less heterosexist in their interactions with clients and their family members, with colleagues, and with members of the larger society.

Although I looked specifically at the individual nurse educator in this study, it is essential that we not lose sight of the bigger picture. Heterosexism and homophobia are bigger than individual thinking, biases, prejudices, and behaviours. Heterosexism and homophobia are “social diseases” if you will. They are systematically included in most aspects of society. Homophobia and heterosexism are insidious and, as Lorde (1984) pointed out, they are built into all of us as “old blueprints of expectation and response” (p. 123). This research calls on nurse educators to begin thinking and acting differently in light of having their consciousness raised within a feminist and emancipatory action research project. Participation in this research required participants to develop a personal commitment to self-reflection, asking and answering difficult questions, and living their lives differently in light of those insights, and at the same time to do this difficult work within a community of others who were awakening to their own insights.

As we gain insights into numerous forms of injustices and exclusions, we will need to develop new knowledge to help us understand how to proceed. This does not make the work easy, quite the contrary, it makes it some of the most difficult and painful work we can ever imagine doing. There are few, if any, role models for how to proceed and even fewer of what it means to be successful. There are few, if any, tangible rewards. People are not even likely to recognize the hard work, let alone applaud it. But to paraphrase Bernice Johnson Reagon (1983), it IS the work that will keep us ALL alive (p. 368).

Simone de Beauvoir challenges you and I to look within our own teaching practices and see where each of us are receiving unjustified benefits and where we knowingly and unknowingly exclude others:

My concern is not with those who remain either unapologetic about or else “culpably ignorant” of, their privilege but rather with the difficulties that their personal privilege presents for those who actively seek to diminish injustice and oppression. For the latter group, privilege is a term of moral disapprobation, for it bestows unjustifiable benefits on certain groups by virtue of exclusion of others. Privilege then, is *intrinsically* a scarce resource. For some to enjoy a privilege entails a structural relationship in which the benefits one group enjoys are denied to another. (Kruks, 2005 p. 200)

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APPENDICES

Appendix A

List of Textbooks Reviewed Regarding Lesbian Content

- Bolander, V., Sorensen, K. C., & Luckmann, J. (1996). *Sorensen and Luckmann's basic nursing: A psychophysiologic approach* (3rd ed.). Philadelphia: W.B. Saunders.
- Boyd, M., & Nihart, M. A. (1998). *Psychiatric nursing: Contemporary practice*. Philadelphia: Lippincott.
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- Craven, R. F., & Hirnle, C. J. (1996). *Fundamentals of nursing: Human health and function* (2nd ed.). Philadelphia: Lippincott.
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- LeMone, P., & Burke, K. M. (1996). *Medical-surgical nursing: Critical thinking in client care*. Menlo Park, CA: Addison-Wesley.
- Lowdermilk, D. L., Perry, S. E., & Bobak, I. M. (1999). *Maternity nursing* (5th ed.). St. Louis, MO: Mosby.
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- Pillitteri, A. (1999b). *Maternal & child health nursing: Care of the childbearing and childrearing family* (3rd ed.). Philadelphia: Lippincott.
- Potter, P. A., & Perry, A. G. (1997). *Fundamentals of nursing: Concepts, process, and practice* (4th ed.). St. Louis, MO: Mosby.
- Potter, P. A., Perry, A. G., Kerr, J. C., & Sirotnik, M. K. (1997). *Canadian fundamentals of nursing*. St. Louis, MO: Mosby.

- Shives, L. R. (1998). *Basic concepts of psychiatric-mental health nursing* (4th ed.). Philadelphia: Lippincott.
- Taylor, C., Lillis, C., & LeMone, P. (1997). *Fundamentals of nursing: The art and science of nursing care* (3rd ed.). Philadelphia: Lippincott-Raven.
- Videbeck, S. D. (2001). *Psychiatric mental health nursing*. Philadelphia: Lippincott.
- Wong, D. L., Perry, S. E., & Hess, C. S. (1997). *Maternal child nursing care*. St. Louis, MO: Mosby.
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Appendix B
Agenda Outline for Orientation Meeting

1. Introductions
2. Purpose of gathering
3. Summary of Research Project
4. Interventions
5. Time commitment
6. Questions
7. Consent Forms
8. Information regarding lesbian health care concerns
9. Handouts
10. Further information needed by participants
11. General information regarding lesbian cultures
12. Brainstorming regarding possible interventions
13. Questions
14. Summary

Appendix C
Information Letter

[University of Victoria Letter Head]

Information Letter

Inclusion of Lesbian Content in Nursing Education

Date [current date]

Name
Address

Dear [participant's name],

As a nursing instructor, I am concerned about the reports from lesbians and nurses about the limited information provided to nursing students about lesbians and lesbian health care needs. I am exploring the possibility that there are strategies that could make it easier for nursing faculty members to introduce lesbian content into their teaching. My research study, "The Inclusion of Lesbian Content in Nursing Education", is part of the requirements for a Ph.D. in Nursing from the University of Victoria. Dr. Virginia Hayes of the Nursing Faculty is my Research Supervisor.

The overall purpose of this study is to assist in understanding the experiences of faculty who deliberately include lesbian content in their undergraduate nursing courses. Additionally, this research will begin building a foundation of strategies and exercises that nursing faculty can use to consciously include lesbian content in their teaching. The research will document the experiences of nursing faculty as they implement three strategies to include lesbian content in their teaching of nursing knowledge. I plan to interview participating faculty individually and at a focus group to better understand these experiences. Additionally, participants will be offered the opportunity to provide anonymous comments in writing at the conclusion of the study.

A colleague has brought your name to my attention as someone who might be interested in this research. If that is the case, please consider participating in this study. The study involves you agreeing to include three strategies related to lesbian content in your teaching; and attendance at an initial orientation meeting, an individual interview, and a focus group. A transcript will be provided for your review following the individual interview to ensure that you have shared with me the information you wanted. If there are revisions or corrections that you would like to make, you may do so. At the conclusion of the Fall 2001 semester (or the beginning of Winter 2001) a focus group will be conducted to assist in obtaining a greater understanding of your experiences and to brainstorm with the group as to how this inclusion of lesbian content was useful to you and the nursing students you teach.

It is not expected that you have implemented such inclusion previously or that you have specialized knowledge regarding lesbian health. The orientation meeting will offer an opportunity for participants to share ideas and brainstorm possibilities. Additionally, I will be happy to assist you in exploring specific strategies regarding your specific content area and how inclusion of lesbian content might occur. In preparing for the inclusion of lesbian content in your teaching you may require additional preparation time. The exact amount of time is highly individualized and determined by the strategies you have chosen and your personal level of knowledge regarding lesbians and lesbian health care content. In all, it is anticipated that you will spend approximately 12 hours in total participating in this study.

Please consider this request to participate in this study. I believe this research is vital to students' and nurses' understanding of lesbians and their experiences within the health care system. You may contact me regarding your interest to participate or any questions you have at 604.608.2436 or at mergalan@interchange.ubc.ca. Dr. Hayes may be reached at her office, 604.323.5928 or at vhayes@interchg.ubc.ca, should you have concerns or questions regarding this research.

Thank you,

Carla E. Randall, RN, PhD (c)
School of Nursing
University of Victoria

Appendix D
Consent to Participate

[University of Victoria Letter Head]

Inclusion of Lesbian Content in Nursing Education

You are being invited to participate in a study entitled “The Inclusion of Lesbian Content in Nursing Education” that is being conducted by Carla E. Randall, RN, MSN, a graduate student in the School of Nursing at the University of Victoria. This research is part of the requirements for a PhD in Nursing and it is being conducted under the supervision of Virginia Hayes, RN, PhD. You may contact Carla at 604.608.2436 or Dr. Hayes at 604.323.5928 if you have any concerns or questions regarding this project.

This research has been funded by The Lesbian Health Fund (LHF) of the Gay and Lesbian Medical Association (GLMA).

The overall purpose of this study is to assist in understanding the experiences of faculty members who deliberately include lesbian content in their undergraduate nursing courses. This knowledge will assist in building a foundation of strategies and exercises that nursing faculty members might use in the future to consciously include lesbian content in their teaching. Research of this type is important because studies have shown that lesbians are a marginalized group within health care and that little is known about how inclusion of lesbian content in basic nursing education may assist in improving the health care that lesbians receive at the hands of practicing nurses.

You are being asked to participate in this study because you meet the following criteria:

- Are be a full, part-time, or sessional nursing faculty member for Fall 2001 term
- Are teaching at least one course in an undergraduate nursing program within the Lower Mainland of British Columbia that includes at least 15 hours of individual or student-group contact over the semester.
- Agree to include three (3) teaching/learning instances that include lesbian content in the teaching term.

- Agree to attend an initial orientation group meeting and focus group following the semester with other research participants, and an individual interview
- Agree to explore personal meaning of inclusion of lesbian content without own teaching practice, alone and in a focus group.
- Articulate positively the importance of including lesbian content in nursing education.

If you agree to voluntarily participate in this research, your participation will include attending an orientation meeting for 2 hours, an individual interview for 1-1.5 hours, with a possible second interview if agreeable, and a focus group meeting of 2-2.5 hours. Additionally, there will be your preparation time for the three instances of lesbian inclusion. The amount of time this will take is very individualized and will vary according to what you decide to do. It is anticipated that participation in this research project will require a total of between 8 and 12 hours of your time. The orientation and focus group meetings will take place at the University of Victoria Lower Mainland Campus, Classroom, 5th floor, Langara Collage Library, date and time to be announced.

All interactions you have with the researcher regarding this topic will be considered data even if these conversation occur outside the scheduled times mentioned above. For example if you were to call the researcher with a question this conversation will be included as fieldnotes and included as data, unless you specify to the contrary.

There are some potential risks to you associated with participating in this research although they are considered low. You may experience some personal discomfort as discussions and reflections evolve around the experiences of lesbians, the historical and social negativity in which this topic has been previously addressed and the possibility of challenges to personal beliefs, values, and assumptions. You may find it necessary to engage in additional preparation time for this project and it is anticipated that there will be additional reflective time needed as you process this experience. Varying degrees of resistance to the inclusion of lesbian content within the classroom setting might be experienced. To prevent or to deal with these risks you might be referred to services within your university, college or community, for example this might include: academic teaching/learning centre, program development, counseling services, PFLAG chapter (Parents, Friends, Family of Lesbians and Gays) or “The Centre” (previously called The Gay and Lesbian Centre of Vancouver).

The potential benefits of your participation in this research include personal growth and awareness through the development of teaching strategies which give rise to discussions regarding lesbians and health care. Through the knowledge gained from this research project, nursing students will enter the profession with an increased ability to contribute positively to the nursing care received by lesbians.

As a way to compensate you for any inconvenience related to your participation, you will be given \$10 cash to offset transportation costs and parking fees. Refreshments will be provided at the orientation and focus group meetings. Additionally, on-site childcare will be provided by a professional childcare provider at no cost to you during the orientation and focus group meetings should you have child care needs. It is important for you to

know that it is unethical to provide undue compensation or inducements to research participants and, if you agree to be a participant in this study, this form of compensation to you must not be coercive. If you would not otherwise choose to participate if the compensation was not offered, then you should decline.

Your participation in this research must be completely voluntary. Consent is understood to be voluntary and ongoing. You may withdraw from the study at any time. There will be no consequences to you, your job, or the institution should you decide to exit this study. If you do withdraw from the study, you will be asked about the use of data you have provided up to then. If you have no objection, the data will be used in my analysis. In cases where you do not want the data included, they will be destroyed immediately by shredding any hard copies made of the data, including transcripts and fieldnotes, erasing the segments of audiotapes where you spoke, erasing your data from computers and floppy disks. Any part of your data can be returned to you at your request.

In terms of protecting your anonymity, you and your affiliation to a specific college or university will not be identified. Individual circumstances or characteristics will be closely scrutinized so as to not inadvertently identify you. Characteristics of age, educational background, teaching background, gender and ethnicity will be used to generally describe participants, except where it will reveal identities. You will be given the opportunity to select a pseudonym for the study and your real name will appear on one master list referencing you to your pseudonym. This list will be kept in a locked filing cabinet in the researcher's home office, separate from the data. The nature of the Orientation Meeting and Focus Group are public but confidential settings. You also understand that you have a responsibility and obligation to the other participants in terms of maintaining their confidentiality by sharing only your own experiences and stories once you leave the group meetings.

Confidentiality of the data will be protected by being kept in a locked file cabinet at the researcher's home office. No one other than the researcher, the supervisor, and a transcriptionist will have access to the tape recordings, transcripts, and field notes. Your real name will not appear on the cassette tapes, transcripts, or field notes. Your real name will not be used in any part of the data or subsequent writing and dissemination of this research. Others involved with the data will sign a confidentiality statement indicating they will only discuss the information with the researcher and her supervisor.

Data from this study will be disposed of after ten years. All cassette tapes, transcripts, including disk copies, will be destroyed by electronic erasure and shredding.

It is anticipated that the results of this study will be shared with others in the form of a follow up meeting with participants, dissertation, published articles, and presentations at scholarly meetings.

In addition to being able to contact the researcher and the supervisor at the above phone numbers or email addresses, you may verify the ethical approval of this study, or raise

any concerns you might have, by contacting the Associate Vice President Research at the University of Victoria 250.721.7968.

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researcher.

Participant Signature

Date

A COPY OF THIS CONSENT WILL BE LEFT WITH YOU, AND A COPY WILL BE TAKEN BY THE RESEARCHER

Appendix E
Demographic Information

Inclusion of Lesbian Content in Nursing Education

The following questions will be used to give a general description of the participants involved in this study. These responses are meant to be anonymous; please **DO NOT** put your name on this form. The information will be used to describe the group as a whole and in no way will the information be used to identify an individual within the study.

Age:

What type of basic nursing program did you graduate from?

What is the highest degree in nursing you have obtained?

What is the highest academic degree you have obtained?

Number of years in nursing:

Number of years teaching nursing:

Number of educational settings that you have worked at:

Do you work?

Full time

Part time

Indicate which apply to you:

Tenured

On tenure track

Permanent non tenured

Sessional

Other

Do you consider yourself a member of a minority or marginalized group or groups?

Y N

If yes, please describe

I would describe my sexual orientation as primarily:

Bisexual

Heterosexual

Lesbian
Nonsexual
Pansexual
Transsexual
Other

Has this identity fluctuated over your lifetime? Y N
If yes, please described in what ways this has occurred?

Appendix F

References for Participants

These references deal with heterosexism, homophobia, lesbian health, strategies, and resistance. Participants were given a copy at the orientation meeting.

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Appendix G

List of Trigger Prompts/Statements/Questions for Individual Interviews

Previous Teaching Experiences

1. Tell me a bit about the teaching you've done in the past. What areas of nursing?
2. In what sorts of ways have you included lesbian content in your teaching?
3. Have students come out in classes that you teach? What sort of responses do you recall having to this knowledge? In what ways did this affect your teaching?
4. Describe how you have witnessed heterosexism and homophobia within nursing education and health care.
5. I'm interested in your experiences with lesbian or gay students...could you describe for me what that has been like?

Current Participation and Interest

I'm interested in how you came to participate in this study. What prompted you to volunteer to be in a study that addresses issues of heterosexism and homophobia and asks you to include lesbian content in your current teaching?

*Experiences in the Classroom**Teacher Comfort*

1. In thinking about the strategies that you've implemented so far would you describe what these experiences have been like for you? (Note: There will have been at least two strategies by the time of the individual interview.)
2. Would you talk a little about your own comfort level in including lesbian content into your teaching?
3. Thinking about the content that you've included, describe for me the preparation you used to present this content to students.

Student Reaction

1. Please describe the reactions students had throughout the semester to the addition of lesbian material. In what ways was this different or similar to past experiences?
2. If there were resistive responses, could you explain in more detail what these included and your response to them?

*Academic Freedom, Curriculum Issues, Institutional Philosophy, Social Mandate for
Entry-level Practice*

Next, I'd like you to talk about how you view the inclusion of lesbian content within the institution that you teach. (This is likely to bring up discussion of academic freedom, preparation needs of students, institutional philosophy, personal experiences, and I would specifically ask about these if the participant doesn't bring them up in their initial response.)

Awareness and Personal Insights

1. Would you describe for me the most challenging aspect of participating in this research?
2. What personal learning has occurred for you and how has this affected your relationship with students, colleagues, and others you encounter?

Is there anything else you would like to share with me, or comment about?

Appendix H

List of Trigger Prompts/Statements/Questions for Focus Groups

1. I am interested in hearing about your experiences of what it was like to deliberately include lesbian content into your teaching this semester. Would you describe for the group a situation where you felt successful in including lesbian content?
2. Can you share a time when you felt inadequate or realized that you didn't have enough information in presenting lesbian content?
3. In thinking about including lesbian content when you teach in the future, describe for us specifics from this experience that would encourage you or discourage you from doing so.
4. Describe what modifications you would make to the strategies you engaged in this semester. Are there specific pieces of information you would feel better about having before you would do this again?
5. In what ways have you discussed your experiences with colleagues? What were their responses and how did you find these responses to be encouraging or discouraging in your thinking about including lesbian content in future courses you teach?

Appendix I
Anonymous Response

Inclusion of Lesbian Content in Nursing Education

Please return this form to Carla E. Randall 201-1127 Barclay Street, Vancouver, BC V6E 4C6 in the enclosed self addressed stamped envelope.

Over the course of the past semester you were asked to include lesbian content into your classroom and have occasion to meet with me regarding these experiences. I realize that there may be other things you have thought of and would like to share, or things you might want to share but not have them directly attributed to you. Please feel free to comment on anything that has come up for you over the past semester regarding your inclusion of lesbian content. Additionally if you want to say anything else about this topic, please feel free to include that here.

Is there anything else you would like to share with me regarding your experiences of including lesbian content into your teaching this semester?

Appendix J
Confidentiality Statement for Contract Workers
(transcriptionists and research assistant)

Inclusion of Lesbian Content in Nursing Education

As part of my being paid as a contract worker on the research project “Inclusion of Lesbian Content in Nursing Education”, I understand and have agreed to maintain strict confidentiality of the data that I have contact with. I understand this to mean that anything I hear in conversations with participants or on audiotapes, or read in transcript or field notes will not be discussed with any one other than Carla Randall 604.608.2436 or mergalan@interchange.ubc.ca, the student researcher, or Dr. Virginia Hayes, her faculty supervisor, 604.323-5928 or vhayes@interchg.ubc.ca.

I understand that the content of the interviews I have been hired to transcribe may affect me in some unanticipated way. In order to prevent any untoward affects I understand that Carla or her supervisor may check in with me regarding my responses to this work. I also understand that I may contact either one of them to discuss my thoughts or feelings regarding the topic of this research project.

I have received a copy of this confidentiality statement and have had the opportunity to have any of my questions answered before signing it.

_____ Signature

_____ Date

Appendix K

On-line Resources Regarding Lesbians and Lesbian Healthcare

1. Wellness—Gay, Lesbian & Bisexual Health Links
<http://www-hsl.mcmaster.ca/tomflem/gay.html>
2. Lesbian Health Research Center— Access to health care and medical information
<http://www.lesbianhealthinfo.org/>
3. Lesbian Online Will— \$49 Attorney Quality Online Price Secure, Affordable, Easy, Private <http://www.lesbianwill.com/>
4. Murray Research Center: National Lesbian Health Care Survey
<http://www.radcliffe.edu/murray/data/ds/ds0894.htm>
5. Lesbian Health Care Needs During the Childbearing Process
<http://hometown.aol.com/bonnieDoula/myhomepage/business.html>
6. LCCP: The Lesbian Community Cancer Project, in Chicago, offers many health care resources for women. <http://www.lccp.org/events/events.html>
7. Toronto Coalition for Lesbian, Gay and Bisexual Youth— A network of social service professionals, health care providers, educators, youth and parents of youth. <http://www.tclgbty.com/>
8. American Family Physician— Health Issues for Lesbian Patients— Explore health issues in gynecologic and obstetric care for lesbians.
http://www.findarticles.com/cf_dls/m3225/1_60/55391812/p1/
9. HSLS: Sexual Orientation and Health Care
<http://www.hslls.pitt.edu/guides/internet/orientation>
10. Medicine: Gay & Lesbian Medical Association (U.S.)— Promotes quality health care for LGBT and HIV-positive people; fosters a professional climate in which diverse members can achieve their full potential, and supports members challenged by discrimination. <http://www.glma.org/>
11. Health Education Services
<http://www.georgetown.edu/student-affairs/healthed/lgbthealt...>
<http://data.georgetown.edu/be/article.cfm?ObjectID=521>

12. Women and well-being: Invisible Women: Building a Lesbian Health Agenda
<http://www.readwriteact.org/lesbianhealthagenda.html>
13. (Re)searching Lesbian Health Care
<http://www.usc.edu/isd/archives/queerfrontiers/queer/papers/>
14. Breaking the Silence: Lesbian Health Care Issues Speaker
<http://www.ena.org/education/programs/346.PDF>
15. Common fallacies...step toward separating myth from reality in lesbian health care
<http://www.chc.ucsf.edu/archives/lesbianhealth.htm>
16. Homophobia As a Health Hazard
<http://www.ohanlan.com/phobiahzd.htm>
17. Lesbian mothers support society
<http://www.lesbian.org/lesbian-moms/text.html>
18. Mautner Project— Lesbians and Cancer
<http://www.mautnerproject.org/>
19. Parents family and friends of lesbians and gays (PFLAG)
<http://www.pflag.org/>
20. National and International gay and lesbian organizations and publications
<http://faculty.washington.edu/alvin/gayorg.htm>
21. Gay and lesbian organizations and publications of the northwest and British Columbia. <http://faculty.washington.edu/alvin/nwgorg.htm>