The Qualitative Experiences of Queer Women Accessing Mental Health Services in Ottawa

by

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Abstract

This project explores the experiences of six queer-identified women who have navigated the mental health system in Ottawa, Ontario, Canada. The qualitative accounts included in this study address the historical experiences of each woman, offering the reader some background into the woman's individual life story and thereby some insight into the way she might perceive or interact with the mental health system and mental health professionals. The project explores these women's experiences through feminist and queer theory theoretical frameworks, also including some aspects of structural social work theory. The resulting document presents detailed accounts of the participants' individual life experiences, both past and present. The thesis outlines how encounters with homophobia, heteronormativity and sexism shape the way queer women access mental health services in Ottawa.

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Chapter 1: Exploring the Climate of Mental Health Care for Queer Women

Introduction:

The purpose of this qualitative research project is to enhance professional understanding of the experiences of lesbian and bisexual women within Ottawa's community mental health system. In this project, I explore how heterosexism and heteronormativity impact lesbian and bisexual women's interactions with the mental health system in Ottawa. In designing the research instrument, the key question I sought to answer was: how have the experiences of lesbian and bisexual women accessing mental health care been impacted by heteronormativity? Within the parameters of this project, the mental health system includes psychiatrists, community health centres, family counseling centres, community agency counseling services, university counseling services, private practice social workers and psychologists, employee and family assistance counselors, and in some cases, support received from family physicians and general practitioners. In order to assess the impacts of heteronormativity on the *mental health care seeking* [1] experiences of these women it was necessary to broaden the scope of the project and look at both these women's past experiences of heterosexism and experiences external to the mental health system. I felt that it was necessary to look into the past experiences of the participants in order to locate how these women may interpret current experiences of heterosexism from within the context of their past experiences. It was also my feeling that the historical experiences of the women would influence or complicate their mental health care accessing experiences.

[1] *Mental health care seeking* refers to a person's willingness to access or the frequency of accessing health/mental health care services. Amongst queer women this may be compromised by barriers of institutionalized homophobia, sexism or heterosexism (Banks, 2003; Kitzinger & Perkins, 1993; Van Wormer, Wells & Boes, 2000).

Historical Context

Until 1974, homosexuality was classifiable as a mental illness according to the Diagnostic and Statistical Manual (Hunter & Hickerson, 2003). This classification has done much to stigmatize lesbian and bisexual women. Documented long-term negative mental health implications such as depression and addiction in addition to poor health care seeking behaviours have been noted amongst lesbian and bisexual women, while biased and heterosexist practices endure in the mental health profession (Hunter & Hickerson, 2003). Tensions have long existed between mental health professionals and the lesbian/bisexual community, due in part to the historically exploitative relationship between the two. This relationship has been characterized by the pathologizing of queer women as being psychologically frail to subjecting queer women to a battery of painful treatments and experiments simply for exhibiting gender variant behaviour or defying 'female' norms (Kitzinger & Perkins, 1993).

For the aforementioned reasons I have determined that it is not necessary that participants in the study have diagnoses according to the DSM-IV Multiaxial Classification System (Sarason & Sarason, 2002). There is a strong theoretical and factual body of literature suggesting such diagnoses do not need to be emphasized in this type of study (see, for example, Kitzinger & Perkins, 1993; Brown, 2006). This is primarily because the DSM, as a clinical tool, has historically pathologized many women and in particular, many queer women. The focus of this study veers away from typical studies of phenomenon related to sexuality and diagnoses instead concentrating on queer women's experiences within the community mental health system. The specific intent of this research is to

explore some of the barriers experienced by queer women accessing mental health services. In approaching the research from this perspective the objective is to uncover whether queer women continue to be disadvantaged within the mental health system and to explore how the participants felt the system could be reshaped in a manner to better service their needs.

Another objective of this project is to determine whether, and if so, how queer women are impacted by the negative attitudes that have been cultivated in regard to sexual minority women. When present, these attitudes have been shown to impact queer women's functioning within society including their experiences within the healthcare and mental health care systems (Pearson, 2003; Kitzinger & Perkins, 1993). Attitudes of health and mental health professionals have often focused on the abnormality of lesbians and bisexual women, reflecting heterosexist norms (Kitzinger & Perkins, 1993; Anastas & Appleby, 1998). Heterosexism within mental health service agencies impedes mental health workers' ability to work effectively with the lesbian and bisexual population and to facilitate a strong and supportive network for their lesbian and bisexual clients (CRHC, 2004; Banks, 2003).

Mental health has historically been researched from a clinical, medical perspective that has implied deviance and pathological weakness on the part of mental health consumers (Fook, 1993). Many studies have sought to liken gay, lesbian and bisexual individuals to pedophiles and adulterers or have attempted to make a connection between queer identity and an inherent susceptibility to alcohol and substance abuse (for a reflection on these

studies see Pearson, 2003). What much of this research has failed to take into account is the hostile environment in which many queer individuals live, with many people having been rejected by family, ostracized by co-workers or neighbours or being marginalized from services and supports. When considering mental illness in the lesbian and bisexual community, the pathologizing of behaviours amongst this population continues (Kitzinger & Perkins, 1993). Kitzinger and Perkins (1993) refer to the concept of 'heteropatriarchal oppression' and the role it plays in the provision of services and treatment of lesbian and bisexual women with mental health concerns. The authors state:

> Feminist theory has always pointed out that some of what is conventionally labeled 'madness' is in fact ordinary and 'normal' behaviour for women. It is labeled as madness either because it deviates from male behaviour (the male as-norm argument) or because it deviates from male definitions of appropriate female behaviour (Kitzinger & Perkins, 1993, p. 159)

Although overt perspectives of this nature are not socially acceptable among contemporary mental health professionals, it is impossible to overlook the impact of ableist, sexist and heterosexist perspectives within mainstream North American culture. This does much to perpetuate the stigma felt by queer women who may have mental health distress influencing their ability to access services or impacting the comfort within the care environment.

Stigma is a powerful force in the existence of any marginalized individual. The stigmatized person is often situated and relegated to a disadvantaged social position. Stigma, combined with the destructive nature of internalized homophobia, often has enduring impacts on individuals (Healthy People 2010, no date). Some queer women may find the prospect of coming out as lesbian or bisexual so daunting that a host of negative

mental health outcomes result. Alcohol and drug abuse, depression, self-harm, self-destructive behaviour and other mental wellness issues are more prevalent in the queer population due to the common internalization of the negative messages about alternative sexuality that they have learned from mainstream culture (Morris et. al., 2001). Heterosexism and the continued implicit pathology of queer individuals by some professionals and agencies leads to problems in accessing service for many queer women there is a perception that disclosure of sexual minority status will result in inferior care (Healthy People 2010, no date). There are few queer targeted or queer positive services, causing many queer individuals to remain closeted (Banks, 2003). The feeling of having professionals, services and agencies available as queer positive resources serves to reinforce belonging and wellness for queer individuals. An awareness of queer positive services and supports can be directly linked to mental health wellness and resiliency (Rosario, et. al., 2004).

For many of the participants in the study, their existences as queer women and women who have accessed mental health services are articulated in political terms. At several points throughout each woman's narrative they speak to the political nature of their existences, making a connection to the feminist notion that the personal is indeed political for all of these participants (Braun, 2006). The lack of services for queer women is not only a social issue but a political issue as it is a result of decisions made by political platforms that do not support queer persons. This fact alone places this project in a distinctly political light in that all of the women are identifying deficits in the mental health system and indicating how best the defects can be remedied. The question is not so

much whether agencies are ready to begin incorporating more queer positive programming and services, but more importantly, how to motivate governments and policy makers to begin to recognize and identify the needs of this community and make the resources available to serve them adequately.

Terminology

In order to clarify terminology and how it will be used in the context of this project, I will provide several definitions. As a preface, I would like to clarify that the terms lesbian, bisexual and queer will be used interchangeably throughout the document. Addressing fluidity of sexuality was important to me as a researcher, however presenting some of the existing research as being inclusive of "queer" identities was not possible. In order to not compromise the intention of the existing research, the terms of lesbian and bisexual will appear frequently in the document in addition to the term queer, which is a preferred identifier for several women in this study.

Concepts of homophobia and heterosexism are central to this study. Homophobia can be defined as "any belief system that supports negative myths and stereotypes about homosexual people, or any of the varieties of negative attitudes that arise from fear or dislike of homosexuality" (Banks, 2003, p. 11). Internalized homophobia is an additional term that is deeply connected to the mental health of the lesbian and bisexual community. Internalized homophobia can be defined as "the inner feelings of fear and shame felt by lesbian, gay or bisexual people about their sexuality. These are often caused by negative attitudes and/or personal prejudices" (Duncan, et. al. 2000, p.2). These terms will

resurface throughout the body of the study as the sexual identities of the participants are explored. Heterosexism is more subtle and prevalent than homophobia and can be defined as "A belief system that values heterosexuality as superior to and/or more natural than homosexuality; that does not acknowledge the existence of non-heterosexuals; and that assumes that all people are heterosexual" (Banks, 2003, p.11). Heterosexism also speaks to the social organization of society, with heterosexuals or those presenting themselves as heterosexual in the higher echelons and those who openly identify as sexual minorities left in positions of disadvantage (Kirsch, 2000). These terms speak to the prevailing societal attitudes and social organizations which impact queer women. They are helpful tools to use when explaining how marginalization affects the lives of queer women.

Defining sexual minority status is more contentious and varied, largely depending on individual preference. Binary views of sexuality are currently being abandoned by many within the lesbian and bisexual community in favour of less structured conceptualizations. However, not all members of the lesbian and bisexual community adhere to these contemporary definitions. Therefore I will use both conventional and more fluid definitions to define sexual minority identities. Throughout this study I will often refer to the participants as 'sexual minorities'. This term refers to individuals who identify as 'other' than heterosexual. Within this umbrella term fall several more specific definitions that women may choose to identify themselves. According to McInnis and Kong, bisexuality can be defined as "the potential for being sexually and/or romantically involved with members of any gender" (Dobinson, 2003, p. 6). A lesbian can be defined

as a female identified person who is physically and emotionally attracted to people of the same sex (Duncan, et al., 2000). Despite traditional implications of these terms it is important to emphasize that women who identify as either lesbian or bisexual may, at any given time, be involved with people of other sexes or of the same sex, yet still identify according to these terms. Some lesbians and bisexual women may also choose to position themselves as "queer". This is a reclaimed term that is often used as an umbrella word for the gay, lesbian, bisexual and transgender (GLBT) community. The term "queer" has been embraced by many primarily due to the fact that "its definitional indeterminacy, its elasticity, is one of its constituent characteristics." (Jagose, 1996, p.1). In this study I will use the terms queer, sexual minority, lesbian and bisexual.

The term and concept of heteronormativity, an insidious phenomenon often present within our social environments, will also be used within this study. Heteronormativity can be defined as "the domination of heterosexuality as a pervasive sexual 'norm'...therefore any expression of sexuality other than heterosexuality is... 'out of place'" (Burgess, 2005). The women in this study have encountered multiple experiences of heteronormativity, including experiences of silencing or ignoring the implications of their sexual minority status and it's relevance to the helping relationship. This problem is not new for many queer women who have been faced with the denial of their lived experiences by many or all of the institutions with which they interact (Westerstahl & Bjorkelund, 2003). Contemporary Canadian society still places significant strains on queer women, as will be explored throughout this chapter.

Research on the experiences of queer women accessing mental health services provides substantial evidence that particular barriers, social problems and relationship affecting this population are largely invisible to mainstream mental health professionals (Saari, 2001). According to Saari,

> In a society in which there is an unthinking assumption of heterosexuality unless another sexual orientation is expressly communicated, lesbians often find their sexuality and the significance of their partner relationships ignored, even by people who are aware of their sexual orientation (2001).

Such experiences epitomize the concept of heteronormativity, a concept which explains the systematic denigration of queer existence through persistent oversight of queer realities. While heterosexism is often viewed as a less intentional oversight of queer existence via such things as un-inclusive language, heteronormativity posits heterosexuality in an expressly positive light with all other forms of sexual expression located in some other deviant category.

In the experience of many queer women, one of the most devastating encounters with heteronormativity and invisibility comes with accessing mental and physical health care (Danforth & Schlozman, 2003). Within a society that places high importance on the authority and knowledge of mental health and healthcare professionals, this lack of recognition of the particular difficulties of queer existence serves to reinforce the sense amongst many queer women that the system is not designed to meet their needs (Hunter & Hickerson, 2003). Unfortunately, as Anastas and Appleby (1998) state in regard to the social work professions, "Because homophobia and heterosexism are social forces that permeate all aspects of social life, social service agencies and social work professionals are not immune to them" (pp. 272). It is clear from this study that social workers can and

do replicate heterosexist values and, as a result, inflict a significant amount of harm on some queer women.

Foundations of Study:

In undertaking qualitative research I feel it is important to situate myself as the researcher. I am a 28-year-old Master of Social Work student from Carleton University in Ottawa, Ontario, Canada. I come from the perspective of a white, middle-class, queer-identified woman with 5 years of experience working within the field of mental health crisis intervention. From this experience, I have come to believe that minority sexuality status continues to be taboo within the mental health community and amongst mental health service providers (Hunter & Hickerson, 2003). In order to assist mental health service users to move forward in their *recovery* [2], I believe it is necessary for them to begin to address the impact that their sexuality has on their life and how it has shaped their interactions with mental health service providers (Rogers, et. al., 2003). Without allied mental health service providers and a variety of programs to meet the needs of this population, self-acceptance is difficult for many.

It is important to acknowledge that I take a social constructionist perspective when considering mental illness. Although I believe that there is a genetic and/or biological component to mental illness, I believe that the experiences of both queer and heterosexual women place them in a particularly vulnerable position for psychological distress. Although there any many people within our society who experience abuse in countless

[2] Within this study, the term *recovery* will refer to the accessing of support and services for queer women and the overall sense of community that is realized by the availability and quality of these services and supports (Rosario, Schrimshaw & Hunter, 2004; Hunter & Hickerson, 2003).

different ways, I feel that women, particularly queer women, experience treatment and judgment by broader society that leaves them prone to many social problems, including mental health distress. This perspective is well supported by a wide range of research (Kitzinger & Perkins, 1993; Schlicter, 2003).

Existing Research:

As many studies have shown, lesbian and bisexual women differ very little from their heterosexual counterparts regarding overall psychological stability (Dobinson, 2003; Van Wormer, Wells & Boes, 2000). Yet, "evidence suggests that lesbian, gay, bisexual and transgender people may disproportionately utilize mental health services" (Gay and Lesbian Medical Association, 2001, p.205). What is now known to be a major catalyst in the increased levels of mental health service seeking and overall mental health distress are the psychosocial and environmental factors that affect lesbian and bisexual women, particularly heterosexism and homophobia. For example, Banks argues, "Most psychological problems experienced by GL (Gays and Lesbians) are due to coping with the negative reaction if he/she is openly homosexual and coping with the anxieties of keeping sexual orientation hidden and fear of disclosure if he/she is not openly homosexual (Banks, 2003, p.33).

It should also be noted that the experiences of bisexual women are markedly different than those of lesbian women and should therefore not be considered one in the same, as doing so would mean overlooking the role of opposite sex relationships for bisexual women (Dobinson, 2003). Due to the limited resources available for this project, an in-depth look into the experiences of bisexual women is not possible, however the particular

challenges faced by one bisexual participant are explored in the data analysis sections of this thesis. Although the experiences of bisexual women and lesbians are markedly different they do share a common experience of dual oppression as both are women and sexual minorities (McNair, 2003). However, bisexual women are faced with the particular stress of existing in a space between the binary view of sexuality. As such, they are subject to discrimination from both mainstream society and the lesbian community. Their relationships and the particular challenges of their lived reality are perhaps less understood by mental health professionals, making accessing help even more challenging (Dobinson, 2003). If lesbian women have access to fewer specialized services and programs, it would not be inaccurate to assume that there are fewer resources for bisexual women. At least two of the participants did not rule out the possibility of relationships with men. As a result, barriers facing bisexual women will be discussed within this study.

The data produced from this project showed many commonalities between the participants, all of whom have very personal definitions of their sexual identity and who generally resist concrete labels being assigned to them. In particular, the lack of professional understanding of sexual orientation, as well as common social determinant of health implications facing sexual minorities wove through the narratives of these women. Ryan, Brotman & Rowe found that lesbian and bisexual women in Canada are "a population that has been widely ignored and is seriously lacking the kinds of contacts that gay men have established with health care providers in the last two decades" (2000, p. 19). According to a study completed by Pink Triangle Services (2001) bisexual women may be at a particular disadvantage due to common misconceptions about the

nature of bisexual relationships. As well, professional categorization of individuals into a sexual minority 'box' may be detrimental in the face of contemporary notions of sexuality as fluid and changing over time (Kirsch, 2000).

Nature of Discrimination Toward Queer Women:

Discrimination toward queer women in Canada has changed dramatically over the course of the past few decades. We now see prominent Canadians who are publicly "out", we have seen the legalization of gay marriage and we see more positive attitudes towards queer sexuality, particularly among younger generations. The purpose of this project is to look behind these broad level shifts, to explore what is happening in the daily lives of queer women. Despite the prevailing discourse of acceptance there is a secondary discourse of covert disapproval that is rarely articulated or demonstrated in ways that make it visible. These are the stories and experiences that will be outlined in this project, with particular reference to queer women's experiences of accessing mental health care.

Lesbian and bisexual women are regularly subject to this covert discrimination by healthcare providers, employers, family, social networks and broader social and political structures (Clermont & Sioui-Durand, 1997). Those lesbian and bisexual women who utilize mental health services are subject to further discrimination based on the historical classification of homosexuality as a mental illness and the current influence of heterosexism in today's culture. "The belief persists amongst some segments of society that LGBT people are 'mentally ill' because they self identify as LGBT" (Gay and Lesbian Medical Association, 2001, p.206).

Heterosexist acts are not consistent or uniform. Acts of heterosexism could be considered on a spectrum. Overt acts of hatred and hostility are located at the extreme end, signifying explicit homophobia or homonegativity and more commonly seen incidences of heterosexism focusing on exclusion or oversight at the other end of this spectrum. Incidences of heterosexism explored in this study range from the absence of lesbian and bisexual staff in healthcare agencies, to social exclusion, to the silencing of the concerns of lesbian and bisexual clients as a result of services and staff that presume heterosexuality. While some workers may have knowledge of lesbian and bisexual issues, or may in fact identify as lesbian or bisexual themselves, mental health agencies cannot rely on these individuals alone to encourage consistency in queer positive practice. Heterosexist assumptions may impede a worker's ability to identify clients who may be queer or may create a hostile environment in which clients do not feel safe coming out to their workers (Banks, 2003). Heterosexism may also affect a worker's ability to make proper referrals for clients out of fear or lack of education about issues facing lesbian and bisexual women (CRHC, 2004). Clients who may be hesitant to disclose their sexuality and to offer helpful information that will allow for a more therapeutic relationship are more able to do so within an agency and with a mental health professional who is explicitly non-heterosexist or who is queer-identified (Banks, 2003).

Study Themes:

There are significant barriers to lesbian and bisexual women's access to mental health services; such as the lack of explicitly GLBT positive services and intake processes incorporating presumed heterosexuality (Saulnier & Wheeler, 2000). While many

agencies may be open to lesbian and bisexual women, there are no specialized services for this population and many front line employees have little training or awareness of lesbian and bisexual issues (Saulnier & Wheeler, 2000). In other agencies, although programs may exist, the lack of a queer presence in the agency encourages lesbian and bisexual women to remain hidden and fosters a sense of 'invisibility' for this population (Ryan et al., 2000; Saulnier & Wheeler, 2000). According to research conducted by Ryan et al., "health care providers receive little training about homosexuality as part of their educational curriculum and as a result, they often have little knowledge of the theoretical and psychosocial aspects of homosexuality" (2000, p.10). Recent studies have found that many mental health services available to lesbians are 'biased, inadequate and inappropriate' (Saulnier & Wheeler, 2000, p. 412). In effect, the mental health system has been established according to a heterosexist framework that continues to disadvantage this population, resulting in significant gaps in service. This project will identify some of the specific ways in which agencies and service providers fail to meet the needs of the women involved in the study. This in turn will hopefully contribute to resource development for queer women and foster awareness of the need for social change.

Heterosexism emerged as a dominant theme in this study, clearly indicating that although there is a perception of progress in regard to tolerance and acceptance of the GLBTQ community, significant strides need to be made in order to remove heteronormativity from our social consciousness. According to Ryan et al., "The heterosexism of health care providers and the person's discomfort with their own sexual orientation may be barriers to health care accessibility for gay, lesbian and bisexual people" (Ryan, et al.,

2000, p. 7). In particular, access to mental health services may be more stigmatized due to historically negative considerations of both women's sexuality and mental health (Kitzinger & Perkins, 1993). Hunter and Hickerson note that queer individuals have experienced such punitive treatments as "induced seizures, nausea-inducing drugs, electric shock, covert sensitization...lobotomy and supplementations of various hormones." (2003, p. 198). The ultimate goal of early therapies for homosexual patients was a 'cure' for homosexuality (Hunter & Hickerson, 2003). The legacy of these interactions was not lost on the participants of this project. The issue of trust also emerged as a significant theme amongst the participants, implying that the perception of disdain from the health system endures. The implications of the historical treatment of the queer community is relevant to this study in that they introduce us to the early origins of the tension between mental health professionals and the lesbian and bisexual community.

Social Determinant of Health Analysis:

An Australian study indicated, "Health inequalities exist for lesbian and bisexual women, largely related to experiences of discrimination, homophobia, and heterosexism. These issues can lead to avoidance of routine healthcare..." (McNair, 2003, p. 643). However, an important observation is that the prevalence of mental health problems is not static between the two sexual minority groups. Sandfort (2001) suggests that lesbians experience similar rates of mental health disorders to heterosexual women, however rates of substance use disorders are significantly higher. Recent studies have also indicated that bisexual women have significantly poorer mental health than their lesbian and heterosexual counterparts (Rothblum & Factor, 2001; Saphira & Glover, 2000). This was

attributed in part to "negative attitudes about bisexuality... common in both the dominant society and lesbian communities" (Rothblum & Factor, 2001, p.68). According to Saphira & Glover (2000) bisexual women have often lost the emotional support of family and friends as a result of their orientation, further contributing to feelings of alienation and marginalization.

There is no information to suggest that queer women have higher incidences of mental illness. However, the factors that often influence mental illness and addiction often disproportionately affect queer women, such as poverty, abuse, social exclusion, limited social supports and negative societal perceptions, among other things (Hunter & Hickerson, 2003; Anastas & Appleby, 1998). The reasons that queer women are more commonly exposed to these social problems are complex, however, the key to the prevalence of these issues amongst queer women may be linked to prevailing heterosexism and in particular, heteropatriarchal perceptions (Kitzinger & Perkins, 1993). Youth exhibiting behaviour that is not in line with gender norms may be subject to more abuse and ridicule from peers, teachers, family and others, leading to early internalization of negative feelings about their sexuality and an increased susceptibility to social problems in adulthood (D'Augelli, 2002).

Of primary importance is an assessment of the indicators that may additionally contribute to poor mental health amongst the target population. According to the Ottawa-Carleton GLBT Wellness Project's 'Wellness Guide' (2001), social factors related to illness require further study in order to properly address the needs of the GLBT population.

These social factors or 'health indicators' vary from region to region and from one community to another. Differences between Ottawa's lesbian and bisexual women are apparent in a recent study completed by Pink Triangle Services (2001). This study found that bisexual individuals (both men and women) in Ottawa reported poorer health overall (PTS, 2001). These findings are relevant to this project in that they suggest a deficit in overall health and wellness promotion, service availability and access for lesbian and bisexual women in Ottawa. It is these particular gaps and how they are experienced by a small group of women that this project aims to explore.

Diamant et al. found that "lesbian and bisexual women were more likely to have poor health behaviors and worse access to health care" (2000, p. 1043). The socio-economic factors outlined at the beginning of this section have been found to have a direct impact on overall wellness. The needs of lesbian and bisexual women accessing mental health care vary on an individual basis and also according to membership of particular minority groups. Intersections of race, ability, class, religion, cultural belief and a multitude of other factors will affect the needs of the individual, necessitating flexible and open-minded mental health service provision (Duncan, et. al., 2000). Numerous studies have shown the vulnerability of individuals with mental health problems to poverty and homelessness (CMHA, 2004; Healthy People 2010, no date). The lack of family support, increased use of substances and lack of services for sexual minorities leave them at particular risk of homelessness, leading to associated difficulties experienced by the homeless population (Banks, 2003)

In considering the social determinants of health, the invisibility of queer mental health consumers may serve to fragment them from the general queer community. The lesbian and bisexual population, as with many other marginalized communities, continues to struggle with non-conformity within their own community. Queer women of colour or queer disabled women often feel ostracized within the gay community (Ottawa-Carleton GLBT Wellness Project, 2001; O'Toole & Brown, 2003). Although literature on the topic is limited, the same could be said of queer women who experience mental health problems. The heteropatriarchal prescription of what is normal dictates who, even within lesbian and bisexual communities, is 'normal' thereby diminishing their support networks (Kitzinger & Perkins, 1993). The six women involved in this study, although diverse in terms of identity, ability and experience, share many common factors such as class, race, and education level. The stories of these women provide insight into their experience of barriers facing some women who are marginalized within queer communities however do not speak to the invisibility experienced by those experiencing racism, classism and other relations of oppression.

Approaches to Service Provision:

Many service providers and agencies, although well intentioned, are not providing a safe or welcoming approach to service provision that would facilitate access for many queer women (Banks, 2003). Yet, there are service frameworks that have been created that encourage agencies to assess their own biases and challenge them to offer more responsible services for the Queer community. For example, agencies such as the GLBT Health Access Project (no date) acknowledge that there are specific objectives that health

service agencies should aim to provide in order to offer high quality services to GLBT clients. They highlight: (1) inclusive employee hiring practices and queer employee visibility; (2) staff awareness and competency in service planning and delivery for GLBT clients; (3) consideration of client rights; (4) fair, unbiased and culturally appropriate intake process; (5) client confidentiality; and (6) and community relations and health promotion to the GLBT community (GLBT Health Access Project, no date). Similar objectives are outlined in the Wellness Guide produced by the Ottawa-Carleton GLBT Wellness project (2001) as well as a 2003 study completed in Australia (Blanch Consulting, 2003). The intention of this study is to identify specific gaps in queer positive practice within community mental health agencies as identified through the experiences of the participants, with the resulting document offering personal reflections from the participants as to how their experiences might have been improved.

Models of service that include the fundamental objectives outlined in the GLBT Health Access Project have the potential to encourage diversity and acceptance and create safer spaces for both GLBT employees and service users, moving away from tokenism and marginalization that traditionally has created strong barriers for the GLBT community. While an important step forward, service delivery models resembling that of the GLBT Health Access Project are not seen as ideal by all members of the GLBT community. They are sometimes seen as problematic for both individuals who prefer GLBT exclusive services, and those who prefer services to be offered within mainstream agencies. While GLBT exclusive agencies are tuned into the needs of the GLBT community, they inadvertently promote notions of difference in regard to GLBT persons. Similarly,

Epstein states, " by hardening a notion of group difference, identity politics present a highly visible target". (Cain, 1998. p. 200). Mainstream agencies offering GLBT services serve to normalize and validate GLBT health concerns yet the GLBT focus can easily be lost within a mainstream context (Blanch Consulting, 2003). This is relevant to the project in that I hope to begin exploring how agencies can start to negotiate the introduction of non-heterosexist services while still maintaining a balance that will accommodate as many members of the lesbian and bisexual community as possible, preventing perpetuation of the historical obstacles to service. In this way, I will be building on the experiences of my participants to suggest that a middle ground can be established. This middle ground would recognize the current lack of availability of queer targeted services therefore emphasizing factors in facilitating access to queer positive services through mainstream agencies.

Theoretical Context:

In order to assess the structural issues facing lesbian and bisexual women with mental health concerns, I felt that it was important to introduce a critical theoretical perspective comprised of both queer theory and feminist analysis. However, structural social work theory has its place in this study as it has also assisted me in uncovering many of the systemic and structural barriers the women participating in the study face. It is my hope that those practicing structural social work and other forms of affirmative practice will use this study as a tool to inform their work.

Conventional neo-conservative ideology dictates that the source of most social problems, including that of mental illness, can be traced to a fundamental flaw in the individual. Mullaly outlines the implications of this perspective when stating;

> At the individual level, the source of social problems is seen to lie in within the person...: a person is not conforming to the rules, norms, and expectations of society because of some individual trait. Poverty, mental illness, drug addiction, and criminal activity are blamed on supposed personal defects (1997, p.121).

In contrast, radical social work, from which structural social work has evolved, incorporates a critical analysis of social problems and avoids individualizing common social problems (Mullaly, 1997). The radical and structural social work perspective that will be employed in the research project have served to identify the structural causes of individual problems (Fook, 1993). Knowledge of the real and perceived barriers identified by lesbian and bisexual community mental health service users in this study will also add to a body of work that may aid social work professionals working in the area of mental health support and counselling in addressing the long standing gaps in service provision for this client population. Within structural social work theory's analysis of systemic barriers is incorporated the social determinant of health approach which was highlighted earlier in this chapter. Social determinants of health speak to the structural barriers commonly faced by queer women, resulting in poorer socio-economic and health related outcomes that affect overall wellness (Banks, 2003).

Structural social work, although critical of social structures and the nature of interpersonal relationships, power and privilege, retains a more rigid view of the reality of lesbian and bisexual women's lives. Structural social work, while it is helpful in

analyzing some social and political realities of the population to be studied, lacks the ability to appropriately address the subjective experience of lesbian and bisexual individuals. Structural social work is often criticized for it's failure to realize the diversity of experience within oppressed groups, implying that experiences of oppression are uniform, in this case, implying a uniformity of experience amongst queer women (Valentine, 2000).

Incorporating postmodern feminist and queer theory perspectives into my theoretical standpoint has provided me with a more flexible analytical framework with which to approach this study. At the center of both queer and feminist theory lies a questioning of the nature of sexual relationships, desire and the impacts that sexuality has on the individuals' lived experience (Jagose, 1996; hooks, 1984).

The broader theoretical context of this study is queer and feminist theory. I draw on concepts from both of these theories that complement one another. Feminism offers a focused analysis of female oppression, particularly by focusing on patriarchal power, racism and classism (hooks, 1984). Queer theory offers an analysis that moves away from categorizing sexual relationships, instead utilizing postmodern interpretations of gender and desire (Jagose, 1996). Queer theory's rejection of traditionally structured relationships and attraction allows me as the researcher to introduce new knowledge to the Ottawa community from a theoretical perspective that continues to evolve and inform practice in the helping professions.

However, it is important to note the theoretical departures of queer theory and feminism and the dissonance between them. Cossman outlines these differences succinctly in the following statement:

> For queer theory, feminism is reduced to one side of the sex wars—those who seek to regulate the harms that sexuality presents for women, while queer theory casts itself as a more liberatory politic that seeks to destabilize the disciplinary regulation of sexuality. For feminism, queer theory is reduced to a sexual libertarian and representation politics devoid of ethicality, unconcerned with the material conditions of women's and other oppressed people's lives in general, and the role of sexuality in producing inequality in particular. (Cossman, 2004, p.852)

Despite these tensions, I believe that the analysis from both of these theoretical standpoints assists in the study of queer women. Feminism allows us to understand how it is that queer women have come to be disadvantaged within the mental health system that has historically been dominated by men, something that queer theory is less capable of identifying. However, queer theory embraces the subjective nature of sexuality and fills in the gaps that the feminist interpretation of sexuality is sometimes unable to address.

Feminist theorist Dorothy Smith explores feminist methodology and the complexities of it. Throughout this research project I discovered, true to Smith's own assertion, that we as queer women do not necessarily share common experiences, however we are all faced with the reality of our exclusion from social and political systems. There is a shared oppression, but for each woman there is a unique interplay of encounters and oppressions that shape the lived experience (Smith, 1987). As a result, this project does not attempt to present any sort of far-reaching uniformity of findings, but rather a connection of stories of various meaning and power for the women, reflecting a similar pain and oppression.

Centering the research within feminist and queer theory with an eye to structural social work theory allows for the consideration of anti-psychiatry ideology that has been embraced by progressive theorists within all camps (Kitzinger & Perkins, 1993; Wilchins, 2004; Fook, 1993). Power, or the psychiatric patient's lack thereof, is a central concept of the anti-psychiatry discourse. This power imbalance, coupled with the vilification of natural female behaviour, and rejection of women who refused traditional female roles has made lesbian and bisexual mental health a taboo subject (Jagose, 1996, Kitzinger & Perkins, 1993). Historically, those within the psychiatric profession have utilized their heteropatriarchal power to incite fear in patients and force certain behaviours more fitting with mainstream expectations (Kitzinger & Perkins, 1993).

Within this project I attempt to break down the concept of power within the mental health professional/client relationship and identify the particular impacts of the power differential on the women in this study. However, when considering the experiences of queer women, it is important to note that power is not simply held by mental health care providers. A perceived power imbalance can also be present in the participants' interactions with greater society, given the historical marginalization of both women and queers. This reality factors into the study in that broader societal experiences further impact queer women's perceptions of power holders, thereby influencing their experiences. Most importantly, this project seeks to uncover participant definitions of power and their own recognition of how they have been affected by power imbalances within the system. Incorporating feminist theory and utilizing it within the context of this project has been a valuable tool in researching this often oppressed and poorly served

client population and deconstructing the complexities of the subjective female identity, queer identity and mental health service user identity.

The introduction of the concept of heteropatriarchy assists in identifying the oppressive components of the 'modern' mental health system that reflect the archaic and enduring notions of women's sexuality, roles, mental health and pathology (Kitzinger & Perkins, 1993). In addition, queer theory assists in addressing the subjectivity of sexual identity for the women participating in this study and for many queer identified individuals. Utilizing feminist analysis accompanied by queer theory will assist me in identifying how women have been subjected to controls within the mental health system. Queer theory shaped my exploration of how lesbian and bisexual women in particular have been victimized due to their resistance to typically female roles (Jagose, 1996). This study begins to draw connections between heteropatriarchal oppression and mental illness, as experienced by the six participants. This is particularly applicable to diagnoses related to substance use in the lesbian and bisexual community, which are linked to not only biological and hereditary factors, but as explained earlier, also to internal and external responses to social environment, homophobia and heterosexism (Cabaj, 2005). Queer theory also locates the medicalization and deviancy of same sex attraction as being a contributing factor to the 'otherness' of the GLBT community within mainstream society (Kirsh, 2000, p. 67).

A common connection can be made to both queer theory and those movements that are critical of psychiatry. Both identify that medicalization and pathologization on the part of

patriarchal authority has negatively impacted women affected by mental illness, and in particular, queer women. Duncan et al. state, "More recent work on sexuality actually describes a fluid and changing range of expression for sexual identity throughout the lifespan...this newer work, remains outside the 'common knowledge' of many people, including many health professionals" (2000, p.5). This understanding of sexuality and fluidity is informed by queer theory and contradicts the medical approach of solidifying identities and reinforcing normality. The term 'queer' is often regarded as a politicized identity in which the boundaries of belonging are less rigid than is usually seen within a society that is focused on labels and concrete identity. The commonality between queer theory/politics and critical psychiatry, a similarly politicized movement, is the sharing of a common experience of oppression. According to Davis:

> Queer politics is not a politics based on who you are, or your similarity to a group, but a politics of collective political affiliation. Queer is based on a political position which embraces the stigmatized sex, seeks to challenge the privatization and regulation of sex and includes all people who are interested in pursuing this types of politics. It is not a politics of who you are, but of what you do and what you think. (2005, pp. 23)

Compare the preceding definition of the queer political movement and the definition of critical psychiatry below:

> Critical psychiatry is part academic, part practical. Theoretically it is influenced by critical philosophical and political theories, and it has three elements. It challenges the dominance of clinical neuroscience in psychiatry (but does not exclude it); it introduces a strong ethical perspective on psychiatric knowledge and practice; it politicizes mental health issues. Critical psychiatry is deeply skeptical about the reductionist claims of neuroscience to explain psychosis and other forms of emotional distress. (Thomas, no date)

The crux of both queer politics/theory and critical psychiatry is the challenging of fixed or uniform experiences and identities for any individual. Both theories incorporate

consideration of social and historical factors that shape the present day experiences of both queer and/or mentally ill individuals. Both perspectives question the motives of society for relegating these respective groups to the margins and focus on the necessity of the existence of discrimination toward these communities as a promotion of conservative notions of normalcy.

Lesbian Feminist theory assists in locating the root of heteropatriarchal oppression within the mental health system. Adrienne Rich's notion of 'compulsory heterosexuality' highlights the invisibility of lesbian and bisexual women and the pathology that they have historically encountered in medical and academic discourse (1980). According to Jensen, Rich's exploration of compulsory sexuality outlines how men are positioned as powerful, resulting in the normalization of women's existences only when they are linked to a male counterpart (1999). This understanding of male/female relationships successfully strips women as individuals of their power and underscores the impropriety of female relationships. Rich's innovative work, although radical, did much to draw attention to the perceived existence of women as subservient possessions of men as opposed to situating women as equivalent and independently capable without the complement of men. In highlighting the lack of power of women, Rich also identifies the deviance of same sex relationships among women and the perceived futility of seeking legitimacy without the presence of a man. As a complement to 'compulsory heterosexuality', bell hooks introduces the concept of 'competing sexualities' and how lesbian and heterosexual women have been pitted against one another (2000). hooks draws attention to early conflicts within the feminist movement between these two groups of women and how

heteronormativity succeeded in vilifying queer women as the "purple menace" within feminist circles. It is necessary to address this enduring issue as she argues that this conflict has suppressed the needs of lesbian and bisexual women, or in this case, the overall health and mental health concerns of queer women and the ability of the mainstream feminist movement to address them.

Critical feminist theorists have historically asserted that psychiatry in particular has attempted to justify women's oppression via the construction of gendered differences in psychological make-up (Schlichter, 2003). Over time, women who have resisted the patriarchal norms of mental health have come to be viewed as heroes and champions for the feminist movement. Queer women have been central to this resistance, as their defiance of male notions of femininity has been particularly overt (Schlichter, 2003; Kitzinger & Perkins, 1993).

Research Strategy:

The basic intent of this study was to elicit narrative accounts from a small sample of queer women who have used existing mental health services. Ultimately, I hoped to determine what barriers have prevented or made it complicated for them to access service. Previous research indicates that a clear social problem related to heterosexism and barriers to mental health service exist, yet research obtaining detailed feedback from the lesbian and bisexual community has not been widely completed. Due to the sensitive nature of the research and the lack of information on the research topic, I opted for a qualitative design in order to provide data from which theory can be generated. Bauer and

Wayne (2005) note that cultural sensitivity is vital to gaining trust and in accessing the participant population. This was of particular importance to me as a member of the queer women's community I hoped to study. In order to help establish trust, I used culturally appropriate language, identified myself as both a queer woman and a mental health worker, and advertised my study in queer positive spaces (Bauer & Wayne, 2005). Solarz (1999) notes that establishing a positive relationship is vital as there is an enduring sense of mistrust for researchers within the lesbian community. In introducing myself as a mental health worker I highlighted both positive and negative aspects to the system so as to position myself as relatively unbiased. It was my hope that the disclosure of both my sexuality and my work in mental health would create an increased sense of trust and rapport with the participants.

As mentioned in the previous sections on identity, Solarz (1999) also notes that definitions of sexual orientation are not consistent across communities or from individual to individual. For this reason I selected a qualitative approach in order to allow the participants to accurately explain how they identify and what their definitions/understandings of the terms are in order to incorporate this for consideration in the project outcomes. Solarz states that qualitative research is appropriate in order to "better understand how lesbian sexual orientation is defined by different subgroups of lesbians" (1999, pp. 114). Qualitative analysis was used in order to systematically obtain information and develop emerging themes and information. Within the confines of this study, qualitative research allows for interpretation of the material in order to identify

each unique experience. This is of particular value in the under studied area of bisexual mental health.

A qualitative approach was important for me to undertake as it probes not only the underlying problems of the existing mental health system, but provided space for me to use critical analysis to explore the subtleties of the subjective experiences of lesbian and bisexual women within a system that has not yet made explicit efforts to meet their needs. Critical analysis is an appropriate framework to use to analyze qualitative data as it allows for the thoughtful breakdown of the inherent problems associated with the medical model along with other powerful socially constructed systems (Rothe, 2000). As Rothe continues,

> The critical themes are the ideological dominance of the privileged professionals, the reduction in improved health status of the populations, and the empowerment of the individuals to take control of their own health, of communities to promote quality of life and of marginalized people to define their own needs (2000, p.55).

Critical analysis adopts the radical social work perspective. According to Galper, "making links from individual actions to the larger problems is the key to moving social work into a more effective sphere of operation, into making a contribution to movement building and structural changes" (Carniol, 1990, p.115).

To my knowledge, a critical analysis of the specific experiences of lesbian and bisexual women and how they interact with mental health services and service providers has never been completed in the Ottawa area. For this reason it is important to employ a qualitative approach, as qualitative research is ideal to use in areas that have not been empirically

explored and are helpful in generating theory (Rothe, 2000). Utilizing qualitative research methods within this study has also uncovered some valuable information about the social and structural realities facing the women participating in the study.

The goal of this exploratory qualitative project was to obtain nuanced and in-depth information regarding the experiences of an understudied group. The participants in the study include a non-probability sample of 6 women who identify themselves as lesbian/bisexual/queer and also as having had mental health distress that they have accessed services for within the past 3 years. The decision to focus on those who have sought mental health services within the last 3 years was intended to reflect more recent trends in mental health service provision. All participants were residents of Ottawa at the time of the interviews and their mental health care was provided in Ottawa. Women participating in this study did not require a mental health diagnosis, as the focus for the project is not on the illness itself, but the experiences of lesbian and bisexual women in accessing mental health services.

Participants were recruited through flyers and information (see Appendix A) posted within mental health service agencies, community health and resource centres, and GLBT service agencies. A call for participants was also sent out via email through a local women's email group. Finally, a posting was placed on an online bulletin board for the GLBT community in Ottawa. All participants self-selected for the study and made initial contact with me via email or confidential voice mail. Of the participants, three learned of the study through a message that I had sent out via a local women's anti-violence email

group. One participant learned of the study through a posting I had placed on an online queer bulletin board. Another participant learned of the study through an info session on the study that I had given to a local queer social group. The final participant had seen the advertisement for the study on an information display at her workplace.

Upon contact with the potential participant I provided a letter of information (see Appendix B) that explained the nature of the study, including tasks and time requirements. Interested individuals were invited to participate and subsequent to their consent, a mutually agreed upon appointment for the interview was made. During this appointment and prior to the actual interview, I reviewed the informed consent documentation (see Appendix C) aloud with the participant, who then signed the form, indicating their consent to participate in the study. Subsequently, participants in the study took part in a semi-structured interview that lasted approximately 90 to 120 minutes. An interview guide (see Appendix D) was used during the interview session, however, additional questions were asked in order to allow for clarification or elaboration on certain statements. Following the interview, participants were provided with a debriefing package, both verbally and on paper (see Appendix E). This debriefing included a listing of mental health support services should the participant feel the need for mental health intervention following the interview process. In addition, all participants were asked if I could contact them for follow up and clarification. In some cases this was necessary and this clarification was given via telephone and secure email.

Interviews were recorded with the permission of study participants. Participants were informed that information spoken about in the interviews, while anonymous, could not be kept completely confidential. As the researcher, I have been the only person to have access to the taped interviews and the resulting transcripts. The interview tapes and transcripts will be kept in my possession until one year following the completion of the project and will then be destroyed. The interview transcripts were analyzed according to content analysis methodology, using constant comparisons to identify emerging themes in the data. As I worked through each transcript I flagged relevant themes, some stronger, some less defined, and slowly worked toward finding the commonalities between the themes and linking them together with theory. Information gathering and analysis occurred concurrently, allowing for emerging themes and categories to be identified in a less structured manner. Once the interviews were transcribed, the participants were contacted and offered a copy of the transcript in order to allow them to review their statements and make any clarifications of changes to the data. This is consistent with feminist methodological approaches which value transparency and the participants control over their personal narrative (Bloom, 1998).

As the topics under discussion within the research project were seen as potentially upsetting for participants, some psychological risks were possible. In most cases individuals were contacted 2 days following the interview and at most within a week of the interview in order to offer follow up. Debriefing following the interview was made available to all participants in the form of follow up via either telephone or email, opening up the possibility for further discussion of the distress or if necessary, referral to

an external support service. Participants were encouraged to seek additional supports from existing mental health support services that they may currently utilize. In addition, each participant was provided with a debriefing package that included information on mental health and GLBT crisis services that could be accessed following the interview (See Appendix E). All participants were made aware of possible risks of the study, both verbally and within the body of the consent and letter of information. Participants were fully informed of their rights to withdraw from the project at any time without penalty and were also aware that they could choose not to answer particular questions.

Participants were also made aware that as a social work student at an accredited university, I am bound by the Canadian Association of Social Workers Code of Ethics. Principles in this Code of Ethics require that I "uphold each person's right to self-determination, consistent with that person's capacity and with the rights of others...; respect the client's right to make choices based on voluntary, informed consent...; uphold the right of society to impose limitations on the self-determination of individuals, when such limitations protect individuals from self-harm and from harming others." (CASW, 2005, pp. 4-5).

Participants in this project received complimentary refreshments during the interview process. Each participant also received a ten-dollar gift certificate for a local women's bookstore and were also reimbursed for any parking costs. The Master of Social Work Student Association provided a grant of $100 intended for the remuneration of the participants. Long-term benefits for participants were seen as being the contribution to a

project that addresses the community mental health needs of an understudied portion of Ottawa's GLBT community. It is also seen that this project will allow the concerns of lesbian and bisexual women with mental health needs to emerge from within a community that may overlook the requirements of the doubly oppressed amongst them. In addition, it serves to address the still persistent silencing of lesbian and bisexual voices within the mental health community. This study does identify isolated problems with mental health service provision as they applied to the particular lesbian and bisexual women who participated in the study. It is assumed that some of these issues may be facing the population for broadly and therefore the study will make specific recommendations coming from the narratives of the participants in hopes of improving access and services for queer women.

Limitations:

It is important to note that this study reflects the responses of a limited group of individuals and thereby that does not reflect the diversity of the queer women's community in Ottawa. All of the participants are "out" to some degree and have some sort of connection to mainstream GLBTQ services and service providers. All participants were somewhat connected to support services or have the means to access some form of support, whether it be in the form of professional or family/social supports. The sample of women were not diverse in terms of education, racial identity and class. The lack of diversity in this sample means that the perspectives of those with many forms of oppression were not able to contribute their feedback and their unique perspectives.

Access points for securing a sample were women's service agencies, women's information email groups, GLBT service agencies, online GLBT notice boards, community health centers, women's book stores, university campuses and businesses that identify as being GLBT positive. The access points for participants in this study limited the ability of the project to attract individuals who may not be out, are isolated or who may typically have difficulty accessing mainstream services due to cultural, linguistic or accessibility reasons. Although attempts were made to distribute the posters and advertisement materials as broadly as possible, these strategies drew relatively few participants.

It is also important to acknowledge that the women who participated in the study may have been drawn to the project for particular reasons. All of the participants felt they had important experiences within the mental health system that they wished to share with other queer women. In all cases, these experiences had a negative slant. These negative encounters and the need to speak openly about them may have been a catalyst to participate. Understandably, those who have had more positive experiences may have been less inclined to participate in a study of this kind.

An additional limitation of the study was the initial advertisement asking for women with experience accessing services from mental health care providers. Due to the reality of barriers to accessing mental health supports, several of the women cited that they were or had used a family physician or general practitioner as their primary mental health service provider (a phenomenon that is similarly significant in mainstream communities). As

such, some stories that are linked to physical health were included in the data as these coloured the type of therapeutic relationship the participant had with their doctor. The overlap between mental health and physical health care was actually cited by several participants as part of the reality of the shortage of mental health care providers in Ottawa therefore it is of particular importance that these stories be included in this study.

Introduction to the Participants:

There were six participants contributing to this small qualitative study. The women varied in age from 20 years to 46 years. All participants identified as white and of European ancestry. Three of the participants (Julia, Sandy and Shelly) were involved in paid employment. Two (Wendy and Carrie) were on disability benefits at the time of the interviews. The final participant (Karen) is a full time university student. The following section will briefly introduce you to each participant's story, with the body of the study offering more analysis of their personal narratives.

Carrie:

Carrie is a 46-year woman 'gay' identified woman who grew up in suburban Ottawa. She is the mother of 3 children and is currently living on disability benefits. Her life has been marked by profound internalized homophobia. She expressed that this suppression of her feelings manifested itself in the form of substance abuse, depression and self-destructive behaviour, including suicide attempts. Carrie indicates that she felt 'different' from a young age. She immersed herself in sports as a young adult and had many queer-identified friends. As she moved into adulthood she says that she began to struggle more

with her sexual identity. At this point she was married and says that she felt the need to hide herself within the heterosexual world. Over this time she developed more severe depression and her use of substances increased.

In her mid-30s Carrie was diagnosed with a chronic illness that began to impact her ability to live independently. Around this time she began to seek help from a faith community in order to deal with her physical illness. When this faith community learned of Carrie's struggle with mental health concerns, addiction and her queer sexuality, they ceased contact with her. Carrie moved on to seek help from several addiction programs both in Ottawa and in Toronto. These experiences were both positive and negative. After finally finding the support she needed, Carrie got connected with effective mental health and addiction services. She connected with a community support group for queer identified women. In her early 40s, now divorced from her husband, she came out to her family and since then has been proudly out in most aspects of her life. At present Carrie is living in a special care facility where she is faced with the pressure of remaining closeted on a daily basis.

Karen:

Karen is a 20-year old "bisexual" identified woman who grew up in suburban Ottawa. Karen is presently a university student. As a young teenager she began to question her sexuality and consequently began to come out within her public school context. When she later moved to a Catholic high school she began to feel pressure to remain closeted, leaving her feeling very isolated. As she moved through her teenage years she

experienced depression and began seeing a therapist. In the past Karen has taken medication for depression and continues to do so when needed. She states that she feels that if she had received the validation that she needed when she was coming out she would not have struggled through the experience of depression.

Karen currently lives in her parental home. Her parents display a significant amount of homophobia that has impacted her profoundly over the years. She has felt judged by her family and feels that she cannot communicate openly with her family about her sexuality. As a young child Karen was sexually abused by a male babysitter. She has not told her parents about this incident for fear that they would link this to her current queer identity. She has also not disclosed her sexuality or this experience of abuse to her family physician who is currently providing her mental health support. Karen says that she fears the judgment that may resulting from disclosing this information about herself to her doctor.

Wendy:

Wendy is a 40-something "queer" identified woman who also grew up in Ottawa. Wendy is currently accessing disability benefits. As a young adult Wendy can recall serious incidents of gay bashing that have impacted her perception of the issues facing queer individuals presently. Wendy expresses a significant amount of skepticism of the objectivity of the psychology profession. Much of this skepticism centres around several negative experiences in recent years following a workplace harassment complaint that she launched. Wendy has worked within male dominated professions in the past and it

was in one such environment her male employees harassed her for asserting her opinions as a women. She was openly targeted for being a woman and for being queer.

Wendy's complaints about this treatment fell upon deaf ears and her quest for support has met many barriers. In order to access disability funds after leaving her workplace she was subjected to no less than three psychiatric evaluations to confirm a diagnosis. At the time of the interview her workplace refused to acknowledge that sexual harassment and homophobia were issues within their workforce. As a result she is still struggling to have her complaints heard and to access the financial remuneration for which she is entitled.

Julia:

Julia is a 46-year old queer-identified woman who grew up in the Gatineau area. She is the mother of 2 children and is a working professional. After a long-term marriage Julia begin to recognize that she was not happy in the relationship. She indicates that she had likely known that she was different earlier but that the concept of being a lesbian was something that had never been introduced to her as a young adult except in a negative context. As Julia moved through the divorce she sought counseling. She also sought counseling for her feelings around subsequent relationships.

Julia's experiences in accessing counseling were not positive. Her first counselor was a great match and they worked well together. Once this counselor retired Julia struggled to find the help that she needed. Julia does not entirely attribute these negative experiences to her queer identity. Her narrative indicates more of a feeling of lack of professionalism

among service providers. Julia's narrative highlights the importance of positive professional practice and the impact of poor counseling relationships on women who may feel that they have limited service options, such as marginalized queer women.

Shelly:

Shelly is a 29-year old queer-identified woman who has lived primarily in suburban Ottawa since her teenage years. Shelly is currently a working professional. Shelly had relative ease in coming to terms with her queer identity in high school. When she went to university she encountered her first bout of depression and sought treatment from a campus therapist. This experience left her dubious of future encounters with mental health professionals. Since that time she has struggled to find a good fit with a counsellor. During periods where she has been unable to access counselors she has sought mental health support from general practitioners at drop in clinics. Here she has been frustrated by service she has received in regard to both her mental and physical health needs.

Shelly indicates that her family context is supportive and that her family demonstrated little to no homophobia as she was growing up. She expresses that she had felt isolated from the queer communities in the past. More recently she has been connecting with these communities and has felt tremendously validated and welcomed.

Sandy:

Sandy is a 42-year old lesbian-identified woman who grew up in a rural Nova Scotia community. Sandy is currently a working professional. Sandy recognized from young

adulthood that she was queer, coming out in her early 20s. Throughout her life she has had co-existing problems with mental health, substance use and physical illness. She presently has a positive relationship with her mental health professional however this has taken years to solidify. Her experiences with past professionals as well as with addiction support services have less than desirable, having resulted in feelings of invalidation.

Sandy's family context offered little support for both her self-esteem as a woman and as someone living with mental health concerns. She expresses particular influences of misogyny and sexist attitudes around women's roles and women's mental health. However, Sandy has become a powerful advocate for herself against the powerful forces of the medical and mental health system. Although she indicates that it took many years to develop the skills to be able to assert her will against these powerful establishments, she is finally beginning to feel the validation that she has sought as a queer woman living with co-existing health and mental health issues.

Summary of Participant Profiles:

The preceding brief introductions to the six participants offer some insight into their experiences and social locations. As we move through the body of the document we will learn more about their individual histories and how these histories may have impacted their interactions with the mental health system. It is not possible to relay all the nuances of the women's experiences within this document, however I have attempted to include excepts of their stories that offer the most accurate reflection of the manner in which they shared their personal narrative.

Overview of the Study

The body of this document will outline the specific experiences of six queer women in Ottawa who have accessed mental health services. Although the overriding theme of this study is that of heteronormativity and the impacts of it on the lives of the participants, the document is subdivided into 3 key theme areas, each section including additional sub-themes. Throughout the study both feminist and queer theory will be used to interpret the narratives of these women.

The second chapter touches on the experiences of each women during their coming out process. This chapter focuses on the telling of each participant's story with reference to specific areas of their lives where they were particularly impacted by heteronormativity and homophobia. This chapter addresses the primary question of the thesis in that it explores instances and contexts within their life that they identify as having profoundly impacted their awareness and understanding of heteronormativity and their specific location within society as queer women. The third chapter moves on to a discussion of trust and the interplay of abuse within the trust dynamic of client and professional. Several different manifestations of abuse will be discussed, including childhood physical and sexual abuse, workplace harassment and insidious trauma. I would argue that these forms of abuse factor into the way in which queer women interact with society and the experiences of various forms of abuse led to pathologizing or blaming of the queer woman for their mental health distress. To reflect upon the primary question of the study, this chapter begins to explore more directly the ways in which the participants have felt

heteronormativity, particularly within power imbalanced contexts such as counseling sessions, schools and doctor's offices.

The fourth chapter touches on the notion of belonging and the difficulty of finding it within the queer community. This chapter will move into topics such as representation within the community, geographic queer spaces and social community as well as resources and role models for queer women. The fourth chapter will also highlight positive experiences within the mental health system and how, for these women, their overall experience within the mental health system could have been improved. The fourth chapter addresses the research question through an exploration of what women need within their community network in order to feel included, thereby contributing to mental wellness. In addressing both positives and negatives of community, this chapter draws attention to the ways in which professionals can begin to understand the effects of their interactions with queer women and how they, as professionals can assist in creating more holistic interventions that address the broader social issues facing queer women and their mental wellness. The final chapter brings together the various themes and concepts introduced throughout the body of the document, drawing final conclusions specific to this study and this sample.

Chapter 2 - Identity Formation: Impacts on Mental Health

Introduction:

Despite significant progress in the awareness of barriers facing queer women accessing mental health services, research continues to be limited on this subject matter (Hughes, 2003). Although the scope of this research project does not encompass a broad scale analysis of the experiences of queer women in Ottawa it does serve to identify the common experiences of a small group of women, highlighting the depth of their stories. This project uncovers commonalities amongst the women and provides recommendations for the next steps in research and overall improvement to the quality of mental health care for queer women in Ottawa. As a result of a lack of awareness regarding the experiences of queer women there are significant gaps in mental health service provision and overall quality of service.

There is a tendency for service providers, when they do have awareness of issues experienced by queer women, to view the challenges of the queer community as being uniform (Pearson, 2003). In reality, the experiences of queer women are broad and diverse with their mental health distress resulting from homophobia, heterosexism or any other number of life stresses. While mental health stress can have a variety of roots, Smith and Ingram argue that being a sexual minority does place an individual in a vulnerable position for mental health distress due to an unaccepting social climate (2004).

Overview of Chapter:

In this chapter I will explore the dominant theme of the women's experiences in their coming out process and identity formation, surveyed through the lens of heteronormativity. Initially I will explore the notion of power and how the women in this study have felt, at varying times in their lives, more or less power as queer women. This section will also explore the resistance that several of the participants have demonstrated in regard to their stigmatized identities as queer women who have accessed mental health services.

Emerging from the overall theme of identity formation are several prominent sub-themes that were, to varying degrees, shared by the participants. The first theme is that of sexual identity. All of the women shared a common resistance to static labels and indicated some sort of preference for more fluid identifiers or identifiers that they associated with less stigma and negativity. A second common theme that shaped the women's perceptions of their experiences is that of early heteronormative experiences and learning. This is important to highlight as the participants' reactions to more recent experiences within the health care system were shaped by the heteronormative experiences of their youth (D'Augelli, 2003). All had negative experiences with heterosexism as children and young women that shaped their ability to negotiate marginalization today. A third sub-theme among the women was that of limited workplace support for their sexuality and their mental health concerns. The upholding of a heteronormative, paternalistic or even misogynist environment within the workplace could be traced through several of the women's narratives. The final subtheme I will explore in this chapter was shared by all of

the participants. Heteronormativity and in some cases, thinly veiled homophobia is reflected in their interactions with the health care system. All of these themes provide insight into these women's lives, thereby an exploration provides us with a sense of the mental health strains that they are living with a presumably bringing into a counselling relationships.

In summary, within this chapter, I will explore how the women who participated in this study negotiate their identities in the context of past life experiences, their workplaces and general heteronormative practices. The common link that binds all of these sub themes is that of heterosexism or the normalizing of heterosexual experiences and how this social phenomenon has shaped the identities and coming out processes of each of the participants. Throughout this chapter I will touch on the interplay of resistance and power and how these influence identity formation, and to some extent, resilience. Although the concept of resilience is relatively overlooked within mental health research, particularly amongst queer women, there are some strong examples of resilient behaviour amongst the six participants. This chapter offers insights into the women's sexual identities and understandings of how their identities influence their perception of professional and societal interactions and conversely, how their sexual identity influences how professionals and others perceive them. The discussion within this chapter provides the vital insight into how these women see themselves and allows us to place their narratives into a clearer context as we move through the study.

Power and the Resistance of Pathology:

I approach this chapter with an eye to post-structural feminism and related approaches to counselling and social work, attempting to abandon notions of absolute truths and diagnostic labels, instead operating from the point of each participants subjective experience (Brown, 2006). Within the women's narratives I also see an element of the feminist notion of the power and resistance. All of the women who participated in this project indicated their need to share their stories in order to help others and to share the pain, frustration and/or triumph of their experience. I see this as embracing a feminist notion of reclaiming shameful and painful experience and drawing power from it, while also incorporating resistance to some extent (Brown, 2006; Ali, 2002). Ali (2002) explores how feminist approaches to counselling that incorporate power and resistance can assist the patient in emancipating themselves from the stigmatized identity, by speaking to it and separating themselves from it. This is of particular importance within the context of this project as I see the participants as resisting the pathology and stigma of two identities that continue to retain deviant status, that of mental health service user and sexual minority.

Ali cites Inglis' definition of emancipation as being "critically analyzing, resisting and challenging structures of power" (2002, p. 233). Although this may not be the explicit intent of the women who contributed to this study, they have, in their own way been able to identify what has been problematic for them in accessing care, and in that process, contributed to a body of work that will go on to challenge the problem areas within the web of power created by society, mental health professionals and health agencies.

The concept of power is significant in the stories presented within this study and within this chapter in particular. It is in many ways the perception of a lack of power that plays into the distress felt by many queer identified women. In her research, Juhila introduces the concept of 'speaking back to stigmatized identities'. By this she means " acts which comment on and resist stigmatized identities related to culturally dominant categorizations and which have the function of presenting the difference between one's own self or a group and the dominant definition" (Juhila, 2004, p. 263). The experiences of these women are unique in that they have been impacted by the complex interplay of negative societal views of women, the devaluing of non-heterosexuality and the vilification of mental illness. It is important to emphasize that the resistance women perform is not always intentional or would not be defined as an act of resistance by the participants themselves. The acts that the women highlight, such as speaking out about their inferior treatment within the system, refusing to abide by labels, seeking out alternative services or simply choosing to participate in the study speaks to their resistance of the stigmatized identities of mental health service users or queer woman, and the negative stereotypes that go along with these identities. Yet, in making the choices or taking the steps that they did they have offered some sort of message to the systems they interact with, with society and perhaps even solidified a stronger understanding of themselves (Ali, 2002).

The importance of speaking back to these stigmatized identities is evidenced by the common feeling of isolation and otherness that often lead to mental health distress in queer women. However, it is important to highlight that many lesbian women experience

mental illness as separate from their coming out process and not as integral to it (Duncan, et. al., 2000). As mentioned previously, there is a risk of regarding mental health problems as being inherent to queer women's existences and pathologizing these experiences as being linked to a deviant sexuality. Other participants see their mental health distress as being linked more to external experiences and pressures and not as being intrinsically linked to their own personal failings. This supports existing theory that deflects the association of mental illness and minority sexuality status (Kitzinger & Perkins, 1993).

Mental Health and Identity:

In moving through this exploration of the women's stories it is important to reflect upon the impossibility of locating a single origin of mental health problems. Two participants felt they had an identified hereditary predisposition to mental illness. Others argued their mental health problems were a result of living in a society that was disapproving of their sexuality and their relationships (Pearson, 2003). For others still, it was simply the nature of their partnerships and the stressors within them that led to their mental health distress. In highlighting the various ways women articulate the causes of their mental health distress, I am hoping to help readers to see the complexity of the lives of women who access mental health services.

The experience of psychological distress is subject to much stigma within the North American context, particularly within socially and politically conservative times. The intersections of sexism, heterosexism and the stigma of mental illness often result in

queer women feeling apprehensive about accessing mental health services for fear of judgment (Dobinson, 2003). These feelings are often the result of earlier experiences of heteronormativity or homophobia when seeking mental health care. This fear is sometimes a result of a specific experience of support or at other times, general awareness of how people make sense of sexual orientation:

> I don't tell my doctor about [my bisexual identity] and I don't tell my health care provider about that because then I knew that they would be like, "Oh! Well you know you're a lesbian because a guy touched you when you were 7. There's the link right there. That's your problem." And I didn't want to be judged.

In Karen's case, her fear of judgment was probably further entrenched because of existing heterosexist encounters with her healthcare provider (who also provides mental health care). As Karen does not presently have access to a counsellor, she is constrained in her therapeutic relationship with her family doctor by the precedent of silence around sexuality that has already been set. The weight of past experiences accumulated for Karen and have silenced her around her sexual identity, which could potentially be very valuable to discuss within a therapeutic context. An additional barrier for Karen lies in the reality of the physician shortage facing many Canadian cities. The potential of possibly souring her relationship with a precious medical resource should she disclose her sexuality is a distinct barrier to Karen.

As many of the women worked through the interviews they were able to pinpoint the heteronormativity within these interactions and they expressed clear limits of what they would and would not tolerate in future. For example, Sandy spoke about how she has had

to establish her own expectations of how her relationships should be regarded within a therapeutic dynamic:

> I've kind of been able to say to myself, 'you know what, you're wrong and I'm going to have to follow my own truth on this". But I mean, I'm 42, it's taken a long time for me to say I'm not going to listen to what you think. And professionals have a certain clout in my mind. That [the professionals] say we should move on then for the rest of however long it takes I'm questioning and questioning the relationship. I think relationships have been ruined for me because professionals have thrown doubt into my mind.

In the context of these interviews, it became clear to both interviewer and participant the powerful and sometimes internalized impacts of invalidating experiences, particularly with mental health and medical professionals. This in turn seemed to shape their perception of their own worth as queer women, the value of their relationships and their sense of belonging not only within the mental health system, but also within the medical system and greater society. The common perception amongst participants of a cold social climate or limited social community for GLBTQ identified individuals will be discussed at length in later chapters.

Coming Out - The Struggle for Identity:

During the interviews completed in this study it was clear that heteronormativity had been significant in shaping the women's experiences of coming out in their personal lives, at work and in school. In the following section I will unpack the impact of these experiences so as to show the complex and varied ways in which heteronormativity affects women's mental health and queer identity. Further to this, I will also explore how heteronormativity impacts the mental health system and the professionals from whom the women in this study received treatment and support. This section will move through the

painful experiences of women and attempt to locate the socially constructed origins of their shame and pain, often found in the heteronormative practices of greater society, institutions and families.

For many queer women, the process of coming out continues to be a conflicting and isolating experience. Recent literature suggests that despite the illusion of a more accepting and modern society, young women coming out today continue to be negatively impacted by homophobia and heterosexism (Rogers, et. al., 2003). This impact reflects earlier times when homosexuality was regarded as pathological or deviant (D'Augelli, 2003). Whereas the visibility of lesbian and bisexual women was less apparent to youth of generations past, today's queer youth are facing very open and apparent disdain for "out" queer women, having a potentially devastating effect on their identity development during adolescence (D'Augelli & Grossman, 2001). Despite the progress that has been made in attitudes toward queer women, prejudice in some arenas does continue. Several of the participants identified this objectification/vilification of queer women as being problematic, indicating that it does factor into the consciousness of at least these women.

Societal positionings of queer women range from the more pervasive misconception of these women as deviant and or fundamentally flawed, to that of queer women existing solely as a sexual fantasy for heterosexual men. Through the lens of heteronormativity we can understand female same sex relationships as being acceptable as long as the relationship is either temporary or for the pleasuring of heterosexual men (Kitzinger & Perkins, 1993). The women imagined in these relationships can only be this if they fit

clearly within gender norms (i.e. feminine) and are not representative of what many might stereotypically view as being a lesbian. Women who veer away from this sort of identity and more toward engaging in same sex relationships out of genuine love and partnership are often seen as a threat to heterosexual norms, being portrayed negatively in the media and face more insidious criticism (Kitzinger & Perkins, 1993).

Julia describes her perception of how heterosexual men see queer women: "we are sex objects so the thought that you can have these two women making love or some man can fantasize about what they are doing... or god forbid he should be able to watch or participate that would be just like... wonderful!". Sarcasm speaks to the frustration she described with heterosexual men who are only able to understand women's queer sexuality when it is imagined for their benefit. The following statement from Karen serves to support Julia's statement:

> I'm bisexual. But there is a lot of stigma around the word bisexual. Well people think that it's an invitation to orgies you know? You're a girl who gets drunk and you're a slut is basically what goes through people's minds when you tell them that you're bisexual.

The implication here is that someone who is bisexual is simply a tease and that their attractions are not meaningful or valid. These perceptions of queer women are particularly powerful when perpetuated within mainstream communities or by mainstream agencies. Within queer communities, negative perceptions of bisexual women in particular are not uncommon, often placing bisexual women in a limbo between the two communities and thereby reinforcing feelings of isolation and disconnection (Ryan, 2003).

The extent of the impact of negative mental health care seeking experiences of the sample of women involved in this study are in part dependent on the competencies they may have developed over their lifetime to deal with heterosexism and homophobia. In exploring the development of competencies that will assist in coping within a heterosexist society it becomes necessary to look at the process of identity development in queer women. Sexual identity development is difficult, even within a seemingly accepting social climate we continue to see very little normalization of sexual minority relationships. Combine this with the enduring mass media images spoken to by Julia and Karen of women as promiscuous or submissive, or of queer women as sexual fantasies for straight men, queer youth are met with powerful social messages of queer sexuality as deviant or something other than what they might want for themselves (Banks, 2003).

As all of the participants indicated that they felt unaware or unsupported in their youth around their sexuality, I will briefly touch on the importance of supportive environments in developing competencies for coping as an adult. Youth are faced with the very powerful force of educational institutions that regulate their lives as they begin to discover their own personal identities. Educational institutions are often very effective in sending distinctly heterosexist and even homophobic messages to students in that they continue to protect and uphold heterosexuality (Skelton & Valentine, 2003). In many Western school systems sexuality is actively suppressed, and if there is acknowledgement, it is only an acknowledgement of heterosexual sexuality (Epstein, et. al., 2001). Religious schools may further entrench notions of deviance into the curriculum and also connect sexuality to sin.

The educational system sends a problematic message to students in presenting the purpose of sex and sexuality as primarily for reproduction. This results in the reinforcement of traditional familial relationships, placing same sex relationships in a deviant location, invalidating the experience of attraction and desire beyond the 'traditional' sense (Epstein, et. al., 2001). The resulting confusion of queer youth within the aforementioned educational frameworks can be highly stressful and lead to lower self esteem, substance use, delinquent behaviour, lower grades and higher dropout rates amongst queer youth (D'Augelli, 2003). In the long term, many of these ill-adjusted teens will grow up to become ill-adjusted adults with an increased vulnerability to a multitude of social problems.

While the experiences of queer youth are significant in understanding the coming out process and the development of supports and capacities for coping, the coming out process for older lesbians is more relevant to the sample within this study. The experiences of the younger participants will be unpacked as we look at their individual narratives within the body of this document. For older queer women seeking to come out of the closet, the disadvantage of not having developed resilience and relative comfort with their sexual identity in their youth is significant. According to theories of identity development, the development or awareness of same sex attraction in young women is known by the late teenage years (D'Augelli & Grossman, 2001). However, this does not predict their preparedness to act upon these attractions or their security within a queer identity (D'Augelli & Grossman, 2001). Sexuality and sexual identity can change over time as Jensen (1999) details,

> Formerly, identity was believed to be the goal reached by mature adults that, once attained, remained stationary. Theorists now believe that all aspects of identity formation constitute an ongoing process, not an end result.

Consequently, queer women who come out later in life struggle to attain some sense of "continuity or consistency" over time, leading to higher incidences of internalized oppression and emotional distress (Jensen, 1999).

The powerful forces of societal influence can seriously retard the identity formation process for many lesbian and bisexual women. Confident queer identity formation can in many ways be influenced by the strength of external supports such as family, friends and community services and resources, in addition to internal factors such as self esteem, cultural or racial identification, and a sense of queer identity (Harper, et. al., 2004; Collins, 2000). Yet our female socialization in a world where men still retain explicit and implicit dominance is a powerful force that can lead to internalization of the negative perceptions of queerness and female existence (Jeffreys, 2003).

Identity formation is often more complicated for queer women given the enduring notions of a women's role as being that of mother and caretaker, seeing this as a possibility in the context of a same sex relationship is very difficult (Kitzinger & Perkins, 1993). Therefore, many women, unable to fully acknowledge or come to terms with their attractions toward people of the same sex, may become involved in heterosexual relationships (Jensen, 1999). For queer women in heterosexual relationships or marriages the prospect of coming-out presents the possibility of profound loss. Loss not only of family and children, but of financial stability, social supports, status and networks

(Jensen, 1999). Queer women continue to be fed information that their same sex attractions are deviant therefore loss is not only tangible, but psychological as they are faced with the punishment of realizing their sexual desire (Jeffreys, 2003; Jensen, 1999). This type of change or the possibility of it can trigger intense emotional distress for women. Emotional and psychological distress is not inherently linked to sexual minority women, but rather a very real result of socially constructed views about women's mental health, the female worth and women's sexuality (Pearson, 2003).

Julia provided a particularly powerful account of how she recognized her own closeted sexuality and the complications she knew it would present for her:

> you get married and you have kids and then everything goes along fine and then until you start putting the pieces together and one day you read something in a book and you go "ohh!" and then your husband rents a movie and there are scenes that ah... and oh, whats that? oooh! That's nice ... and you know, you meet someone and something happens and then... all of a sudden you realize, this is it! I'm living a farce. And the realization was very difficult. I think I went in a deep depression. For about a year. And... and ... Once I realized, there was no turning back, there was no pretending it wasn't there. It was there and... I no longer wished to be married to this person. And yes, I had four children but, the fact that I left him and openly lived a different lifestyle might be difficult for them to deal with now, but not any worse than having a marriage that made no sense. And...someone who is dead inside. How can you raise children in a manner that is going to...even make them flourish if you are dead inside?

Needless to say, for both older generations and younger, the experience of coming out in a heterosexist environment can be negative and complicated by the very real potential for social exclusion and loss (Jensen, 1999). As detailed in Julia's account, she did have concerns about the impact of her coming out on her family. This logically factors into mental health distress in that many women feel profoundly misunderstood, undervalued

and marginalized as a result of their sexual minority identity. The added difference of mental health distress may further isolate these women from society. When we consider the process of coming out and the importance of societal acceptance in our lives, many queer women, particularly those with mental health concerns, may feel distinctly oppressed and as such may find it all the more difficult to emerge from the coming out experience confidently. This incorporates notions of identity and how women experiencing co-existing stigmatized identities navigate these complex aspects of themselves (Collins, 2000). In these cases, social support is the most concrete factor in resiliency, yet predicting how someone will respond to a this disclosure is not possible, leaving many women paralyzed by this lack of support (Cooperman, et. al., 2003).

Despite the common perspective that sexual minorities are born as such, there is still a complex shift of identity from the socialized heterosexual self to that of lesbian, bisexual or queer that must take place (Pearson, 2003). Three of the women in this study Sandy, Carrie and Julia, identified as coming out somewhat later in life (all of them indicate having come out in their late 20s or older). For two of these women (Carrie and Sandy), the experience was complicated by mental health distress, addiction and physical illness. It is important to emphasize that only Carrie clearly linked her battles with depression and addiction to her struggle to come to terms with her sexuality. For Sandy, there was no clear link between these experiences and her sexual orientation. Her distress seemed to be more focussed around having a diagnosed mental illness. For Julia, another participant who came out later in life, she indicated that she simply did not know that there were other options besides being heterosexual. She indicated a certain amount of disapproval

from her family and society connected to what little she did know about 'homosexuality'. Had she known more about queer identity, or been less impacted by the negative associations of queer identity, perhaps her coming out process may have been easier than it was. When taken collectively, these various accounts illuminate the fact that oppression, in any form, whether heterosexism, ableism or sexism, can have an overall impact on wellness.

Sandy feels that her reactions to certain experiences, such as negative interactions with her care provider, might not be as extreme as they might be for women who have been out for longer:

> I didn't have my first experience with a woman until my late 20s so I was straight in my head. But I went through that transition, and I think people who have always been lesbian identified ... maybe have a stronger reaction [to heterosexist experiences]. But because I saw myself go through it and question and wonder what was going ... I cut myself slack and I cut others slack.

Within the context of this study, some of the more intense perspectives on the negative societal impacts of heterosexism come from the younger participants Shelly and Karen. Although other participants had similarly negative experiences, the skepticism of both of these participants is, at times, more profound. For instance, Karen's perspective on the Catholic school system and her resistance to expressing her sexuality to professionals; or Shelly's feelings of anger and frustration around her treatment by the medical system. Whereas some of the older participants seemed to see this sort of behaviour as par for the course, both Karen and Wendy make specific reference to the fact that feeling unable to express sexuality freely should not be a reality for them in present society. Karen states:

> we always talk about, you know, equal rights and that but when it comes down to it, like every time you go to the doctor every time you go see a counsellor you think "should I tell this person? When do I come out to them? Should I come out to them?" in an equal society why should I have to come out to them. Why would it matter?

Similarly, Shelly expresses her frustrations about her treatment within the therapeutic dynamic. Here she speaks to her experience when a doctor blushed after she disclosed her sexuality:

> That's not professional ... and it wasn't a big serious issue either but because I'm that sort of person I was pissed off by it. You know... like that's not ok for you to behave that way. You're a physician. You're a member of a professional body. Like you have ethical obligations to behave otherwise.

These statements seem to reflect a notion of being entitled to equality that was often not present in the narratives of the older women. When the myth of equality was exposed to younger queer women, the fracture between expectation and reality created emotional distress. As both of these participants are younger, this could well be a generational difference reinforced by the progress we have made in terms of queer rights and not having lived through the criminalization of queer identity.

Social Isolation:

Few of the women linked their mental health distress directly to their sexual orientation, but instead saw the relevance of society's disapproval and/or the lack of support they received from their social networks. For instance, Julia speaks to having felt very isolated as a woman struggling to come out:

> If you're like me and you're trying to come out and you don't know anyone who is gay... have fun! I mean, I was married and I had 4 kids. I was called a "don't touch" [by the lesbian community]. You don't talk to this woman. She is married and has 4 kids. You know... so therefore I

> was branded labelled and discarded. Then you have those women who do sports and they only talk to each other and nobody else. I mean I heard about the bar in Hull. Someone said, don't go there. They're all snobs and they won't talk to you. Well then where the hell do you go?

The stress associated with Julia's coming out period was emotional and the stress was intensified because she did not have a cultivated social circle who understood her situation, who could support her or hear her out. As previously discussed, this type of informal support is vital to our emotional and psychological well-being and its lack is one of the ways in which queer women become more vulnerable to mental health distress.

Several of the other participants expressed a similar sense of isolation. Again, the younger participants, Karen and Shelly, identify having a supportive network of queer or queer allied friends. Karen discusses feeling supported by her friends and the discovery of their queer orientations:

> I would say that I don't have any bisexual women friends. I have friends who are lesbians and I have friends who are straight, and I think that I'm really lucky that it's all one group of friends. Because actually, what happened was, I didn't have any gay friends when I first came out. And then, a whole bunch of my other friends started coming out after me... which was kind of cool to see! ... So that was kind of cool because I didn't have to go out and make friends because all of my friends just became gay. ... So I got lucky in that way in that it worked out that way that my straight friends were my gay friends in the end

Although Karen has social supports, there is still an element of isolation indicated in her narrative in that she does not have friends who are bisexual. This sense of isolation will be explored at more length in the subsequent chapter on belonging. Despite feeling generally supported on a social level, both Karen and Shelly spoke about limited resources and services. Conversely, the older participants were more inclined to indicate that they felt that services were adequate, if not abundant. However, many of these same

women indicate that they have few connections to the queer community. Carrie speaks to her experience as she struggled to come, with particular reference to an experience with a homophobic friend:

> We've been friends since our early 20s. ... So our lives have been together but I know she's had problems dealing with my coming out. I was drunk one night and I came home and she was home and I had expressed [ ] my confusion and fear and everything about my sexuality. ... Within a week she was gone. So a lot of anger and anxiety on my part and possibly she was afraid I was going to make a play for her and who knows. But her way of dealing with me was getting the hell out and she moved out. But we got through it and we remained friends. Things like that happened. People who I thought were friends no longer remained friends.

These disclosures offer important insights into the nature of mental health distress within this sample. This indication of a general lack of social and professional support can be linked to research findings that mental health distress in the queer individual can instead be seen as a symptom of the larger social problems of homophobia and heterosexism (Anastas & Appleby, 2002). The negative attitudes of society toward queer sexuality or the perception of negativity felt by queer individuals leads to increased isolation and significant distress during the coming out process.

In all of the narratives that will be explored in this study there was a discussion of feeling stripped of power, whether it be through lack of resources or through feeling misunderstood or devalued. Wendy's experiences speak to this perception of feeling devalued by service providers. Here she discusses her feelings about mainstream religious affiliated agencies that advertise themselves as being queer positive:

> my own biases, my perception is that [the agencies] had to [advertise being queer positive] in order to get universal funding from the United Way. Which I think might be the core funder I presume. But... that kind of

> shift, how much of the shift is political and how much is substantive? ... if it was the only service available, would I at least try to seek help there? Yes, but ... seeing that there are other [queer targeted] services, I am happy to look elsewhere first.

This skepticism is shared by other women in the study to varying degrees, particularly in relation to religious affiliated service providers. In Wendy's excerpt we see that she feels limited in the types of services she can access as she does not particularly trust the motives of mainstream agencies. This speaks to the sense of power and agency that queer women have to address their mental health and wellness concerns. Again, it is important to reflect on the role of layered identities in this lack of power. It is difficult to pinpoint what aspects of each woman's identity led to these feelings of disempowerment however feminist research indicates that both the female and queer identities can lead to these perceived decreases in power and agency (Kitzinger & Perkins, 1993).

Naming of Identity:

For most of the women in this study, there was a relative amount of discomfort with some of the terms commonly used to identify individuals within queer subcultures and communities. Many scholars allude to the problem of fixed identities within the queer community and the lack of consideration of the diversity within and the layered identities held by each individual (Gibson, et. al., 2000). Postmodern re-conceptualizations of identity as ongoing and transitional are central to the ways the participants' constructed themselves within this study. According to the Sophie Freud, identity can be defined as the following:

> identity is a thread spun of cultural models, values and assumptions, and spinning this thread is a lifelong task aimed at supplying unity and continuity to our many selves. Identity is not static ... because different

> contexts, different life phases, and different political circumstances highlight different categories and thus change our identity (2001, pp. 336)

It was important for the participants in this study to reflect on identity as being something more than sexual. The participants identified as mothers, professionals, students, persons living with a disability, and recovering substance users among other things. For the purposes of this study, I focused on the sexual, health and mental health aspects of their identities but acknowledge each participant's layered identities.

Several of the women expressed discomfort with the word "lesbian" and many indicated a preference for the word "queer". This is evidenced by the excerpts of the women's narratives that are included in this section. Most women also acknowledged the fluidity of sexuality and how it had played out for them in their life. The women who identified as queer made reference to the term being 'political' and they indicated that this term held a certain power for them. This connection to the term queer being political makes a clear reference to the reality of heteronormativity and the linkage of personal identity to the broader political context of our society (Jagose, 1996). As with many reclaimed words, the word queer offers a pointed response to the negativity associated with sexual minority status (Wilchins, 2004).

Many of the women indicated a certain apologetic attitude about the words they chose to use to identify their sexuality. Carrie disclosed that she feels a subtle disapproval when she identifies as 'gay', while Karen, Sandy, Wendy will sometimes change the word they use to identify their sexuality depending on the social context or what kind of relationship they are in. Whether they alter their language for their own comfort or for the comfort of

others remains unclear. Queer theory suggests that these kinds of labels can, in fact, be more fluid (Jagose, 1996). People may choose an identifier that seems appropriate to them, but their actions or relationships can deviate from what someone might normally associated with that particular identity (Wilchins, 2004). Queer theory frames sexual identification in terms of the subjective experience and does not require behaviours to have some sort of consistency for all those choosing that particular term as an identifier. This type of fluidity seemed to fit with the participants practices of self-identifying. For example, Carrie attempted to explain her discomfort with the term 'lesbian'. For her, it was difficult to articulate, perhaps indicating that her discomfort is possibly related to the impact of consistently negative references to lesbian women made by broader society.

> I've had a hard time in the past with the word lesbian. I don't know why. I just generally refer to myself...as "I'm gay" and to me that's enough. Now, some people get a little uptight about [the terms] gay and lesbian. For some reason the word lesbian has... it doesn't roll off my tongue as easily as saying "I'm gay" but that's really the only issue that I... that's a personal issue. Like I know that when I say that I'm gay, ok I'm not using the word [lesbian]... but for me that's fine, you know. I am gay, and so be it...you know having labels and stuff, I dunno, gay just fits. For me I'm comfortable with the word, I'm comfortable with myself in using the word... I don't tend to use the word lesbian very much.

Carrie's identification with the term 'gay' also offers some sense of ambiguity. It does not buy into the strict definitions of binary sexuality that we often try to apply to ourselves. For Carrie, the use of the word 'gay' (usually associated with men) may be a subversive resistance to the term "lesbian" which, from her perspective, is problematic.

Although Karen's perception of her sexual identity seems to be constant, her identifier does change depending on context and audience. This is not unusual, particularly considering the double oppression experienced by bisexual women (Ochs, 1996). While

Karen was the only woman in the study to identify as bisexual, her experience of oppression within the greater queer community is not unique. There has been much research on the reproduction of oppression within the queer community. The perception of bisexual women as under suspicion speaks to the oppression, framing queer experiences as hierarchical (Stone, 1996).

> A lot of the time just to make it easier on myself and out of frustration of always having to explain myself I'll just say "oh, I'm gay" or "I'm queer" you know "I'm a dyke" or whatever. People shut up after... you know they just kind of take it. Whereas if you say "I'm bisexual" you know, "oh, you're a fence sitter" "you can't choose a team" or you're stuck in between or you're just confused. You just get tired of hearing that bullshit, but I would say that I'm bisexual.

Karen's statement reflects her profound frustration with seeking out a queer community that might welcome her but finding no sense of acceptance and belonging. According to Ochs (1996) "Bisexuals are frequently viewed by gay and lesbian-identified individuals as possessing a degree of privilege not available to gay men and lesbians, and are viewed by many heterosexuals as amoral, hedonistic spreaders of disease and disrupters of families" (no page). This often results in an invisibility of the issues facing bisexual women that can foster a great deal of frustration and an even greater sense of invalidation. In turn, it is clear that one's experience as bisexual can impact upon one's mental health. It is problematic, I would argue, to not see these experiences as key to understanding one's psychological distress.

Through our discussion of her sexual identity, Sandy disclosed that she is constantly evolving in terms of her sexuality, having moved from what she indicated may have been more of a bisexual identity to that of lesbian:

> I'd say now I identify as lesbian... you know the continuum theory? I think I lean on the lesbian side of it but I am not only lesbian. But I mean I am lesbian, like I have certainly been with men. And I find men attractive but if I had my druthers I would prefer to be with women. So I find it gray to pick. Right now I'm in a relationship with a woman but that makes me identify more clearly as lesbian. If that were to end, would I be with a woman or a man? Probably a woman but it could be a man. So I'd say, that's how it's constantly changing.

Like many of the other participants in the study, Sandy has had experiences with men. Sandy's words about her sexual identity are interesting in that she clearly indicates that she finds men attractive and that she connects with the queer theory notion of fluidity. Sandy and Karen were unique in this study in that they both clearly indicated that they still considered men to be attractive and that they do not rule out the possibility of future relationships with them. If this view was shared by other participants, it was not disclosed within the interviews. There is an implicit pressure on queer women (from both queer and mainstream communities) to choose an identifying term, thus providing them with a particular community to align with (i.e. bisexual, lesbian etc). However, if a woman does not necessarily want or feel as though she needs to identify with a particular community, this may lead to feeling of disconnectedness (Wilchins, 2004). The stresses highlighted by Karen and Sandy related to the pressure of identifying with one particular identity have a clear link to mental health in that we all live within a North American context that focuses on fixed identities. As the concept of fluidity is difficult for many people to grasp it leads to undue strain placed on the individual in terms of constantly qualifying their lives, their relationships and having to make conscious decisions as to whether or not they want to share their identity status with others (Wilchins, 2004).

Of all participants in this project, Sandy most clearly located herself within a queer theory understanding of her sexuality. However, her identification is not located in theory, instead it is something that she has simply come to realize about herself over the years. Sandy alluded within her narrative to the political importance of the word queer however shied away from applying the word to herself. However, the excerpt of her narrative above does reveal a subtle influence of understanding sexuality as fluidity and the rejection of concrete labels. It is also important to note that Sandy clearly separated her sexual identity from her identity as a mental health service user and a woman with physical illness. This implies that she views herself as someone with many complex identities and perhaps does not integrate them into one overarching themes, instead allowing space for these aspects of herself within an overall framework of wholeness (Smith, 1987).

For Wendy, the word queer appeared to hold a symbolic and politically charged meaning. Although she too chooses different identifiers for different contexts and social interactions, the term queer resonated with her as something that represented who she felt herself to be in terms of sexual identity.

> Queer. One of the reasons I like it is its, different, it's me. I'm different and I like that. I like that distinction. There is no negative side to it as far as I'm concerned. You know... queer as the wallpaper... so queer I could fly right out the window. Otherwise, lesbian, just because I do like to be specific. To me... now mind you I understand that that depends on the person who is using the term... but I guess that's my effort to be clear.

Wendy's reference to the fact that she feels the need to use a more concrete identifier (lesbian) in certain contexts speaks to the difficulty of mainstream society to account for the variance within the queer community and the subjective, shifting nature of identity.

The fact that Wendy should have to identify differently for the benefit of other's understanding is problematic and indicates the pressure to define oneself in stable, concrete terms. Wendy clearly indicated within her interview that she identified as a lesbian when working with health professionals. Whether the health professional has the knowledge of queer identity or not, the perception that Wendy should need to be clear indicates that, at least, in her historical experience, there in a perception of a lack of understanding of sexuality on the part of medical and mental health professionals. The necessity to situate ones identity as stable or fixed is affirmed in professional systems where there are forms to check off and assessments to be made. The individual awareness of the provider is obscured by the overall interests of the system to "know" others through categorization.

Julia makes very clear distinctions about what her sexual identity is. Her reasons for identifying as 'queer' appear to be not only about identity, but about the impact of the hostility she perceives around the 'lesbian' identifier. Like Carrie, Julia seems somewhat vague about her reasons for her disdain for the word, suggesting again that the impact of the social stigma is insidious, thus difficult to pinpoint. There is an intangible dislike for the word "lesbian" that connects all of the women participating in this study. Julia clarifies her sexual identity by ruling out what she sees the other identifiers as representing:

> ...define queer? So you have the category of lesbian, bisexual or queer? So what does that mean when you ask people where they fit in terms of this definition? I don't like the term lesbian. I'm not bisexual. So I guess I'm queer. [laughs] ...I don't call myself anything...The term lesbian seems to have a negative connotation so I don't ever want to identify with that... it's almost like a slang word, an insult.

Julia's likening of the term "lesbian" to an insult is telling. Julia removes herself from association with this term and throughout the course of the interview refrains from using any identifiers to refer to herself aside from the initial statements around identity. The drive to define self in terms of sexuality is solely a modern phenomenon. Here we see a participant resisting such definitions, storying her life as actions, not as the categories we desire for knowing (Butler, 1987; Wilchins, 2004).

Shelly, not unlike Julia, expresses a relative amount of ambiguity about labels. She indicates that her claiming of the word queer seems to have come as she has become more politically aware of her position as a sexual minority woman in society. During the interview she rarely refers to herself with a particular identifier aside from initially indicating that the identifier of 'queer' is fine.

> I don't really care that much. Queer is fine. Anything is fine. Why do I not choose... I think that I never was really political and so being queer feels like a fact of life. And so it doesn't really... I don't have too much concern about what those labels mean. Now that doesn't mean I haven't thought about it or delved into the issues but you know... if queer means you're not straight, then I'm queer. If lesbian means that you like girls, then I'm a lesbian. It doesn't... I can use any title... not title, term, because it's, they're just words to describe my reality you know? Make sense?

Shelly argued that she doesn't feel the need to have any particular word to identify herself. This could reflect an engagement with queer theory or her own conclusions about her sexuality. Her statement that she has begun to explore some of the issues around queer sexuality is an interesting one. Without using concrete words to identify herself, she still has very strong feelings about the type of service she should receive from mental health and health care providers. From her perspective, the words people use are less

important than them working from a nonjudgmental and professional position. This is a prominent theme within Shelly's narrative that will be explored in subsequent chapters.

As noted above, these stories of identification are unique and diverse, reflecting the individual women's past experiences and current comfort levels. As we move through this chapter we will explore the various life experiences that have influenced the identity formation for many of these women. In particular, experiences of heterosexism related to work, education, and counselling relationships will be explored and will be analyzed from the perspective of how these encounters may influence attitudes toward mental health care seeking and mental health care seeking behaviour in general.

Early Experiences in Identity Development:

Many of the women participating in the study identified a keen awareness from their youth of negative attitudes toward queer sexuality. All of the women reflected that these experiences factored into difficulties they have with their own sexuality or with trusting professionals around sexuality issues. For instance, Wendy illustrates where she feels some of her mistrust for professionals may be rooted:

> in the case of being queer then, there's a certain level of apprehension, at least in my case. And that's furthered I think by my age. As a generational thing. Based on my experience again. I remember very clearly, queers being thrown off the bridges here in Ottawa, our fair capital.

Wendy's experience of having lived through a time when queer people where openly victimized can certainly contribute to a mistrust of the motives of professionals (Anastas & Appleby, 1998). Whereas the younger participants in this study may have fewer reference points for overt homophobic acts, the older participants, including Wendy, have

seen it, been affected by in and recognize the heteronormalizing effect these acts have on all members of society. Karen, a 20-year old participant, describes her own experience of coming out in a high school setting just a few years ago:

> I left a public high school after grade 9 and I went to a Catholic high school and I didn't find that same openness for discussion there. And I went in there with that same attitude because at the public high school I found that you could kind of talk about it and then I went to Catholic high school so I kind of shut up about it and I never mentioned it again.

Some of the most damaging experiences of heteronormativity for at least two of the women occurred during their high school education. The educational experiences of youth represent not only a time of formal education, but the learning that comes with social relationships and groupings (Epstein, et. al., 2001). These educational institutions, according to Foucault, imprint on us a notion of knowledge that is correct and moral, thereby reinforcing in the mind of queer youth that their thoughts, feelings and behaviours are immoral (Epstein, et. al., 2001). As a result, it stands to reason that youth might internalize the information they learn within an academic setting about themselves and their sexuality.

A standout experience that Karen ties to both her difficulty in coming out and her later mental health problems is that of her time in Catholic school. Karen relates her painful experience in high school and her difficult transition from public school to Catholic school as being a pivotal time for her identity development. The intersecting issues of the education system and religion represent a powerful barrier for Karen. Religion will be discussed further in subsequent chapters.

> I kind of started stepping out [of the closet] at the end of grade 9 in high school. You know, I think that's kind of when people start questioning

> themselves in high school. And I kind of fell in that category and I kind of had a few friends who I could talk to about it and they were experiencing similar things... I think that if I had stayed in the public school system that things would have been really different for me. In a big way. I have a lot of disdain for the Catholic school system for it. You know how people hold a grudge. Well I hold a grudge for the Catholic school board because you just, you couldn't talk about it, there was nothing they had like, in front of the counsellor's office, they had the thing with all the fliers... and there was nothing there. It was you're hetero, you're Catholic, these are the services you can access and that's it. And so I didn't know that there were services available to me if I was feeling this way.

It is difficult to determine how Karen's experiences might have been different had she not attended Catholic school. However, it is highly important that youth, queer or not, learn in open and accepting environments without being impacted by regulation of identity and expression. The lack of resources available to her within the conservative context of her Catholic high school may have reinforced Karen's need to hide her sexuality. Through the school's lack of information on sexuality they clearly relayed their stance on the issue. The atmosphere of silence perpetuates the feelings of difference for youth within these environments. Youth know enough to know that queer sexuality exists, however, never seeing it normalized within their school context contributes to anxiety and decreased self confidence (D'Augelli, 2003; Epstein, et. al., 2001).

The silencing that Karen felt during her high school experience only a few years ago was not drastically different from Carrie's experience at high school in the 1970s. Carrie, who is in her mid 40s, identifies generational factors as being the root of the problems she experienced in school. Within her narrative she expresses that she is still impacted by the silencing she felt during those years. This is not an unusual experience for many queer youth who are being exposed to either overt or covert heteronormativity. As one author

notes, this teaching tends "to be part of a general moral education that may be part of the hidden curriculum or located within a specific curriculum such as values, health, personal and social, religious philosophy, civics, and/or citizenship education" (Besley, 2005, pp.76). In reading the following except of her narrative, our understanding of Carrie's unsafe high school experience becomes more real:

> I went to a [community meeting] and the youth were running the meeting and it was just full of GBLT people and all the council and stuff...and two girls I believe they were a couple, went to...[the high school] I went to in the 70s. They were saying that the principal is accepting and the teachers and they have a feeling of safety and security and it prompted me to stand up and say, I went to that school, I hung out with my sports friends, I played girls hockey and eventually women's hockey and baseball in the summer. Very known sports for lesbians. And I said, you know, in school it could never be spoken about in school. Never. You never discussed it with a teacher, you never discussed it with the office, you never discussed it with other students outside of your little group and I said that at that time, I didn't openly know I was gay but I hung out with all gay people. And I said, my life possibly could have been quite different today if I had had that feeling of security in the school. That feeling that we did not have that you guys have today.

It is interesting to note the link between the stigma facing lesbians and the presumption of lesbianism in female athletes. Carrie explains how many of her friends in the sports world were also lesbian and that this was in fact a comfortable environment for her despite her as yet undiscovered queer identity. This involvement with women who were queer may have assisted Carrie in developing a comfort with queerness and allowed her to cultivate friendships with queer women that may have assisted her in eventually coming to terms to with her sexuality (Dolance, 2005).

Despite the comfort of being surrounded by a relatively open-minded group of women in a sporting context, it is impossible to overlook the impact of negative attitudes toward queer women in sport. This lack of support for women in sport within any context, but in

particular, Carrie's school context, promotes unsafe feelings for queer women involved in these activities, particularly if sporting environments are one of the few pleasures in their young life. As Demers (2005) notes in regard to sexist and heterosexist attitudes toward women in sport, "behaviours and feelings of these kinds create unsafe environments that impede learning, adversely affect friendships and hurt teams, athletes and coaches alike" (pp.2). It may well also spread beyond these described groups of individuals to the classroom and school, with students taking their perspective about female athletes out into the community. Additionally, there are obvious links between physical activity and mental wellness. In cases where queer youth are discouraged from engaging in sports in order to abide by gender norms, the link between exercise and wellness is not reinforced, potentially leading to negative lifestyles choices in adulthood (Dolance, 2005).

The role of sports and in particular sports that are seen as aggressive or team oriented as a factor in the coming out process for women is relevant to this study in that there is a link between heteronormativity and the regulation of women in sport. Demers (2006) links this to the socialization of young girls and the enduring notion of female fragility and passiveness, which is disrupted by the view of female athletes as strong and assertive or even aggressive. Therefore women involved in sport are often seen as masculine and subsequently, queer. We can also see the conflation of masculinity and lesbianism in Julia's discussion of her past interest in the military. In her own exploration of this time in her life she clearly reveals her own perspective that queer women are perhaps more likely to be a part of the military, a traditionally masculine space.

> ...there was a summer program for the army, the reserves, and I did that and at the end then you could sign up because you could join the army

> right then and there because they considered that to be your basic training. And I remember calling the recruitment office and signing up but I guess I must have fallen through the cracks because they never got back to me. Well I can tell you that if I had joined the army at 17 I would never have married and had 4 kids.

This statement implies that the military is a haven for queer women. Indeed, there is a homoerotic element to military life in the bonding of military women, the closeness of their relationships and the common experience that they share (Shilts, 1993). Queer individuals have historically been positioned as deviants within Canadian culture. In joining the armed forces, there may be a sense of normalization or acceptance that comes automatically with this often respected role (Shilts, 1993). So, much like female athletes are respected for their discipline and strength, it is possible that there is a similar mindset for queer women in the military. There is a link to both of these worlds in that women involved in sport or military are subject to the will of others, such as coaches, higher ranking officers and other members of their team. The focus within these environments is on group bonding and solidarity, something that a queer identified person may often crave if they were not able to experience this in their youth. There is a disciplining strength to both of these worlds that many queer women view as a welcome escape, where uniformity is encouraged and community is built in (Winslow, 2005).

Although the experiences of many of the women in high school and within their teenage years were conflicted and in many cases, demoralizing, not all participants described having gone through such difficult times. Despite the negative experiences of several of the women during their high school years, at least one participant in the study had no recollection of negativity directed toward herself as a sexual minority. Shelly's

experience in school was distinctly different than both Carrie and Karen, who shared negative memories of the educational system.

> Well, I don't think it [sexuality] ever really existed. I don't think...I can't recall ever having heard of gayness for the first time or anything. In high school my friends and I ... we had a teacher who we felt was gay and he referred to experiences with men too but he was married to the head of the middle school so who knows...who was a woman. So we were...very into like, gayness but I thought it was very much a male thing. But you know, I had some positive reinforcement. Then when I came back to Ottawa and went to [high school] where there was a lot of positive reinforcement for being queer. And ah, because it's an arts high school...I went there for grade 12 and OAC and there was a lot of positive reinforcement for being gay there and that helps.

Although Shelly does not recall any explicitly negative associations with homosexuality, it was clear that she had few queer female role models and really did not appear to be aware of sexual minorities in general. As Shelly grew older she became more aware of homosexuality, however her association with it being a primarily gay male phenomena is quite entrenched in popular culture and media images of homosexuality (Valentine & Skelton, 2003). The fact that Shelly went to an arts high school where queer identity was more common and less frowned upon may have resulted in the relative ease of her coming out. Having a teacher who spoke about minority sexuality in a positive manner may have served to normalize queer identity for Shelly, perhaps making it less of an issue to struggle with as a teenager.

Family Relationships and Upbringing:

The women in this study also told stories of their family of origin shaping their sexual identity and mental health. Our earliest memories regarding awareness of the existence of queer individuals often come from our home life contexts. Depending on the perspective and openness of the family, queer youth can emerge with a positive framing of queer

individuals or can be faced with the condemnation of queer individuals via either covert or overt means (D'Augelli, 2003). All of the participants referenced experiences in their youth that shaped their understanding of queer individuals and their realities. Wendy outlined her experiences growing up and the impact that her family and generational context had on the way she perceived not only herself, but other people, including service providers:

> Part of [the way I perceive people] is a product of upbringing. And I wonder if, depending on your participants, you might notice a generational difference. So part of [the issue], just upbringing, yes. Things that I was formally taught about different aspects of society. And then also through experience, being middle aged, and having to live through [experiences of homophobia].

Wendy does not disclose particular instances where she was faced with homophobia within her family context, however she does implicitly speak to stereotypes and information that she would have gathered through her upbringing that shaped her understanding of people. Here Wendy speaks about how she was taught to take things at face value based on what she knew about those labels:

> in terms of window dressing for queer issues [those titles are] so important. Maybe less so now, and again maybe less so for the younger generation. But again, in my time it was pretty transitional and certainly the generation behind me. It was what I grew up with that's how you made your judgements about labels. Because nobody, well, generally speaking, you didn't self label. Openly, and ah, so there were other clues, you know. That children may learn. So... and again, maybe, the religious labels, of what Catholic meant, of what Jewish meant. When they continue, when those trappings continue. For me individually, I still wonder what they mean.

Through this statement, Wendy demonstrates how her childhood and what she was taught factors into how she perceives people and professionals presently. Although her understanding of these labels of identities may have changed, she acknowledges the bias

that her initial upbringing may have instilled in her. She often built from her personal experiences, a more general narrative in which she reflects on the biases of professionals who come from her generation and she notes the powerful influence of upbringing, religion and generational context on attitudes toward queer individuals.

Julia's experience growing up reflected a lack of awareness of homosexuality as an option. For Julia, the possibility that she may actually be queer took some time to come together. As she discloses in the following statement, not having learned that being with women was an option, it did not occur to her. It was something almost mythical that happened in places that she didn't go:

> The way I explain it is that the way I grew up, where I grew up, the word homosexuality did not exist. There was nobody that we knew and the only thing that I knew about homosexuality was my uncle. He was a taxi driver and he used to tell these tales about taking guys to the Lord Elgin Hotel and whatever it was that they were doing at the Lord Elgin Hotel, you didn't want to be!

In this way, invisibility, absence and homo-negativity come together in families to provide children with clear messages about what is normal/abnormal or right/wrong. Oftentimes, a family history of mental illness can mean a childhood shrouded in silence and fear. This can in turn lead to problems with not only internalization of sexual feelings but can also lead to internalization of negative feelings around mental health problems. The two women in this study who come from families where mental health issue existed in previous generations both reflect on the profound silencing that impacted their families. When one considers the compounding factor of parental silence around issues of sex and sexuality, this might lead to a state of absolute confusion and an inability to cope in a healthy way in regard to worries about their own mental health and sexuality.

Sandy's experience growing up in a patriarchal family where her mother was also living with mental health concerns left a lasting impression on her that may have shaped her own feelings about her mental health status:

> In my family... there were no expectations on me. All the expectation was around my brothers to achieve and succeed and it was sort of no expectations on me to get married and have kids, almost like I was the unknown. So it was almost the opposite in that there was no cheering squad and no conquer the world or 'go out there and get a career' or go out there and have kids. My family was a bit different in terms of the boys had more value than girls. So we were really a couple of generations back.

In this quote, Sandy describes her family expectations reflecting patriarchal gender norms. However, Sandy, having overcome the stigma of having a formal mental health diagnosis, physical illness and past addiction issues, has rewritten the story that her family may have envisioned for her. Given the powerful societal and familial influences facing her, she demonstrates a profound constitution and vision of her own self-worth. However, Sandy's reference to herself as the family "unknown" or black sheep may also reflect her family's likening of her to her mother, who had struggled with mental health concerns herself and was often subject to criticism for it. Sandy continues to recount her story, detailing the blame she was subjected to for her own mental health distress:

> What I can tell you is that I grew up with mental health as having been an issue in my family and with my mom and her family. And I have 3 brothers who never sought help. And I sought help in my early 20s. And they sort of buy into the idea that it's just "me" [who has mental health problems]. So I know that it exists in my family, and whether they have sought help they certainly don't talk about it but I do... I know that they have equally as many problems but they don't seek the help.

In the following statement, Sandy continues to detail the particular impacts of the misogyny she experienced at the hands of her family members:

> Oh yeah, like if my brothers were to have problems similar to my problems it would be "I think you're with the wrong woman" or "you

> should get into a different kind of relationship". Or it would be some kind of external thing that it could be attributed to. But with me it would be, "it's your medication, maybe you should see a doctor" so yeah, it's true. ... it's funny because you don't realize misogyny is in your family... and then you talk about things like this and you see that it is. You know that it definitely the problem. You know, it's me or it's their girlfriend or it's... you know? But it's never [my brothers]. Or that kind of thing, never them or their mental health or their ability to cope.

Sandy's pinpointing of the misogyny that impacted her growing up and that continues to be directed toward her from her family is an interesting reflection. The statements that she highlights having heard from her family reflect a powerful pathologization of women in regard to mental health distress. If not pathologizing women, the men in her family are effectively blaming women for the distress in their lives. If this is a message that she has had to endure from a young age it would undoubtedly cause some frustration and stress for her in her interactions with her family.

Sandy's feeling of otherness was not only rooted to her sexuality, something that she began to acknowledge in her twenties, but also rooted in the way her family was regarded by members of her small, rural community. As she discloses, she and her family were seen as different for several reasons. Here she speaks to the reality of being one of the few Catholic families in her community:

> [my community] was rural. I would say it was quite progressive and open-minded - roughly influenced by faith although we weren't taught very much that way. ... we were Catholic in a 98% protestant town, so we were always different/bad/not 'ok' in the eyes of the town. Overall, not an accepting environment.

Considering the reality of Sandy's context growing up these feelings of being different may have impacted her in the coming out process. Interestingly for Sandy, her narrative

reveals that she may have been more concerned about the mental health status of her mother and consequently herself than she was about her sexuality.

> If ... you have a mentally ill mom and people keep saying "God, you're just like Mom" from the age of 3. Does it make you think "God, I'm crazy just like Mom" and everyone's whispering about "Mom's Crazy" doesn't that play a part in your overall self-confidence?

Sandy's statement here indicates that her mental health status, or her internalization of her mother's own mental health problems may have had more impact on her than her sexuality itself. She makes little reference to profound difficulty in coming out, but instead refers often to her struggle with her mental and physical health problems. Sandy's story highlights the ways in which mental distress, feelings of otherness etc. can't always be reduced to issues of sexuality. Her statement also points to the stigma around mental health issues and the link to pathologization of women in the mental health system. In this way, service providers need to find a balance between seeing sexuality as irrelevant to mental health or as all mental illness being reduced to experiences of heterosexism.

Sandy goes on to explain her feelings about living with a mental illness and as a lesbian. She particularly focuses on how she feels she was affected by her family context growing up and the impacts of the lack of support and negative reinforcement from immediate family members:

> The lesbian thing came out later... but I can remember as a teenager... I just never... see I think my Mom is also an unidentified lesbian/bisexual woman. [ ] I really do. and I have for years... because well, for many reasons. But she also strongly reacts to it like, "don't you touch me". [...] a lesbian tried to touch her one time, and she freaked out. And that was an unusual reaction from somebody [...] like my mom for me, how she looks, how she behaves...how she, everything for me tells me... my intuition tells me that she is a lesbian. So I mean... second generation of both [mental health issues and lesbian identity]. But I can tell you that I

> have had all [of the social problems asked about in the interview questions] and I do have both mental health and the lesbian stuff... although I believe that I could be lesbian and bi-polar and not have [those social problems] on my plate. If had been believed in. See, I always thought that my father... for example, discredited my mom a lot. And I feel like, if his attitude had been like "well your mom is sick and we love her and we're going to take care of her" and he supported her and was her champion, we'd have a totally different view on it. I've never felt ashamed of being lesbian. My family has always been accepting of it, right from the very beginning. So there's never been any shame around that. Even from my Mom. A little bit, sometimes she slips, but for the most part she accepts.

For at least one other participant, a family history of mental illness was also reported. Carrie, who shares the coexisting issues of mental health problems, physical health concerns and addiction issues with Sandy, indicates that there was a family history of depression. Carrie highlighted the fact that the mental health concerns which, according to Carrie, hereditary, were never discussed openly.

> it was something I was quite aware of growing up. [ ] my mom had four siblings, so 5 altogether and all five had been on anti-depressants. My mother was the last one. I'm on anti-depressants now. I have been for about 4 years. And it's very apparent in my mom's family. My aunt was as nutso as they come and she had a lot of problems. My mother believes my grandmother had problems with the same kind of thing but because of when it was, she raised her family during the 30s, and she just persevered. My mom was the last one of her siblings to go on anti-depressants... So there's a definite lineage. My brother, who will be 50 this year. He has suffered from depression as well but his has been manageable through his doctor and him. And if my sister was still alive. My sister was having problems with alcohol abuse, so its there and I'm very aware of it being potentially there with my children. So we talk about it as openly as we can. It's a different generation, different beliefs [than in the past].

Carrie points out that the family did not necessarily discuss issues of mental health but that the knowledge of it being a family issue was there. Clearly, some of this silence centres around the stigma of mental illness. It is fine to talk about mental illness when it is external to the family, but when it is closer to home the issue is often suppressed

(CMHA, 2004). However, when we consider that queer sexuality is often highly invisible, particularly in contexts where it is frowned upon (for instance, within a homophobic home environment), it is more likely to be discussed and denigrated openly. This may lead to internalization of homophobia, as those who are or may be queer are not likely to disclose it to others or demonstrate it openly. Here Carrie discusses what she recalls of her family's perspectives about queer identities:

> I grew up with [my father] coming home from work and listening to him making comments like "you should have seen these fags I saw downtown". He just couldn't deal with it. ... But ... my parents have been great and have done the best that they could do in accepting me as a person and not as a label. But it's been hard on them because when you have kids you don't want them to grow up and be suffering in any way. They are very well aware that I have chosen a lifestyle that is not accepted by everybody. And I use the word chosen very lightly because for me it's not a choice. [ ] it was choice to try and live a heterosexual life and it just caused me a tremendous amount of problems.

Carrie's statement that it was a 'choice' for her to live a heterosexual life is profound. Although she clearly identifies that being queer was not a choice, as she moved into her adult years and became more aware of her sexuality, she felt that remaining closeted was a choice. It may have felt as such to Carrie, however, it is very common for women who have grown up in and functioned within the heterosexual world to find difficulty in making the transition to a queer life (Jensen, 1999). Therefore, although she may have put her own pressure on herself to come out of the closet, it may not have been an active choice to remain so, instead the result of a lifetime of social pressure and expectation.

It is interesting to note that both Karen and Shelly comment on religion and family within these excerpts of their narratives. Although family context and religion can be considered as separate entities, many people gain their initial religious knowledge and religious

foundations in their youth and within their family contexts. As sexuality and in particular, female sexuality, is often taboo within many western religions, it makes sense that the participants in this study might make a connection with family context, sexual repression and religion (Jensen, 1999; Kitzinger, 1989). Although Shelly highlights the fact that her family was not religious, she expresses a particular knowledge that religious teachings often influence the acceptance of queer sexuality within many families:

> My parents are not religious, we never sort of belonged to any religious group that frowned upon homosexuality and my father at least, and my mother following that lead to some extent, [ ] is actually a very ... liberal thinker. And so, with any issue that, upon critical analysis, with evidence of viewpoints ... there's no real issue against being gay. And so, my experience with my family was neutral.

Whether the lack of religious influence in Shelly's life was the reason for her family's ease in accepting her sexuality is difficult to ascertain. However, the lack of conservative religious views during her coming out process, have resulted in Shelly's particular resilience during times of emotional distress and her determination to continue to seek services, even after negative experiences.

Karen's family context presented her with mixed emotions about the possible responses her family might have to her coming out. Karen felt that her father's traditional upbringing might lead to a homophobic response while her mother's employment in a typically open-minded profession implied possible acceptance:

> my Dad is Catholic Italian and my mom [works in a helping profession] and so I was expecting my mom to be really understanding and accepting and my father to freak but it was the reverse. My dad didn't seem to care at all and my mom was really hurt by it. She, was like, 'you know I'm disappointed in you, I'm angry. You know, don't tell anyone else in the family, this is embarrassing, I'm disappointed in you' [...] at first, my girlfriend wasn't allowed in the house for 3 months, my mom didn't want

> her in the house. You know, and it was really bad and we fought a lot and things were really bad at home. We fought a lot and I failed a couple of classes that year at school... she's coming around now, like big changes. She's coming to terms with it. She'll use the word partner now and then and I giggle [laughs] its like, she's warmed up to it.

The homophobic response of her mother in particular appears to have had an impact on Karen. According to Jensen, it is not uncommon for mother's to worry about their daughters not embracing typical female roles and leading a life that might be familiar to them (1999). That Karen's mother, a trained helping professional, was not accepting of her daughter's sexuality might factor in to Karen's hesitation to disclose to professionals. In Karen's case, she was let down by someone she had hoped to have an ally, as both a parent and someone who would be objective, at least professionally speaking. Again, when we consider the implications of religion in Karen's narrative, she expected her father, who was raised Catholic to be disapproving. However, his reaction deviates from common understandings of Catholic opinion about queer sexuality, placing her father as an exception. This is an important observation as these exceptions reinforce to queer individuals seeking to come out that support can come from seemingly unlikely locations. Despite the generalizations we may make about the opinions of individuals from certain cultural, social or religious locations, the interpretation of learning within these groups is individualized. In many cases, when a disclosure of this kind occurs, members of the family may re-evaluate their values and perspectives in favour of their loved ones, as we have seen for many of the participants (Jensen, 1999).

For many women, the fear of the loss of family support is significant and has a profound impact on their mental health. As we have explored, studies indicate that those individuals who have strong family support are more able to cope positively during the

transition to queer identity (Jensen, 1999). As a result, these stories of family context offer us some insight into the context in which the women were raised and how their conceptualizations about queer identity might have been formed. It also allows us to see the particular strains that each woman might face in regard to their family context and the process of coming out.

Impacts on Identity in the Workplace:

Just as family offers supports and influences our own perceptions of ourselves and our sexual identities, so too does the workplace. The support for queer sexuality in the workplace can leave us feeling more empowered and secure in our sexuality, or can undermine and suppress our understandings of ourselves on a daily basis. Many of the women participating in the study happened to work in helping professions or employment that was considered to be institutional (government, healthcare, etc.). All of these women have had experiences of homophobia in the workplace and several had extremely negative experiences around support for their mental health concerns that had been arranged through their employers. Interestingly, despite the progressive face of many of their places of employment, the end results for most of the women were occasional and most often constant feelings of invisibility and homonegativity.

The impact of heterosexism and homonegativity on a queer-identified worker can be more damaging than one might initially expect. Frequent references to normalized heterosexual experiences can often lead to a sense of invisibility and frustration for queer employees. Even if the queer employee can speak to these experiences, they may be regarded as somehow different due to their queer context. The importance of feeling

secure within the workplace means feeling able to make social associations with one's co-workers and having some sort of understanding of their values and perspectives. As studies have indicated, experiences of heterosexism in the workplace lead to decreased job satisfaction and performance and lesser satisfaction with life and self-esteem (Smith & Ingram, 2004). As queer women are often faced with additional pressures external to their work identities, the culminating result of a stressful workplace can be one of mental health distress and potentially, unemployment (Dunne, 1997; Smith & Ingram, 2004).

The stories of the participants around their workplace experiences are predominantly negative. None of the women indicate an expressly positive environment, with all identifying a sense of silencing of the queer existence within their agency structure. Sandy has gotten to a place in her life where she seeks to be open about her sexuality with her co-workers. However, as she discloses in the following excerpt, those within her workplace have not been so open to this expression of herself:

> Yeah, I find the straight community is very [ ] they're silencing with their silence. Even with National Coming Out Day... At work I put up a sign that said "I love women" and one person made a comment, I mean everybody saw it because I worked up at the front. And one person made a comment. People would rarely ask me about my weekend. Probably scared that I was going to get into some kind of graphic sexual detail about my weekend. You know, so you adapt and you are silenced by their silence and their refusal to include you as a part of... and my work is a very forward thinking place so I found that very discouraging. And so... in my workplace, in a group, whether we like it or not we are not as advanced as we think.

An additionally concerning fact about Sandy's experience is that she works within a social service agency. Again, given the current, more progressive social climate it would seem reasonable to assume that a social service workplace would at least be accepting

enough to allow Sandy to express her sexuality openly. Sexuality is not the only issue that Sandy feels she cannot speak openly about in the workplace:

> I'd be sitting at tables at work where people are talking about someone who has been acting in a certain way. And they'll say "well she is bipolar"... I wanna stand up and say something, but then I'm afraid to... I don't know if there's ever been a link to being lesbian where I'm not afraid to say something they'll say "Oh, it's because she's lesbian", I'm not worried about that... my mental health issues I'm more worried about than my being identified as a lesbian in a work setting... Even medically, I have Crohn's Disease and Bi-polar. When I'm sick, I tell people that my Crohn's Disease is acting up. I don't say, I really didn't sleep last night because I was having a lot of anxiety and I don't use my mental health... I am grateful that I have a physical health problem that I can lean on to take the heat off the bi-polar.

Although the complexity of this statement reaches beyond the workplace, there are some important disclosures here. It is significant that Sandy feels that she should be concealing her mental health concerns. In her own words, she is grateful to have a physical health problem to "take the heat" off of her Bi-polar diagnosis. This indicates that, whether real or not, Sandy perceives a great deal of hostility and stigma directed at women with mental health concerns. Further to this, she worries that being a lesbian is somehow going to become the scapegoat for her mental health concerns. Sandy's comments highlight the ways in which queer sexuality and mental illness remain stigmatized and linked despite contemporary changes to the DSM and psychiatry in general.

Wendy's experience in the workplace presents a more menacing reality. She identified that her male co-workers within a male-dominated profession seemed to feel threatened by her presence and would often make sexist and homophobic remarks. In the following statement she indicates how her workplace's Employee Assistance Program counsellor attempted to normalize her experience as a regular expectation of the job:

> She tried to tell me that I should just be more accepting of my workplace. The 'boys will be boys' thing [ ] like if I would insist upon intruding upon their playground then... that's just the way it is. You know, that I should try to be more accepting of pornography and statements like "fuck the women" so... certainly on the social level there's a lot of [men] doing that. and certainly it transcends [beyond the social level].

Wendy's experience demonstrates a sexist male workplace culture in which her co-workers and even her employers were attempting to police her behaviours as a woman and as a lesbian (Dunne, 1997). In this case, her Employee Assistance Program worker attempted to maintain the status quo within the workplace and refused to acknowledge the presence of a problem. Wendy openly identified as a lesbian to the EAP counsellor as her sexual identity was a clear reason for her treatment within her work environment, yet, at the time of the interview she had still not received any resolution for this situation. When I asked Wendy was when she considers it important to self-identify to a mental health worker, she stated:

> When it becomes, to me, relevant to the path of the discussion. [ ] and in my case, I do very often. It's essential to why I go... they didn't tell me "you're going to get yours now dyke" because being a dyke wasn't an issue.

Wendy's need to be clear about her sexuality when seeking counselling for her workplace experiences is expressly linked to the homophobia she encountered from her co-workers. For Wendy, her affirmation of her queer existence reinforces to the counsellors that this was not simply about being a woman, or about being difficult to work with, it was about her queer identity, which seems to have been made invisible by the counsellors that she has worked with thus far. Below we see a concrete example of the invisibility of queer women's experiences, specifically within a male dominated workplace. Wendy indicated a tremendous sense of helplessness in addressing the issue:

> how much was just a gender bias. Where do you draw the line in gender these days? [laughs] how much that they're just biased against me being a woman working in a man's job. And how much was it that me maybe being a dyke working in a man's job. That I'm not sure... I definitely believe those [psychiatrists] did have their own biases from what they expressed about me. And... bringing on the problem just by being. Was it because I'm queer or because I'm a woman? I don't know.

Carrie had a similarly frustrating experience with her attempt to obtain support through her workplace EAP program. In this instance, her struggle with her sexuality was downplayed and the heterosexist advice that she received contributed to a major setback for her mental health:

> I went through the EAP program through work. I got put in touch with a social worker ... I guess she was a psychologist. And I talked openly to her about some things and eventually it totally worked itself around to her trying to get me to go back to my husband or to stay with my husband, build on our relationship, raise our kids and it was like the last thing I needed ... a lot of conflict came out of that. That was one of my first introductions to not fully trusting the healthcare kind of system.

For both Wendy and Carrie, the EAP counsellors offered inappropriate and invalidating feedback. For both of these women the responses from these counsellors were heard as implying that their difficulties were in their own mind. Both of these participants felt that they struggled to find more appropriate supports and that their paths to recovery may have been complicated by the messages they received from these service providers. In both cases, the reality of the sexual identity that they expressed to the counsellor was brushed aside in favour of a more heteronormative response.

Julia's experience in her workplace was less damaging by her estimation, but certainly contributed to an uncomfortable work environment. Her experience centred around observing her co-workers gossip about others who they suspected were gay. After the

fact, she reflected on how her co-workers interacted with her and what they might have been surmising about her:

> And now I know that when I was working at there I'd walk into some place and as soon as I'd arrive they'd stop talking. And I'd say... what going on? Why are you stopping? Are you telling stories about me? If you're telling stories about me, why don't you ask me because I could tell you even better stories than you could make up so you might as well ask me! [laughs]

Although the intention of this gossiping may have simply been curiousity, in an already hostile social climate for queer women it could lead to discomfort within a work environment. It is important to feel accepted and not judged by co-workers in regard to these issues. Open discussion and support of queer identity within workplaces has obvious benefits for mental health in that employees will not feel excessive pressure to remain closeted (Smith & Ingram, 2004). In the case of both Carrie and Wendy who accessed service from in-house EAP programs, this was not an optimal arrangement. The lack of support from the EAP counsellor could be translated into lack of support from the agency, possibly leading to a sense of invisibility and discrimination within the work environment.

Shelly has also had a similar experience of isolation within her workplace. As she works within a particularly conservative, institutional environment, where she is not permanently employed, her sense of security in coming out is particularly diminished:

> I feel [isolation] in the workplace too. Because I'm not out at [my workplace] at all, nor do I wish to be. Unless I have a [permanent] job, because...you don't want someone to not hire you because you're gay. And it's awful to feel that way and I don't like it. It makes me feel really uncomfortable to not be out... And [my workplace] can be... really homophobic environments. Like in the staff rooms, the [staff] generally aren't homophobic but they can be very heterosexist. And I've talked about this with friends who are also [in my line of work] but who are not

> queer and they say, 'you know its really tough because everybody is married and has kids and I'm not... And I have to out myself to them as someone who doesn't have a husband'. Yeah. Poor you... I can't even feel comfortable talking about the fact that I have no desire to have a husband. ... I think that that type of daily support is important to people's lives. You know. I see people in the workplace talking about their spouses and kids all the time and they're not doing it to make conversation, they're doing it because that's what people do. You know. And so if you are queer and you don't have a [work] environment in which you feel is supportive or accepting or anything, you are isolated from that level of social support.

Shelly's discussion of support in the workplace is very illuminating. Within the work culture it is difficult for an employee to find a sense of security when they are not accepted in settings such as the cafeteria lunch break conversation. Being accepted at the social level involves discussion of a home life, social activities, and interests. If someone is not picking up on cues that the work environment is safe to disclose their sexual identity, then it may put them at risk of becoming socially isolated within the workplace and leading to mental health distress within a work context (Smith & Ingram, 2004).

Conclusion:

The discussion in this chapter has covered a variety of influences on identity formation and mental health distress. As indicated by some of the narratives of the participants, early experiences can reinforce negative internalized emotion regarding queer identity. However, experiences in the coming out process and throughout adulthood can be similarly powerful, as these stories indicated. The stories told in this chapter also suggest that there may be a generational difference in regard to expectations around treatment by the mental health and healthcare system. While older participants have come to expect this sort of treatment, the younger participants feel as though these institutions need to bring their services more in line with the current, more accepting social climate for queer

women. Now that the early experiences of the participants have been explored we move on to the common theme of mistrust toward service providers. The personal and social contexts noted in this chapter help us to understand the women's perspectives on service providers. This provides a foundation as we move through the exploration of their interactions with care providers in the following chapter.

Chapter 3 – Mistrust: Historical Factors and Impacts on Mental Health Care Seeking

Introduction:

In this chapter I will deconstruct some of the experiences these women have had when accessing mental or physical health services as well as addiction services. In unpacking these experiences and the process of disclosure to professionals, some of the background that may have fuelled existing mistrust of mental health and complementary service providers is explored. The experiences of the women vary from overt encounters with heterosexism to more subtle experiences. While some of the participant experiences are chalked up to the reality of their lived experience as queer women, in some cases these encounters have been internalized and have posed major obstacles to overcome in their identity formation and in some cases, their recovery from mental health and addiction problems.

Within this chapter I will introduce the current state of invisibility for queer women and the resulting lack of services to meet their needs. I will then move into a discussion of the phenomenon of mistrust amongst the participants, the possible roots of this mistrust and how it has manifested itself when accessing community based support services. From here I will move to a discussion of the implications of disclosure for these women and their consequent willingness or unwillingness to reveal their sexual preference within some or all of their therapeutic relationships (including mental health professional, general practitioner and addiction counselling/support). Moving from the complex issues facing an individual contemplating disclosure, I will explore the difficulty of therapeutic relationships, including power imbalances, heteronormativity and sexism. From here I

will touch on the specific histories of abuse that may impact the ways in which the women respond to mental health professionals and their interventions. Given the pathology associated with queer women who have experienced abuse, this is a powerful sub-theme. Finally, I will explore the significance of religious history and how this impacts the women's perceptions of mental health care providers, but in particular, agencies and workers associated with religious groups.

Mistrust and skepticism have powerfully influenced many queer women's perceptions of the mental health and medical systems (Kitzinger & Perkins, 1993). The experiences of the women in this study impacted them powerfully, however all participants show a remarkable amount of resilience and an overall perseverance that is not necessarily reflective of all queer women. According to Balsam (2003) resilience amongst queer women is often contingent upon several factors, including social support and resources. For all of the women in the study, although resources were difficult to find, they eventually did access the services that they needed. The participants in this study had the knowledge and means to seek out services and resources and continue to find the fit between patient and professional that suited their needs. This is not always the case and is heavily influenced by race, class, citizenship status, language, ability and other factors.

It then becomes important to point out that the ability to access services is often contingent on an individual's sense of agency. The more marginalized the individual is, the more difficult it may be for them to get linked to the services they require. If an individual has grown up within a more privileged or less marginalized milieu, they may

have developed more capacity to work through their mental health distress and their negative experiences within the mental health system (Rosario, et. al., 2004). However, many of the women in the study share racial and class privilege therefore in-depth analysis of how these relations may impact resilience is not possible in this study. The influence of race and class privilege in the women's lives will be explored more generally throughout this chapter, however it is important to note that this is just one analysis of many possible reasons why these women have demonstrated a shared resilience in the face of emotional distress and societal oppression. Though all of the participants experienced barriers to accessing mental health services they did not experience difficulty to the extent that they were deterred from accessing services again.

Invisibility in Accessing Services:

The enduring binary understanding of sexual preference within medical and mental health systems has led to a feeling of invisibility of health and wellness concerns for this group of queer women. Presumed heterosexuality is often a reality for many bisexual women, particularly if they are with a differently sexed partner. This fact alone means that within counselling contexts or doctor/patient relationships, important questions are not being asked from the onset such as social support, feelings of stigma and marginalization that may impact mental health. Sandy speaks to her reality as a queer women involved in the mental health system and how she has simply grown accustomed to the presumption of heterosexuality:

> really the worst part is that I don't expect [queer inclusivity] from [health professionals]. So when they aren't sensitive or they don't provide me with adequate resources, I don't expect it. I'm not surprised. So I feel it's my job to know what exists in the community, which is a shame. Cause

> really, as a professional, it would be nice that they took some initiative but I've just never seen it [happen] that way.

That queer women often have to hide their sexuality, or simply do not get asked about it sets a tone of mistrust that is difficult to undo. We are led to believe that our health and mental health care providers have knowledge and information to pass on to us, however, in the case of queer sexuality, many professionals lack this vital knowledge (Mule, 1999). Some individuals who fall under the queer umbrella are perhaps more disadvantaged in terms of accessing supports, services and knowledge. Recent studies have indicated that bisexual individuals are even less likely to come out to care providers or to seek supports in general due to a perception of lack of safety (Dobinson, 2003). In the case of the one bisexual participant in this study, this research finding reflects some of the feelings she reported in the context of her interview. Here, she discloses the difficulty she has found in accessing services that were specifically targeting bisexual women:

> I've had people mention different groups that go on in the city. But again, I have a lot of reservations about joining groups because you know, if they're a lesbian group I don't want to be ostracized and be the one bi-girl. And then theres bisexual groups I think for women over 30 but again I haven't ever heard of anything available for how I'm feeling.

Karen's disclosure speaks to the reality of support for bisexual individuals. Not only are they faced with the prospect of presumed heterosexuality by professionals and peers alike, but they are also subject to judgment regarding their experiences and their belonging within the queer community (Ochs, 1996).

A recent Canadian study indicated that there are far more services for gay men than there are for lesbian women in Canada (Ryan, et. al., 2000). However, due to the invisibility of the bisexual population, it would be reasonable to assume that there are even fewer

resources and services for these women. In the Ontario Public Health Association's position paper on health care access for bisexual individuals, many bisexual women indicate the feeling of having to educate their care provider's on the reality of their experience (2003). An understanding of the issues facing bisexual women, such as perceived rejection by both heterosexual and queer communities, is not widely shared amongst care providers. An awareness of the impacts of homophobia is certainly present for many providers however but it would seem that the subtleties of heterosexism and biphobia are not adequately understood by many professionals (Pearson, 2003). However, the experiences of the women participating in this study seem to be supported by research that indicates that within a North American context, mental health care seeking has been somewhat normalized (Hunter & Hickerson, 2003). While they perceived stigma from within the system, none of the participants indicated feeling any particular stigma from the queer community in regard to their accessing of mental health services. In fact, several of the women were recommending services to their queer friends without negative feedback.

In the following chapter I will explore the impacts of negative life experiences that the participants have had in relation to their status as women, sexual minorities and women with mental health concerns. Throughout these stories is a powerful message of mistrust, tying in factors of culture, religion, familial experiences and generational factors. These stories offer insight into some of the powerful factors that impact queer women throughout their life experience, contributing to a sense of mistrust in the mental health system. The overall theme coming from these stories is that although this particular group

of women did not experience barriers to accessing service, what they took from their interactions with the health system as well as society contributed to apprehension and relative discomfort with the system in general.

Mistrust and the Interplay of Accessing Community-Based Services:

Despite the resiliency found in the sample of women participating in this study, it is necessary to understand the root of their oppression through the health and addiction fields. The reality of treatment of queer individuals was reviewed in the introduction to this study. Obvious progress has been made in the manner in which professionals work with queer individuals, however the damage of history still colours many of the participant's interactions with professionals. Beginning in the 1970s following the declassification of homosexuality from the DSM, mental health professionals began to develop GLBT affirming practices (Hunter & Hickerson, 2003). Under this affirmative practice approach professionals promote "a healthy view of LGB sexual orientations and overcoming internalized oppressions" (Hunter & Hickerson, 2003, p. 199). However, the development of these practices is not necessarily uniform within social work or counselling curricula (Mule, 1999). Given this, of particular concern is the insidiousness of heterosexism and heteronormative practices, particularly when many counselling programs may not be encouraging their students to identify these biases within themselves (Pearson, 2003).

There is no guarantee of mental health professionals receiving specific training in regard to GLBT issues. Although the needs of the GLBT community are clearly recognized in

many of the mandates of professional accreditation bodies, interpretation of these regulations by many educational institutions is not as clear (Appleby & Anastas, 1998). In fact, as Appleby and Anastas (1998) highlight, though education, particularly within the social sciences is applicable to practice with GLBT individuals, putting this knowledge into practice is often a major obstacle for professionals who have no first hand experience working with the queer community.

With particular reference to the social work profession, although it is difficult to standardize social work curricula, social workers can find common ground in regard to practice with sexual minorities through the code of ethics (Mule, 1999). The implication that mental health professionals must be GLBT positive is not enough according to Cole (1996). Mental health professionals must continually seek to work on their heterosexism and homophobia, for just as it takes a lifetime for many queer women to overcome the impacts of internalized homophobia, so too is the case for mental health professionals to overcome their internalized bias, despite any amount of education (Pearson, 2003). The participants' experiences with professional bias will be outlined within this chapter.

The heterosexist experiences of the women participating in this project range from seemingly innocuous interactions to blatant experiences of discrimination. Regardless of the explicit nature of these events, all of the experiences left a mark on these women and in several cases resulted in delays in their movement toward wellness (Davis, 1996). While many of the heteronormative experiences in other contexts of their life such as work or personal relationships revealed a great deal of pain, all of the women involved

exhibited the most displeasure with their experiences within the mental health and/or healthcare system. Karen (age 20) offers insight into how her life might have been different had someone assisted her with what she felt were obvious signs of needing help:

> I think it's funny that, nobody ever asked me. You know what I mean? I was presumed hetero by everybody around me. You know... the doctor never asked me. My counsellor... when I was in counselling, my counsellors never asked me. My parents never asked me and so... I kind of thought that was weird because this is something that I've been dealing with since grade 9. If somebody had just said, "Hey Karen, are you questioning your sexuality? Do you wanna talk about that?" [ ] maybe I wouldn't have ended up in counselling and on pills [laughs]! The whole nine yards you know?

It is important to note here that Karen came out relatively recently as opposed to some of the older participants. Yet, her struggle to find someone to confide in, someone to validate her experience was similarly difficult. For instance, Carrie (age 46) expresses her difficulty in coming to terms with her sexuality, a process that she indicates she has been going through since her youth:

> I came out to my family in my early forties. My journey to coming out, probably has been all my life. I went through some pretty horrific times with attempting suicide and being hospitalized and living in the heterosexual world.

Despite the difference in age, both participants struggled with depression and internalized homophobia. This may indicate that despite the perception that our current society is more accepting, perhaps the more covert forms of homophobia that exist now may be just as damaging as the overt manifestations of the past (Banks, 2003).

Resilience in Queer Women:

Many of the women in the study indicated that they were tempted to give up finding a mental health service to meet their needs, yet something within their nature kept them

pushing to find something else. For several of the participants, there seemed to be an underlying recognition, that if they had been less assertive or been less aware of resources, they may have given up. Shelly's awareness of her privilege offers a powerful commentary on the mental health system's valuing of those who have a voice and the implication that those who do not have this facility must fend for themselves. Here she relays her experience of completing the telephone intake processes for several of Ottawa's counselling services:

> I don't know if they praise everybody who calls [laughs] but I would call and I was very practiced at this because I was making all these phone calls and I had a few of them say to me "you're very articulate about your issues, that's very good that you can advocate for yourself" and I was like, good! So it made me wonder too... what if I couldn't advocate for myself? What if I couldn't name this as an issue? Would it have been the same?

This recognition on behalf of several of the women indicates the reality that queer women who may not be as familiar with the culture of service provision or for whom English is not their first language may be faced with further disadvantages in accessing quality mental health care (Rosario et. al., 2004). There is a complexity to navigating the mental health system and, oftentimes, those who are more privileged are more able to have their needs met or to know of ways in which they can access what they want. In Carrie's situation, even after many negative experiences, she pushed through and ultimately got the services she needed. Here Carrie outlines some of the negative experiences that severely impacted her ability to move forward with her recovery from substance use, depression and the complications of internalized homophobia:

> you're getting condemnation from [mental health professionals]. It really puts a fear in you to try other professionals. Because I had experiences from some professionals that ended up causing me more damage, more damage than good. There was obviously something from my inner being

> that kept me going back, that kept me looking, because the alternative... I was very afraid of the alternative. And I knew full well that the alternative would have been to just end my life. And that, you know because of the depression and because of the sexuality issues, there was some pretty heavy stuff that would just take me down and when I got down, it was pretty hard to get out of being down.

This statement clearly indicates that for Carrie, her expectations for support are very specific and if she feels uncomfortable, she will move on. Although this is admirable, it implies a certain amount of resourcefulness that may not be typical of the broader queer community. As discussed earlier, many queer women will be daunted by the perceptions of intolerance on the part of professionals. As we move through Carrie's story we will discover that she possesses a certain resolve and sense of entitlement around her care that may have been influenced by her lengthy involvement with mental health, addiction and physical health professionals throughout her lifetime.

As a result of Carrie's physical health problems she is often working with new health professionals. Due to symptoms of her illness she finds it difficult to recall whether she has disclosed her sexual orientation to them in the past and sometimes finds that she assumes that most people already know:

> If I get sicker, then I'll have to start dealing with [disclosing] things again, but... I know that my diabetic nurse who has been my nurse ever since I was diagnosed with diabetes... only recently have I told her that I'm gay and she is ok with it. But she had no idea. Whereas I thought she just knew. So I have those [problems]...with the medical profession and especially because I have a memory problem because of my MS I assume some things that people just know and then when it comes up for whatever reason it surprises people. So then there is a little bit of ... ok, is this person going to shy away from me are they going to be supportive of me? Does this person have issues with the GBLT? That kind of thing. That's when I get a little concerned about... you know, I just assumed this person is, or I thought I had told this person, whatever medical profession this person might be in. [ ] I get very defensive I guess. It's when I do get a

> negative kind of reaction or feeling or whatever. It's like, ok fine you're not comfortable then I don't want anything to do with you. And it's like... your issues and my issues, there's a wedge there. That kind of reaction makes me a little uncomfortable, you know because I believe in this day and age that people should be tolerant and accepting or honest. You know, if somebody was honest enough to say to me, I'm not comfortable enough around your type of lifestyle, fine, I don't want to make you uncomfortable. I would expect the same.

Although Carrie expresses that she would simply find another care provider if they were uncomfortable with her sexuality, the reality is that this is easier said than done. The limitations of healthcare and mental health care services mean that a switch in professionals could mean a lengthy wait. Many people may not be willing or able to endure this and may choose to conceal their sexuality in order to get some sort of help. Similarly, Julia relays her frustration with several attempts to find appropriate care. Julia has had a wealth of professional experience that would have given her insight into reasonable expectations of quality care. Her frustration with the quality of care she receives may come from a place of knowing the standard of care that should be expected:

> The first [counsellor] I saw was excellent. The second person I saw when the other one retired was terrible. So, what was it related to? I don't know. Was she like that with everyone? I don't know. She was like that with me. And it... certainly made my mind that I was never going to go back there and probably was a while until I sought help again. And then I... contacted the psychologist who I had originally seen at [a local university] and that's when he put me in touch with their new psychiatrist who is doing family counselling. And he was [ ] not a very helpful person. He didn't do anything to help me. [ ] I was sitting in his office and I was talking and he fell asleep. So I waited until he woke up and I said, "Well, you've had your little nap and maybe when you're interested in what I have to say I'll come back".

Although Julia's experience is not specifically related to her existence as a queer woman, the fact that she, as a queer women, was poorly served by two professionals is significant. Queer women already have limited options in terms of individuals they may feel

comfortable working with, therefore the particular incidences that affected Julia could serve to further limit her prospective options and comfort in future counselling contexts.

The Implications of Disclosure:

A shared experience amongst all of the women in the study was the pressure of having to disclose their sexuality. Disclosure often creates a significant amount of stress for queer women, and in some cases, results in their not seeking health care (Dobinson, 2003). For those women not comfortable disclosing, it may be necessary for them to interpret their own meaning from the heterosexist information given by the provider or in some cases, fill in the blanks in terms of supports and resources if the care provider has failed to probe about the possibility of the patient being queer (CRHC, 2004). This reality was spoken to by Sandy earlier it the chapter. With this lack of insight into the particular difficulties of queer women, many care providers may also fail to make appropriate referrals or to consider the particular barriers, limitations of obstacles facing the client/patient (Banks, 2003). For women who are not able to disclose their sexuality the assumption of heterosexuality is often made, leaving the care recipient with limited knowledge and in many cases, leaving them to find their own information, solutions or resources for any concerns related to their sexuality (Pearson, 2003).

Sandy reflects on her experience working with care providers and the impact of the assumptions that often get made about her sexuality:

> I never thought of that. Because I do pass as straight. [ ] I always have to self identify. ...I will identify a partner and say 'she' but I would usually tell them that first before I [disclose], you know? So I'm getting less afraid of it now, but that could be because all my doctors know. But I

> have been, I never thought of this, assumed [heterosexual] until I make a point of telling them that I'm not.

As Sandy feels that she does pass as a straight woman, would she feel it necessary to self identify if she were to begin working with a new professional? If this professional did not incorporate queer positive practices, how difficult might this be? Conversely, for any woman who may fit stereotypical constructions of what a queer woman may look like, it is possible that assumptions would be made about their sexuality that could perhaps be harmful. For instance, that they do not have sexual relationships with men or that they may not be struggling with internalized homophobia. In these situations, assumptions about sexuality and the nature of sexual relationships become problematic and has the potential to silence the patient (Appleby & Anastas, 1998).

The women in this study had a broad range of comfort and discomfort with the idea of disclosing their sexuality to health and mental health professions. While some women regarded that moment of "outing" oneself as a casually mentioned necessity, most of the women experienced discomfort with prospect of the interaction. Saari asserts that there is a justifiable discomfort in "having to declare one's sexual orientation, to refer to it repeatedly to people who do already know of it can feel very much like a violation of privacy, indeed a violation that exposes one's very basic identity to scorn or presumptions of sin and pathology" (2001, pp.647).

In Karen's case, she has never felt comfortable expressing her sexuality to her family physician (who provides her mental health care at present). As she contemplates moving

and finding a new physician she is faced with some difficult decisions that call into question the realities of healthcare in this city:

> I was thinking of looking for a new doctor, I'm going to be moving away from here so I was looking for a doctor downtown. [ ] You know, I was thinking, I want a female doctor and I don't want her to be too old because if I tell my doctor that I'm a lesbian or I'm a bisexual I don't want to be judged by my doctor and so, you know, definitely you have to think twice and second guess yourself a lot when you're talking to health professionals. I think. The question always crosses your mind of should I mention this or how should I mention it or is it even an issue?

Karen's perception of doctors from an older generation as not being open to working with queer clients is common amongst the women in this study. The perception that there is a generational wedge that will not allow different generations to agree on service provision for queer clients is reasonable given the longstanding position of the mental health and medical communities around homosexuality (Hunter & Hickerson, 2003). Several of the participants indicated concerns about doctors of an older generation and additionally, that they preferred to work with female doctors. This is an ageist and potentially inaccurate assessment that could be reflective of youthful regard of older generations as having moral views that are not progressive or reflective of the times (Hunter & Hickerson, 2003). However, as bias is difficult to overcome and professional education in the past would likely not have addressed the internalization of heterosexist attitudes, it is a valid concern (Pearson, 2003).

Karen later added to her statement by saying that she too felt that an older doctor or counsellor might not view her concerns in an objective manner. As she explains, this has actually prevented her from discussing her sexuality with professionals in the past:

> I guess it's a little bit of ageism and judgment on my part too is that I judge older people and I don't think that they'd understand and I don't think that they'd be as open minded to it so I wouldn't want to go to a doctor that's older or a counsellor that's older because I can't discuss the issues around me. And I think that was part of you know...with my counsellor that I was seeing when I was younger, she was a much older woman, she was like in her 50s and maybe I never mentioned the confusion around my sexuality because she was older.

Above, Karen names her concern in the context of ageism, but also reflects that her fears are linked to the rapid changes in social acceptance of queer sexuality. For Wendy, the age of a potential service provider is also a lingering concern. The impact of societal homophobia and heterosexism over her lifetime has resulted in skepticism of the mental health system's efforts to take on a more progressive view of sexual minorities:

> I can't remember when it was, but it was during my lifetime whether it was DSM III or what. That's my lifetime... they decriminalized it in my lifetime. So even the things that I grew up with. Which means then, that any shrink of my age or generation and back also grew up with that. And how much have they, just because the DSM was updated... how many of them have updated their own [views]... if they did all their schooling, and their own upbringing believing that it was a deviancy and criminal. I just don't believe that they all of a sudden chucked it. If they believed it to begin with whereas they might have been taught it but never bought it.

As Wendy's narrative will illustrate further in this chapter, her experiences within the mental health system, particularly with men, have served to reinforce her skepticism.

Accessing Care - Varying Contexts:

In having reflected on the difficultly of coming out within a counselling relationship, it is important to note that not all of the women receive their mental health care within a traditional counselling relationship. It is vital to address the experiences of women accessing care from a variety of healthcare providers so as to draw attention to the different lived realities of queer women. In Ottawa, and throughout the country many

queer women do not have the luxury of accessing private professional care or cannot access appropriate mental health care for a variety of reasons. For many women, their mental health support comes from family doctors and, in the case of one woman in this study, from a series of general practitioners at drop in clinics. The problems within the health care system in this country were highlighted within this small sampling of women.

For several of the women, their mental health support came from general practitioners. In at least two cases, the experiences of participants receiving care from general practitioners did not meet their expectations or needs. For Karen, her experience at a young age with her physician may have affected her decision not to disclose her sexuality. The heteronormative precedent that had been set in previous interactions with her doctor made it very difficult for her to ask questions that were tied to her own physical and mental wellness:

> With my doctor because my physician has been my counsellor since I stopped going to counselling... she's never asked me about it. I think when I was like 16 or something. You go for your first pap smear or whatever and I think she asked me if I was a virgin and I remember thinking to myself... well, define virgin? Because, I had had sex with a woman but I had never had sex with a man. Does that make me a virgin, like what is she talking about?

Karen's story is particularly interesting as her bisexual identity was invalidated within this interaction. The definition of virgin would be rightfully confusing for her. We are taught to believe that legitimate intercourse is between members of different sexes, so Karen could easily have believed that she in fact was a virgin until she had sex with a man. This could lead to confusion around risks of STIs and sexual practices, which in turn could have a negative impact on mental wellness.

Shelly is another participant who had both negative and conflicting experiences with health care providers. In Shelly's circumstance, she does not have a family doctor and, until recently, had relied on general practitioners at drop in clinics for both her physical and mental health care. It should be noted that in the Wellness Project of queer identified people in Ottawa completed in 2001, 14% of respondents did not have a family physician or regular medical care. 18% of respondents accessed "other" forms of health care, defined in the study as chiropractor, community health centre or walk-in clinic. It is not known what percentage of this 18% utilized walk-in clinics (Ottawa-Carleton GLBT Wellness Project, 2002, p.25). Shelly is one such person who accesses her health and mental health services through a drop-in clinic. In chapter 2, (page 62) Shelly described her experience accessing health care from a physician at a drop in clinic. Shelly's anger in this situation may not be so much in regard to the involuntary blushing of the physician who asked her why she would not get pregnant, but more of a response to the continued invalidation of her sexual orientation by the medical profession. Although as human beings and professionals we cannot help our automatic responses to particular prompts, we can be conscious of our wording, how we respond to these scenarios and our knowledge of the realities of marginalized clients (Anastas & Appleby, 1998).

In another experience with a series of drop in clinic physicians Shelly received conflicting messages about the need for her to have a pap test as a queer woman who had never had sexual intercourse with a man:

> I go to the walk in clinic by my house whenever I need health care and I talk to so many doctors now and they all are very shifty about stuff. Like, I'm 29, turning 30 and I've never had a pap smear. Doctors tell me in the past that you don't need a pap smear. And I'm like, really, because in the

> [United States] they do pap smears all the time and they said no, no, no. It's just to check for HPV and whatever blah, blah, blah. And...] you now if you haven't had intercourse then you haven't been exposed to that. Well, when should I have one? Should I ever have one? And I've had several doctors say to me... well, by the time you're 30. So this winter I went to a doctor and I said, I've never had a pap smear. Don't I need a pap smear? I'm turning 30. And she's like, no you really don't. So what were they doing, lying to me when they told me I needed a pap smear by the time I'm 30 and she said, I don't know. And I said well were they just trying to put me off assuming that I would have had intercourse by now? And she said yeah, probably. And I was like, so what is the answer? [...] I don't understand. Like do I need a pap smear or do I not need a pap smear?

In Shelly's statement, similar to Karen's experience with her physician, we can clearly see that by 'intercourse' the doctors mean vaginal/penile sex. Yet, depending on the particular sexual practices that she might engage in with a woman, there is the potential for her to be at risk for STI's (Cooperman, et. al., 2003). This conflicting information about the need for pap tests for women who do not engage in intercourse with men indicates that the general practitioners may lack the competency to be working with lesbian and bisexual women. Similar experiences amongst other queer women requiring pap tests were noted in Kia Rainbow's research project on the health and social service needs of lesbians in Ottawa (2003). Shelly was treated as an oddity because she had not had sex with a man. This could easily be translated into a lack of comprehension of the realities facing queer women and the realities of queer women's intimacy. Further to this, their discomfort with her request for a pap test poses serious questions about the practitioners competency to counsel a queer woman or even direct her to appropriate services for her physical and psychological care.

Care for Substance Use Problems:

In addition to formal medical and mental health system care, several women had negative experiences when accessing assistance for their substance use and/or addiction problems. Although these problems are often considered to be distinct from mental health, many women would identify their substance use and addiction problems as being linked to their mental health. There is a lack of empirical research on the correlation of queer identity and substance use, however many smaller scale studies seem to indicate that there is, at least, an increased risk for substance use amongst queer women due to the continued existence of stigma and oppression that this community faces (Van Wormer, et. al., 2000). Carrie's story supports this theory:

> I believe that [my addiction and sexuality are] very intertwined. One fed the other kind of thing. Until I reached the stage that I'm at now, I can deal with them as separate entities. But before, I'm sure that my depression... I drank a lot to hide in a heterosexual world that I was very uncomfortable in. but I was never sure that that was because I was gay or because I had these weird beliefs or whatever. There was never a clear separation between them. Now there is a definite clarity between the two... but they are very interrelated at least in my life they have been very interrelated and I definitely know that all my problems with drinking was definitely related to my not [being straight]. I don't think I was consciously aware of what I was doing at the time. But the only time that I attempted at all to talk to anybody about my sexuality, concerns and fear and everything else, was when I was drunk.

From Carrie's perspective, at least some of the link to her addiction problem was her closeted identity. This is not an uncommon phenomenon and certainly one that many queer individuals have identified as a method of coping with their internalized homophobia (Cabaj, 2000). However, this trend is also seen in other groups of people who experience oppression or who have been exposed to trauma throughout their lifetime. Ultimately, this indicates that queer individuals are no more likely to experience

substance abuse issues than anyone else, however, it is the strain of their often marginalized existences that leave them vulnerable to substance use (Hicks, 2000). According to Matthews et. al. (2005), the particular needs of queer individuals experiencing addiction must be addressed by mental health and substance use providers, even if there is no evidence that addiction rates are higher in this population.

The experiences of many queer women in mainstream addiction programs are less than positive. Studies indicate that the primary reason for this is that these programs were designed to meet the needs of men and to also meet the needs of a non-diverse population, thereby overlooking sexuality, faith, race and other factors that might necessitate different approaches to recovery (Van Wormer et. al., 2000). Queer women require a safe, non-heterosexist environment in order to be able to express the unique challenges that they might face. In particular a feminist approach that encourages sharing and trust among program participants might prove to be particularly cohesive for many queer women (Van Wormer et. al., 2000). If such a queer positive addiction program for women exists in Ottawa, the two participants in this project were not aware of it. Again, this calls attention to the reality of addiction for many lesbian and bisexual women and the enduring inadequacy and scarcity of addictions programs able to work with sexual minorities in general. Although Sandy did not disclose negative encounters in accessing treatment, she did disclose difficulty in finding adequate support. Sandy discussed her negative experience with an addiction support group, where her sexuality seemed to be suppressed for the benefit, or comfort, of the group:

> I belong to a 12-step committee and when I would go to the meetings, I would refer to my partner as 'they'. And then I found out there was a

> GLBT group and that just totally changed my experience. That I could talk about my partner and not to worry. I could say 'she' or 'her' and I needed the support of the GLBT group to be able to... because I felt the 'straight pressure' in the other group and... I'd tell people and they'd gasp... and I don't think it's my fear because I'm not really afraid, but when you're trying to be accepted or get to know people, you never know the right time to say it. You know, and with the GLBT group, all the pressure was gone.

This observation of the inadequacy of existing addiction and mental health services is supported by other stories from the participants of this study. Carrie felt that her experience in treatment was a major setback in her mental health and addiction recovery:

> I had my experience with the social workers... in the... the alcohol and drug treatment program. I remember one counsellor that I had when I was in the program... I remember the last day I was there she said to me, 'You're here for a drinking problem. Your sexuality problems have nothing to do with this, if you have problems with that I hope you find help but you're here because you've got a drinking problem'. And I looked at her and I thought, 'I'm here because I have a drinking problem because I have a problem with my sexuality and it's my way of being able to live for the last 20 years!' How can you separate the two? So that was another setback. Big time.

In this circumstance, the staff's lack of understanding of the powerful relationship between internalized oppression and substance use for queer women is particularly evident. Van Wormer, et. al. (2000) identify internalized feelings about 'deviant'sexuality and the lack of role models as being primary factors related to the prevalence of substance use in queer women. Several studies have indicated a lack of understanding of sexuality amongst addiction workers. Although many of these programs could be described as 'accepting', they may not be affirming. Many addiction programs are intended to be supportive and non-judgmental environments. Affirming programs where the queer individual is valued as opposed to marginalized are particularly important in order to ensure that this lack of judgment is extended to queer individuals seeking treatment (Matthews, et. al., 2005)

This view of sexuality as being external to struggles with addiction is problematic in that oftentimes addictions can be clearly linked to marginalized identities (Cabaj, 2000). In addition, if an individual has a coexisting mental health and addiction concern it is important to address them as a complex but unified problem as opposed to treating them as separate problems. Many mental health service providers are embracing this approach to service, acknowledging the complex interplay of mental health distress in substance use behaviour (Mueser, et. al., 2003). Historically, 12 step programs have sought to de-emphasize the importance of what they have viewed as external issues such as sexuality or mental health as it has been seen as a detractor from the central issue of substance use (Mueser, et. al., 2003). As both of these participants can attest, this is not the case within their lived realities.

The Dark Side of Counselling Relationships:

Moving beyond experiences within specific contexts such as working with general practitioners or addiction specialists, many of the women in the study have had negative experiences within general counselling relationships. Several of the participants have expressed that these experiences plant a seed of mistrust, resulting in difficulty confronting the issue for fear of causing a rift within an otherwise successful professional relationship. This is a particularly relevant concern given the difficulty of finding adequate mental health care in Ottawa. Sandy relays one recent experience where she felt very frustrated with her counsellor's response to her attempt to work through a relationship concern:

> Something like that happened this week and its happened before in the sense that they're not trying to work save the relationship that I'm in. I believe that if it were a different situation they would... you know, I talk

> about having a normal problem in a relationship and... it isn't abuse, it isn't anything like that. There's no conflict resolution [from the counselor], no problem solving, no 'lets try to help you make this more manageable for you'. It's 'maybe you should move on to someone else'. And it's like it's almost like they believe that that's what happens in the [queer] community, that people just keep flopping from one relationship to another or they don't see it as credible, they don't see it as valuable, they don't see it as something you want for the rest of your life.

It is difficult to determine the basis of the counsellor's intervention with Sandy, however it would not be unreasonable to assume that some internalized bias could have had an influence on the counsellor's response. Stereotypes about the nature of queer relationships continue to endure and it may be possible that the counselor is expressing this internalized understanding of Sandy's relationship (Hunter & Hickerson, 2003). These stereotypes can range from the belief that a relationship between same sex partners is more about lust than love, to the belief that someone involved in a queer relationship is usually a survivor of abuse, therefore likely to become involved with an abusive partner.

However, for many of these women, their historical experiences with the system endure, leaving a lasting trepidation when accessing new services. This often casts a cautious air over their existing counselling relationship. Carrie revealed her personal fear about accessing care that is shared by many queer women:

> I'm still nervous if I have to go to a new doctor. There are certain aspects of my life that I don't talk about for fear of a negative reaction from the health care professional. There is always the fear that, and maybe a right or wrong perception on my part, but a fear of kind of getting second rate care because of my life choices that may disagree with the professional. In my lifetime that's still there. It's a whole lot better than it used to be.

In Carrie's circumstance, her contact with new professionals is more frequent as a result of her complex health concerns. Carrie's concern about receiving inferior care is not

dissimilar to Karen's concern that disclosing her sexuality will result in poor service. According to existing research, this is a concern shared by many queer individuals (Dobinson, 2003; Healthy People 2010, no date).

The power of an early experience with the mental health system can result in long-term negative outcomes for a mental health service user. Here, Shelly relays an experience she had ten years ago when she was experiencing depression. It has left a lasting impression on her and seems to have assisted in further entrenching her own conviction that medication is not the only solution to mental health distress:

> I think she was a psychiatrist... I spoke to her for a brief interview and she immediately told me that I had to go on medication and I said no, no, no. I'm not interested in going on medication. I'm not suicidal... you know, I'm depressed [ ] I'm not at risk so I've no interest in ever taking medication and she basically said, no you have to. I said "see ya!" and then the private psychologist I went to also was encouraging me quite strongly to go on medication and I felt that it was something that I never wished to do... I hadn't had strong views at that time about medication I could have been easily pressured into taking it. You know, which is a problem and I think that that is perhaps even more of a case now because doctors are pretty fast to prescribe medication these days and I have concerns about it.

Although psychiatric medications benefit many people, it is important that patient's have the required knowledge and desire to be on these medications. Shelly's commentary brings us back to the discussion of personal agency within the mental health system and the individual's ability to navigate these complex counselling relationships on their own terms. If the individual's agency is complicated by other oppressive factors it may be difficult for them to exert their own will within these dynamics given the inherent power differential between counsellor/doctor and client (Fingerhut, et. al., 2005). In this situation, Shelly was able to decide, despite the pressure of professional opinion, that she

did not want or need the medication. Whether she needed the medication or not is unclear and not something that this researcher is qualified to comment on. However, Shelly did possess the strong will to resist being medicated, something that may not necessarily be a choice for other queer women who may be more profoundly affected by the influence of medical opinion (Kitzinger & Perkins, 1993).

Wendy's negative experience with psychiatry left her feeling helpless in the face of blatant misogyny, homophobia and sexism. She experienced extreme harassment in her male dominated workplace. This harassment was directly linked to her existence as a queer woman. Wendy eventually left this workplace and sought disability benefits while recovering from the impacts of this experience. In order to access these benefits she was evaluated on three separate occasions by three different psychiatrists for the purposes of an insurance claim. Two of the psychiatrists were women and their evaluations included fewer opinion-based statements or judgments concerning Wendy. Her experience with the male psychiatrist was more frustrating. His patriarchal bias and gender normative expectations are reflected in the language of his evaluation where he comments on her being a "bespectacled woman with short hair, and no makeup". These gender normative expectations also rely upon heteronormativity and are often heard by queer women as an indictment of their ability to fit within the gender norms of a heterosexist society. This is primarily due to the reinforcement of gender norms that many queer women cannot or will not access. Wendy perceived this as a judgment of her appearance based on his knowledge of her sexuality and his ascribing to common stereotypes about queer women. Here, Wendy speaks to how the assessment of the male psychiatrist left her feeling:

> And all of these are opinions. Professional opinions... in the case of the 2 women [psychiatrists], they always provided backup for their opinions. They provide specific examples. [the male psychiatrist] here didn't. But...again, that gets [ ] to me, my bias, of what my perception of what I'm reading here and what is his bias of what he is writing here. [ ] to me, the words do speak for themselves. To me, these are concrete examples...

Wendy's specific frustration with the male psychiatrist was his evaluation of her appearance in comparison with those evaluations of the female psychiatrists. While the female psychiatrists indicated information about her appearance that spoke to her mental wellness (such as cleanliness, appropriate dress etc.) the male doctor commented on her physical appearance, with an almost judgmental perspective that a woman should have long hair or be wearing makeup. These are, after all, the expected attributes assigned to straight women by mainstream society. Wendy goes on to discuss her perception of the power differential between patient and counsellor. Here we can begin to see that her perception of mental health and the power held by these professionals has had a profound effect on her and brings up a certain amount of fear:

> These people have a lot of power... it worries me that, like, when I walk in the door... seeking psychiatric help, they get to ask their questions and make their own judgments. And then, with some potentially very serious outcomes... to the extent that they could have you committed. So it's a pretty scary, very lopsided relationship to begin with.

Wendy's perception here is particularly meaningful given the lack of credibility allowed to those with mental health concerns (Kitzinger & Perkins, 1993). Within helping professions, the power imbalance can become destructive. From the structural social work perspective, power imbalances should be levelled, eliminating the hierarchical models of the past (Mullaly, 1997). However, developing this awareness of power as a professional is a particular challenge that many find difficult to negotiate. This is a

particularly salient issue when working with marginalized communities such as queer women who may already be skeptical of mental health professionals.

Sandy's perception of professional power has had a profound influence on her life and her relationships. As she illustrates, it has taken many years for her to become comfortable challenging professional opinions:

> I'm 42, it's taken a long time for me to say I'm not going to listen to what you think. And professionals have certain clout in my mind. That they say we should move on then for the rest of however long it takes I'm questioning and questioning the relationship. I think relationships have been ruined for me because professionals have thrown doubt into my mind. Well yeah, because then you're starting to look at it differently. the whole and the difference between 'it sounds like she really makes you happy so how can we you know..." the difference between that kind of an approach and "I think you should get out of this" is day and night. And I'm often met with that. And I feel that it is the privileged nature that people see two women in a relationship.

The issue of her counsellor not validating her relationship is a serious one in that this is a constant battle for any queer individual. In the face of enduring negative portrayal of queer relationships the counsellor should, as Sandy asserts, be focussing on the positive aspects of her relationship while recognizing that difficulties occur in any relationship. This type of interaction serves to normalize her experience and give it validity as opposed to focussing on the problematic and ignoring the positives that Sandy clearly gets from it (Saari, 2001; Hunter & Hickerson, 2003). This type of validation is particularly necessary for queer women who have few models for positive relationships, as opposed to the constant flow of messages that heterosexual couples may encounter about how to cultivate a healthy relationship. The mechanics of a positive relationship, gay or straight, are the same. Yet, the lack of visibility of positive queer relationships reinforces the

likelihood of failure in relationships for queer women (Levy, 1996). When we consider that there is enough negativity around coming out as a queer woman, the feeling that their relationships will never be successful or they will never find 'the one' is not uncommon. This can understandably lead to mental health distress and internalized homophobia. This attitude is more likely a result of societal misconceptions and stereotypes about queer women and the myth of the lifetime of loneliness that awaits a lesbian (Jensen, 1999).

Mistrust - The Legacy of Insidious Trauma and Abuse:

In moving through these stories there is a clear thread of mistrust that binds all of these narratives. Indeed, over the years the medical and mental health system have not given much reason for queer women to feel safe in their care. Though times would appear to have changed, these perceptions continue for many of these women. It is difficult to assess where the mistrust of the mental health system is located for these women. However, it is not an overstatement to suggest that many of these women were impacted by the common societal assessments of queer women. Although only four of the women in the study identified that they had experienced direct abuse or harassment, all of the women told stories of general social marginalization. It has been brought forward by many feminist researchers that as women we all suffer from the effects of the enduring patriarchal perspectives of Western culture (Brown, 2006). Balsam refers to the phenomena of 'insidious trauma' as the daily, ongoing stress associated with oppressions such as homophobia, sexism and racism" (2003, pp. 5). Abuse of any form often leads to a mistrust within relationships, however the mistrust that comes from the lifelong, insidious abuse faced by many queer women manifests mistrust in countless different

ways. Balsam qualifies this by indicating that "any direct trauma that takes place in the lives of lesbian and bisexual women must be understood against a backdrop of cultural or insidious trauma" (2003, pp. 5).

This section will explore the experiences of direct and indirect abuse experienced by the participants. A theme that can be followed throughout the stories of the women is that of fear and mistrust as a result of how they feel society, family and health professionals regard women who are queer and/or have experienced abuse of any form. Within the interview context, participants were asked about social issues that they feel may have affected their lived realities. One of the possible social issues that I presented to the participants was that of 'abuse', leaving the definition of this word open for their interpretation. As a result, some of the narratives included specific references to sexual or emotional abuse. Other encounters with abuse or trauma come from a less overt experience and more from a general familiarity with societal oppression. Additionally, some of the stories reflect secondary trauma from incidents that the women have heard about or witnessed over their lifetime.

For many queer women who have experienced abuse, particularly sexual abuse, there is a fear that medical and mental health professionals will assume that this is the root of their queerness (Robohm, et. al., 2003). In the accounts of Karen and Sandy we see this concern reflected powerfully. In the following quote, Sandy reflects on the insinuations that professionals have made about her history of abuse and her lesbian identity:

> yeah... and I think there is a lot of ignorance around it and there are a lot of people trying to understand. You know, what makes you decide that? And for me, I was abused by men and women. So maybe I could say I

> was exposed to both so knew that both were possible. And I mean, if we all were then we would do that [be with both sexes]...[laughs] I mean this could be anything right? I mean how can you know the answer to that question?

Obviously Sandy sees her sexuality as being distinct from her past abuse. This common perception that a woman could not be queer unless she had had an abusive or traumatic experience has certainly impacted Sandy's interactions with professionals. Yet her observation is profound in that the abuse that she has experienced has been with individuals of both sexes thus disrupting the belief that women become lesbians to avoid abusive men.

Karen shares a similar concern about disclosing her experience of abuse as a child. She minimizes the impact of the abusive experiences that she relays, almost as if to downplay any possible role it might been seen as playing in her current queer identity:

> I did have you know, not to say if it's small it's ok, but I had a very small sexual abuse encounter when I was about 6 or 7 with a babysitter. And not trying to say that it makes it ok but it wasn't anything drastic, it was you know, I wasn't you know, raped or anything. It was a very small incident and ummm. I say that because in my mind I think it could have been a lot worse. And there's a lot of kids who have been sexually just tormented beyond belief and not that it was nothing but it was pretty much nothing compared to what it could have been. And ummm... I don't tell my doctor about that and I don't tell my health care provider about that because then I knew that they would be like "OH! Well you know you're a lesbian because a guy touched you when you were 7". There's the link right there. That's your problem. And I didn't want to be judged.

Karen clearly states that she does not want to be judged by this one experience in her life. The fact that she should have to fear re-victimization as a result of a memorable experience from her childhood speaks to the aforementioned need for our society to seek out a reason for the queer existence (Robohm, et. al., 2003). Yet later in her narrative

Karen clearly states her stance in regard to men and indicates that she does not have enduring trust issues as a result of this past experience:

> I don't, because if I felt mistrust towards men or if I felt that I was a lesbian then I might question it. But because I identify as bisexual and I don't have problems trusting men then I don't think it factors in. you know, if I was having trouble feeling comfortable around men, trusting men. That kind of thing or if I was a lesbian I might question the link but because that hasn't been the case I don't think its affected me that way. Not that it hasn't affected me but in that way... and so I keep it quiet because I know that people would be like... I mean even my...mother doesn't know that that happened because she has said to me before that she believes that lesbians are just women who have been abused or can't find a man. And so I was like, well now I'm really not going to tell you. because you're going to turn around and tell me "well the babysitter touched you and that's why you like titties!" [laughs]. Like you know?! Exactly, that's so absurd and so I keep that quiet because I know that a lot of people think that way and I just don't want to hear it.

The perpetuation of the supposed link between same sex attraction in women and sexual abuse is unfortunate and can lead many women to desire to keep their childhood sexual abuse to themselves. In the statement above we can clearly see why Karen does not want to disclose this experience from her past. If the stigma associated with queer identity is not already distressing for Karen, certainly the stigma attached to an experience of abuse would add to her own sense of stigma. According to Robohm et. al., "both a minority sexual identity and sexual abuse involve sexual feelings which can feel confusing and can carry a sense of societal stigma or shame" (2003). That Karen might want to avoid this stigma is understandable.

Carrie's painful childhood experiences of gender regulation resulted in a great deal of self loathing for her. As she outlines in the excerpt of her narrative below, the trauma that is

significant from her childhood came from adult regulation of her 'feminity' as opposed to an understanding of abuse that might be more typical:

> I was so mixed up at that time that is never entered my mind... I hated being a girl at that time because I wasn't allowed to play sports the way I wanted to. At school, back then it was ok, I was the only girl for the most part that was able to play with the boy, like scrub and stuff because I was better than most of them. But at school the teacher said that either all the girls play or Carrie doesn't play and that's the way it was dealt with at that time instead of an individual hey, kids are kids, let them play... so that kind of discrimination started very early for me... the other thing growing up was, girls wore dresses and boys wore pants, and I hated that. I actually think, grade 5 I had to wear a dress but I always managed to, not consciously, but if I looked at old school pictures and stuff I always had beat up dirty running shoes on. No laces. But I had the proverbial dress [laughs]... Now you look at the kids, I look at my own kids and it's like, pull up your pants, you look like a slob. Put something decent on. But that's a generational thing. But because girls were girls they had to wear dresses and you know, look pretty and be dainty and not get dirty at recess. That, I always balked at. I had a real problem with that.

This suppression of Carrie's identity formation as a child can be read here as having impacted her own perception of herself and what is and isn't appropriate for a woman. This again speaks to the school system and the upholding of particular types of behaviour in order to meet the status quo (Epstein, et. al., 2001). The negative associations between abuse and sexuality continue to impact queer women, as this section illustrates. The participants' perceptions of being judged for their past abuse is an unfortunate by product of the pathologization of women's mental health and of queer existence (Balsam, 2003).

Mistrust - Religion and It's Impact on Perception:

Religion and the influence is has over many women in the queer community is particularly powerful. Not only does religion and spirituality play into overall wellness, but it influences all aspects of our lives, even if we are not religious. Many agencies providing mental health services in Ottawa have affiliations with faith groups, however,

many of the negative attitudes people hold about queer sexuality are based in religious teachings. Whether it be mainstream society harbouring negative attitudes about queer sexuality based on religious teachings, or queer individuals themselves internalizing the teachings they may have learned, the outcomes are damaging. All but one of the participants in this study indicated that they had some sort of Christian religious affiliation at some point during their lifetime. Morrow likens the experiences of many queer women around Judeo-Christian faiths as being highly traumatic and invalidating, leading to very serious internal conflicts (2003). For many queer women, the faith that they have been raised in, with contributing factors of culture, race, community among other things, has a powerful impact on the coming-out process. For many woman who came from practicing Christian households, their sexuality represents something very oppositional to what the church dictates is true and proper (Morrow, 2003). Additional complications of sexism and anti-psychiatry that creep into Christianity may further complicate many women's experiences (Morrow, 2003).

Within the North American context, religion has played a powerful role in condemning sexual minorities and vilifying the nature of their relationships. As well, due to the normalizing of Christian values early in the establishment of Canada's political structures and processes, our social systems have been constructed so as to systematically disadvantage relationships that do not reflect the Christian ideal. Due to the sexism ingrained in many Christian religions, same sex relationships between females are often the ultimate taboo (Morrow, 2003). As the church was established under a patriarchal model, a woman who deviates from her genetically functional role as mother is seen as of

no use whatsoever. Heterosexism within mainstream Christianity continues to be an issue. According to Morrow, "Even though the moral development of gays and lesbian has been found to be equivalent to, or in some cases, beyond that of comparable heterosexual samples, mainstream religion continues to define gays and lesbians as immoral and spiritually corrupt" (2003, pp.111).

When considering the intersection of religion and illness, the history is quite complex. For Carrie, when her physical illness began to become more serious, she turned to religion for healing. This religion also professed that it could cure her of her homosexuality as well. It was with a great sense of hope and belief that Carrie immersed herself in this faith community, only to be rejected not only for her sexuality, but also because of her problems with mental illness. Her acceptance was not unconditional and this experience left her incredibly disillusioned with this faith community and with a group of individuals who she had come to care about:

> also in my search of trying to [ ] be normal or whatever I got very involved [...] with a religious group that really seriously damaged me... ummm... it was all around the time when I got involved with this group and my marriage and I knew that I was gay. this religious group I got involved with, they could change me, they could change my medical situation and you know, I wanted to believe, I wanted to be involved, I wanted to be accepted into this group. But as soon as I started enforcing what my beliefs were and what my being was, that's when I started getting into trouble with this group and they started to [...] shun me and they felt that they could change me and they could make my diabetes go away and all kinds of crap and I know better now but during that time I was going through all of this with these people and trying to come to terms with my sexuality and my marriage and my children and everything, just, well... I attempted suicide. At that time and I ended up in the psych ward. And the people that I was involved with in this church came to me in the hospital, the leaders and, well, they said, oh they said I was going to hell because I had attempted to kill myself and that I was sexually deviant and ... although at that time I had never actually crossed the line, I had

> never [ ] become involved in any kind of lesbian relationship until after I left my husband and family and stuff but I just knew I was. It was a rough few years and I'm very lucky to be alive still.

The experience highlighted by Carrie is one that stood out from the other women's stories of religion, yet is not uncommon more broadly. For many queer individuals, fundamentalist religious groups offer the support and belief that they may need to overcome many of the difficult aspects of their lives, whether it be financial marginalization, addiction, illness or, in some cases, sexual orientation. However, the individual must be willing to abide by the expectations of the faith group in order to be 'cured', leaving them unsupported, as we see in Carrie's case, if they stray too far off the path to recover (Hunter & Hickerson, 2003). In Carrie's case, the withdrawal of the support of the church and their refusal to embrace her after her suicide attempt, left a lasting and damning impression of religious interventions for recovery from illness.

For many of the participants, having a previous negative experience or association with organized religion deterred them from seeking help from agencies that were aligned with faith groups. The experiences were not uniform in that some of the women were raised Catholic, while the majority were not, but retained negative ideas of what the service might be like and how they would be received. In some cases, the women could not identify why they had negative perceptions of these services, but they were certainly impacted by the power that these faith groups wield. In particular, agencies associated with the Catholic faith were seen as unfriendly toward the queer community. Given the reality of the persecution of many GLBTTQ individuals in the name of God, this is not without some historical basis (Hunter & Hickerson, 2003).

Given the historical stance of the Catholic church on homosexuality, many queer-identified individuals would share a well-founded concern about Catholic affiliated services. Within the context of this project, four of the six participants cited concerns about heterosexist and homophobic bias from Catholic operated services. In the statement below, Wendy indicates how the religious affiliation of an agency may deter her:

> I don't know if you would call them mental health services, but support services? That label themselves, how they label themselves can be an issue for me in that... I worry upfront what their biases may be ... something like Catholic Family Services. That to me, that doesn't speak to me as a lesbian. Especially a single lesbian with no children.

Wendy's perception that Catholic Family services, an Ottawa based support service, seems to be reasonable given the Catholic's church's resistant stance on 'homosexuality' and same sex unions. Shelly expresses a similar skepticism in the statement below:

> I never called Catholic Family Services because I thought that I wanted to have nothing to do with Catholics. I don't know about Jewish family services and I don't care, but Catholic, I want nothing to do with them. No offense to Catholics. Or offense! Take offense!

Shelly's statement reveals slightly more hostility toward the Catholic church than Wendy's hesitance based on her historical understanding of Catholicism. However, why should Wendy or Shelly believe that a service like this would have anything to offer them if the faith group's view on queer existence is so condemning? The following statement from Julia may cause some people to rethink their ideas about a service like Catholic Family Services. Her statement indicates how it is possible that the name of this service could deter some from considering it an appropriate service to meet their needs:

> Catholic Family Services. Are you familiar with them?...Don't worry, there is nothing Catholic about it. You don't have to be Catholic, they will never ask you your religion. And there's nothing really. I guess that's where they receive their funding from, but that's their name...but unless you've been, you don't know.

The relevance of this common negative opinion of the Catholic church by the queer community is that this perception could conceivably close the door on a viable resource for queer people. Religious agencies like Catholic Family Services do, in fact, have queer positive mandates and counsellors who incorporate affirmative approaches. However, the association between religious doctrine and the influence on morality and sexuality continues to be a powerful deterrent for many, leading to further limited access points for mental health support (Hunter & Hickerson, 2003).

Wendy's mistrust of the influence of religion is partly rooted in her lived experience, her own religious upbringing, and her memories of the treatment of sexual minorities in the past. Her statement also offers an interesting connection to politics, underscoring the reality that although church and state are meant to be separate entities, there is a complex interplay between the two:

> They don't have to publish their personal biases. And they are people so they do have them. I know that...it's supposed to be the badge of professionalism to not let them interfere. But to some extent or another. As far as I'm concerned, they have to. An analogy being the current political goings on about the catholic bishops in Canada saying that Paul Martin isn't a good catholic because he allowed same sex marriage. So... what then about some psychiatrist who wants to be a good catholic. Or whatever... I don't mean to pick on Catholics. Well, I'm Anglican and my church is superficially accepting yet I certainly wouldn't call the Anglican church supportive. So whatever the religious description. There's all kinds of them that are not... accepting. So what, I guess that's my point. Is that these people carry those personal teachings and learning into their side of the support service. Whereas the consumer doesn't know what they are. And in the case of being queer then there's a certain level of apprehension, at least in my case. And that's furthered I think by my age. As a generational thing. Based on my experience again. I remember very clearly, queers being thrown off the bridges here in Ottawa, our fair capital. So ah, to me, ah, labelling, self-labelling as queer isn't just political it's a safety thing. Its something I choose to do anyway... but I worry about what that, how that may negatively affect the service I receive

Wendy clearly articulates what many of the other participants also alluded to. It is understandable to question how powerful the influences of faith or morality are on professionals as these perspectives will influence professional interactions (Pearson, 2003). For queer individuals who have experienced the regulation of their sexuality through religion, such as Carrie, Karen and Wendy, it is even more understandable that they be apprehensive, given the impacts of homophobia propagated by religious groups (Morrow, 2003). It is indeed an interesting observation made by Wendy that within a society so often referred to as having 'lost their faith' that a major political figure with strong religious faith should be targeted for his personal beliefs around human rights for GLBTTQ individuals. This reference indicates the social controlling power that the church still holds over Canadians and the deplorable scare tactics that some members of faith communities resort to in order to uphold their vision of appropriateness.

Conclusion:

The focus of this chapter has been on experiences within the lives of the participants that might have affected their trust levels when interacting with the mental health and medical systems. These experiences, as mentioned in the previous paragraphs, can be influenced by family relationships, societal factors, religious communities, experiences in treatment or within therapeutic relationships. From the perspectives of the participants, these negative experiences with people, agencies or institutions that we are taught to trust have left a lasting impact. As we grow up many of us gain a sense of where we can expect safety, respect and unconditional support. Particularly in the case of religion, the support is not unconditional for queer individuals, sending a strong message of otherness that may have been reinforced from childhood given the role that religion has played in their life.

Medical professionals, health care professionals, educators and religious leaders are thought to be professional, trustworthy and compassionate. However, in all of these professional areas, women, and particularly queer women, have historically had experiences that left them feeling they had not received unconditional trust. The violation of this trust has created a lasting sense of skepticism within the queer community that cannot be undone without concerted efforts to educate professionals about how their behaviour impacts queer individuals and how to make institutional changes. In chapter 4 I will address the notion of belonging. The negative experiences addressed in this chapter speak to a need for queer individuals to find a sense of belonging and community in the face of enduring societal disapproval. In Chapter 4 I will address how the participants define belonging, and will focus on suggestions for improvement to the mental health system in Ottawa that will facilitate queer inclusion.

Chapter 4 – Belonging: Finding Credibility, Community and Services

Introduction:

The notion of belonging in the queer community can have a profound impact on the mental health and well-being of queer women. A sense of belonging is often what grounds us, making us feel safe and as though our lives have meaning (Valentine & Skelton, 2003). When we are experiencing difficulties, we are comforted by knowing we are supported by likeminded others, that there are services out there to meet our needs, that our communities are safe and secure for us. Many marginalized people struggle with this sense of belonging when their reality does not seem to be valued by mainstream groups. The social determinants of health perspective that will be explored more deeply within this chapter can assist in correcting some of the historical wrongs that have affected this community by looking at the structural issues that may be influencing their access to resources. This chapter will explore many of the issues that factor into the women's overall wellness, providing professionals with insight into what constitutes belonging for some women in Ottawa's queer community. Having this insight may assist professionals in making more appropriate referrals, in developing support networks for their patients, and understanding the complexity of the lives of queer women.

Progress in the acceptance of queer individuals is certainly evident. Within Canadian society we have seen agencies embrace queer positive practice, we have seen openly queer public figures and politicians and we now have legalized same sex marriage. On the surface, queer sexuality is now generally accepted, with overt homophobia being frowned upon. However, there is need for consideration of the layers of acceptance of

queer sexuality, the public face and the private face of social acceptability. In the face of enduring heterosexism, a sense of community and support is often what assists many women in moving forward and coming to terms with their sexuality in the face of widespread negative images (Rosario, et. el., 2004). This feeling of support and community links directly to mental health resiliency and wellness. The strength of a community such as queer women feeds into larger issues of addressing social determinants of health and advocating for change in institutional systems. Although uniformity within community should never be the ultimate goal, cohesion and visibility can lead to the attainment of services and the recognition of particular needs for marginalized groups (Valentine & Skelton, 2003).

Within this chapter I will explore several sub-themes that can be linked to the overall feelings of belonging to community. The first sub-theme is that of housing, a basic and fundamental element of an individual's feeling of safety and wellbeing. Tied to geographic community is the notion of social community. In this chapter I will also explore how these women have experienced the queer women's community in Ottawa, the role it has played in their lives and the impact it has had on their overall wellness. An additional sub-theme I will explore is the availability of services for the queer women's community and how the perception of an adequate or inadequate network of queer services impacts the women's feelings of community and wellness. In the final sub-theme I will address credibility and how the women have been able to secure a sense of credibility within a system of service providers that has historically pathologized queer women and often failed to hear their needs. The chapter will be tied together by standout

positive experiences that the women have had in the face of many negative encounters, as well as the participants' suggestions for reform to Ottawa's mental health system.

Social Determinants of Health:

The concept of social exclusion and the social determinants of health are interdependent and provide us with insight into the particular social and political barriers that prevent many individuals from fully participating in society or feeling included in it. Social determinants of health are an integral part of structural approaches to social work and therefore are linked solidly to the theoretical framework of this study. A social determinants of health analysis offers a more precise manner of locating the barriers that may be facing the queer community by looking at various life domain areas such as housing, health, and education. The concept of social inclusion recognizes that inclusive communities are the building blocks to community wellness and that feelings of inclusion can have a profound impact on improved social determinant of health factors. When communities are able to achieve higher levels of inclusion, many of the barriers to optimal health and wellness can be broken down. The social determinants of health focus with specific reference to GLBTTQ populations can be defined as:

> a perspective that moves beyond an illness/disease-based focus to a more holistic view that defines health in psychological, mental, emotional, spiritual, physical, environmental and cultural means with documented concrete determinants of health including conditions that affirm choices of coming out. To this end the diverse GLBT communities must be recognized by health policy as distinct health populations with specific health and wellness issues and needs. (http://www.glhs.ca/docs/resolutions.pdf, 2001)

Of primary importance in any assessment of need for a particular population is determining the indicators that may additionally contribute to poor health amongst the target population. According to the Ottawa-Carleton GLBT Wellness Project's 'Wellness

Guide' (2001), social factors related to illness require further study in order to properly address the needs of the GLBT population. These social factors or 'health indicators' vary from region to region and from one community to another. There are significant disparities in mental health, health care and social service accessing within Ottawa's GLBTTQ community. The bisexual community is often under-served within healthcare environments, usually due to a lack of awareness of the particular issues they may face. A study completed in 2001 found that bisexual individuals in Ottawa reported poorer health overall than their lesbian counterparts (Ottawa-Carleton GLBT Wellness Project, 2001). These findings suggest a deficit in overall health and wellness promotion to the queer community and a lack of consideration of queer perspectives on sexuality and fluidity (Wilchins, 2004). Diamant et al. also found that "lesbian and bisexual women were more likely to have poor health behaviors and worse access to health care" (2000, p. 1043). In particular, lesbian and bisexual women are at risk for more severe health indicators such as poor housing, underemployment and poverty due to the typically lower wages and income instability facing women (The Medical Foundation, 1997).

The sub-themes within this chapter will be linked to the social determinant of health perspective, addressing structural barriers that are preventing queer women from securing these necessities. When these necessities are not secured, queer women are more vulnerable to mental health distress, increasing the need for access and availability of services. In addition, I will explore participant's resilience in the face of a society that has historically denied many queer women access to the basic social determinants of health supports

Housing – The Foundation of Community:

The housing theme speaks to social exclusion in many ways. For many of us, defining ourselves by where we live, who we live with, or what kind of dwelling we live in is not uncommon. Many queer identified individuals gravitate toward larger urban centres, not unlike the participants of this study who discovered more support and more reinforcement of their sexual identity within the urban Ottawa context (Valentine & Skelton, 2003). Karen speaks to the reality of her experience growing up in a suburban area where she did not have ready access to support services for her emerging queer identity. Here she recounts the validation she felt when she had more access to the service located in downtown Ottawa:

> And I had all these [services], the youth services bureau and pink triangle services and the [campus GLBT centre] and I had no idea these things existed because I had been in a little Catholic high school in the corner of [suburban Ottawa] and they were like, you are in a box and don't you dare move. You know?

Urban centres are able to offer more to queer identified individuals, while rural or suburban services may be biased toward mainstream populations. In the queer women's community, the struggle for identity is complex and layered, therefore locating yourself within an area where you can receive appropriate support is often essential. The ability to obtain safe and affordable housing in an area that one might desire can be hampered by sexual identity (Skelton & Valentine, 2003). Some of the women indicate a feeling of helplessness, a resignation to their current living situation that has been complicated by their sexual identity.

The need for safe housing for queer individuals was identified as being so important in Ottawa that a queer positive housing registry was created by Housing Help, a non-profit housing assistance agency. In a recent article in Ottawa's queer community paper, skyrocketing rental costs are cited as the primary reason for many queer individuals having difficulty accessing housing in Ottawa, in addition to a fear of discrimination if they choose to live with a partner or a queer identified friend. As the author also points out, "Moving out of downtown makes Ottawa's queer services and community more difficult to access. Equally important, it makes it more difficult for people to find friends in the gay community, to build a sense of community and belonging." (Sharpe, 2005). This concern for the disconnection from community services was felt by a number of the participants, as will be explored throughout this chapter.

Housing is extremely important to the well-being of people within any community. Many studies have identified that stable housing for those living with mental illness is a particularly important element of recovery and engagement in treatment (Moxham & Pegg, 2000). The double bind of women who are queer and experiencing mental health distress is clear when we consider their vulnerability to housing instability. Within a marginalized group, finances can be a concern, therefore finding safe and affordable housing can be challenging. For queer women, safety in the face of homophobia becomes an additional issue therefore this must also be considered when seeking housing. There are several studies that indicate that a sense of safety can be found in geographic queer communities where comfort comes from being surrounded by those who share a common link of sexual difference (Harper & Schneider, 2003). According to Harper & Schneider:

> Since the beginning of the twentieth century gay and lesbian communities, particularly in large urban areas, not only have provided a safe haven for many LGBT people, but also have served as a source for needed LGBT resources, a focal point for socializing, and more recently, the heart of activism that has resulted in many gains in the area of human rights for LGBT people (2003, pp. 243).

The different experiences of the participants speak to their feeling of being limited in their housing options due to their sexual orientation or at least, how others might feel about their sexuality. Of the 6 participants, 5 spoke about the importance of housing in their lives. The availability of safe and affordable housing is a major issue for many individuals within marginalized communities. The queer community in particular faces a multitude of barriers to secure housing depending on individual circumstance, however the threat of discrimination is very real (de Castell & Jensen, 2002). There is a perception that issues of discrimination are not as serious or as pervasive as they have been in the past. In reality, the discrimination has simply become more covert. A housing project for queer youth cites the following statement from Bennet:

> A small "1" liberal tolerance of sexual diversity has led to a belief even among many sympathetic to the case of "sexual minority" rights, that the problems have been in large part legislated away. However, civil rights only protect those with access to resources necessary to buy or rent in neighbourhoods of their choosing, and with the education and cultural capital necessary to secure employment in areas that adhere to basic human rights codes. (de Castell & Jensen, 2002)

Therefore, many marginalized queer women may feel incapable of accessing housing resources or advocacy. In particular, queer youth, queer women with mental health concerns, or queer women who are multiply oppressed are further disadvantaged by the non-existence of advocacy services and their invisibility within many mainstream agencies.

According to a 2004 Canadian Rainbow Health Coalition publication, "Research indicates that rates of alcohol and illicit drug abuse, depression, low self-esteem, unemployment, physical violence, homelessness and HIV/AIDS are all issues that occur at significantly higher rates in the GLBT community"(pp. 2). Even more interesting is that many of these same social problems that face the queer community at higher rates also face mental health service users. Queer women with mental health concerns may again be facing a double bind in this regard.

The Canadian Mental Health Association identifies housing as being amongst the most important factors for mental health, if not the most important (CMHA, 2004). For several of the women in this study housing was identified as an issue that contributed to both isolation and financial distress. Although the stigma of same sex relationships seems to have dissipated over the years, there was still an apprehension amongst at least three of the participants that they could be discriminated against. In addition, there appears to be a financial strain facing many of the women in this study, for various reasons that may or may not be linked to their sexual orientation. Some studies indicate that queer women are often at a financial disadvantage in relation to their queer male counterparts. This inequality is clearly linked to sexism and the wage inequality that continues to impact all women, regardless of sexual orientation (Dunne, 1997).

In exploring the narratives of the participants in regard to housing, Carrie's situation is unique yet inextricably linked to the stories of the other women. Due to her physical health concerns Carrie lives in a supported living complex in suburban Ottawa. She expressed her concern that someone in the home will have a problem with her sexuality.

Because many of the residents are from a generation that is unaccepting of queer identity, this is a legitimate worry. However, Carrie's story is an inspiring one in that she openly identified to the staff of this home prior to moving into the facility, feeling that the management should know about her sexual orientation:

> Coming into a nursing home put some added stress on me, because I had to essentially go back into the closet. Which I struggle with. People here, some people here know I'm gay, but as a whole they don't know and that's purely because of the age difference. You know... most people were my age when I was born! So there's still a lot of... especially with the owners of the place here or the senior staff because I periodically got fed up and was going to tell everybody. They got a little antsy about that. Not a little, a lot. And they don't understand why I periodically get like that. Half the residents here think I'm a guy and the other half think I'm a girl. And I've had everything from well why don't you grow your hair longer or wear some pretty dresses to you know, I've have that extreme to the ultimate other extreme. ... I can't be who I want to be and be proud of who I am in this closed environment. But, I have some good days and some bad days just like that. ... You still have to be kind of careful about who you are and stuff. Like my parents were terrified, and my brother, of me coming in here and announcing who I am. They didn't want me to do that.

Although Carrie is not a senior, the fact that she is living in senior's housing is problematic in itself. Issues facing chronically ill and aging queer women are significant and often result in queer women being forced to closet their identity (Kucharska, 2004). These environments are not safe for queer women. The implication from Carrie's statement is not only that she had a concern for her own safety, but that her family recognized the potential risks for her as a queer women who had few other options than to enter into a seemingly straight and conservative climate. However, the outcome of her current living situation offers the contradictory opportunity to affirm her identity (by disclosure to management and staff) yet also the frustration of the necessity to be closeted around residents for her own safety. As it has taken her a lifetime to emerge from the oppressive presence of her own internalized homophobia, it is necessary to question what

kind of an effect this living environment might have on her emotional and psychological well being.

In the case of Julia, she indicates anecdotally what she has seen within the queer community over the years. She makes a clear connection to housing, relationship situations and mental health care. It is possible that many women stay in these types of dynamics out of fear, out of financial need or for countless other reasons (Dunne, 1997):

> You know, the fear, housing instability. ... you experience this, especially when there is a female couple and they break up. Where are they going to live? They tend to live in the same house forever until one has a new partner. And it's just like, oh my god! In our community I still feel like we have a lack of resources. I feel like we need more mental health workers and physical health workers that we can access.

Julia, may be referring to a phenomenon of secrecy that is not uncommon in the queer women's community. There is a perception that many queer women will live together long after their relationship has ended, whether due to the attachment that they share or fear of the financial burdens of living alone. However, the isolation that may come with queer women's relationships may also result in difficulty in accessing other housing options. As Skelton and Valentine (2003) allude, many queer women may isolate and cut themselves off from queer communities in order to obtain some sort of respite from the close connections of the community. They elaborate on these findings below:

> ...domestic isolation also brings its own risks as young women in particular can be vulnerable to becoming `trapped' in unhealthy relationships or situations of domestic violence. Often families or friends may be unaware of these closeted relationships because the women are fearful of coming out. As such, when things go wrong they have no one to turn to for help and support, being unable, for example, to reverse their housing transition in a way that is increasingly common for young people (Skelton & Valentine, 2003).

This problem is exacerbated by the fact that many service providers and institutions (such as hospitals, police etc.) often fail to recognize the reality of same sex partner abuse, allowing it to remain a relatively unseen reality for many queer women (de Castell & Jensen, 2002).

Sandy focuses on her fear of discrimination. However, the focus is not only on her concerns of discrimination if she were to identify as a lesbian, but also worries about being a single woman with a limited income. Here she explains how much easier it would be financially to live with a same sex partner. However, as she states, this is complicated by her fears:

> I live alone. Part of the reason I live alone is because I think, 'oh well when you move in with someone in a shared accommodation. It would have to be someone that would be open to the fact that I have a partner who is a woman'... and I think that's too much work. So I stop right there...and I don't wanna have to worry about that. You know, so even though I'm paying more in monthly expenses then I need to that could be for other things. And being more isolated...which is quite a bad thing... like so just because I don't want to go through the hassle. Yeah... if landlords didn't presume you were heterosexual and didn't discriminate, if you came out and identified... that would be excellent.

The perception or fear that a landlord may discriminate against her is enough to deter Sandy. The reality too is that because of legislation around housing equity, housing providers are simply more cunning in the ways they select their tenants (deCastell & Jensen, 2002). Housing is not the only factor here contributing to the tension Sandy describes, but it is reasonable to assume that if Sandy could share accommodation with a partner or another queer woman she would have more income which would also contribute to improved wellness.

Shelly's statement speaks to financial marginalization, a common link between all of the women involved in this study. The reality is that queer women are often vulnerable to the factors that lead to marginalization, such as abuse, substance use, under-employment, poverty and homelessness (CRHC, 2004). Financial and housing marginalization can both be seen as significant social determinant of health factors for queer women:

> you know, housing instability is an issue because I want to buy a house so bad I can taste it and I do have moments of like, great irritation when I look at people who have spouses and I'm like, if I had a spouse who had a job I could buy a house. It's not necessarily a queer issue but in some ways it is.

The reality for queer women is that many will never earn the kind of money that men typically make. If two women are in a relationship together, they may be strapped financially simply because they are both earning significantly less money than would be the case if they were in a heterosexual relationship (Dunne, 1997). In this way, sexism does directly impact queer women and leaves them at a disadvantage. This can also place tremendous psychological strain on both the individual and the relationship.

Karen displays a frustration about her financial marginalization as well, but her exasperation is more tangible in that she has felt the direct impact of homophobia by remaining in her existing living situation. However, as she states, she felt that she had no alternative but to remain in this living arrangement. Karen's reality in living with her unaccepting family is shared by many queer women. Many queer women have indicated that the negative experience of living in their parental home or within a closeted environment was actually deeply frustrating for them and contributed to their mental health distress (d'Augelli, 2003):

> I'm still living with my parents...but there was a while there where I felt like I really had to get out of there but I was like where would I go? You know, I don't have the money to move out but living at home is horrible and I'm discriminated against and judged at home but I can't leave, I don't have the money to leave. Where would I go? So that's the only thing that I've faced and fortunately my parents came around I think they're ok now, but that definitely came through my mind. I need to get out of here but I don't have the money to leave where would I go. So I ended up just staying even though it was probably really bad for me because you end up with a lot of baggage whenever [you say]... I'm going out with so and so to [the gay bar] and you just see your mother's eyes roll. You know, it's all the little things and I think those things add up when you're exposed to it every day. You really start to wear on you. And even though it's a subtle thing like "oh, you're going there" you're going with 'those' people. And so I think that leaving that environment would have been a lot better for me mentally because those little things wear on you over time. But I didn't have the money or anywhere to go to move out.

When one considers that Karen is neither out to her family physician or to counsellor's that she has had in the past, there is no existing professional outlet for her to utilize in order to vent her frustrations. As a bisexual identified woman, many studies suggest that Karen is less likely to be out in all aspects of her life, including to her care providers (Morris, et. al., 2001). The previously mentioned study also found that individuals who were more active in the lesbian/bisexual community were more likely to be out, however Karen has clearly stated that she has not found a home in this community (Morris, et. al., 2001). Had Karen had the social support and sense of community behind her, perhaps she could have felt comfortable enough to discuss her experience in the home with the professionals who have been in her life. Perhaps her feelings of belonging might have created some difference in terms of the level of distress she has felt while living in this challenging environment.

Finding Credibility in the Community:

The second sub-theme in this chapter is related to the sense of credibility that was perceived by the participants. Historically, those with mental health concerns have had the least credibility within the medical hierarchy (Staples, 1999). While many members of the mainstream community can feel confident in going to a professional, physician or service provider and have their concerns heard and validated, this is not necessarily the norm for a queer women, particularly one living with a mental health concern (Kitzinger & Perkins, 1993). There is a common theme of credibility issues through all of these women's stories. Credibility speaks to sense of belonging that these women feel they have in the mental health system. Without this sense of being believed or valued, it may be difficult for these women to negotiate the system with any sort of confidence and to feel as though they have a claim to these services. For many of these women it took years to attain the sense that their lives and their relationships were credible and that they were entitled to equitable services. (Jensen, 1999).

Sandy's experience of lacking credibility is reflected in several aspects of her narrative. From her experiences with heterosexist staff in the workplace to her experiences with her counselor. A profound sense of not being validated can be found in Sandy's explanation of her experiences as someone living with a mental health diagnosis as well as having a physical illness.

> Oh yeah, yeah. It's really awful. And you can tell the moment [the judgment] usually happens, in the ER the most. You can tell the moment when they've pulled your file and see "Mental Health" [...]. They'd actually believe that anything physical you are talking about is in your head... So yeah it's really bad [ ] depending on the doctor. Not all are like that, but some of them.

Within Sandy's experience may also lay the influences of a heterosexist medical system and a mental health system with an inherent bias not only toward women, but queer women in particular. Encompassed in the heterosexism of the medical system is the pathology of women and of those with mental health concerns (McNair, 2003; Staples, 1999). In Sandy's efforts to have her voice heard against the power of the medical establishment, she has faced many barriers as a result of her life circumstance as a person with a psychiatric diagnosis. Here she tells of her attempts to complain following an incident where she was nearly discharged from the ER despite being in profound psychological distress:

> I went to the head of nursing and spoke to her and I just felt a little bit of the run around and I was still recovering from having been quite sick and I think that's the hardest part...is that, it shakes you to your core to have been on a psych ward for 2 weeks and then to have to fight city hall for a few [...] I couldn't take it. So I spoke to a nurse, told her I thought it was very inappropriate what happened, and [...] so I really would have liked more action than that but I didn't have the energy to fight it. I mean that's the problem. When you're sick you need [advocates].

The experience relayed by Sandy is very powerful and not uncommon for many individuals with psychiatric diagnoses. That she should feel marginalized at her first point of contact with a hospital (in the ER) may be telling of the enduring hierarchy of illness within the medical model. Sandy discloses that she feels as though women with psychiatric illness have limited avenues for voicing their discontent. When discussing her wish to participate in this study, Sandy clarified her stance on the status of mental health and physical health service users.

> Well, I think I would have to say that I had hoped it would be kind of a forum to speak about that. To be fair, I have accessed mental health and physical health for most of my life. Since I was in my early 20s. I have a lot of experience with it and I often feel that the patient is quite powerless... Because really, sometimes you go to a doctor and sometimes

> you hear that other people didn't find them to be very helpful. So anyway, I thought maybe this would be a chance to contribute to that kind of feedback. I don't think there is a lot of places to go, especially with psychiatric side because...I could go on forever, but it's certainly a passion of mine... And I'm second generation mental illness. Particularly women with mental illness, I think it would be helpful to see something start to happen.

Sandy's experience calls into question the visibility of mental health distress within the queer community. Carrie felt a similar need to speak out about her experience. Carrie's experience of having been stripped of credibility has played out over the course of her life. Carrie reached out to people, hoping that someone would be able to assist her in coming to terms with her sexuality, yet that help was long in coming. She was poorly treated by both a social worker and a psychiatric professional before she found the services she needed. When she accessed the help she needed for her substance use issues she was told that her sexuality was inconsequential and not related to the addiction problem. Here Carrie explores her feeling around the experience with the psychiatrist:

> I went to a psychiatrist ... he was a psychiatrist that dealt with people who were changing their sexuality. Which was like, whoah, that wasn't why I was there. And also too, he was the type of psychiatrist who you lay on a couch and he sits behind you. Don't like that. And so I had some problems there and he generally laughed. He laughed at me once when I was talking about something that was extremely important to me and he laughed and right then and there I though 'I'm out of here" so I didn't go back to him.

As a mental health professional it is vital to validate the patient's experience and to maintain an open and honest communication, particularly with a lesbian or bisexual client (Levy, 1996). Carrie's experience of being repeatedly undermined by the several service providers she accessed had the effect of further entrenching her internalized homophobia, leading to many years of difficulty that included alcohol abuse and suicide attempts.

When we explore the notion of credibility, it is helpful to move beyond individual credibility to the questioning of the nature of queer relationships themselves. Several of the women in this study felt as though their relationships as queer women were invalidated by mainstream mental health practitioners. For these women, emphasis was on returning to their heterosexual unions, which is not uncommon within mainstream mental health care system that has normalized heterosexuality (Jensen, 1999). Sandy's reference in chapter 3 to her counsellor not giving much credence to her queer relationship is a powerful example of this (see page 118). In these instances, it may be that the counselors are being influenced by their own internalized bias toward queer individuals, thereby buying into the stereotypes about the nature of their relationships (Pearson, 1999). For Sandy, this incident clearly had an impact, leaving her frustrated with a counseling relationship that she has identified as being otherwise positive.

The quotes in this section speak to the ways in which queer women are often left to wonder if they are being mistreated due to judgment on the part of the counsellor or if their treatment is reflective of the general systemic tendency toward discrimination of non-mainstream groups. In the following excerpt from her narrative, Julia explores an intangible feeling of being dismissed by her mental health professional:

> If you don't know someone and [ ] this person is there because they are seeking help... why would [the counsellor] not treat me properly. And it was nothing that she said, it was her attitude. Oh, it was sort of what she said. She wasn't listening to me and whatever she was recommending didn't apply. So, but do I really say that that's what it was [heterosexism], I really can't think of any other reason why. She didn't know me.

These experiences of judgment or mistreatment may in turn influence the woman's willingness to seek out subsequent treatment, or to simply move on. In this situation,

although the counsellor was not overtly heterosexist, Julia sensed that she was not open to hearing what she had to say. If Julia had wanted to discuss issues of sexuality, certainly, the approach of this counsellor would have signalled to her that it was not a topic that would be well received. What Julia seems to be saying is that whether gay or straight, the therapeutic environment must be there in order to facilitate an air of trust and openness, which is the basis for any therapeutic environment (Levy, 1996). Julia continues to relay her experience:

> So I found myself needing help so I made an appointment with the new person and I found myself with this woman who absolutely hated me. And I felt that nothing she was saying that was of any benefit and it made me even feel worse to be there so I never went back there. And what would I attribute that to? I have no idea. It just was. I also had a psychiatrist. That has got to be the worst therapist I have ever seen ... he was somebody who was specializing in family relationships. My ex- husband and one of my sons was supposed to come. The morning of and they didn't make it. Of course, my ex-husband was called and he said "I'm not coming" and I said that was fine so when I arrived I told the psychiatrist that he was not coming so his main focus was "when is the rest of your family going to come" so I said probably never. But it doesn't mean that I don't need help. So I felt that because I was coming alone, that he was not interested, and after a few sessions I gave up.

Within this interaction there seems to be an implicit feeling on the part of the psychiatrist that if Julia is not actively working with her family to resolve the situation then any counselling or work on issues outside of this dynamic is not a valuable exercise. This implies a devaluing of Julia as an individual and an undermining of her perspectives on the marriage.

Wendy experienced a lack of credibility both in the workplace, through her experiences with sexist co-workers, and from mental health professionals whose support she sought following her workplace harassment incident. As indicated in the following statement,

this experience did impact her trust of mental health service providers and has affected her willingness to access services. For Wendy, the psychiatrist seemed to fault her and her reaction to the workplace incident instead of externalizing the issue:

> in [this psychological evaluation] somewhere there's something about me actually contributing to the work problem because I refused to compromise. I wish I could find the quote, ah! "any aspects of her personality that may have a contributory role in the lack of resolution of her work conflict or any other problems in her interpersonal problems could be helpful" ... oh it's somewhere else where it's said more blatantly. Where he actually says something about me refusing to compromise. And therefore that that had a contributory role. And I mean, in terms of sexual harassment? No way! No compromise! So again, how does that slant his whole [perception]...when it says right here that I potentially contributed to my own difficulty by refusing to compromise. And that's a personality thing. Well yeah. It's also a political thing.

In this instance there is a suggestion that Wendy was contributing to the harassment because she was not compromising, which is rather reminiscent of past instructions to women to be more submissive to men (Kitzinger & Perkins, 1993). Instead of focussing on the strengths inherent in her uncompromising nature, it was treated as a weakness by several of the professionals with whom she worked, implying that the harassment was not about the men in her workplace, but about a personality flaw in Wendy. This is a particularly powerful example of the pathologization of women and the patriarchal bias within the mental health system (Kitzinger & Perkins, 1993). In particular, Wendy's experience highlights the ways in which mental health professions continue to replicate oppressive relations.

The prevalence of stereotypes about queer women, exist covertly within mental health professions. Sandy has often felt as though mental health professionals have bought into stereotypes about the lesbian community. As a result, she has felt uncomfortable with the

assumptions and labels that they have placed upon her as a survivor of abuse. The belief that lesbian women had experienced some kind of trauma has been quite common amongst mental health professionals (Morris & Balsam, 2003). In Morris and Balsam's discussion of the large volume of research on lesbian and bisexual women and abuse histories, the authors state, "One of the potential reasons for the dearth of literature on LGB women and trauma is the widespread cultural myth that victimization may "cause a woman to become a lesbian". In particular, childhood sexual abuse is often assumed to be a "causal" factor in sexual identity development" (2003, pp. 69). The following excerpt from Sandy's narrative serves to reinforce the presence of this common professional assumption:

> I usually get the question do you think you are lesbian because of your abuse experiences. But I don't think that question is meant as an attack, and my answer is usually 'how could I know unless I grew up beside myself, having not been abused?'. You know, I just don't know how to answer that question.

The absurdity and bias of such a question is made visible when we invert it and ask heterosexual persons whether their abuse at the hands of a same sexed person is what led to their heterosexuality. Karen has had similar experiences around her bisexual identity and her history of sexual abuse. Although she states that this sexual abuse incident was isolated and not insurmountable for her, she worries about what her family and professionals will think if she discloses:

> I wasn't ... raped or anything. It was a very small incident and [ ] I say that because in my mind I think it could have been a lot worse. And there's a lot of kids who have been sexually [ ] tormented beyond belief and not that it was nothing but it was pretty much nothing compared to what it could have been. ... I don't tell my doctor about that and I don't tell my health care provider about that because then I knew that they would be like "Oh! Well you know you're a lesbian because a guy

> touched you when you were 7". There's the link right there. That's your problem. And I didn't want to be judged.

The fact that both of the women in this study who have had histories of sexual abuse feel as though this will factor into their credibility with professionals speaks to the stigmatized identities of queer women. They continue to be viewed as flawed and this alone necessitates some sort of externalized explanation (Kitzinger & Perkins, 1993).

Role Modelling and Contributions to Belonging:

An additional sub-theme that can be linked to community is that of role-modelling. Many of the women shared powerful stories about the lack of role models in their lives. Several of the women explained the impacts of not being able to relate to the stereotypical images of lesbian women as "butches" or bisexual women as "sluts" and having no positive role models to validate their experience. There is again a historical piece that comes into the role modelling discussion. The participants coming from an older generational experience have had significantly less positive role models to identify with in their coming out process. While Karen and Shelly come from a generation where queer women have been positioned in a more positive light, Julia, Sandy, Wendy and Carrie did not have those representations to validate their sense of self. Although queer existence would have been far from supported for the younger participants, heteronormativity was particularly reinforced for many of the older women by the lack of positive queer role models. Here Julia speaks to her lack of awareness of queer existence when she was younger:

> when you grow up in the society where there are no role models, how can you choose to be... an astronaut when you don't know that the moon exists? And that you can go to the moon? ... It all has to do with opportunities. So, if you don't have the opportunities, if you don't know something is possible, you can't be this something. And I find that that is still lacking, mind you for females it's not bad, I mean we have a lots of

> big name artists who are openly gay. More females then males but I think it's always more socially acceptable to be a lesbian ...

Interestingly, several of the older participants came out somewhat later in life (after the age of 25), after having been in relationships with men. It seems possible that the assumption of heterosexuality and the normalization of this lifestyle may have had a profound impact on these participants. The fact that at least 2 of the older participants married and had children despite internalized suspicions of their same sex attractions speaks to the power of societal influence on this older generation who had few openly queer women to look to as role models (see also Jensen, 1999).

The discussion of positive role models is important to reflect upon as many of the public images associated with queer culture continue to be stereotypical (Jensen, 1999). For several of the women, identifying with the stereotypical image of the "butch" lesbian was not an affirming experience, thereby increasing their own internalized doubts of their sexuality. The impact of this lack of representation is reinforced by research conducted on women who came out later in life (Jensen, 1999). Julia expresses her difficulty with coming out in later life, finding the lack of visible queer women that she could relate to daunting:

> well, I'm 46 years old. And the only images that I could think of were those very butchy looking females because at least you knew they were gay. And anybody else, you didn't know. So you sort of developed this only image that you have and that's not true. And at least it's good for the young women that they can be out like this. But again, it might be slightly negative [for people] who feel they may be... but they don't want to look like that.

The invisibility of more femme identified queer women has long been upheld by mainstream culture and media. Due to the misogyny and sexism facing queer women, the

common assumption in the past was that all lesbian women wanted to be men or have a more male persona (Wilchins, 2004; Kitzinger & Perkins, 1993). We now know that this is not the reality and that there are many representations of 'queer' yet this enduring misconception continues to alienate those who do not identify with the more common social representations of queer women (Jensen, 1999).

The discrimination towards more masculine identified women continues and is even seen within the queer community. Julia expresses her own perspective of masculine identified women and some of the social problems that are often associated with queer women:

> feeling discriminated against still happens, what are we doing about it? I think that women, especially homosexual women, there is a segment that lives quite [ ] below the poverty line, they have menial jobs... [ ] ... I was at a presentation on Tuesday and the custodian was a very masculine female. Well, I consider her very lucky that she has a job where she does and that it's acceptable that she look this way. But I think that if you are going to look that way you are marginalizing yourself.

There is a significant amount of judgment within Julia's statement. However, this sort of perspective about queer women is reinforced by mainstream society. Beneath the surface of what Julia speaks of here is that women can still be queer and be feminine and a valuation of gender normativity. Historically, the feminist perspective has been that woman can do what men can do while still retaining a feminine representation. Although this has been an enduring feminist perspective, it is problematic in that it reinforces binary gender expression, thereby further entrenching the notion of difference for queer women who may seek to defy those binaries (Wilchins, 2004). As Wilchins states, "if it's finally acceptable for women to have "masculine" jobs, wield "masculine" power and achieve in "masculine sports", it is still totally unacceptable for women to be masculine."

(2004, pp. 9). Therefore, we see how queer women are subject to disdain within their own community, creating further divisions amongst queer women and undermining the support and cohesiveness of queer communities.

Karen was the only participant who identified as bisexual. She indicated that she that she does not always use a label for herself unless she feels safe to do so. This is clearly linked to the negative perception of bisexual women and the common misconceptions about their lived experiences. For Karen, many of her negative experiences come from within the queer community. As Wilchins attests, even gay/lesbian/bisexual communities and organizations make it clear where their interest in the bisexual agenda comes by the placement of the word within their acronyms (2004). In short, this is primarily for "us", but we can also help "you":

> And then when it comes to lesbian women, I've faced a lot of judgment from the lesbian community in Ottawa ... I've learned not to tell lesbian women in Ottawa that I'm a bisexual until I know them really well because its " oh you're one of them, you're a confused straight girl". You're going to break my heart. You're just here to hook up with girls and get your jollies off and you don't know what it's like to be gay and you don't know what it's like to be judged. I just find that a lot of the lesbian community in Ottawa, I don't know if it's just the people I've met, but I personally have faced a lot of judgment from that community.

Karen's experience as the only bisexual women in the study is unique as she has indicated explicit experiences of judgment from both the straight and queer communities. There are few positive representations of bisexual women within popular culture. Karen's statement that she is often regarded as a "confused straight girl" is perhaps the most prevalent stereotype of bisexual women, effectively invalidating their existence (Dworkin, 2001). There is simply less understanding and social acceptance of bisexuality,

making it difficult to find positive representations or to want to openly identifying yourself.

Shelly also spoke to the experience of having few role models. Though she is one of the younger participants, the continued subversive existence of queer women left her without obvious role models:

> I caught on at the very end of high school but to me, it amazes me when I see this confidence in queer 17 year olds. And I think it's so much easier now. 10 years ago there hadn't been any Rosie O'Donnell, there hadn't been any Ellen. And that makes a big difference. Not only in other people's perception but in your own perception. Like when I figured out I was queer, it was like a light bulb went off. Oh that makes sense! And it was the best news I ever got and it explained everything. But prior to that I didn't have a role model. And its not like I had never heard of gayness, it's like there was just no model for it. It was like it never occurred to me until that point.

From this statement, it seems that if Shelly had had more positive and visible queer role models she might have been able to make sense of her ambiguous feelings sooner. This may have, in return, contributed to increased resiliency. As it stands, there is a growing number of visible role models for queer women, however, within the mainstream media, their sexuality is often subdued or de-emphasized, leaving only those who have access to alternative sources for media and sub culture information to benefits from strong queer role models (Jensen, 1999; Valentine & Skelton, 2003). Lesbian and bisexual women continue to be portrayed in the media in problematic ways, reinforcing negative stereotypes that can have a strong negative impact on their mental health. These negative images also reinforce stereotypes about different sub groups of queer women by members of the queer community, thereby fuelling the notion of difference between lesbian and bisexual women (Stone, 1996).

Finding Community – A Sense of Belonging:

A sense of isolation or lack of connection to individuals who have similar experiences or understandings of their existence has been identified as an issue within Ottawa's queer community (Pink Triangle Service, 2001). Although the results of this report speak to a small group, it does support similar research that has found that isolation is a powerful force in the lives of many GLBT individuals and a leading cause of mental distress. In the case of women, as there are less resources for queer females, there is a perception amongst some researchers that isolation and lack of resources may even be more significant for this population (Ryan, et. al., 2000). As a result, not only is a limited sense of community and support a potential factor for isolation, but efforts to remedy isolation via accessing services are hampered by the profound lack of them to begin with.

While some of the women in the study do not identify isolation as currently being a powerful force in their life at present, they all flag this issue as having been a serious influence on their life and consequently their health over the years. Existing research indicates that the issues facing older queer women who are experiencing isolation may look different than those facing younger queer women and may have different mental health implications (Pink Triangle Services, 2001). The older participants, particularly those who came out at a later age such as Julia and Carrie, indicated that finding other queer women and making social connections was particularly difficult and disheartening. Interestingly, it was both Carrie and Julia who spoke very powerfully about the lack of cohesion within the community and the existence of a type of social or political hierarchy within the queer women's community. While both women fully acknowledged the reality

of social hierarchies within all communities, they did indicate their frustration that it seemed that the community advanced the concerns of a small group of queer women as opposed to a more collective vision for queer women in Ottawa. These issues of social/class/identity stratification or the domination of particular groups within the queer women's community were documented in a study by Valentine & Skelton in 2003.

Within the small sample of women in this study we see several different experiences of isolation, with varying outcomes for the participants. Sandy, Julia and Wendy all indicated that they did not have a large network of lesbian or bisexual friends. Julia talks about her difficulties in finding a place for herself in the community. Carrie also shared this frustration, with both women actually highlighting their frustration with the dynamics of the queer community in Ottawa. For the younger two participants, both identified as being less political at certain points in their life and not being particularly engaged with that aspect of the queer community. While Karen spoke about wishing that there were more groups that were simply for socializing and not for discussing a political agenda, Shelly spoke of her growing awareness of the need for political engagement. The variety of perspectives in this small sample speaks to the diverse nature of any community, suggesting that research on the interests of the many sub-groups within the queer community need to be explored (Cooperman, et. al., 2003).

Both younger participants, Karen and Shelly, indicated a sense of isolation within their community. These two participants both live in suburban areas of the city and, until

recently, had not been connected to the more urban queer community. Here Karen speaks to the experience of attempting to find community when she was coming out:

> I think a couple of times in high school I thought about going to rainbow youth group. Like there was one at I think the [community centre] and I, I actually got to the front door one night and then I turned around and left because I thought what if somebody in [my community] is there and they recognize me and they tell everyone at my high school.

The unfortunate reality of Karen's experience growing up in a suburban area was that she felt as though seeking help would result in her being 'outed'. A similar sentiment is reflected in many of the responses found in the health care accessibility study completed in Ottawa (Pink Triangle Services, 2001). Due to the intimacy of small communities, this is a reasonable concern, leading back to the earlier discussion of the common tendency for queer individuals to move to more central urban locations in order to attain some level of anonymity (Valentine & Skelton, 2003).

Although Shelly did not make any express attempts to connect herself with the queer community previously, once she did make this contact she indicated a new sense of validation. In the statement below, Shelly speaks to her isolation from the queer community and the support that she ultimately received once she got connected to it:

> isolation, yeah sure, totally. It's umm, when you're facing issues, it's hard to get a community of support for any issues you might be facing or relationship issues you might be having. ... I've only really been part of the community for the past year and a bit. Like, I live in [suburban Ottawa] and I wasn't really making effort prior to that. and, the difference I can see in like, my life now is huge. Because I have access to that support ... there's plenty of discussion about issues of mental health and I think it's really good. ... I think there's less stigma in the queer community about you know, getting counselling and talking about depression and stuff than there is in other umm, you know, in other contexts.

The information that Shelly offers in this portion of the interview is revealing in that her perception of the queer community is as being open to people accessing mental health services. This affirms research that supports the fact that younger queer identified individuals are less likely to perceive stigma or negativity around their queer identity than older individuals (d'Augelli, 2003).

Finding community is something that many view to be integral to queer identity development. According to Valentine and Skelton, "Historically, the city has been regarded as a space of social and sexual liberation because the urban is perceived to offer anonymity and an escape from the claustrophobic kinship and community of small towns and villages" (2003, p. 849). For the women in this study, most were from the Ottawa area, however they grew up in suburbs where they felt isolated from the queer community. Both Shelly and Karen indicated that they have felt more connected to the queer community since getting involved in the Ottawa scene as opposed to involvement with the limited services in their respective suburban neighbourhoods. This sense of anonymity can also contribute to mental wellness, in part, through leaving behind the fear of being 'found out' and also through the support that can be found in the queer communities of urban centres.

Yet, isolation does not simply come from geographic location. As a married, closeted lesbian, Carrie felt tremendous pressure to maintain a 'straight' façade. This statement from Carrie reflects the isolation that she felt as a queer woman trying to pass in a straight community:

> I came out to my family ... in my early forties. My journey to coming out, probably has been all my life. I went through some pretty horrific times with attempting suicide and being hospitalized and, uh, living in the heterosexual world. ... I used alcohol an awful lot. Went through alcohol and drug rehab programs, [ ] and had to deal with, or try and deal with a lot of it. So there has been quite a history of problems. I also come from a family situation of serious depression. There's a lineage and ... and you know, being married and having 3 children and coming to terms with that ... it's been quite a history for me.

For both Carrie and Julia, their emergence as queer women who had previously been married left them in a disadvantaged location within the queer community. They were subject to judgment and devaluation of their existence, something that is not uncommon for queer women coming out later in life. Just as bisexual women are seen as menaces to lesbian women, lesbian women who have previously been married are viewed with a similar level of skepticism for not having experienced the same level of homophobia in their lifetime and essentially benefiting for 'straight' privilege (Jensen, 1999; Stone, 1996). If coming out is not difficult enough, being ostracized by the community who you seek acceptance from is demoralizing.

In recent years, many scholars have criticized traditional identity politics, instead opting for the notion of value sharing and the bringing together of individuals who embrace difference and flexibility (Dolance, 2005). Within this study, though some women relished the idea of finding like-minded women who they felt a connection to, others indicated their frustration with the dominant voices in the 'community' who seemed to represent their own personal views and not necessarily those of a collective group containing within it many diverse experiences and identities. Julia speaks to this concern:

> They're vocal. And, [...] they have been in the system, they know the system. They are connected, they know what's going on, they want their

> voices to be heard. And I find that they might be a small minority. I find that their presence may be intimidating for people who wish to speak but can't. because they feel [that they] don't know anything. [ ] I mean I don't know much, I haven't been out in a long time. But I find that in the women's community there is very little to bring us together as a community. I mean, we may meet on the hill or at the parade once a year. But you see people there who you've never seen before and you're never going to see again. And if you're like me and you're trying to come out and you don't know anyone who is gay... have fun!

As the quote from Julia attests, this division amongst the women can be daunting for a woman who is newly emerging as queer or who simply does not want to see the same oppression of mainstream society reproduced within the queer community. This common link between the women suggests that they are perhaps more embracing of the diversity within the personal definitions of queer, and that there is no longer room for the voices of few to represent the experiences of many within their community (Dolance, 2005). This division of perspectives with the promotion of only a few is not unusual and is in fact a re-creation of the dynamics that we see within larger society.

From a queer theory perspective, the politics of the queer women's community can be problematic in that this community too often wants to abide by the binary conceptualizations of sexuality that constrain them in the heterosexual world. (Robinson, 2001). This does not leave room for queer theory explorations of sexuality and identity therefore many women who do not fit easily into conventional conceptions of identity may find themselves marginalized even within the queer community. Additionally, due to the lack of representation of diversity of race, ethnicity and religion within the queer community, some women from these communities may find themselves to be marginalized within an already marginalized existence (Rosario, et. al., 2004). Women in this study highlighted such things as classism, elitism and outright bullying as things that

they could not tolerate about the local queer women's community. In the statement below, Carrie highlights her own perception of the community and her disdain for the direction that she feels the queer community has taken in Ottawa:

> Definitely I've noticed [ ] real, and I hate to say it, but it's typical of any group you're involved with, but there's definitely a social hierarchy within the community. That you know, you are part of this group or you're totally excluded from this group. But that's the same within any... you know...I've definitely run into it and I've seen it and I think it's absolutely... is abhorrent a word? Absolutely abhorrent. In any community I find the class differences, or the perceived classes difference is horrible. ... because, in the long run we're all the same, whatever community we're in, we all go to the bathroom.

Others spoke of feeling marginalized within the community, feeling unwelcome to participate due to their own stigmatized queer identity (i.e. bisexual, having been married, having children etc). Yet, some members had stand-out positive experiences, finding extremely meaningful connections with smaller groupings of women who shared a commonality with them.

Positive Encounters - Emerging from the Heteronormative Experience:

In drawing together the findings of this study that has primarily focussed on the struggles of queer women accessing mental health support, I felt it was important to touch on the many healthy relationships many of the participants have been able to establish with their care providers. These experiences speak to feeling supported and valued in the community as opposed to under-served or marginalized. Despite the negative experiences of many of the women in this study, there have also been many positive encounters with health care professionals who clearly incorporate affirmative practices in their work. All of the women in this study indicated that although initial experiences with the mental health system were negative, they eventually were able to find services and service

providers who met their needs. There is a particular resilience amongst this group of women that is not necessarily reflective of the experiences of the broader community of queer women. Again, as most of the women in this study come from the comparatively privileged perspective of white, middle class, Canadian-born, women who are reasonably well connected and supported.

However, this study does reflect the experiences of two women with chronic physical illness, one woman with a serious psychiatric diagnosis, and two women with substance use issues. Their experiences within the health system were further complicated by the pathologization of the complex challenges they were dealing with. Their paths to obtaining care that met their standards took many years and was fraught with many setbacks. Carrie experienced several very damaging encounters with mental health professionals before she got connected with services that worked for her. In Carrie's case, she struggled for many years as a result of the combined impacts of what she believes to be a family history of depression, her own substance use issues, along with her own internalized homophobia and serious health concerns in more recent years. However, she did eventually find the support that she needed:

> ...if I hadn't had help from [local addiction service] and Jean Tweed Centre in Toronto and having a gay counsellor I have no idea where I'd be, probably dead. But because I managed finally to find these two places and then through [local addiction service] they paired me up with an outreach worker...she and I spent a lot of time together and it was through [her] that I got introduced to [queer social group]. Between [local addiction service], the counsellor that I had, Jean Tweed Centre in Toronto and the gay counsellor that I had and the outreach worker who is gay... Through those 3 people I was finally able to find the community that I needed to find and start living my life.

Carrie now has access to a solid group of professional resources. However, her story is marked by negative experiences with agencies and individuals who were able to work with her health related issues and yet not able to comfortably negotiate her sexual identity. This experience characterizes what many of the other participants experienced, namely a mixture of positive and negative experiences.

For Sandy, her positive relationship with her general practitioner (who presently cares for her mental health concerns) has been evolving over the years. Here she discusses how her doctor has made referrals in the past and her sensitivity to Sandy's need for queer positive care.

> Oh no, there's been bad referrals. She's taken responsibility for it and tried to get me somebody that... you know who doesn't question me necessarily. If there's evidence that makes the doctor think they are homophobic...so because we have built up this long term relationship, I feel like there is doctor/patient trust there.

This disclosure from Sandy is particularly significant in that it offer hope of professionals evolving and eventually becoming more sensitive to the needs of a queer-identified client. It also supports the importance of openness and dialogue between patient and professional in order to make clear the need for education and professional competency in working with queer individuals.

Although Shelly has had some problematic experiences within the physical and mental health systems, she has more recently been able to find a counselling connection that works for her. Her counsellor employs inclusive language and offers what would appear to be a feminist analysis that very much resonates with Shelly and what she feels her needs to be.

> She's very open, she's very comfortable talking about [sexuality]. In fact, to some degree far more so than I am. And it's made me realize... how much [ ], self-censorship I do... I say 'person' all the time. I've never dated a boy ever but I still... say "I'm dating a person", you know? ... and talking to her and she's much more specific about things. She says... 'dating a woman', 'when you're with a woman'...and ... it has made me realize how much self censorship I do... So she's good.

The use of inclusive language can be especially powerful and validating for queer-identified clients (Pearson, 2003). For many queer individuals it shows a levelling of the playing field between the queer and straight communities, offering cues for safety within the therapeutic relationship. This ambiguous use of terms may be particularly useful for clients who struggle with their identity or who may not feel comfortable coming out within a counselling relationship.

Julia also had some positive experiences in accessing service, however, once her counsellor retired she had a difficult time finding a professional that she could relate to:

> I don't remember [how I found out about the service] really, but the original [counsellor] I saw was excellent. An older woman. Caring, you know you walked in there and you thought Oh my god someone is listening to me and, I don't know how I found them.

Julia's initial positive experience could have set precedence in terms of her expectations of a counselling relationship. Once her first counselling relationship ended and she began seeking other counselor's to work with, there is a positive aspect to her story in that she has clear ideas of her needs and will not settle for something she views to be inadequate.

Wendy's experience is also meaningful given the invalidating experiences she has had with professionals while trying to move through the trauma of her workplace experiences:

> For a couple of years now, I have been seeing a psychological associate. ...And I would say, entirely queer supportive, and to the extent even with her, I have no clue how she would self-identify. Whereas so often is the case, with whomever, when they find out that I am queer they switch in to talking about their husband and family. Just to let you know.

The importance of validation in the face of the denial of her experience by her workplace, EAP program, insurance company and several mental health professionals is significant. The lack of neutrality that has existed within Wendy's interactions with the aforementioned professionals is profound and has been a major barrier to her processing of the negative workplace experience. The importance of this external and neutral mental health support seems to be meaningful to her.

Karen has had fewer positive experiences with mental health professionals. However, one positive trend that she has been impacted by is the changing social attitude, including the attitudes of her friends, in regard to mental health service accessing.

> I've never felt judgment from my friends for accessing mental health services. And I think that's a generational difference too. I think now it's like you accesses mental health care, good for you. You know I think there's a lot more openness about it with this generation. Like if you're in counselling its kind of the norm. I think it's the people who have never accessed mental health care who you have to worry about... I've never felt like I had to hide it from [my friends]. They know that I take Zoloft and [ ] nobody has ever said anything mean about it to me. I've never really felt discrimination from my friends about that so I feel like my friends are really open to it and... I could talk about it to them if I wanted to.

Although Karen has had limited success in terms of feeling comfortable disclosing her sexuality within the context of a professional/patient relationship, the disclosure above may offer some hope of moving through the perceived stigma. That she feel validated by her friends is a powerful reinforcement that may one day help her express her sexuality within a counselling dynamic.

Overall, experiences of heteronormativity have shaped these women's lives in countless ways. The impact of these experiences varies for all the women depending on where they are in terms of their reflection on their past experiences and their integration or recognition of heterosexism. As we moved through the common themes in this study the extent to which these experiences have impacted the women as sexual minorities and as women with mental health distress came into focus. The importance of these positive experiences is then amplified when we consider the influences of a lifetime of negative reinforcement of their queer identities. These glimpses into positive dynamics with professionals speak volumes about the queer woman's reality and expectations from a counselling relationship.

My Utopia - Participant Perspectives on Changing the System:

Having addressed the outstanding moments in counselling relationships for each woman, it is then relevant to locate how each woman feels their overall care could be improved. Within the content of the participant interviews there were many perspectives as to how Ottawa based mental health services could be positively modified for queer women. Although this feedback is not generalizable into formal recommendations, the information does provide some insight into potential issues that may be facing the community and possible suggestions for remedying these problems. Many of these perspectives would not only assist in making services more accessible to queer women, but would also assist in breaking down barriers for people with additional obstacles to obtaining meaningful service such as language, culture, and intellectual or physical disability. The recommendations in this section also attend to the sexism experienced by

many queer women accessing mental health services. As noted earlier, services for queer men are far more numerous than those for queer women due to, in part, the inequality between men and women and the public awareness of the issues facing the male community. These recommendations are not extensive and have been gleaned from the feedback offered by the six participants.

Need for a Queer Directory:

Several of the participants felt that an extensive directory of queer or queer positive mental health and medical professionals would be helpful. Although there are some publications of this type in Ottawa, they are now outdated and the producers are unlikely to have the resources to update them regularly. The suggested directory would be one in which professionals interested in limiting the barriers to access for the GLBT population could advertise to the queer community. This type of directory could also assist other professionals in making appropriate referrals for their queer or questioning clients. The following quote from Carrie speaks to the idea of directory of this kind:

> My Utopia would be if there were services out there and it was published you know, who these people are, what community they are from and I went to my professional and said ok, I would really benefit more by seeing... someone from the gay community to help me move along. If I could go to my healthcare professional and say that and get a proper referral to someone, that's my Utopia. Not what I had to experience when I went to my GP and she could not find or did not know of anybody other than this psychiatrist that ... damaged me a lot more than it helped me. ... To be able to go to my healthcare, whatever and say, ok, who are people that I can go and see [ ] that are within my own community and then from that point I can make the decision as to whether or not [ ] the professional and I can have a relationship that's going to be beneficial to me.

Although resources are scarce in terms of creating something of this nature, it may prove to be beneficial in terms of more efficient and timely mental health care as opposed to the

trial and error that many of the participants have experienced in accessing appropriate care. This could also be seen as something that would be more fiscally responsible for local health care systems. Through expedited referrals there may be an accompanying reduction in more serious forms of mental illness and the associated physical concerns that may face marginalized queer women.

More Queer-Identified Service Providers:

Several of the participants, indicated that there is a need for more mental health professionals who are queer identified. The method through which this might be achieved is unclear however many schools are beginning to actively recruit people from the queer community in order to best serve this population as a result of studies that indicate that queer people respond more positively to queer professionals (Pearson, 2003). A quote from Julia speaks to this perspective:

> I think that until we have mental health workers that are of the queer identification, then we can get proper help. If you have someone who is a heterosexual trying to counsel someone who might be gay... I mean, when you're late, early, I guess any time in your teenage years, your sexual identity has not yet been established and if we feel we are being marginalized because we should have desires for someone of our own sex or some weird sexual practices, who are we going to go and talk to? So, it leads to isolation. I'm not going to tell anyone how I feel. We're going to feel discriminated against if we speak so we don't ... all of these issues, when they're not addressed, they will fester.

In many different ways, the participants indicated that they would prefer queer counsellors or at least to work with women. In the previous chapter, Carrie spoke to finally getting the help she needed once she was connected with a queer addictions counsellor. Sandy also discussed feeling validated once she accessed a GLBT addictions group. Wendy also echoed the need for queer counsellors, while Karen indicated that she

would at least prefer to work with a female doctor who was of a younger generation. Shelly emphasized her own preference for a female doctor, however, she was limited to what she could access by seeking care via drop in clinics. This common theme amongst the women clearly indicates that patriarchal and heterosexist attitudes, or at least, perceptions of them were common within this sample, preventing all of the participants from being able to have a reasonable level of comfort with male professionals and/or those who are not queer identified.

Accompanying this idea of a queer directory is a concept of a more elaborate method of linking queer clients with appropriate services and referrals. This recommendation moves beyond a simple directory to a something similar to a database of referral system that other professionals can be linked to. The following quote from Wendy touches on this issue:

> If there was some sort of resume. You can't even apply for a freaking minimum wage job part-time at Wal-mart without providing a resume ... If you're seeking mental health services, you're maybe not in the best place for making judgments about, who they are seeing. And like I say, we walk in the door without almost any knowledge of this person in whose professional hands we're putting some pretty delicate areas of ourselves. I was thinking that maybe there could be almost kind of a resume kind of thing that a person could put out. You know like "this is my approach to:" especially if they are specializing in certain areas. You know, if they specialize in PTSD etc.

This would include information on the types of services that the professional provides so that the client can make an informed choice about the referral. This would also be a method of increasing the transparency for queer clients who can often feel as though the quality of their care and the types of professional they get is out of their control due to unpublished biases.

Need for Queer Positive Training for Professionals:

Many of the participants felt as though sensitivity training within the workplace would have helped them feel more supported in those environments. Particularly within social service workplaces, it would assist staff in knowing how to appropriately serve queer clientele, in addition to becoming more aware of the issues facing queer co-workers. A broader kind of sensitivity training may also assist staff in understanding the issues facing an individual living with mental health distress as well.

Queer positive training within agencies can shift an agency's culture. It is not the only way to make agencies more safe for queer identified individuals to work or access service, however, it is part of the solution. Additional methods of making service agencies more queer positive include incorporation of a clear statement in regard to incidents of homophobia and heterosexism, and an open dialogue between management and staff on the necessity of these types of policies.

More Visible Queer Positive Mandate for Religious Affiliated Agencies:

Several of the participants indicated that agencies affiliated with faith groups who provide mental health services must have a clear and visible queer positive statement. These participants indicated an inherent mistrust of services that have a religious aspect to them and that in many cases they were hesitant if not resistant to accessing services from these agencies. For a community that already has limited access to appropriate service, it is very important to emphasize queer positive stances. Wendy attests to this apprehension:

> What then about some psychiatrist who wants to be a good Catholic... I don't mean to pick on Catholics. Well, I'm Anglican and my church is

> superficially accepting yet I certainly wouldn't call the Anglican church supportive. So whatever the religious description. There's all kinds of them that are not accepting. My point is that these people carry those personal teachings and learning into their side of the support service. Whereas the consumer doesn't know what they are.

Again, an agency such as this may want to include a queer positive statement in their mandate and include clear policies in regard to homophobia in their policy and procedures. Throughout Wendy's narrative there is an implicit sense of mistrust for any professional agency, but particularly those associated with religious groups. In the excerpt below she problematizes the perceptions that many agencies may give off and our willingness to believe certain things about service providers based one what we feel their agency represents:

> I don't necessarily mean that [services are] as limited as my perception might be. ... I could access some support service through [local queer service agency] With the assumption that whatever the individual would be queer positive ... That might not be the case. And like, right then, maybe again, to go back to Catholic family services as an example, perhaps, I haven't tried it, but perhaps, I could speak with an individual there who really was quite inclusive?

As Wendy highlights, because of what people may believe an agency to represent based on religious affiliation, it may be eliminated from their pool of options for support.

Need for a Queer Community Health Centre:

For many years there has been discussion of a community health centre for the queer community in Ottawa. This issue has come more to the forefront in recent years in Ottawa. All of the participants in this study were supportive of the idea of a queer health centre or community centre in Ottawa. They felt that there were both positive and negative aspects to it, but that overall it would assist in identifying and specifically

targeting some of the more pressing issues facing the community and queer women in particular. The following quote from Shelly speaks to the queer health centre idea:

> I kind of think that it would be very good because I think that there is a certain, you know, having called up all these [counselling services] and told them all this was easy for me, but if you didn't know how to do that would it be easy to look in the phone book and look in the yellow pages for the queer community health centre? ... I think that having something specifically geared toward the queer community would make it easier for people who want to deal with it and don't know what to do.

Concerns about a queer targeted community health centre further marginalizing the queer community were balanced by an additional suggestion that other community health and resource centres continue to have integrated services for the queer community as well.

Outreach to Queer or Questioning Youth in the Education System:

Several of the participants spoke about their experiences in the education system and how isolated they felt. They indicated that perhaps if queer positive agencies were able to come into schools and normalize these feelings for youth then it may be one way of easy queer youth through the coming out process. Karen offers her experience as an example:

> Outreach is really important. ... and so you deal with that as you go and you kind of feel like you're on this mission and you're going solo and there is nobody else behind you and I think that having [queer positive] services reach out to kids, it better prepares them for what its going to be like as a queer adult. And I think at times it's a hard road because I didn't have those kinds of services and I've kind of had to figure out those things on my own.

Karen's experience in high school is particularly powerful, however several of the other participants experienced a dismissal of their questioning during their high school years. Agencies such as the Youth Service Bureau in Ottawa seek to normalize queer sexuality in junior high and high school contexts, and their services may need to be incorporated more permanently into the educational system.

Use of Inclusive Language by Care Providers and Agencies:

Many of the participants spoke about the prevalence of presumed heterosexuality within the contexts of many of the services they access. Although most of the participants have accepted this as a fact of their invisible existence, they all indicated how validating it feels when this assumption is not made. In fact, inclusive language, whether within the therapeutic context or within intake processes, does much to set the tone of the interaction this client will have with the counselor and the agency. The following statement from Sandy indicates just one of the ways in which inclusive language is problematic for her:

> No, I really think, if someone says something like, "are you married with kids?" I'll think, you know you're forgetting a few options there. You know, you're putting them in a box. I think I would now, but I wouldn't have before this, I never even thought of it. But yeah, that kind of education is powerful. You know, married with child. Could be... now it could be married to a same sex... married with children isn't the question... but adding which sex, which gender.

Although agencies can work to use more inclusive language, this is also an issue of professional training. Health and mental health professionals should be talk to use inclusive language in all aspects of the care they provide. Not only does this improve the professional rapport, but it will assist in eliciting information that will help the professional to better serve the patient.

Conclusion:

This chapter draws together some of the common sub-themes that represented the women's feelings of belonging within society. Much of the content of these sub-themes addressed issues that members of mainstream society may take for granted or may dismiss as being unimportant. For the participants of this project, great importance was placed on the elements that they felt allowed them to feel secure within their existence in

larger society. Housing, credibility, community and services all speak to security and a sense of entitlement to wellness. All of the issues identified by the women are social determinant of health factors that, if left unaddressed, will disadvantage queer women as a community. Although this chapter addresses the concerns of a small group of women, the fact that the sub-themes were addressed by all participants (with some exceptions) is indicative of possible systemic barriers. With these issues outstanding in their lives, wellness does not come easily and must be sought out more proactively than would be expected of a group that was less marginalized.

Chapter 5: Conclusions on the Qualitative Experiences of Queer Women Accessing Mental Health Services in Ottawa:

Project Review:

The purpose of this qualitative research project was to enhance professional understanding of the experiences of lesbian and bisexual women within Ottawa's community mental health system. In this project, I explored how heterosexism and heteronormativity impact lesbian and bisexual women's interactions with the mental health system in Ottawa. In order to assess the impacts of heteronormativity on the mental health care seeking experiences of these women it was necessary to look at both the women's past experiences of heterosexism and experiences external to the mental health system. I felt that it was necessary to look into the past experiences of the participants in order to locate how these women may interpret heterosexism based on their historical encounters.

Throughout my conversations with the participants in the project, it was clear that, although the mental health system has adapted somewhat to the needs of queer identified women, there are still deficit areas in serving at least some queer women. These findings are supported by research that assists us in understanding the failure of professional training curriculums to address queer issues, the continuation of heterosexist service delivery models within agencies, an enduring societal homophobia and the difficulty on the part of professionals to eliminate heterosexist bias from their treatment approaches (Mule, 1999; Pearson, 2003; Blanch Consulting, 2003). It is also consistent with the substantial amount of research that indicates that queer women continue to feel marginalized and devalued on a societal and institutional level (Kitzinger & Perkins,

1993; Ryan, Brotman & Rowe, 2000; Duncan, et. al., 2000). These feelings of devaluation evolve from the historical treatment of queer women by the health professions, and their personal experiences and histories of oppression (Hunter & Hickerson, 2003; Kitzinger & Perkins, 1993).

The women involved in this study did articulate a link between their experiences of oppression and mental health distress. All of the participants indicated that they were impacted either directly or indirectly by homophobia and heterosexism and that these experiences provoked a range of feelings, from anger and injustice, to mistrust and skepticism. While the younger participants in the study expected to be treated equitably by society when accessing services, the older participants anticipated some level of heterosexism and had preexisting apprehension about the level of service they might receive from professionals. This generational difference seems to correspond with the shift of societal attitudes in regard to queer sexuality. Identifying past experiences and stressors was what I felt was necessary in order to draw connections as to how these experiences of oppression were reproduced within institutional settings. In this small group it did seem that, if women were disadvantaged in society in general, they would continue to experience this disadvantage within the mental health and complementary care systems.

Homophobic or heterosexist experiences external to the therapeutic dynamic were important to identify in order to determine the extent to which the women might have been impacted by negative messages about queer sexuality prior to accessing mental

health care. Many of these homo-negative experiences happened in the participant's youth, within their families, faith communities, or when attending school. Women also had negative experiences in the workplace, an area of one's life that should ideally be supportive and a source of pride. With these negative reinforcements in many areas of their lives, most of the participants experienced difficulty in their coming out process. For many of these women, these difficulties followed them throughout their lives, leading to social problems such as substance use, isolation and suicidality.

This study also touched on community (both geographic and social) and the importance of community in wellness, safety and cultivation of services for these queer individuals. It was clear in the interviews that a sense of community, and the security that comes with it, were linked to overall wellness and feelings of belonging within greater society. Many of the women felt that this sense of community or a network of supports allowed them to retain a relative amount of personal agency in their accessing of services and supports and control over their own mental wellness.

Although the research sample was small, I felt that a qualitative study would allow me to highlight the powerful individual experiences of queer women when accessing care. There have been many qualitative studies completed to identify the needs of queer women when accessing health or mental health services. However what I felt was missing were the unique voices and perspectives of Ottawa's queer women, as opposed to the impersonal feedback of numbers and statistics. Though quantitative research assists in pinpointing particular issues that need to be addressed, qualitative research initially

uncovers problem areas and possible issues deserving of further research. Within Ottawa, there have been some excellent reports including qualitative and quantitative methods identifying the needs of the queer community. Due to my interest in the enduring pathologization of queer women within the mental health system, I felt that it was important to narrow the focus further and hear the detailed stories of a small group of participants.

The original intention of this project was to isolate the experiences of heterosexism and homophobia that had impacted the women while accessing mental health services. As I moved through the interviews and the experiences of each woman, I realized that each participant's reaction to a negative experience in the mental health system was highly subjective and in many ways, dependent on what their history with homophobia and heterosexism. It was because of that realization that I began to locate other themes within the narratives that explored feelings of isolation, of being "lesser than", or being marginalized in a variety of different ways. It struck me that depending on how each woman identified, the reinforcement of queer identity she had encountered in her youth, the general supports she felt she had, her resiliency and many of the social issues that go along with queer identity and mental health distress might look different.

As a result, the chapters began to form themselves as an exploration of the women's journeys to coming out, and what positive and negative reinforcements there might have been. Queer sexuality holds a different status in today's society, having moved away from the overt discrimination that several of the participants encountered early in life. For the most part, queer individuals in Canada are afforded far more rights and equalities than

in any other nation. However, I would argue that there are two levels of discourse around queer sexuality. The more apparent discourse is one of tolerance and acceptance or even pop culture appeal. The other regulates queer sexuality through covert discrimination, where we see performances of inclusivity that fail to acknowledge the realities of queer existence. With this in mind, it made sense to me that many of the women would have received negative information about their sexuality over the course of their life, even before they may have been aware of their own same sex attractions. This in turn, I felt, would influence their mental health and their overall perceptions of themselves. As was evidenced by the data, many of the participants' adolescence were marked by confusion and the sense of being different in a society that does not regard difference kindly.

Then, moving into experiences within the mental health system, I wanted to explore the varying types of environments in which the women accessed care (which also spoke to their lived realities and the social issues they faced) including drop-in clinics, family physicians, family counsellors and addiction counselors. Here I sought to explore the diverse access points for care and the importance of queer positivity within each of these contexts. It also highlighted particularly stigmatized coexisting issues within the queer community, substance use and a history of abuse. This discussion was included in the chapter on accessing care because it spoke to the pathologized ways in which queer women may be perceived by professionals. In the final chapter, I felt it was important to look at the types of supports the women felt they had within the community. I felt that this was relevant in that it would influence the value of their existences and the feelings of efficacy and power they had in accessing care and supportive environments. This

chapter brought forth such themes as housing, social community, and role modeling. In this chapter I sought to emphasize the role that a sense of community plays in overall wellness. The chapter also highlighted exceptions to the negative experiences that the women had, and perspectives on how their interactions with the system might have been improved.

Originally I had hoped to determine how current service delivery models for mental health care providers in Ottawa were working. My intention was that this study would offer insight into ways that we can rethink these models and ensure equity and accessibility for queer women. However, there were several issues related to the design of the project that prevented me from accurately assessing how service models are working. In speaking solely with the participants, I was overlooking the agency perspective on queer issues and service delivery. The reality is that the experiences of the participants may have been one-time occurrences or could have been with staff who did not particularly ascribe to queer inclusive approaches. Although these experiences are highly relevant to the participants, they do not speak to the overall agency contexts therefore I abandoned this focus of analysis. A much more specific study accessing the feedback of service providers would have to be completed in order to get at this type of information. However, it is my hope that with some insight into the qualitative experiences of these women, agencies will use the information to assess how their service delivery may challenge or disadvantage queer-identified service users.

In addition, I had hoped to look at how the mental health system disadvantaged doubly oppressed queer women. However, due to the limited size of the sample and the

homogeneity of the sample, this was not possible. Moving beyond the parameters of sexual identity and incorporating intersections of race, ability, class, ethnicity among other differences, it would be reasonable to assume that the barriers to accessing appropriate service increase. The US Department of Health and Social Services recently identified that:

> Sexual minority women, especially those who have low income, live in rural areas, and/or have limited facility with English, may face structural or financial barriers similar to members of any underserved population (Rogers, et. al., 2003).

Additionally, the pressures faced by many queer women within cultural minority groups are different than what might be experienced by queer identified women who are part of society's white, middle class. In many minority communities in Canada, religious and cultural expectations lead to increased difficulties in coming out and in confronting internalized homophobia issues (Rosario, et. al., 2004). The expectations of marriage, motherhood and notions of upholding the family name weigh heavily on many women. There are limited lesbian and bisexual role models or representations in the media, however, there are even fewer representations of queer women from multiply oppressed contexts such as queer women of colour or queer women with physical disabilities. This lack of representation of queer women and in particular, multiply oppressed queer women serves to invalidate their existence and leads to a sense of isolation or otherness in many women (Rosario, et. al., 2004).

Overall, this study gave voice to the specific experiences of six dynamic women. Each woman chose to navigate the system differently, yet all had reached a place where they were having their needs met to the best of their ability. However, this does not disregard

the fact that there is still much the system needs to do to be able to identify the needs of queer women, to increase the amount of supports and resources available to them and to decrease the amount of judgment and invisibility that they still face within health and mental health care settings. The process of getting to that place of stability was long for all of these women and filled with frustrations, trauma, and disappointment. Under the guise of queer inclusive policies, many professionals may think that they are doing their best to assist this population. However, as these stories may indicate, reflection and education on the part of the professional may be the most meaningful way to foster this change in how our mental health services operate.

Relevance to Social Work:

The relevance of this study to social work is significant. As professionals I feel that we often overlook the impact of our words or our manner and become fixed in routine and assumptions. We have historically made assumptions that reflect normative views that we have been taught formally and that we have seen within our own lives. Professionals now realize that the impacts of the invisibility forced upon our clients within the client/professional dynamic is a reproduction of the invisibility they face each day within mainstream communities. The enduring legacy of these historical assumptions is that approaches to treatment, service delivery models and virtually all aspects of mental health care are impacted by heterosexist bias.

The purpose of this study was to shed light on the personal impacts of this bias on each of the participants, putting a human face to experiences we may have learned about as professionals, but perhaps had never seen in actual account. It is my hope that this study

will challenge readers who are involved in helping professions to look at their practice, their agencies and the institutional systems they are involved with to uncover how their queer female clients are disadvantaged. It is true that women are no longer regarded in the paternalistic fashion that they once were by health professionals. However, we cannot ignore the impacts of our increasingly conservative social climate, and the blame that continues to face women who exhibit anything but "typical" female behaviour. Considering this, queer women are certainly placed in a precarious position in that they not only defy gender norms, but romantically link themselves with others who defy these same norms.

The voices of the women in this study are valuable to us as professionals as they offer in-depth insight into what some of the experiences of queer women accessing mental health services in Ottawa have looked like. Despite the subjectivity of experience, it would be reasonable to assume that some of the shared barriers to service relayed by the participants go beyond this small group of women and are shared by the greater queer women's community. Below is a review some of the recommendations for improving the system that were offered by the women based on their experiences:

- Use of Inclusive Language by Care Providers and Agencies:

The participants highlighted that the use of non-inclusive language had a powerful impact on their comfort in seeking care. In some cases, the use of non-inclusive language was coupled with heteronegative statements that deterred women from accessing service from that provider in future.

- Outreach to Queer or Questioning Youth in the Education System:

Several of the women spoke of their junior high and high school experiences as youth who were queer or questioning. Some of the women felt that outreach to youth within the school system would help normalize the experiences of queer youth as opposed to further silence them.

- Need for a Queer Community Health Centre:

Given the recent discussion of a queer community health center in Ottawa, this was a popular recommendation amongst the participants. The women felt that in general, a queer community health center would help make services more accessible and would reduce the perceived barriers that many queer people encounter when accessing mainstream service.

- More Visible Queer Positive Mandate for Religious Affiliated Agencies:

Overall, the women participating in this project were skeptical of religious affiliated counseling agencies and services. Despite the fact that several women had had positive encounters with theses services, an overall recommendation was that these agencies have a clear and vocal queer positive statement.

- Need for Queer Positive Training for Professionals:

In general, the women noted that some professionals presented as uncomfortable or judgmental once the participant disclosed their sexuality. These types of experiences led to many of the women presently being or at one time having been closeted about their sexuality in order to retain a positive professional relationship. The women felt that it was important for professionals to have a clear understanding of the issues facing queer women and to validate and provide support for these experiences.

- More Queer-Identified Service Providers:

Despite the fact that several of the women had positive relationships with non-queer identified service providers, the women broadly felt that having more queer professionals was preferable in addition to having female professionals. It was highlighted by several of the participants that having a service provider who had first hand knowledge of the reality of queer existence would create an easier and more trusting professional dynamic.

- Need for a Queer Service Directory:

Finally, several of the participants highlighted the need for a queer service directory that could be used to make appropriate referrals for queer identified individuals. The idea behind this directory is that individuals and agencies listed within it would be queer or queer positive. As several participants highlighted, this would hopefully eliminate some of the guesswork involved in finding appropriate professional support.

As a queer-identified woman working in the social work profession, I have seen the need for all of the recommended changes brought forth by the participants in this study. The reality of social work is that there is still a great amount of work to be done in order to support marginalized individuals we may encounter professionally. One of the most marginalized and under-served groups of individuals are those experiencing mental distress. However, the availability of services to mainstream individuals, let alone queer identified ones, is limited. When we dig deeper and look at who is encompassed within this grouping of people who access mental health services, we see that there are disproportionate numbers of both women and queer individuals. We, as professionals, need to question why this is and address the continued marginalization of queer women as a result of the prevailing negative societal beliefs and attitudes. Although the

information coming from this study is not exhaustive, it should give us pause to think about the ways in which professionals can work to change the system so that supports and services are more readily available to queer women.

Summary:

The purpose of this project was to highlight the qualitative experiences of six queer women who have accessed mental health services in Ottawa. Although this information is not generalizeable to the greater queer women's population it offers an in-depth look into the diverse experiences of this small group. I have not found extensive research to support some of the themes identified in this study therefore I view this study as a starting point for looking at how queer women interact with the mental health system. The reality is that, although research amongst the queer population is increasing, there are still many deficit areas that need to be explored. This qualitative project has highlighted a need for this research to be completed on a broader level so that the mental health care system in Ottawa can better serve marginalized populations such as queer women.

As the research explored throughout this study has suggested, heterosexist attitudes impact queer women's functioning within society, including their experiences within the healthcare and mental health care systems (Pearson, 2003; Kitzinger & Perkins, 1993). Attitudes of health and mental health professionals have often focused on the abnormality of lesbians and bisexual women, reflecting heterosexist norms (Kitzinger & Perkins, 1993; Anastas & Appleby, 1998). As the stories of the women in this study have highlighted, heterosexism may manifest itself in different ways. Each woman expressed

their individual encounters with homo-negativity, with each experience able to be linked back to a root of patriarchal bias that has been sustained in many of our institutions (Banks, 2003, Kitzinger & Perkins, 1993). This heterosexism within mental health service agencies impedes mental health workers' ability to work effectively with the GLBT population and to facilitate a strong and supportive network for their lesbian and bisexual clients (CRHC, 2004; Banks, 2003).

The research utilized in this project suggests that progress has been made on the part of professionals, community members, allies and those within the queer community to alleviate the stigma associated with queer identity and mental health care seeking. However, reflected in the stories of these women is evidence of the remnants of the historical discrimination against queer identified women that has negatively coloured the women's encounters within the mental health care system. Within the first chapter of this study readers were introduced to the theory that clarifies the origins of the pathologizing of queer women by the mental health system. In the literature review I explored the history of the experiences of queer women and the establishment of a patriarchal assessment of women's purported frailties. I also introduced the theoretical framework of the study. Both feminist theory and queer theory were used as analytical lenses through which the women's stories were interpreted. Structural social work approaches was also used as a supporting approach to better analyze the particular structural barriers within society and within formal institutions such as the education system and the medical/mental health systems.

The second chapter focused on the particular sexual identities of the participants as well as their many other roles and identities, including mother, professional, student, person living with a physical disability and recovering substance user. Throughout this chapter the impacts of societal influences on the coming out process were also addressed. Factors that may complicate the coming out process were explored. Among the influences discussed were family context, the educational system, and feelings of support and validation. All of these factors offered insight into the participant's historical contexts.

The third chapter explored the common theme of mistrust amongst the women participating in the study. Although many had had positive experiences, there was an underlying skepticism of mental health service providers. This skepticism was linked in most cases the participant's belief that the societal attitudes toward queer women cannot be removed from the mental health professional's consciousness. As a result, many of the participants questioned the motives of their counselors, became frustrated with their responses or their chosen interventions. In many cases the women continued to look for other forms of support, eventually finding something that they felt would meet their mental health care needs. This chapter looked at the various types of supports that women accessed, including conventional mental health services provided by psychiatrists, social workers and other trained therapists. As other women had accessed the services of general practitioners during periods when they did not have professional mental health care, this was also addressed. Other women had accessed support for addiction concerns and the experiences of the participants' within these contexts were also explored.

In the final chapter I explored the concept of belonging and what this meant to the women participating in the study. The analysis in this chapter revealed that for many of the women, the notion of belonging was related to having access and to the availability of resources, community and social spaces. As belonging is so often tied to the elimination of judgment and the support of expression and openness, participants explored such aspects of community as housing, identity, social community and political activism, role modeling and service availability. The overall experiences of many of the participants seemed to support that there is still a struggle for a unified queer women's community in Ottawa and that the fractured community can often reproduce a sense of marginalization.

The statistics in regard to the mental health status of GLBTTQ individuals offer a sobering reminder of the vulnerability of this population. Despite the progress that has been made in regard to equality and inclusion of GLBTQ individuals in society, there are still many barriers to full inclusion. The "insidious trauma" of living as a GLBTTQ-identified individual within a predominantly heterosexist society places these individuals at increased risk for depression, substance use and other mental health related issues (Balsam, 2003).

The invisibility of queer mental health consumers serves to fragment them from the general queer community. The GLBTTQ population, as with many other marginalized communities, continues to struggle with non-conformity within their own community. As previously mentioned, sexuality encompasses people from all social groupings, ranging from ability to race. GLBTTQ people of colour or disabled persons often feel ostracized within the gay community (Ottawa-Carleton GLBT Wellness Project, 2001).

Although literature on the topic is limited, there is evidence that lesbian and bisexual women with mental health concerns are particularly marginalized and have difficulty accessing all levels of service. This is likely linked to the historical connection of women's non-conforming sexuality with deviance and illness, as determined by a mental health system of practices that was established by men. The heteropatriarchal prescription of what is normal dictates who, even within lesbian and bisexual communities, is 'normal' thereby diminishing their support networks (Kitzinger & Perkins, 1993).

The findings of this study indicate that there are clear deficits in mental health service provision for the queer women who participated in this study. It is hoped that this study has offered some insight into the particular experiences of the six participants, thereby indicating possible barriers to service that may be faced by other queer women. As the social and political climate in Canada moves further to the right, a reasonable concern is that services for marginalized communities such as queer women will be threatened. From a fiscal viewpoint, addressing the current needs of this community will prevent long-term health and mental health costs for queer women. Facilitating access and providing avenues for prevention and support is key to the development of healthy queer women. Further to this, from a social perspective, queer women have a right to be treated equitably and to have their realities validated. Promoting the importance of investment in queer positive programs, services and education for mental health providers will ensure that the impacts of heterosexism and sexism become less toxic for queer women.

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Appendix A: Advertisement Poster

FEMALE RESEARCH PARTICIPANTS NEEDED

I am a Master of Social Work student at Carleton University. As a queer-identified woman I am interested in conducting a research project studying the experiences of lesbian and bisexual women within the community mental health system in Ottawa.

If you identify as lesbian or bisexual, are over the age of 21, and have sought support for mental health concerns within Ottawa in the last 3 years you may be a suitable candidate for this study. The purpose of this study is to determine lesbian and bisexual women's perspectives on mental health care. What experiences do queer women share, and what areas can be explored further? This is an opportunity to share your unique personal views on an issue that affects many of us.

Participants will be asked to participate in a 90 minute interview, during which they will be asked questions related to their experiences as lesbian and bisexual women who have received mental health support in Ottawa. Participants **must** be open to the possibility of follow up interviews to allow for clarification.

All participants will be entered in a draw to win one of three $20 gift certificates from Ottawa-based businesses owned and operated by women.

Participants will receive complimentary refreshments during the interview process.

If you are interested in participating in this research project please contact me at or leave a message for Pam at (613) 520-2600 extension 0239.

Appendix B:

Letter of Information

Experiences of Queer Women Accessing Mental Health Services in Ottawa

Dear Participant,

My name is Pamela Murphy and I am a Master of Social Work student at Carleton University. I am interested in conducting research on how lesbian and bisexual women have experienced their interactions with the mental health system in Ottawa. I would like to speak with 6 to 8 women who identify as lesbian, bisexual or queer who have received services from mental health service providers and agencies within the past 3 years.

The aims of the research project are to explore how queer women experience the services of local mental health service agencies and how they perceive their own interactions within this system. I would like to uncover whether women participating in the study feel as though their sexual preference affects the experiences that have and type of service they have received. Please note that this is a thesis research project and as such, the data you disclose may be published at a later date and could be presented at professional conferences.

Each participant will be asked to participate in a semi-structured interview that will last between 90 to 120 minutes. It may be necessary for me to contact you at a later date for follow up questions to clarify data gathered in the initial interview.

There is some potential for discomfort related to participation in this research project. You will be asked to reflect on your history and experiences as a lesbian or bisexual woman within the mental health system. This includes reflection on memories that may be difficult to discuss. Please consider this when consenting to participate in the research project.

The information collected will be used only for research purposes. All participants will be identified by a pseudonym. Your name or any specifics that may identify you will remain confidential however some the information that you discuss during the interview may be directly quoted and used in the study. At no time will this information be attributed to you. All participant interviews will be tape-recorded. Information relating to participant identities will remain under lock and key in a secure location. All participant responses and participant information will be retained by the researcher following the completion of the research project.

If you consent to participate in this research project you have the right to withdraw at any time. Should you withdraw, you may decide at that time whether the researcher may use some or all of the data you have contributed to the study. Participants also have the right to refuse to answer any particular questions contained in the research project. Please be aware that as a social work student bound by the Canadian Association of Social Workers Code of Ethics, I am required to report information disclosed within interview sessions that may indicate a wish to harm yourself or others.

Please note that the findings of this research project may be published or presented at academic conferences. At no time will information regarding your identity or your comments be disclosed.

If you have any questions or comments about this research project please contact me at lbwomenstudy@yahoo.ca or (613) 520-2600 ext 0239. You may also contact my faculty advisor Professor Sarah Todd by phone at (613) 520-2600 ext 4498 or via email at sarah_todd@carleton.ca. Written correspondence may be sent to either myself or Professor Todd at:

School of Social Work
Room 509 Dunton Tower
Carleton University
1125 Colonel By Dr.
K1S 5B6

The Chair of the Carleton University Research Ethics Committee is Professor Antonio Gualtieri. He may be reached by phone at (613) 520-2517 or via email at ethics@carleton.ca. Written correspondence can be sent to:

Prof. Antonio Gualtieri, Chair
Carleton University Research Ethics Committee
511A Tory Building
Carleton University
1125 Colonel By Dr.
K1S 5B6

I appreciate the interest you have taken in this project.

Sincerely,

Pamela Murphy
Tel: (613) 520-2600 Ext. 0239

Master of Social Work Candidate
School of Social Work
Carleton University

Appendix C

Consent: *Queer Women Accessing Mental Health Services in Ottawa*

The purpose of an informed consent is to insure that you understand the purpose of the study and the nature of your involvement. The informed consent must provide sufficient information such that you have the opportunity to determine whether you wish to participate in the study.

Research Personnel: The following people are involved in this research project and may be contacted at any time: Researcher: Pamela Murphy – Email: lbwomenstudy@yahoo.ca or Telephone: (613) 520-2600 ext 0239; Thesis Supervisor: Professor Sarah Todd – Telephone: 520-2600 ext 4498 or Email: sarah_todd@carleton.ca. Carleton University Research Ethics Committee Chair: Prof. Antonio Gualtieri – Telephone: (613) 520-2517 or Email: ethics@carleton.ca.

Purpose: The purpose of the present study is to examine the experiences of lesbian and bisexual women who have had contact with community mental health services in Ottawa within the last 3 years. This study is part of a thesis requirement for a Master of Social Work program. Data that you disclose may be published or presented at professional conferences.

Task requirements and duration: You will be asked to complete a 90 to 120 minute interview in a safe, agreed upon location. You will be asked about your experiences within the mental health system, particularly in regard to experiences that may have been influenced by your sexual identity. The interview will consist of an open-ended series of questions.

Potential risk/discomfort: It is possible that some of the questions may cause some discomfort, as you will be asked to reflect on your mental health experiences, sexuality, and health seeking behaviour. You will receive a follow-up session within 2 days of the initial interview. You will also receive a debriefing package that includes contact information for crisis and counseling services in Ottawa. Arrangements for follow-up or professional intervention will be made as required.

Anonymity/confidentiality: All data collected will be assigned a pseudonym and will not include your true name. While your name will not be attributed, contents of the interview(s) will be included in the study therefore confidentiality cannot be offered. As the researcher, I will be the only person with access to the research data. All transcripts and tapes will be kept in a locked location. Upon completion of the research project all information will be retained by the researcher in a secure location. Please note that I am required by law to report disclosure of information that may indicate intent on your part to harm yourself or others.

Right to withdraw: Your participation in this study is completely voluntary and you reserve the right to stop participating at any time for any reason. At the time of your withdrawal you may choose whether I may use all or a portion of the data you have

provided. You also have the right to not respond to any question(s).

I am aware that the interview(s) will be audio taped and I provide my consent: Agree ___ Disagree __

I have read the above description of the study and I am aware that my participation is voluntary and that the data gathered are anonymous. My signature indicates that I agree to participate in the study.

Participant's Name: _____ Date: _____

Participant's Signature: _____

Appendix D
Interview Guide

1. The posters and flyers advertising this study were asking for lesbian and bisexual women. It is important for the purposes of my study to understand how you identify. Could you please explain how you identify and what this means to you?

2. In accessing mental health services, have you felt that there were fewer options for treatment or services as a result of your sexual identity?

3. Please explain your experiences within the mental health system in Ottawa. Please identify if heterosexism (i.e. staff assuming that you are straight etc.) was part of your experience. Please define what heterosexism means to you and if you feel it is relevant for you.

4. Women in general, but particularly queer women have had a complicated history within the mental health system. Do you feel that some of the historical issues that queer women have faced in accessing mental health are still evident or relevant in your life today?

5. Sometimes heterosexism may result in fear and avoidance of certain interactions for lesbian and bisexual women. Have you ever felt the need to hide or avoid discussing your sexual preferences with a mental health service provider? If so, please elaborate on these experiences?

6. How have mental health service providers regarded your concerns as a lesbian/bisexual woman? Have you felt that their responses to your needs have been adequate and sensitive?

7. Have you ever felt pressured or influenced to make certain choices or act in certain ways as a result of your work with a mental health professional?

8. Do you feel as though any of the following issues closely associated with mental health have been a factor in your life? Is there something more the mental health community could offer to address these issues within the lesbian/bisexual community?

-addiction	-housing instability
-access to physical/mental health care	-poverty
-isolation	-lack of resources
-discrimination	-abuse (physical, mental)

9. Have you ever felt that as a lesbian/bisexual woman, your need for mental health support was frowned upon or discouraged by other members of the queer community? Do you share your mental health experiences openly?

10. What do you feel is needed in order to improve access and use of services by lesbian and bisexual women?

Appendix E

Debriefing: Queer Women Accessing Mental Health Services in Ottawa

The purpose of the present study is twofold. First, I intend to examine the experiences of lesbian and bisexual women who have accessed community mental health services in Ottawa within the past 3 years. Research conducted within the broader GLBT community in Ottawa reveals that GLBT individuals accessing physical and mental health services in Ottawa feel as though their needs are not being met by community services. Additional research indicates that the GLBT community is significantly more at risk of mental health problems and related concerns than the general population. In particular, lesbian and bisexual women represent a suppressed minority, even within the GLBT community, whose needs have not been met. The present study is intended to obtain detailed information from lesbian and bisexual identified women to obtain a clearer understanding of individual experiences within the community mental health system. This information will then be analyzed to locate any commonalities.

The second purpose of the present study is to examine whether heterosexism or perceived heterosexism within these community mental health agencies may have negatively impacted lesbian and bisexual service users. For example, are lesbian and bisexual women less likely to access the services of an agency that does not have an explicitly GLBT positive service mandate?

Should you have any further questions or comments about this study please contact me, Pamela Murphy, at 520-2600 ext 0239 or lbwomenstudy@yahoo.ca. You may also contact my thesis supervisor, Professor Sarah Todd at 520-2600 ext 4498 or sarah_todd@carleton.ca.

Please note that I will be contacting you within a week of completion of the interview in order to further debrief and refer to community resources if necessary. If you have any concerns about your mental health in the days following the interview please contact your family physician, a mental health professional or your local community health centre. Should you wish for additional support related to mental health and/or sexual orientation please contact Pink Triangle Services at (613) 563-4818; the Carleton University Gay Lesbian Bisexual and Transgender Centre at (613) 520-3723; the Canadian Mental Health Association at (613) 737-7791. 24-hour assistance can be sought by calling the Distress Centre at (613) 238-3311; The Gay Line at (613) 238-1717; or the Mental Health Crisis Line at (613) 722-6914 or 1-866-996-0991.

Thank you for your participation and assistance.

Pam Murphy
School of Social Work
Carleton University