From Margin to Mainstream: Lesbian Health & Social Service Needs

By
Kia Rainbow

A Thesis submitted to the Faculty of Graduate Studies and
Research in partial fulfillment of the requirements
for the degree of Master of Social Work

School of Social Work
Carleton University
Ottawa, Ontario

January, 2003

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submitted by Kia Rainbow, BSW

in partial fulfillment of the requirements for

the degree of Master of Social Work

Thesis Supervisor

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ABSTRACT

There is persistent evidence that health and social services inadequately serve lesbian clients (Pink Triangle Services, 2001). This, in large part, has been predicated by the 1952 American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders II (DSM II) classification of homosexuality as a mental illness (Karlen, 1971; Kitzenger, 1987). The social construction of heterosexism has had a profound effect on the lives of lesbians. For many years they were viewed by medical professionals as sick, degenerate, immature and psychotic individuals (Bergler, 1948; Bragman, 1934; Greenberg, et al, 1968; Kenyon, 1968; Owensby, 1940; Wittenberg, 1956). Consequently, lesbians often perceive or experience interactions with health and social service providers differently than heterosexual women (Jay, 1995) and men.

In the Ottawa region, there are thirteen Community Health and Resource Centres (CHRC). This research was conducted in order to understand more clearly the specific issues with which lesbians struggle, their health and social service needs, and how those needs are, or are not, met by their local Community Health and Resource Centres.

Eighteen women from the Ottawa area, who self-identify as lesbian, were interviewed. Findings of this study reveal that lesbians are not receiving accessible and comprehensive mental health services from their local Community Health and Resource Centres. All participants identified stress as an issue of concern for them; rating sexual orientation as their highest source of stress. As well, all participants sought some type of support for an

issue of concern to them. Most identified having a negative experience when accessing support, identifying eleven barriers to service. The largest barrier identified was the assumption of heterosexuality among service providers. Due to this assumption, and the fear of a negative reaction from service providers, most women did not identify as lesbian when accessing service thereby limiting safe and comprehensive services. All participants would like to see services offered to lesbians at their local CHRC. It is vital to highlight that six participants (34%) expressed that they would ONLY access service at their local CHRC, stating that they would not be comfortable accessing service at an exclusively gay, lesbian, bisexual and transgender community centre for fear of being “found out”.

The research concludes with a number of recommendations to support the provision or increase of service to lesbians at Community Health and Resource Centres.

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I would like to acknowledge, with special and heartfelt appreciation, the women who took time from their very busy lives to participate in this research. I thank them for their interest, courage and the opportunity to learn with them.

I would like to thank Dr. Elizabeth Whitmore, my thesis advisor, for her guidance, challenges, time and encouragement. Thank you to my thesis committee members Karen Schwartz and Denise Veilleux.

Thank you to my talented and skilled family and friends, Linda Baker (my mother), Chantal Bernier, Sherrie Bushen, Sue Desilets, Karen Flainek, Chantal Pombert, Eileen Sametz and Tracy Thomson, for all their assistance. Their interest in my work, practical support and encouragement inspired me and helped to keep me on track.

A special acknowledgement to my daughter, Tisha, for it is because of her that I continue to pursue my dreams.

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APPENDIX A

Definition of Terms

Bisexual	Someone who is emotionally and sexually attracted to people of both genders.
Coming Out	The process in which a person acknowledges, accepts, and appreciates their lesbian, gay or bisexual identity. This often involves the sharing of this information with others.
Heterosexism	The assumption that all people are or should be heterosexual and therefore excludes the needs, concerns, and life experiences of lesbian, gay and bisexual people. The system of advantages given to heterosexuals.
Homophobia	A pervasive, irrational fear, hatred, or intolerance of lesbian, gay, bisexual or transgender people. Based on myths and stereotypes, it ranges from mild disapproval to violent hate crimes.
Homosexual	Sexual attraction felt by a person for another person of the same gender. The term homosexual is used to describe both gay men and lesbians.
Lesbian	A term understood to mean a woman who relates sexually and emotionally to other women (Ponse, 1978). Some lesbians refer to themselves as dyke, gay or queer.
Mental Health	“The capacity of each of us to feel, think and act in ways that enhance our ability to enjoy life and deal with challenges we face. It is a positive sense of emotional and spiritual well-being that respects the importance of culture, equity, social justice, interconnections and personal dignity” (McGuire, 1998).
Passing	Hiding a lesbian, gay or bisexual identity. Also referred to as “In the Closet”.
Pink Triangle	The symbol that was used by Nazi Germany to identify the gay people in its concentration camps. Tens of thousands of gays wore this symbol to their deaths in the gas chambers. It remains the symbol of one of history’s most extreme examples of homophobia and a reminder of the need to undertake a struggle against homophobia in all its forms.

Rainbow	A gay pride symbol. A calling card used by individuals and organizations indicating a lesbian, gay, bisexual and transgender-friendly environment.
Social Services	Community Health and Resource Centres offer social services that include: Information and referral, crisis intervention, individual and couples counselling, advocacy, support groups, drop-in groups, community health promotion and community development. Social service programs include: Children's programs, youth programs, counselling and support groups for abused women, parent education groups, senior's services, support for persons living with disabilities, employment services, help with housing and food, and home support services (Directory of Ottawa Community Services, 2001).
Straight	A slang term used to describe heterosexual persons.
Support Services	The term "support services" is utilized in lieu of the term "social services" in the interview guide. This wording was chosen after pre-test interviews revealed that the term "social services" was too ambiguous.
Transgender	A blanket term used to describe anyone who bends or challenges "traditional" gender roles. Transsexual: A person who psychologically identifies with the opposite sex. Transvestite: An individual who dresses in the clothes of the opposite sex usually for emotional satisfaction and psychological well being.

APPENDIX B

Participant Recruitment Flyer

Are you Lesbian, Bisexual or Questioning your Sexual Orientation?

Have you ever struggled with ANY of the following issues?

☐ Coming out	☐ Partner abuse
☐ Isolation	☐ Relationship issues with an intimate partner
☐ Stress	☐ Blending families/step parenting
☐ Depression	☐ Parenting and child rearing
☐ Substance abuse	☐ Caring for an ill loved one
☐ Feeling suicidal	☐ Death of a loved one
☐ Anxiety	☐ Physical, emotional and/or sexual abuse
☐ Loneliness	☐ Job loss

If so, would you be available to participate in a research project aimed at increasing the supports available to lesbians in our community?

You must be willing to participate in a one-hour interview. Confidentiality is assured.

For more information or to register, please contact
Kia Rainbow at 591-3686.

Kia Rainbow is a Lesbian and Social Worker,
completing her Master of Social Work Thesis at Carleton University.

APPENDIX C

Interview Guide

1. I am going to hand you a question sheet. Please take your time to read through it and put a check beside the items that are or have been issues for you. Please check as many as apply. (see Checklist: Issues Identified)
2. Have you ever sought support for the issues you identified? If so, what support services did you access and what was your experience with those services? If not, why not?

Throughout the Ottawa area there are 13 Community Health and Resource Centres (CHRC) that provide, free of cost, support services such as individual counselling and support groups to all people in the community.

3. Have you sought support at your local CHRC? If so, what services did you access and what was your experience with those services? If not, why not?
4. What barriers might cause you difficulty when accessing support services at your local CHRC? Probes:
 - Fear of getting a negative reaction because of being lesbian
 - Feelings of embarrassment or shame about being lesbian
 - Lack of awareness among providers of service about the needs of lesbians
 - Other
5. What is your experience with “passing” (not letting service providers know you are lesbian) in order to use support services?
6. What kinds of support services would best meet your needs as a lesbian?
 - information and referral services
 - crisis intervention
 - counselling (individual and couples)
 - advocacy
 - support group
 - drop-in group
 - public education
 - other
7. Is there a need for specialized and separate support services for lesbians? If yes, why? If no, why not?
8. Is there anything else you would like to add?

Checklist: Issues Identified

Date: _____ Code: _____

The information I will be asking for on this sheet will be kept strictly confidential.

Put a check beside the items that ARE or HAVE BEEN issues for you. (Check as many as apply).

- ☐ Sexual orientation
- ☐ Coming out to family
- ☐ Coming out to friends
- ☐ Coming out to co-workers
- ☐ Loneliness
- ☐ Isolation
- ☐ Stress
- ☐ Anxiety
- ☐ Depression
- ☐ Job loss
- ☐ Substance abuse (alcohol, illegal drugs, prescription drugs, food)
- ☐ Feeling suicidal
- ☐ Historical abuse (physical, emotional and/or sexual)
- ☐ Relationship issues with an intimate partner
- ☐ Partner abuse
- ☐ Parenting and child rearing
- ☐ Blending families / step parenting
- ☐ Caring for an ill loved one
- ☐ Death of a loved one
- ☐ Other issues you face as a lesbian: _____

APPENDIX D

Fact Sheet

The information I will be asking for on this sheet will be kept strictly confidential. It will be kept under lock and key in a separate location from the interview data. Thank-you for taking the time to fill this out.

Date: _____ Code: _____

I live in the area of: (West to East)

☐ Goulbourn, Kanata, West Carleton	☐ South-East Ottawa
☐ Nepean	☐ Lowertown
☐ Pinecrest-Queensway	☐ Vanier
☐ Carlington	☐ Overbrook Forbes
☐ Somerset West Ottawa	☐ Gloucester
☐ Centretown Ottawa	☐ Cumberland
☐ Sandy Hill	

I would describe my neighbourhood as:

☐ Urban / downtown	☐ Rural
☐ Suburban / residential	☐ Other (please specify) _____

My year of birth is: 19____

What was your total income (gross before deductions) from all sources in the past 12 months?

	My personal income	My household income
Under \$5000		
\$5,000 - \$9,999		
\$10,000 - \$14,999		
\$15,000 - \$19,999		
\$20,000 - \$29,999		
\$30,000 - \$39,999		
\$40,000 - 59,999		
\$60,000 - \$79,999		
\$80,000 - \$99,000		
\$100,000 or more		
Don't know		

What language do you prefer to receive services in?

☐ English	☐ French
☐ Either French or English	☐ Other (please specify) _____

APPENDIX E

Carleton University School of Social Work Letter of Consent

I, _____, agree to participate in the study being conducted by Kia Rainbow as part of her Master Thesis, School of Social Work at Carleton University. I am aware that this study will examine the specific issues that women who identify as lesbian struggle with, their social service needs and how those needs are, or are not, being met by local Community Health and Resource Centres.

I understand that:

- Participation in this study will involve one face-to-face interview of approximately one to one-and-one-half hours, to be held at a mutually selected location.
- The interview will be audio taped and these tapes will either be returned to me or destroyed at the completion of the study.
- My name and any identifying details will be kept strictly confidential.
- Participation is voluntary and I am aware that I may withdraw at any time.
- Follow-up counselling support can be obtained, free of cost, through the Community Resource Centre of Goulbourn, Kanata and West Carleton Crisis/Intake Program, 591-3686.
- The results of the study will be written up as a thesis and submitted for examination to the Faculty of Graduate Studies and Research.
- A copy of the Executive Summary of *From Margin to Mainstream: Lesbian Social Service Needs* will be available to me at my request.

In the event that I have comments or concerns about the project I may contact:

Researcher: Kia Rainbow, 591-3686.

Thesis Supervisor: Professor Bessa Whitmore, (613) 560-2600 ext. 6692.

Supervisor of Graduate Studies: Roy Hanes, (613) 560-5601.

Chair of Ethics Committee: Klaus Pohle, email: klaus_pohle@carleton.ca, (613) 520-2600 ext 8080.

Participant's Signature: _____

Date: _____

APPENDIX F

September 26, 2001

Carleton University
School of Social Work
1125 Colonel By Drive
Ottawa, ON K1S 5B6

Faculty of Graduate Studies and Research:

The Community Resource Centre of Goulbourn, Kanata and West Carleton (CRC) is one of thirteen community health and resource centres that service the City of Ottawa. We are writing this letter to commit to the provision of counselling support for the ten to twenty women participating in the research being conducted by Kia Rainbow.

Kia Rainbow has informed us that she will be working with women who identify as lesbian to explore with them their social service needs and how those needs are, or are not, being met by mainstream social service agencies.

The CRC recognizes that women who identify as lesbian are a vulnerable population therefore we are prepared to provide short-term crisis intervention support at the request of the women.

If you require further information, please do not hesitate to call me at (613) 591-3686.

Sincerely,

Carole Miller
Program Manager
Crisis Intake & Program Against Abuse

APPENDIX G

Excel Worksheet

Category: Mental Health Service Needs																				
Themes	Participants																		#	%
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18		
Separate Support	1	1	1		1	1		1	1	1	1	1	1	1	1	1	1	1	16	89%
Specialized Service	1	1	1		1	1		1	1	1	1	1	1	1	1	1	1	1	2	11%
Female Service Provider	1	1	1		1	1		1	1	1	1	1	1	1	1	1	1	1	16	89%
Not available				1			1												2	11%
Feminist Service Provider								1	1	1									3	17%
Lesbian Service Provider		1			1			1	1	1		1	1			1	1	1	10	56%
Trained GLBT Positive Service Provider	1	1	1		1	1		1	1	1	1	1		1	1	1			13	72%
Out Service Provider					1								1						2	11%
Couple Counselling								1	1	1				1					4	22%
Information and Referral			1		1			1		1	1	1					1		7	39%
Individual Counselling								1	1	1	1	1			1		1		7	39%
Support Group	1	1	1		1			1	1	1	1		1	1	1	1	1	1	13	72%
Support Group for Sexual Abuse								1	1										2	11%
Support Group for Parenting					1			1											2	11%
Support group for Relationships													1			1			2	11%
Support Group for Parnter Abuse					1			1							1				3	17%
Support Group (not specified what type)	1	1							1										3	17%
Support Group for Youth					1					1			1	1					4	22%
Social, Drop-in Group			1		1					1			1			1			5	28%
Support Group for Coming Out					1					1	1		1	1		1	1	1	7	39%
Service through all CHRCs	1	1		1	1	1		1			1	1		1	1	1	1	1	12	67%
Centralized GLBTQ centre			1		1	1	1	1	1	1	1	1	1	1	1	1			10	56%
Displaying a symbol ex. rainbow flag		1						1							1	1			4	17%
In GLBT community		1						1	1	1									4	22%
In CHRC literature					1			1		1		1				1	1	1	6	33%

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CHAPTER I

INTRODUCTION

The purpose of this study was to understand the specific issues with which lesbians struggle, their health and social service needs and how those needs are, or are not, met by local Community Health and Resource Centres.

BACKGROUND

As difficult as it is to be a woman in a patriarchal society, women who identify as lesbian face additional pressures (Jay, 1995). The experience of growing up “different” in a society that demands or expects that everyone be exclusively heterosexual can be devastating. Because of anti-gay stereotypes, along with negative beliefs and attitudes in mainstream culture, virtually all children learn to disapprove of lesbianism. Women who question their assumed heterosexuality and begin to identify themselves as lesbian are immediately faced with the additional burden of knowing that this emerging identity is condemned by society at large.

Lesbians experience stereotyping, stigma and discrimination on a daily basis. The result is that they feel enormous stress and profound isolation (Jay, 1995; Jordan & Deluty, 1998; PTS, 2001).

Society’s negative attitudes toward lesbians makes them fearful of persecution, often compelling
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them to hide their lesbianism from friends, family members, people in the workplace and the general public. Internalized beliefs about lesbianism complicate the process of lesbian self-acceptance, and often have profound effects on a woman's mental health (Jordan & Deluty, 1998).

Research indicates that lesbians and heterosexual women share many of the same mental health concerns (Anderson, et al, 2001; Collett 1982; Hughes, et al, 2000; Jay, 1995; Neisen & Sandall, 1990; Rothblum, 1990; Trippet, 1994; Woodman, 1989). These concerns can include relationship issues, separation from an intimate partner, partner abuse, depression, feeling suicidal, blending families, parenting and child rearing, job loss and childhood abuse. However, the difficulty of dealing with these issues is uniquely compounded for lesbians who also experience incredible isolation and stress over their sexual orientation and being forced to be 'closeted' (Jay, 1995). This isolation and stress is further compounded by limited accessible and comprehensive social services that deal specifically with lesbian-identified concerns (PTS, 2001).

Despite its removal as a mental illness from the American Psychiatric Association's DSM II in 1973 the classification of homosexuality as a mental illness has had a profound effect upon the lives of women who identify as lesbian and has impacted greatly upon their access to social services. This removal from the DSM II did not entirely erase the attitudes, and resultant damage, created by its initial inclusion. Today a large portion of those in the helping

professions, as well as in the general population, continue to regard lesbianism as abnormal and sick (Jay, 1995).

Consequently, lesbians experience enormous barriers to mental health services; barriers such as the assumption of heterosexuality, lack of service specifically for lesbians, and lack of awareness of lesbian issues among service providers. A study entitled How Well Are We Doing? A Survey of the Gay, Lesbian, Bisexual and Transgender Population of Ottawa: Main Report (PTS, 2001) surveyed 826 members of the gay, lesbian, bisexual and transgender (GLBT) community. It found that GLBT persons are not getting the health and social service supports that they need.

A look at mainstream health and social service agencies would reveal that institutional heterosexism continues to thrive within most agencies. The PTS (2001) study states that the majority of respondents (65%) would like to be able to use the variety of wellness services available to all Ottawa residents without having to hide their sexual or gender preference and without having to explain and educate workers on how to work appropriately with GLBT people.

In my role of Social Worker at one of the thirteen Ottawa area Community Health and Resource Centres, I have personally experienced the assumption of heterosexuality under which many social service agencies continue to operate. My position as Community Developer at the Western Ottawa Community Resource Centre has allowed me the opportunity to work with women who identify as lesbian. Over the past six years I have advocated for an increase in social services for lesbians and this has resulted in the provision of lesbian self-esteem and

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healthy relationships groups at the Centre. It has been through facilitating seven groups over the past four years that I have learned of lesbians' fears in accessing health and social services and their frustrations with the limited number of these services.

RESEARCH STATEMENT

This study will explore the specific issues that lesbians struggle with, their health and social service needs and how those needs are, or are not, being met by Community Health and Resource Centres in Ottawa. The goals of this study will be to: 1) facilitate an understanding of the specific issues with which lesbians struggle; 2) identify lesbians' health and social service needs; and 3) encourage the development of accessible and comprehensive health and social services within Community Health and Resource Centres.

In addressing this topic, the following areas will be explored: (1) The specific issues that lesbians have or are struggling with; (2) The supports that were sought, if any, for the issues they identified; (3) The supports that were sought, if any, at their local Community Health and Resource Centre; (4) The barriers, if any, to accessing their local Community Health and Resource Centre; (5) How "passing" has affected their use of health and social services; (6) What kinds of health and social services would meet their needs; and (7) The need, if any, for specialized and/or separate health and social services for lesbians.

CHAPTER II

THEORETICAL FRAMEWORK

In order for the reader to understand why it is that lesbians often feel a need to hide their lesbianism, and why most health and social service agencies are not offering accessible and comprehensive services to lesbians, the reader must have a clear understanding of the development of heterosexism. This chapter moves the reader through time in order to explore how heterosexism was constructed and the impact it has on the delivery of contemporary health and social services and the lives of women who identify as lesbian.

Before an act can be viewed as deviant, and before any class of people can be labeled and treated as outsiders for committing the act, someone must have made the rule which defines the act as deviant (Becker in Greenberg, 1988:6).

Deviance-defining rules can be traced to the interests, moral values, and political power of particular groups (Greenberg, 1988). The specific issues that lesbians face and their access to Community Health and Resource Centres have been influenced by the historical, social and

political construction of sexual orientation. The theoretical base of my research will be rooted within a social constructionist framework.

Social constructionism asserts that knowledge is not an objective representation of nature but, rather, a linguistic creation that arises in the domain of social interchange. This epistemological doctrine surfaced from a growing intellectual landscape termed *constructivism* in which objectivist ideals were replaced by subjectivist methods of inquiry. The social constructionist movement has also been described as emanating from a larger trend termed the *postmodern era*. The social constructionist framework has set forth implications that diverge significantly from those models that correspond to the realist epistemologies that had largely informed psychology, psychiatry and social work. These latter disciplines have tended to define problems in terms of what they consider to be an objective domain (e.g., repressed complexes, Freud, 1949/1964). In contrast, social constructionist approaches eschew the notion that it is not possible to attain such “objective” criteria and, instead, contend that problems are linguistic creations which are maintained and perpetuated in the domain of inter-subjective conversation (Guterman, 1994).

The social constructionist framework rejects pathologizing conceptualizations of individuals, instead, the individual is considered within the context of heterosexist society.

Lesbianism exists and always has existed, among all peoples, in all parts of the world, at all historical times (Klaich, 1974:10).

Homosexuality [lesbianism] has existed in all places and times (Greenberg, 1988; Karlen, 1971; Klaich, 1974; Mondimore, 1996; Weeks, 1991). Social Constructionists argue that sexuality, as a contemporary phenomenon, is the product of a host of autonomous and interacting traditions and social practices. These include religious, moral, judicial, economic, familial, and medical practices (Greenberg, 1988).

The beginning of official Western institutional condemnation of homosexuality can be traced to religious censure wherein lesbianism was declared a sin. After this, civil law in most Western countries, taking its text from ecclesiastic law, decided homosexuality was a crime. Next, science labeled it a congenital disease, and finally, a mental illness. It is only recently that lesbianism is being viewed as an issue of human rights (Foucault, 1990; Greenberg, 1988; Kitzenger, 1987; Klaich 1974)

By examining historical research, it becomes easier for us to identify those institutions that have had a greater influence in developing sexual norms. We can see how heterosexuality came to be a value and a norm, a matter of morality and taste, of politics and power (Katz, 1995).

TRIBES & BANDS

In explorations of remote areas of the world there have been studies of isolated people whose ways of life seem not to have been touched by the complex progression of ideas which have

shaped modern civilization. Research has shown that the hunter-gatherer peoples in isolated areas of the Amazon, the Pacific Rain Forests, and remote Africa practiced homosexual initiation rituals (Greenberg, 1988; Mondimore, 1996).

The study of several cultures by anthropologists Margaret Mead in the 1920s and Gilbert Herdt in the 1970s led to a revolutionary reappraisal of sexual attitudes. Both Mead and Herdt noted that in several primitive cultures of New Guinea, sexual relations between men and adolescent boys represented an important social institution endowed with cultural and religious meanings. Additionally, they performed an important function in family and tribal relationships (Mondimore, 1996).

Women and men lived in separate dormitory-style houses where members of the opposite sex were forbidden from entering; consequently "married" persons never spent the night together (Greenberg, 1988). The women within these patriarchal tribes were responsible for the care of small children. Later a boy child would be separated from his mother and enter into the male house. The Sambia people believed that a boy would not mature physically and be capable of procreation himself unless he was implanted with the semen of an adult male. Valued male qualities, such as courage, proficiency in hunting, and the ability to dominate women, were transmitted in the same way. Repeated intercourse built up a supply of the vital substance in the boy's body. Because taboos on heterosexual intercourse were extensive, while there were none on homosexual relations, male sexual outlets were predominately homosexual between the ages of ten and forty. By contrast, heterosexual intercourse was considered physically debilitating to

men; it depleted their vitality. Were a man to give all his semen to a woman, she would grow strong enough to dominate him. The entire cluster of homosexual beliefs and practices was kept secret from women, lest they learn that their subordination was a precarious accomplishment, rather than part of the order of nature (Greenberg, 1988; Mondimore, 1996).

There are fewer accounts of lesbianism in the history of tribes and bands. Patriarchal society has deemed women and their sexual behaviours inconsequential, other than in relation to procreation. Because information on lesbianism is so scarce, efforts to explain homosexuality have focused on the male pattern. However, there were hints of ritualized lesbianism in a few Melanesian cultures. As well, egalitarian homosexuality [lesbian behaviors] could be found among Nandi women of Kenya. Lesbian affairs were virtually universal among unmarried Akan women of the Gold Coast (now Ghana), sometimes continuing after marriage (Greenberg, 1988).

ANCIENT GREECE

The ancient Babylonians and Egyptians practiced homosexuality [lesbianism] widely and openly. Among the Greeks, it was not only accepted as a natural expression of the sexual instinct (Katz, 1995) but praised as being even more genuine and tender than heterosexual love (Karlen, 1971). Ancient Greek philosophers such as Sappho, Socrates, Plato, and Homer made numerous references to same-gender sexual relationships (Karlen, 1971; Mondimore, 1996).

Numerous artistic and literary works from this period depict homosexuality [lesbianism]. Vases and other pieces of pottery dating from the fourth, fifth and sixth centuries B.C. have homoerotic decorations. Greek theatre plays have numerous allusions to male-to-male and female-to-female contact (Mondimore 1996). These men and women were not considered to be “homosexual”, or at least, not in our modern meaning of the term; the Greeks had no such word or concept. The Greeks practiced a sort of “bisexuality” in that sexual activity with partners of both sexes was accepted as natural (Katz 1995; Mondimore, 1996). These attitudes are linked to the male domination of Greek society and to a domination/submission model of sexual relations; there was no criticism of a male who sexually dominated anyone, male or female. Among the ancient Greeks, honourable and accepted sexual practices for men were not defined by the gender of one’s partner or by whether sex took place within an exclusive relationship based on romantic love. Instead, a particular sexual pairing was considered to be acceptable, or not, depending upon the age and social standing of the partner. For men at least, whether the partner was male or female and whether one was married to his partner or not, was almost inconsequential. It was perfectly acceptable for a man to have both a wife and a male partner (Mondimore, 1996)

The modern term for female homosexuality – lesbian - takes its name from that of the Greek Island of Lesbos. Sappho, the island’s most famous resident, wrote passionate love poems addressed to women (Karlen 1971; Mondimore, 1996). A review of the life and works of Sappho reveals that the women of ancient Greece, at least of Lesbos, could express heterosexual or homosexual eroticism freely, without societal condemnation and without any need for a label

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(Mondimore, 1996). The first recorded female homosexual voice to come from Greek society, and the first in the Western world, was that of Sappho. Sappho was born around 612 B.C. in the town of Mytilene, on the island of Lesbos, off the coast of Asia Minor. Her name and her home (the isle of Lesbos) quickly became generic words for female homosexuality. Sappho wrote more than five hundred poems relating to women, erotica and romantic love, totaling twelve thousand lines. Today, largely due to destruction of those texts by Christians, who were gaining in popularity and power at the time, there remains only seven hundred lines of Sappho's work (Karlen, 1971).

SINS OF THE FLESH

Historians such as Mondimore (1996) have traced a gradual shift in attitudes toward homosexuality from the fall of Rome through the beginning of the Renaissance from relative indifference toward homosexual behaviours in men and women to gruesome punishments for single acts of same-sex intimacy.

Our cultural restraints on sex can be seen as stemming from Judeo-Christian tradition, as opposed to the alleged sensuality of "Pagans". Christianity emerged around the time of the fall of the Roman Empire; a time of confusion, upheaval and slaughter. The laws and attitudes toward sex that subsequently developed in Europe reflected the slow coalescence of various tribal traditions with Christian doctrine. During the Dark Ages (between 600 and 1000 A.D.),

“Barbarians” slowly adopted Christianity one by one – some moved by missionaries, some forced by military conquest. People like the Greco-Roman non-Christians, who were sexually unrestrained, gradually fell under the yoke of Christian repression (Karlen, 1971).

The crucial figure in the development of Christian sexual attitudes was St. Augustine (Karlen, 1971) whose teachings became a Western official code of conduct. Augustine wrote:

Marriage is a rung on the ladder to salvation, but a lower one than chastity. It would be best if man and wife lived without sex, but if they cannot, they should couple for procreation, not pleasure. Therefore oral sex, masturbation, sodomy – which cannot lead to conception – are forbidden (Karlen, 1971:76).

Through Confession, a book of Christian sexual morality, Augustine condemned any “sexual” acts that were practiced for pleasure alone; sex during menstruation, lactation, sex after menopause and, of course, homosexual [lesbian] sex. All people, Augustine concluded, are born as a result of lust; that is, they are conceived in sin. The task of each person is to make up for original sin by giving their will control over their impulses. In Augustine’s thought, we can see the juxtapositioning of logic, sanity, asexuality and virtue on the one hand, and impulse, unreason, sex and sin on the other. This made sexual restraint a cornerstone, even a synonym, for “moral” behavior. The Church adopted the ideas of lust and original sin, and most of Augustine’s other teachings on sex and marriage as well. In the Thirteenth century, Thomas Aquinas systematized and expanded Augustine’s thinking, and the result became doctrine by

papal decree (Karlen, 1971). Thomas Aquinas defined as “unnatural” those sex acts that do not lead to conception (Karlen, 1971; Katz, 1995).

It was at this time that the word “sodomy” was introduced. In ancient Christian writings, sodomy had many different meanings and by no means referred to “homosexuality” alone. Sex between Christians and Jews or between Christians and Muslims and sex with animals were seen as acts of sodomy or bestiality. Masturbation, heterosexual intercourse in any position other than the “missionary” position, genital-oral contact, anal intercourse, coitus interruptus (withdrawing the penis before orgasm during heterosexual intercourse, a commonly-used birth control method), were all considered acts of sodomy. All sexual behaviors identified as non-procreative in nature came to be grouped under the heading of sodomy and “sins of the flesh” (Karlen 1971; Katz, 1995; Kinsman, 1987; Mondimore, 1996).

The concern over non-procreative sexual behaviour rested with the “spilling of seed”. Since semen was considered to be the sole embodiment of human life, wasted semen or semen that was not used for procreative purposes, was seen as squandering a precious, limited resource. Although women were perceived to have “seed,” a woman’s erotic acts with another woman were not apparently thought of as wasteful, or as squandering her seed-ripening ability. So these were considered to be lesser violations in the procreative order. Non-procreative sexual behaviour went against the divine law to be “fruitful and multiply” (D’Emilio & Freedman, 1988; Katz, 1995)

The Roman Catholic Church gave final definition and authority to these doctrines at the Council of Trent in 1563. The beliefs of Augustine and Aquinas became unshakable law for the faithful. During the early Middle Ages, ecclesiastical law governed sexuality and those who transgressed from marital reproductive sexual behaviour were punished to varying degrees. In 309 A.D., thirty-seven out of eighty-seven canon laws enacted by the church council of Elvira concerned sexual behavior. It was at this time that Emperor Constantine proclaimed Christianity as the state religion of the Roman Empire and canon law became civil law throughout Europe. Christian zealots omitted references of same-sex relations in the works of the Greek philosophers such as Sappho, Socrates, Plato and Homer. In 380 A.D., Saint Gregory of Nazianzus, Bishop of Constantinople, ordered Sappho's writings burned wherever they were found, calling them *gynaeon pornikon erotomanes* – roughly, “lewd nymphomaniac”. Pope Gregory VII had many of Sappho's surviving works burned in 1071. The destruction of these writings led inevitably to the invisibility of lesbian reality throughout Western history (Foucault, 1990; Karlen, 1971; Mondimore, 1996).

CRIMES AGAINST NATURE

During the Middle Ages, as the laws of the Christian religion were fused with those of the State, the Church and State divided the jurisdiction over investigating and punishing various offences. Many sexual crimes came under the jurisdiction of ecclesiastical rather than civil courts; but since the Church could only assign penance and not itself spill blood, it handed over the

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convicted offender to civil authorities for punishment under civil law (Karlen, 1971). Under civil law, “sins of the flesh” came to be defined as “crimes against nature” (Kinsman, 1987).

Gradually, the Roman Catholic Church came to have greater and greater influence over all aspects of European life, as Bishops, under the direction of Popes, steadily consolidated their power across the continent. By the Fourteenth century, monarchs and princes throughout Europe bowed to pressure from the Roman Catholic Church to make “sodomy” criminal and a capital crime (Mondimore, 1996).

The prosecution of sodomites was carried out in reckless fashion, since the penalty was exacted even without an accuser. “Pederasty” became the crime of those to whom no crime could be imputed. Those who were convicted had their testicles removed and were paraded through the streets (Karlen, 1971). Thirteenth-century English law called for persons who had intercourse with Jews, children, and members of their own gender to be buried alive. The same code called for arsonists, sorcerers, and heretics to be burned at the stake (Mondimore, 1996).

Almost all of our knowledge about the lives of persons living prior to the mid-Nineteenth century, whom we might call “homosexual”, is derived from accounts of these criminal prosecutions (Mondimore, 1996). It was around 1869 that the word “homosexuality” was first coined (Mondimore, 1996; Weeks, 1991). A German minister of justice, in drafting a new penal code for the North German Federation, included a section in the Prussian criminal code which stated that sexual contact between persons of the same gender was a crime. The German

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minister termed this practice of sexual relations between two men or two women as “homosexual” (Mondimore, 1996)

Because the majority of literate persons during this time were priests and monks (an exclusively male domain), and since the Church was at times obsessed with preventing “unnatural” acts and punishing “sodomites”, only a sketchy historical record exists of same-sex eroticism during the Middle Ages. Nevertheless, there are enough clearly homoerotic letters and poems (ironically, largely by clerics) to suggest that a homosexual subculture existed within the monasteries of Tenth-and Eleventh-century Europe (Mondimore, 1996).

Modern societies have discarded most of the Medieval rules governing sexual life. Seriously held and gruesomely enforced proscriptions against most forms of “sodomy” have been abandoned. Christians are no longer jailed for having intercourse with Jews or Muslims, heterosexual intercourse in other than the “missionary position” is not considered a sin, and neither is heterosexual oral-genital contact. However, negative attitudes toward homosexuality persisted. Throughout most of Europe, same-sex contact continued to be punished, if not with death sentences, with prison terms and other dire punishments typical of the time such as castration. The condemnation of homosexuality continues today through discriminatory statutes and laws. Mondimore (1996) suggests that the political and psychological dynamics of majority attitudes toward a minority group would seem to account for the continued discrimination toward homosexuals in a much more compelling way than theological principles.

Unpopular rules get changed when they are unpopular with the majority, and unlike the rules against heterosexual "sodomy", the rules against homosexuality affect only a minority of individuals (Mondimore, 1996:27).

CONGENITAL DISEASE

A turning point in history occurred as science replaced the Church as chief arbiter of principles of sexual behaviour. Lesbians that had been looked upon as sinners or criminals would now be looked upon as having a congenital disease (Karlen, 1971; Klaich, 1974). Lesbians began to pass out of the hands of God, and the courts, into the hands of the medical men (Klaich, 1974).

The emergence of psychological and medical models of homosexuality was intimately connected to the legal system. European writers such as Casper and Tardieu, the leading medical-legal experts of Germany and France, were chiefly concerned about whether the "disgusting breed of male perverts" could be physically identified by the courts, and whether they should be held legally responsible for their acts. According to Magnus Hirshfeld, most of the one thousand or so works on homosexuality that appeared between 1898 and 1908 were directed at the legal profession. Lesbianism, however, was often excluded from this legal discourse, paralleling the subordinate position of women in both Europe and North America, and the middle-class "Victorian" beliefs around women's sexuality and gender roles (Karlen, 1971; Kinsman, 1987; Weeks, 1991).

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By the end of the Nineteenth century, neuroscientists and physiologists began to study lesbianism and male homosexuality. The works of Casper, Tardieu, Ulrichs, Westphal, Kraft-Ebing and Freud all sought to define, and hence psychologically or medically construct, new categorizations of sexuality (Karlen 1971; Klaich, 1974; Mondimore, 1996; Weeks, 1991).

Sexology undertook to manage and study sexual behaviour by developing a system of classification wherein sexual behaviours came to be grouped according to their degree of “deviance”. The biological basis of sexual behaviours was examined by investigating the functioning of the brain and nervous system, sexual anatomy, and the regulation of hormonal systems in humans and animals. Richard von Krafft-Ebing, Professor of Psychiatry and Neurology at the University of Vienna, wrote Psychopathia Sexualis, first published in Germany in 1882. This study attempted to consolidate, describe, and categorize every possible human sexual activity that deviated from the basic unadorned male-female coitus. The book contained over two hundred medical case histories, seventeen of them about lesbians. Lesbians, who in some way were visible and available for investigation, were psychiatric patients confined in mental hospitals or women incarcerated for criminal acts such as prostitution. As later research would prove, the great majority of lesbians fall into neither of these categories (Katz, 1995; Klaich, 1974; Mondimore 1996).

Krafft-Ebing, director of a mental institution, became a specialist in nervous diseases, an expert in medico-legal problems and served as a psychiatric consultant to the courts of German and

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Austria. The findings in Psychopathia Sexualis (1882) informed the conditions of law. The book was meant for members of the medical and legal professions, however, Krafft-Ebing's writings catered to a desire by society in general, to be shocked and sensationalized by stories of "deviant" behaviour and tortured "perverts". He introduced his cases with adjectives such as "revolting," "disgusting," "horrible," "shameful" and "monstrous". Virtually every literate European household of the time possessed a copy of Psychopathia Sexualis. It is through the widespread reading of Krafft-Ebing's work that the public got its first inside "scientific" look at lesbianism, a subject that they knew virtually nothing about. To locate lesbians, it was necessary to wade amongst necrophiliacs, lust murderers, rapists, and child molesters (Karlen, 1971; Klaich, 1974).

To understand how Krafft-Ebing came to his conclusions about lesbianism, it is necessary to understand his attitudes toward women and sex, attitudes that were shaped by Christian religious doctrine. According to Krafft-Ebing, the physically and mentally "normal" woman would have little sensual desire, be passive, and be dedicated to marriage. He held the Christian belief that the real object of the sexual instinct was procreation of the species. From his definition of "normal" women it followed that lesbians were not "real" women. They were not passive, they were oversexed, and they did not consider marriage the be-all and end-all of their existence. And from his definition of what "normal" sex is, lesbians clearly did not possess a "real" sexual instinct because lovemaking did not have baby-making as a goal, (Katz, 1995; Klaich, 1974).

Krafft-Ebing concluded that lesbians did not differ physically from heterosexual women. He stated that since lesbians had normal sex glands and normal primary and secondary physical sex characteristics, their condition must be due to a "cerebral anomaly," part of an inherited, diseased condition of the central nervous system. In other words, lesbians were born lesbians because their genes were faulty. He stated that one could not tell from her external actions whether or not a woman "suffered" from lesbianism. However, he mentioned certain behaviors or attitudes that might indicate this: A dislike of attending balls (one patient even went so far as to prefer intellectual talk to dancing); smoking and drinking to excess; the disdain of perfumes; interests in the sciences rather than the arts; and concerns about being denied access to higher education. Other indicators were females wearing short hair; those who dressed in the fashion of men; and women who pursued the sports and pastimes of their male acquaintances (Klaich, 1974). Many of these stereotypes about lesbians have evolved to the present day.

Kraft-Ebing argued that congenital lesbianism was pathological, a loathsome disease that had to be exorcised. Because lesbianism was congenital, the only "cure" was to give up sex, any kind of sex, and strive for "ideal chastity"; to become (as he reports one of his patients did) a decent, sexually at least, neutral person (Katz, 1995; Klaich, 1974). The text of Richard von Kraft-Ebing was significant in directing the scientific community for the next 80 years in equating homosexuality with deviance and pathology.

However, debates over the physiological, biological and psychological origins of homosexuality continued. Researchers such as Edward Carpenter, Magnus Hirschfeld, Havelock Ellis and Iwan

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Block, whose labeling, categorizing and taxonomic zeal led them outside their own cultures, began to express more cosmopolitan views. The works of early sexologist Edward Carpenter attempted to demonstrate the trans-historical existence, and the value, of homosexuality as a distinct sexual experience. Magnus Hirschfeld preached understanding and acceptance of homosexuals [lesbians] and sought to support his activism by scientific methods. Havelock Ellis claimed that different-sex and same-sex eroticism was inborn and therefore biologically determined. The works of Havelock Ellis and Iwan Bloch had clear-cut historical sections. They established the parameters of homosexuality [lesbianism], what distinguished it from other forms of sexuality, what history suggested about its etiology and social worth, the changing cultural values, and the great figures – in politics, art, literature – one could associate with the experience (Katz, 1995; Mondimore, 1996; Weeks, 1991).

MENTAL ILLNESS

A decade after Krafft-Ebing's formulation of heterosexuality and his attempts to offer a physiological explanation of homosexuality, there began to appear, in certain medical circles, a shift in emphasis to a psychological explanation (Katz, 1995; Klaich, 1974).

Sigmund Freud was the pioneer in this phase of theorizing. Freud's works provided the heterosexual canon with some of its most intellectually developed, and double-edged, texts.

Underlying Freud's theories is the social construction of heterosexuality, providing the most

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complex support for heterosexual rule and important tools for challenging heterosexual domination (Katz, 1995).

Freud believed that lesbianism was not necessarily a neurotic illness. He did not categorically lump lesbians into the broad category Krafft-Ebing had labeled “perversions”. Although Freud considered lesbianism to be a sexual practice that “deviates from the usual one”, he felt that there were degrees of “non-average” sexual behaviour; homosexuals [lesbians], he wrote, “do at least seek to achieve very much the same ends with the objects of their desires as normal people do with theirs” (Klaich, 1974:69).

Freud attributed the state of lesbianism to the Oedipus complex. His theory begins with the supposition that a female’s libido at birth is composed of both heterosexual and homosexual possibilities – i.e., a female child starts out in life bisexual. In the process of her growing up, several stages of sexual development must be gone through before one of the possibilities becomes overt, and the other is sublimated. During very early childhood, a girl’s eroticism is focused on her mother, and her sexual activity is centered on her clitoris. It is during this pre-Oedipal phase that the girl discovers that she does not possess a penis, experiencing the feeling of castration. This castration complex is a turning point in her life when she rejects her mother and turns to her father, in the hopes of obtaining a penis. In rejecting her mother and turning to her father, she enters into what Freud called the feminine Oedipus situation, a phase of passive sexuality. If, in turn, the girl replaces this wish for a penis into a wish for a child (a symbolic penis), the path is paved for the development of adult heterosexual behaviour. If however, the

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girl's attachment to her father had been unusually strong, instead of projecting her need for a penis/baby onto other men, she will reject all men. In this instance, the girl is said to be fixated at an "immature" level of sexuality, stuck in a feminine Oedipus complex and the way is open for a possible slide into adult homosexuality. This is one way, according to Freud, that a girl becomes lesbian (Karlen, 1971; Katz, 1995; Klaich, 1974).

Another way is for a girl never to enter the Oedipus phase at all. In this case, the girl child refuses to reject her first love object, her mother, and clings to active sexuality, and clitoral masturbation, instead of entering the passive sexual phase. The girl unconsciously believes that she already has a penis, so does not need to obtain one from her father. In later years, this girl may project her erotic feelings for her mother onto other women. She is then fixated at an "immature" level of sexuality stuck not in an Oedipus complex but in a Masculinity complex. Lesbianism, in Freud's thinking, results from a woman's unconscious fear of all men. She thus lives her life within the framework of the Oedipus complex, or excessive penis envy, wherein a woman denies she does not possess this organ and lives her life within the framework of a Masculinity complex (Klaich, 1974).

Freud did not believe that lesbianism could be "cured" through psychoanalysis. He believed that the determining factor is constitutional, that the strength of the homosexual element in the original bisexual makeup would turn out to be greater than the heterosexual element, thus tipping the balance (Klaich, 1974). Freud wrote:

It is not for psychoanalysis to solve the problem of homosexuality. It must rest content with disclosing the psychical mechanisms that resulted in determination of the object-choice, and with tracing the paths leading from them to the instinctual basis of the disposition. There its work ends, and it leaves the rest to biological research...
(Freud in Klaich, 1974:72).

Although Freud suggested that homosexuals were stuck at an early phase of development, he also suggested that most heterosexuals were also fixated on one particular, exclusive sex. Freud perceived exclusive heterosexuality to be the socially restricted result of an original, roving sexual instinct. This normal heterosexuality is by no means natural. It's the limited social product of a difficult developmental process. The child, in Freud's theory, moves into heterosexuality through stages, from polymorphous to exclusive, from nature to culture, from biological to social, from primitive to civilized, from infantile to mature (Katz, 1995).

Freud's work expressed the dominant morality of the time, which required heterosexuality. For Freud, maturity and immaturity took on extremely value-laden meanings. Heterosexuality is mature, normal and good, homosexuality is immature, abnormal and bad. Freud and other sexologists affirmed the difference between heterosexual and homosexual, and proclaimed the heterosexual's superiority. The fixed, immature, non-procreating, pleasure-seeking, homosexual served as the doctor's totem of the monstrous and abnormal, while the non-procreating, pleasure-seeking heterosexual blossomed with normal sexuality (Katz, 1995).

In 1952, the American Psychiatric Association classified “homosexuality” as a mental illness, listing it in the Diagnostic and Statistical Manual of Psychiatric Disorders (Karlen, 1971; Kitzenger, 1987). Lesbians were viewed as sexually deviant, perverted, aggressive, masochistic, narcissistic, sadistic, neurotic, and schizophrenic (Bergler, 1948; Bergler, 1958; Bragman, 1934; Greenberg, et al, 1968; Kenyon, 1968, Owensby, 1940; Wittenberg & Rudoph, 1956). They were viewed as having a psychological disorder and cure, therapy and prevention of lesbianism, was proposed (Katz, 1995).

Frank S. Caprio, author of Female Homosexuality: A Psychodynamic Study of Lesbianism (1956), states:

The vast majority of lesbians are emotionally unstable and neurotic... Lesbianism is capable of influencing the stability of our social structure. Much of the incompatibility between the sexes is closely allied to this problem. Unconscious or latent homosexuality in women affects their personalities and constitutes an important factor in marital unhappiness being responsible in part for our present increasing divorce rate (Caprio, 1956:viii).

Lesbians were excluded from society via hospitalization and the degradation of lesbians incarcerated in mental institutions is well documented (Perkins, 1996). Lesbians who refused to conform were given electric shock treatment, and medical procedures such as female genital mutilation were performed. This rendered lesbians powerless in society, forcing them to remain invisible and isolated.

However, debates on the “causes” of homosexuality continued. Alfred Kinsey’s report on Sexual Behavior in the Human Male (1948) questioned the scientific terms of “normal” and “abnormal”, contesting an absolute either/or antithesis between exclusively heterosexual and exclusively homosexual behaviour and feelings. Kinsey stressed that the heterosexual/homosexual division was not nature’s doing but society’s doing (Katz, 1995).

Writers such as D.S Baily, Francois Lafitte, and Donald Webster Cory, reformists of the 1950s and 1960s, accepted the frameworks established by the pioneering works of Edward Carpenter, Magnus Hirshfeld, Havelock Ellis and Iwan Bloch. Baily, Lafitte and Cory continued to trace some of the forces that shaped public attitudes and viewed homosexuality as a distinct social experience allowing debates to continue in the Church and the courts (Weeks, 1991).

It was not until the late 1960s that sexual orientation moved beyond the medical field and into the public eye, as an issue of human right.

HUMAN RIGHTS

A significant proportion of homosexuals are apparently satisfied with their sexual orientation, show no significant signs of manifest psychopathology, and are able to function as effectively as heterosexuals. Homosexuality, per se, therefore cannot be considered a mental disorder (Weisstraub in Kinsman, 1987).

On December 15, 1973, the American Psychiatric Association removed "homosexuality" as a mental illness from its list of psychiatric disorders in the Diagnostic and Statistical Manual of Psychiatric Disorders (Karlen, 1971; Kitzenger, 1987). This decision to depathologize same-sex desire was likely influenced by two factors. The first was the socio-historical milieu of the 1960s and 1970s, when the gay rights movement visibly strengthened (Kinsman, 1987), and the second was the feminist movement, which entered its second wave. Both were interested in addressing the issue of equal rights.

In 1969, lesbian and gay people fought back against a routine police raid at the Stonewall Tavern in New York City. Thus was born the modern gay liberation movement, which challenged the power of the psychiatrists, psychologists, and medical doctors. The gay movement mobilized the hidden, isolated lesbian and gay population, creating new social needs, capacities, and pleasures (D'Emilio, 1983; Kinsman, 1987; McLeod, 1996; Witt, et al, 1995).

The emphasis of more recent research has been on reasserting the values of a lost experience, stressing the positive value of homosexuality and locating the sources of its social oppression. A major emphasis was on recovering the pre-history of the gay movement itself. What began was the search for "ethnicity" and validation of a minority experience which history had denied (Weeks, 1991). This is demonstrated in Jonathan Katz's Gay American History (1996).

The first Canadian gay liberation group, the Vancouver Gay Liberation Front, was formed in November 1970. In 1971, the Toronto Gay Action network coordinated a protest by hundreds of

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lesbians and gay men, in Ottawa, to demand equal employment rights and the right to be gay and serve in the Canadian Armed Forces. Gays of Ottawa was founded in 1971 and spawned mental health services, self-help, and political organizations. Tension between lesbians and gay men, which is largely caused by sexism on the part of the men, eventually led to the formation of lesbian caucuses and separate lesbian groups (D'Emilio, 1983; Kinsman, 1987).

The 1970's also marked the second wave of the feminist movement, when feminists began once again to question the social reality of women's lives. Early feminist perspectives and resulting social changes had put into question the relations of patriarchy and sexual regulation, allowing this new phase of the feminist movement and the gay liberation movement to go much farther.

By critically examining gender, feminists argued that gender was central in the shaping of our consciousness, skills and institutions as well as in the distribution of power and privilege. Women's one-down position in society was therefore attributed to gender inequalities existing between women and men and the socialization practices that constructed female identities to behave according to sex-role stereotypes. Women were considered to be acting in gender appropriate ways if their behaviour and physical appearance reflected a "feminine image", if they engaged in heterosexual relations, acted passively, had few career aspirations, accepted their "intellectual inferiority", and had as their goals to be traditional wives and mothers (Bunch, 1975; Ferguson, 1981; Hooks, 1984; Katz, 1995; King, 1990; Shelley, 1970).

These gender norms were considered by feminists to be oppressive to women because they served to keep women from accessing the social and economic privileges available to men. They were also considered to be integral to the construction and maintenance of a patriarchal social order. Feminists identified sexism, or the prejudice against one group of people because of their sex, as being an insidious form of male domination; thus, feminists concluded that all women suffered from a common oppression (Hooks, 1984).

While some mainstream feminists were debating sexism as being the sole cause of women's oppression, black women, lesbians, and other oppressed women began to voice their concerns about the ethnocentricity of feminist theory. While mainstream feminist theories assumed the homogeneous identity of all women, others were concerned with the issue of identity in terms of political and personal power relations of all people who are repressed and marginalized. This marginalization was occurring not only on the grounds of gender but also sexual orientation, race, class and ability. The acknowledgement of the diversity of oppressions experienced by some women prompted some feminists to redefine the meaning of feminism (Bannerji, 1995; Katz, 1995).

This redefined feminist perspective asserts that our society is comprised of hierarchies that foster an inequitable distribution of power and privilege, and that oppression is central to maintaining this power and privilege (Bunch, 1975; Ferguson, 1981; Hooks, 1984; Katz, 1995; King, 1990; Shelley, 1970). The dominant group, particularly heterosexual, white, non-disabled, upper-class men, enforces oppression. All individuals who do not fall within the ideal standards set out by

this group are at risk of coercive domination. Hierarchical rule and coercive domination are seen as natural and are essential to maintaining the existing social order (Hooks, 1984).

The emerging lesbian-feminist perspective validated the life experiences of lesbians in a heterosexist society. They stated that to be lesbian is to experience historical, political, social and economic oppression as both a woman and as a lesbian (Bunch, 1975; Ferguson, 1981; King, 1990; Shelley, 1970).

Lesbian-feminist perspective stated that socially defined "sex roles" and sexual "categories" were major ideological forces that channel women into reproductive and erotic relations with men. Heterosexuality and homosexuality were prominent among those questionable categories (Katz, 1995).

Homosexuality is a by-product of a particular way of setting up roles (or approved patterns of behavior) on the basis of sex; as such it is an inauthentic (not consonant with reality) category. In a society in which men do not oppress women, and sexual expression is allowed to follow feelings, the categories of homosexuality and heterosexuality would disappear (Koedt, et al, 1973:241).

The social construction of heterosexism and ensuing Freudian theory that named lesbianism as sexual pathology were detrimental to lesbians even within the feminist movement (D'Emilio, 1983). In 1970, mainstream feminist Betty Friedan, was quoted in the *New York Times* complaining about the lesbian-feminists who, she thought, were giving feminists a bad name.

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Lesbian-feminists argue that the language of “lesbian” and “dyke” are used by men to uphold male and heterosexual supremacy. “Men throw “lesbian” and “dyke” at any woman who questions male authority” (Katz, 1995:143). This language served, and continues to serve to keep women branded, divided and conquered.

In examining the history of sexual orientation, it is revealed that lesbianism has indeed existed in all places and times. Lesbianism has been viewed as a “sin”, a “crime”, a “disease” and a “mental illness”. Today, however, sexual orientation is a matter of human rights. Human rights protection in Canada exists for lesbians, gay men and bisexuals through the Charter of Rights and Freedoms, the Canadian Human Rights Act, and since 1986, the Ontario Human Rights Code. All protect against discrimination based on sexual orientation (PTS, 2001).

Health and social services are defined as a basic human right (UN Declaration of Human Rights, 1948). Therefore, lesbians have the right to equal access to safe, appropriate and comprehensive health and social services. They have a right to be treated with compassion and respect, without bias or discrimination.

In summary, a social constructionist framework allows the reader to understand the impact of the historical context on definitions of lesbianism. It allows for an understanding of religious, moral, juridical, economic, familial, and medical practices in relation to lesbianism.

The construction of heterosexist society has been detrimental to women who identify as lesbian. Lesbianism has been viewed as a sin, a crime, a disease and a mental illness leaving a legacy of prejudice, discrimination and stigmatization. This has had a profound impact the provision of mental health services to lesbians. There is persistent evidence that health and social services inadequately serve lesbian clients. As well, the construction of lesbian as mentally ill has greatly impacted lesbians access to mental health service. Numerous years of being viewed by medical professionals as sick, degenerate, immature and psychotic has resulted in lesbians often perceiving or experiencing interactions with health and social service providers differently than heterosexual women (Jay, 1995) and men.

CHAPTER III

LITERATURE REVIEW

The following chapter explores and examines the literature pertaining to lesbians and their mental health. It has been categorized into four distinct sections:

- Lesbians in Social Science Research
- Lesbians and Mental Health
- Lesbians' Access to Health and Social Services
- Gaps in Research

LESBIANS IN SOCIAL SCIENCE RESEARCH

Research and literature concerning lesbians has been, and continues to be, greatly influenced by the historical, social and political construction of sexual orientation. History shows that it has been the bigoted and judgmental who have resisted the gathering of lesbian and gay-friendly scientific data. One of the first and largest libraries of case studies and other material for the study of sexual behaviour, *The Institute of Sexual Science*, led by the German psychiatrist and activist Magnus Hirschfeld, was looted and burned by the Nazis in 1933. This library

housed the works of reformists such as Carpenter, Ellis and Block and with the destruction of the Institute, historical research that valued homosexuality virtually ceased (Greenberg, 1998, Mondimore, 1996). Therefore, research which pathologized lesbianism and homosexuality occupied all research space.

Tully, in Lesbian Social Services: Research Issues (1995) identifies five major phases of lesbian research beginning in the 1930s. They are: (1) Etiology, (2) psychological functioning, (3) social functioning, (4) life span development, and (5) clinical intervention.

According to Tully, the first phase of research and literature was conducted primarily by men, and dealt almost exclusively with the question of lesbian **etiology**. This research attempted to link “female homosexuality” to body size, birth order and handwriting (Gundlach & Riess, 1967; Karlen, 1971; Klaich, 1974; Kenyon, 1968; Kinsman, 1987; Mondimore, 1996; Weeks, 1991). The physicians and psychiatrists who wrote of it were primarily interested in its causes, prevention and treatment (Greenberg, 1988). Tully (1995) notes that, to date, research on the etiology of lesbianism is contradictory and inconclusive.

Tully’s second major phase of research was based on the **psychological functioning** of lesbians. Psychoanalytic theory played a key role in the designation of “lesbian” as having a psychological disorder and in the proposing of the cure, therapy and prevention of lesbianism (Bergler, 1948; Owensby, 1940). Following the traditional medical model, these studies

assumed that gross differences would exist between heterosexual and homosexual women and that such differences constituted psychological pathology in the lesbian (Hughes, et al, 2000; Tully, 1995). This model of lesbianism as pathology, which dominated social scientific theorizing until the 1970s, can be an easy target for criticism and has been widely challenged for its methodological inadequacies and ideological biases (Kitzinger, 1987). At this time very little sociological work on the “causes” of homosexuality were being undertaken, probably because the subject was considered more suitable for biologists and psychologists. Some researchers may also have feared that if they studied homosexuality, they would be suspected of it themselves (Greenberg, 1988:2).

Research and literature in relation to homosexuality began to shift, as the social and historical milieu of the 1960s energized a national Gay Rights Movement bringing lesbian and gay issues “out of the closet”. This marked Tully’s third phase of research: **social functioning**. The gay liberation movement vastly broadened the scope of scholarly writing on homosexuality. It weakened prejudice enough to permit scholars to publish on this topic, without committing professional suicide, and it expanded the demand for lesbian and gay-friendly research. The research being conducted at this time began to move homosexuality out of an illness/medical model and viewed homophobia as the problem (Herman, 1993).

However, research still emphasized the gay male subject to the neglect of research that might specifically benefit lesbians. Perceived as similar to gay men, lesbians were further removed

from traditional realms of inquiry, thus obscuring the interrelationship between heterosexism, homophobia and sexism. Thought of as homosexuals, and defined in opposition to heterosexual women, lesbians were excluded from most areas of scientific research, most notably from obstetrics/gynecology, the medical specialty devoted specifically to women's health (Anderson, et al, 2001; Sorensen & Roberts, 1997).

It is not until the 1970's that the research and literature begins to shift, with small amounts of work conducted in the area of lesbians and issues of identity, self-esteem, self-acceptance, social support and coming out. Tully's (1995) fourth phase of research, **life span development**, was conducted primarily by lesbians and viewed lesbians as healthy individuals. While this research on lesbian health has certainly been beneficial to the lesbian community much of it has been conducted with small, homogenous samples (Hughes, et al, 2000).

Tully's fifth phase of research begins in the 1980s and addresses **clinical intervention**. The mental health service needs of lesbians is an area of research that has been getting more attention since the 1990's. This research addresses the complexities of homophobia and heterosexism and the impacts that negative stereotypes and misinformation (or lack of information) have on lesbians. The provision of mental health services to lesbians is being examined from the standpoint of assessment, specific therapeutic issues, and ethics (Tully, 1995).

The portrayal of lesbians in social science research has moved progressively forward from prevention to acceptance of lesbianism. Today, some social science researchers can be seen examining lesbians' mental health concerns.

LESBIANS AND MENTAL HEALTH

Lesbians are exposed to the same female socialization process as heterosexual women. The social world in which heterosexual women and lesbians have to function is one in which sexist and heterosexist social organisation prevails; women are urged to see their identity in terms of their success as wives, mothers and sexual companions, and social institutions and dominant ideologies maintain women's subordinate positions and limited power (Perkins, 1997).

Lesbians and heterosexual women alike share the stresses that are caused by male oppression; stresses such as male violence, sexual abuse, poverty and strains of living in a world defined by men. Therefore, many women experience problems with self-esteem and assertiveness. This is related more to the condition of being a woman in a sexist society rather than to being lesbian (Perkins, 1997).

Much research has shown that lesbians and heterosexual women share many of the same mental health concerns. These concerns include relationship issues, separation from an intimate partner,

partner abuse, blending families, parenting and child rearing, job loss, childhood abuse (physical, emotional and/or sexual), substance abuse (alcohol, illegal drugs, prescription drugs), depression, anxiety, feeling suicidal, caring for a loved one and/or death of a loved one (Anderson, et al, 2001; Collett, 1982; Hughes, et al, 2000; Jay, 1995; Neisen & Sandall, 1990; Rothblum, 1990; Trippet, 1994; Woodman, 1989).

Relationship issues and depression can be problematic experiences for any woman, but the compounding issue for lesbians is society's negative attitudes toward lesbianism. Relationship issues and depression experienced by a lesbian have a different source than those experienced by a heterosexual woman. For example, a lesbian's relationship with another woman may be hidden from family and known by only a few friends. If the relationship breaks up, the woman has a limited support group to turn to for help in her grief (Trippet, 1994).

At a societal level and on a day-to-day level, a lesbian's experience of living in a homophobic society make her more vulnerable and at higher risk of certain health issues. Internalized beliefs about lesbianism complicate the process of lesbian self-acceptance, and often have profound effects on a woman's mental health (Jordan & Deluty, 1998).

In a study of 503 lesbian women (Trippet, 1994), individuals were asked whether they had ever experienced any of a list of eleven mental health problems. Relationship issues rated highest at 76%. Next was conflict between being in the closet at work and out socially (66%), depression

(66%), conflict over coming out (60%), contemplation of suicide (38%), conflict over religion (27%), alcohol abuse (23%), drug abuse (17%) and attempted suicide (11%).

The PTS (2001) study shows that 44% of GLBT respondents have one or more health conditions that have been diagnosed by a health professional, and that have lasted or are expected to last six months or more. The types of conditions mentioned most often were depression, anxiety and/or panic disorder and chronic fatigue syndrome. The study looked at twenty possible issues that can affect a person's health and wellness. Eighty percent of the respondents checked at least one issue of concern. Forty percent of respondents indicated three or more issues of concern. Depression (37%) was reported most often as an issue of concern. Next was finding friends (35%), finding a partner (33%), loneliness/isolation (33%), family relationships (31%), homophobia (29%), parenting (27%), staying in school (24%), coming out (21%), and job search/job loss (20%).

▽ Safety & Secrecy

Centuries of oppression have left lesbians experiencing discrimination on a daily basis. The result is that they feel enormous stress and profound isolation (Anderson, 2001; Collett 1982; Hughes, 2000; Jay, 1995; Jordan & Deluty, 1998; PTS, 2001) which impact greatly on their mental health.

Carrying with them a collective history of violence that includes unjust incarceration in jails and mental institutions, discrimination and harassment, lesbians often deem it unsafe to be “out” in society. Feeling safe and free from crime and harassment is an important issue for everyone, but especially for lesbians. Anti-lesbian and anti-gay hate violence is an extreme extension of heterosexist ideology (Herek & Berrill, 1996). So-called hate crimes operate within the oppressive system of heterosexism and only recently have acts of violence against lesbians been recognized as a form of hate violence.

Throughout the 1980’s the National Gay and Lesbian Task Force, through its Anti-Violence Project, attempted to document the nature of the problem. Although anti-lesbian and anti-gay violence is the most recently recognized form of hate-based violence, lesbians and gay men are probably the most frequent victims of any and all types of hate-based violence (Herek & Berrill, 1996). Thousands of incidents of violence, ranging from verbal abuse to homicide, are reported annually in Canada. The categories of incidents recorded by the National Gay and Lesbian Task Force include murders, assaults, hate group activity, police abuse, arson, vandalism, threats and harassment, campus violence, military incidents, AIDS-related violence, and defamation.

The Ottawa PTS (2001) study confirms lesbians’ feelings of being unsafe. Respondents were asked how safe they feel living in Ottawa on a scale of 1 to 5, 1 = very safe, and 5 = very unsafe. The majority of respondents (68%) selected 1 or 2, indicating a general feeling of safety. The places respondents did not feel safe being themselves included the work place (56%), place of worship (56%), at school (46%) and in the neighbourhood (42%). The study also showed that

there is a difference in how safe respondents felt in Ottawa by time of day. During the daytime, most (81%) of respondents reported that they felt safe everywhere. However, at night, 44% of respondents reported that they don't generally feel safe. This statistic may not differ from reports of heterosexual women in terms of feeling of safety.

The PTS (2001) study indicates that verbal abuse is a common experience among GLBT persons; 38% of respondents had experienced verbal abuse three or more times and 35% indicated that they had never been verbally abused. In a 1997 study, the Coalition for Lesbian and Gay Rights in Ontario (CLGRO) found a similar trend. In this Ontario-wide study, 71% of respondents reported that they had been verbally harassed. The PTS (2001) study shows that GLBT persons have had three or more experiences with threats of violence (13%), and acts of crime or attempts (9%).

Lesbians' experiences or fears of harassment and violence force many to remain invisible in society. Several authors have spoken about the stress of "secrecy" in lesbians' lives (Collett, 1992; Gartrell, 1987; Gentry, 1992; Gillow & Davis, 1987; Liljestrand, Gerling & Saliba, 1978; McDermott, Tyndall & Lichtenberg, 1989; Neisen & Sandall, 1990). Society's negative attitudes toward lesbians make them fearful of persecution, often feeling compelled to hide their lesbianism from their friends, their family members, and from people in the workplace (PTS, 2001). The decision to remain "in the closet" affects all parts of a lesbian's life. Lesbians often feel they must be careful of the company they keep, the activities that they engage in, what they

share with colleagues about their social life, whether they can engage in a discussion about gay rights, etc. (Collett, 1982).

▽ Secrecy & Stress

Stress is a logical reaction to simply living as an outsider in a heterosexist world. Research reveals that being lesbian exposes persons who identify as such to higher rates of both external and internal stress, and this stress is believed to be associated with a higher risk for some mental health problems (Hughes, et al, 2000).

In a study comparing lesbians' and heterosexual women's mental health, Hughes, et al, (2000) note that both lesbians and heterosexual women reported moderate levels of stress. The differences came in the sources of stress, with heterosexual women rating children, and lesbians rating sexual identity as their highest source of stress. Some of the most recent issues addressed in the literature on the mental health concerns of lesbians include the relationship between homophobia, stress (Neisen & Sandall, 1990), and depression (Rothblum, 1990; Woodman, 1989).

In the Ottawa PTS (2001) study, it is noted that high stress is a part of daily life for many GLBT persons. Using a measure taken from Statistics Canada's Community Health Survey (2000), the PTS study asked respondents how life was most days – very stressful, quite a bit stressful, a bit

stressful, or not at all stressful. Forty-two percent of respondents indicated that life was quite a bit or very stressful most days.

Perhaps as a result of acknowledging the significant stressors inherent in being lesbian in a straight society, many past studies have focused on the suspected increased risk of suicide and the increased abuse of alcohol for gay men and lesbians (Hall, 1992; Hughes, et al, 2000; Diamond & Wilsnack, 1978; Rofes, 1983; Saunders & Valente, 1987). Studies dealing with suicide and suicide risk among homosexual men and women have found that lesbians had two and one half times more suicidal behaviour than heterosexual women (Hughes, et al, 2000; Saunders & Valente, 1987). They identified three predictors of suicide among lesbians: Past suicide attempts, alcohol/drug abuse, and interrupted social ties (Saunders & Valente, 1987). Significant differences between lesbian (51%) and heterosexual women (38%) were found in the Hughes report of whether they had seriously considered committing suicide. In addition, significantly more lesbians (22%) than heterosexual women (38%) reported previous suicide attempts. Twice as many lesbians as heterosexual women reported suicide attempts during their 20s (Hughes, et al, 2000).

Bradford, et al, (1994) studied 1,925 lesbians on a variety of issues. Suicide ideation was identified as occurring "sometimes" or "often" by 21% of the women. Saunders et al. (1988) surveyed 996 lesbians. Depression (49%) was the most frequently cited of the specific difficulties identified by lesbians. "Excesses" were identified as drinking (35%), eating (35%),

and smoking (34%). Other concerns were suicidal feelings (29%), anger beyond control (24%), drug dependency (12%), and loss of contact with reality (13%).

In terms of depression, Bradford, et al. (1994) and Sanders et al. (1988) found that about half their sample reported feeling depressed, and that the degree of how 'out' a lesbian was, and her experience with being out, affected her health. In the Hughes, et al. (2002) study, a slight majority of lesbians (56%) were more likely to report depression than heterosexual women (49%). Lesbians were also more likely to report alcohol-related problems, anxiety, depression, and suicidal feelings when they were young, especially when dealing with issues related to stigma, discrimination and coming out.

Some past studies identified a higher use of alcohol in the lesbian population (Diamond & Wilsnack, 1978; Hall, 1992; Lewis et al, 1982), but many of these studies have been criticized for possibly inflating these rates due to their selection of samples from environments, such as bars, that already have an increased incidence of alcohol use (Mosbacher, 1988). Mosbacher suggests that surveying a sample of lesbians outside of bar environments may result in the reporting of lower rates of alcoholism and alcohol use in general. In the Hughes, et al. (2002) study, lesbians were more likely than heterosexual women to report abstinence from alcohol.

This literature has important implications for assessment and treatment of lesbians in terms of stress, coping, and risk for mental health problems (Hughes, et al, 2000). It is important that practitioners working in mental health and social service settings be aware of these potentially

higher risks. However, many mental health professionals do not have an understanding of lesbians' mental health needs creating unequal access to health and social services.

LESBIANS' ACCESS TO HEALTH & SOCIAL SERVICES

Mental health services have long been associated with heterosexist bias. As noted earlier, historically, the discipline of psychology has maligned and pathologized lesbian persons in both theory and in practice. While the removal of homosexuality as a mental illness from the DSM II in 1973 has been a giant leap forward, there are still enormous barriers that exist for lesbians in accessing health and social services. These barriers include an assumption of heterosexuality or lack of awareness around lesbian issues among service providers.

Research findings indicate that similar to other women, lesbians seek out therapy as a coping strategy to deal with issues such as depression, and relationships (Sorensen & Roberts, 1997). However, some studies have shown that higher rates of participation in therapy/counseling were found among lesbians (Hughes, et al, 2000; Bradford et al, 1994). A significantly higher rate of lesbians (78%) reported that they had received counseling for an emotional or mental health problem than heterosexual women (56%). The most common reason for seeking help, reported by both lesbian and heterosexual women, was for problems with a spouse or partner (Hughes, et al, 2000).

The Ottawa PTS (2001) study shows that 40% of GLBT respondents used counselling/therapy services within the past five years, on average between three and four services. Other services used in the past five years were youth services (23%), alternative therapies (19%), mental health services (11%), addiction services (4%), suicide/crisis lines (4%), home support (3%), child care services (2%), senior services (<1%), immigrant services (<1%), and shelters (<1%).

Twelve percent of respondents felt that they had received poor or negative treatment because they were gay, lesbian, bisexual and/or transgender. The services where the highest percentage of respondents reported poor or negative treatment were child care services (25%), public housing (18%), home support services (17%), social services/welfare (17%), suicide/crisis lines (15%), ambulance, fire, etc. (14%), addiction services (14%), youth services (13%), mental health services (13%), hospital in-patient (11%), hospital emergency (11%), and divorce services (11%) (PTS, 2001).

In terms of unmet needs, the PTS (2001) study indicates that half of the GLBT respondents are not getting adequate support. Fifty-one percent of respondents with issues reported at least one unmet need, 32% had one or two unmet needs, and 19% reported three or more unmet needs. Areas of concern were violence in a relationship (75%), finding a partner (69%), finding friends (62%), child custody (59%), loneliness/isolation (57%), job search/job loss (52%), homophobia (50%), involvement with the criminal system (50%), pregnancy/adoption (50%), substance use (48%), family relationships (45%), parenting/child rearing (43%), feeling suicidal (43%), caring

for an ill loved one (39%), the end of a relationship (38%), coming out (33%), depression (30%) and the death of a loved one (26%).

Heterosexism and psychology's history of pathologizing lesbianism impacts on an individual's decision to seek mental health services, even prior to the stage of referral. For lesbians, the assumption of heterosexuality prevalent within organizations will determine if they will access the health and social services system. To ensure that comprehensive care is provided, lesbians must often make a declaration of their sexual orientation. Fears that such a disclosure will be met with disgust, fear, hostility or misunderstanding can cause lesbians to avoid accessing much needed services (Anderson, et al, 2001).

According to Herek & Berrill (1996), the threat of secondary victimization often acts as a barrier to seeking medical or mental health services. The anticipation of a negative reaction may discourage lesbians from being "out". The fear of identifying as a lesbian means that some lesbians must "pass" as heterosexual women in health and social service settings, therefore, providing incomplete or inaccurate information about themselves in an effort to camouflage their lesbianism and ensure supportive treatment. "Passing" can result in improper service, as well as discomfort and anxiety for the client (Anderson, et al, 2001).

It is not uncommon to find service providers who still view lesbianism as a form of psychopathology. This mistaken belief may surface in response to clients who are distressed by difficulties in coming out or who are ambivalent about their sexual orientation. With such cases,

conflict related to sexual orientation may be viewed as psychopathology rather than as a symptom related to difficulties in achieving good mental health (Anderson, et al, 2001).

The PTS (2001) study states that the majority of respondents (65%) would like to be able to use the variety of wellness services available to all Ottawa residents without having to hide their sexual or gender preference and without having to explain and educate service providers in how to work appropriately with GLBT people. Several researchers have noted the importance of mental health providers being knowledgeable and sensitive to the uniqueness of lesbian experiences (Roth & Murphy, 1986), especially in validating the consequences of living a life of “secrecy” (Gartrell, 1987; Gentry, 1992; Gillow & Davis, 1987; Liljestrand, Gerling, & Saliba, 1978; McDermott, Tyndall & Lichtenberg, 1989). Of the studies that have dealt with specific life and health experiences of lesbians, most focused on lesbians’ negative experiences with health care providers (Gartrell, 1987; Liljestrant, Gerling & Saliba, 1978; Dardick & Grady, 1987; Smith et al., 1985; Stevens & Hall, 1988; Hitchcock & Wilson, 1992; Maggiore, 1992) and the need to increase awareness and sensitivity among providers when caring for lesbians (Owen, 1980; Maggiore, 1992; Stevens, 1992).

The relevance of wellness to the quality of counsellor-client relationships is considered in much of the literature on lesbian health care experiences (Adams, 1989; Edelman, 1986; Gentry, 1992; Eliason, 1991; Smith, Jonhnson & Guether, 1985; Stevens & Hall, 1988; Trippet & Bain, 1992). Most emphasize the responsibility of mental health providers to familiarize themselves with the

social context of lesbian lives in order to provide sensitive care. Research shows that the quality of mental health services for lesbian clients is dependent upon the degree of sensitivity of the staff members to diverse sexual orientations (Roth, 2002). All service providers need to be sensitive to how their staff members welcome and greet clients. This includes using intake forms that are neutral about marital status and the gender of the partner or spouse. Roth (2002) notes that if the intake of an agency includes sexual history, to what extent are the questions and/or interviewer open to the possibility of lesbianism? For example, offering someone who has been in a long-term same-gender relationship the option of checking only "married" or "single" does not adequately recognize or effectively describe her status.

A study by Cabaj & Stein (1996) shows that services may be evaluated in terms of climate of safety or the degree to which lesbians feel safe to disclose their identity. The degree to which staff integrate lesbian diversity into their service directly affects the health of the clients. If clients do not feel safe enough to be open about their sexual orientation, they may become further burdened or inhibited by the need to constantly self-monitor their language and behaviour and therefore limit service participation (Cabaj & Stein, 1996; Roth, 2002).

Recent research has addressed the issue of sensitivity and expertise of staff in the helping professions. Some studies relating to staffing patterns identify the issue of lesbianism and whether staff may be open about their own sexual orientation (Cabaj & Stein, 1996; Herek & Green, 1996; Hughes et al., 2000). Contact with openly lesbian individuals is strongly associated

with more favourable attitudes toward lesbians (Herek & Green, 1996) which affect both staff and clients. In a study by Hughes, et al. (2000) almost all lesbians (94%) compared with heterosexual women (70%) indicated that having a counselor of the same gender was important. Eighty-seven percent of lesbians compared with 65% of heterosexual women, preferred a therapist who was feminist; and 79% of lesbians and 35% of heterosexual women preferred a counselor who was of the same sexual orientation.

The PTS (2001) study reveals that 22% of GLBT respondents indicated that their health care provider had told them (or generally it was understood) that he/she is gay, lesbian, bisexual and/or transgendered. The study also shows that the number of GLBT persons who would prefer a GLBT health care provider differed with age - under 25 (38%), age 25-39 (28%), age 40-59 (21%) and age 60+ (6%). However, not all service providers who work with GLBT persons are GLBT themselves. The PTS study indicates that 32% of service providers who service GLBT clients identify as heterosexual, 42% as lesbian, 17% as gay, and 11% as bisexual.

To conclude, this review of the literature reveals that while lesbians access mental health services at a higher rate than heterosexual women they face enormous barriers. The greatest barrier is the assumption of heterosexuality, which impacts on the development of an organizations policies, programs, services and environment.

GAPS IN RESEARCH

Despite the assumption of higher risk, and despite increased awareness of, and interest in, the health status of lesbians over the past two decades, many gaps remain in our knowledge of lesbian's mental health and their health and social service needs (Hughes et al, 2000; PTS, 2001).

The unique issues faced by lesbians still need to be more closely examined. Although the contemporary women's health movement has drawn attention to the unique needs of women, the diversity of women's experiences has only recently begun to emerge as a focus for research. For example, though the feminist women's health movement has extensively documented the vulnerable and exploitative situation of women in health care, these analyses have largely remained silent on the historical and contemporary stigmatized position of lesbians in health care. This gap in social science research has had many repercussions. For instance, there is a lack of understanding of the trends among lesbians, and very little knowledge about lesbian's conceptions of mental health (Anderson, et al, 2001). As well, further investigation into the health and social service needs of women who identify as lesbian is warranted in order to increase accessible and comprehensive service (PTS, 2001).

In researching for this thesis it was noticed that many of the studies relating to lesbian mental health and their health and social service needs is being conducted in the United States. With limited research being directed in Canada, we are at risk of creating a skewed view of lesbian

mental health. Building knowledge around the Canadian context of health care is essential when exploring lesbian health and social service needs.

CHAPTER IV

METHODOLOGY

Research is the systematic collection and analysis of information. There are many ways in which to do research. To complete this research I undertook an exploratory study, using a qualitative design.

FEMINISM: PART OF AN ALTERNATIVE PARADIGM

Researchers define paradigm as “a world view, a general perspective, a way of breaking down the complexity of the real world” (Maguire, 1987:10). A paradigm is an arrangement of theories, questions, methods, and procedures that share central values and themes. As researchers, the questions we ask are powerful shapers of the world we “see” (Maguire, 1987).

A paradigm has great power as it shapes in conscious and unconscious ways, perceptions and practices within disciplines. It shapes what we look at, how we look at things, what we label as problems, what problems we consider worth investigating and solving, and what methods are

preferred for investigation (Maguire, 1987). The paradigm out of which the researcher operates will directly shape the research from beginning to end, how the research question is developed, how the research is carried out, and how the information collected is interpreted and analyzed.

The aim of feminist research is to provide knowledge that will promote equality in society or a voice for those without one (CRIAW, 1996).

Feminist researchers see gender as a basic organizing principle which profoundly shapes/mediates the concrete conditions of our lives. Feminism is, among other things, a form of attention, a lens that brings into focus particular questions. Through the questions that feminism poses and the absences it locates, feminism argues the centrality of gender in the shaping of our consciousness, skills and institutions as well as in the distribution of power and privilege (Lather, 1991:71).

The overt ideological goal of feminist research in the human sciences is to correct both the invisibility and distortion of female experience in ways relevant to ending women's unequal social position. Feminist researchers make gender the fundamental category for our understanding of the social order. They are concerned with producing emancipatory knowledge, empowering the researched and with eliminating sex-based inequality (Lather, 1991).

In the mental health field, as in most other arenas of social life, it is largely men who have the power to define reality – to name the problem (Greenspan, 1983:6).

Feminists claim that social scientific theories and research practices are representative of a male dominated, hierarchical, heterosexist, racist and class-based society. As such, their sustenance is dependent upon the production of knowledge which accommodates ruling-class interests and perpetuates heterosexist, sexist and racist beliefs (Ramazanoglu, 1989). Feminists stated that the problem with using a medical model approach to human problems was that any human problem can be, and often is seen as, the consequence of individual pathology. When problems are reduced to human pathology, then social problems are ignored (Greenspan, 1983; Phelan, 1989).

Feminists suggested that while there was no one methodology that could, or even should, be developed to explain the many meanings of women's lives, they felt that there are certain criteria that are essential to research involving women. Some feminists argued that an understanding of power and control around gender is not enough when conducting research with an oppressed population (Kohler-Riessman, 1987). Kohler-Riessman (1987) noted that when conducting research with lesbians it is important to acknowledge the socially constructed divisions around sexual orientation. The researcher must recognize and acknowledge the social construction of heterosexism and that heterosexuality is a value and a norm based on power and control.

In conducting this research I have put the social construction of sexual orientation and gender at the centre of inquiry. This research has been guided by a set of values, beliefs and practices that include an examination of issues related to gender, sexual orientation, power and control.

QUALITATIVE RESEARCH

Research is deemed good when it helps to improve the situation of people in the community. Barnsley and Ellis (1992) note that “all kinds of discriminations are fought, first and foremost, by the people who are discriminated against. Effective public policy and programs depend on strong advocacy and input from people with first-hand experience of the issues” (Barnsley & Ellis, 1992:10).

It has been suggested that qualitative designs are the best choice when research is being conducted with stigmatized populations, such as lesbians (Barnsley & Ellis, 1992; Jayaratne & Stewart, 1991; Kirby & McKenna, 1989; Maguire, 1987; Patton, 1990). For this reason, I undertook an exploratory study using a qualitative design.

Qualitative research has allowed me to obtain in depth knowledge of the issues with which lesbians struggle as well as their health and social service needs. Kirby and McKenna (1989) refer to qualitative research with oppressed peoples as “research from the margins”. Researching from the margins is based on the commitment to advancing knowledge through a process of exploration grounded in the experience of people who have usually been treated as the objects of research.

SAMPLE DESIGN

My position as an “insider” in the lesbian community brings me into contact with women who identify as lesbian on a regular basis.

A snowball sampling technique was used to recruit a sample of eighteen women who self-identify as lesbian. Because snowball sampling can produce homogeneity (i.e. people tend to socialize with people of similar backgrounds), various points of entry into the community were utilized. Both personal and professional contacts were used to distribute a Participant Recruitment Flyer (Appendix B). The flyer was distributed in a broad range of formal and informal settings, such as Community Health and Resource Centres, Carleton University, University of Ottawa, PTS Women’s Discussion Group, Lesbian Outdoor Group, Mother Tongue Bookstore, coffee shops, and potluck dinners.

Participants were also sought through informal networks of friends and co-workers. I asked lesbians who had completed the interview to offer a flyer and my card to a lesbian friend, family member, acquaintance, or colleague. To maximize confidentiality, I did not accept the names and phone numbers of women from others.

DATA COLLECTION METHODS AND INSTRUMENTS

In-depth face-to-face interviews were conducted utilizing a semi-structured interview guide (Barnsley & Ellis, 1992; Patton, 1990) with seven open-ended questions and a checklist: Issues Identified sheet (Appendix C). Face-to-face interviews are particularly important when working with this population whose voices are seldom heard. Pre-test interviews had been conducted with three women who self-identified as lesbian. These three women were not among the final eighteen women interviewed for this thesis.

The interviews lasted between 45 and 60 minutes. With the respondents permission, the interviews were audio taped to ensure accuracy and to minimize bias in the recording and reporting of the data (Barnsley & Ellis, 1992).

The interview questions were developed primarily from the process of reviewing the literature and also from my personal experience as a professional Social Worker. The interviews allowed participants to share, in their own words, their health and social service needs and how those needs were, or were not, being met by local Community Health and Resource Centres.

Field notes were utilized to keep track of any analytical insights that occurred during the data collection process (Barnsley & Ellis, 1992; Kirby & McKenna, 1989; Patton, 1990).

PARTICIPANTS

Eighteen women from the Ottawa area were interviewed. It was assumed that because the flyer announced a lesbian focus, the persons who chose to participate would be self-acknowledged lesbians or would have an unacknowledged lesbian orientation. Seventeen of the women identified as lesbian and one woman identified as bisexual.

A fact sheet was presented to the participants at the start of the interview in order to collect relevant demographic data (Appendix D). My research sample was primarily white (14 out of 18), English speaking women, who identified as lesbian, between the ages of thirteen and forty-four. Participants had a wide range of income and most resided in the urban/downtown service area of Centretown Community Health and Resource Centre.

ETHICAL CONSIDERATIONS

▽ Researchers Role

The topic of this dissertation came easily to me. Having ten years experience working at one of the local Community Health and Resource Centres has increased my sensitivity to the health and social service needs of women identifying as lesbian. Working at this Community Health and

Resource Centre has provided me with an opportunity to examine health and social service organizations from the perspective of a social worker and also, as someone who herself identifies as lesbian.

In conducting this research, I acknowledged my special position as “insider” in the lesbian community. Lesbian researchers, who conduct research using lesbian participants in their own community, face ethical dilemmas in the areas of confidentiality, protection of a respondent’s anonymity, and professional boundaries (Woodman, Tully & Barranti, 1995 in Tully, 1995). Tully (1995) points out that due to the invisibility of the lesbian community within heterosexual culture and the fact that homophobia plays such a significant role in the lives of lesbians, the most appropriate persons to conduct research in the lesbian community are lesbian researchers who are aware of the pitfalls of living and working within a such small community.

This research was conducted in accordance with Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans.

▽ Informed Consent

Utilizing a flyer to recruit participants for this research allowed for the avoidance of coercion. An initial telephone call to set up the interview allowed me an opportunity to outline the purpose of the study, the time commitment required, the confidentiality arrangements, and the manner in which the information would be collected and used.

A written informed consent letter was presented for signature and a copy given to each participant at the scheduled interview (Appendix E). Women were informed that their participation was entirely voluntary and that they could withdraw at any time.

▽ Confidentiality / Anonymity

All identifying information was kept separately from the interview data. Identifying information was stored in a locked cabinet, in a locked office with only myself, the researcher, having access. Only my research supervisor and I have access to the raw data.

The final written report does not contain any identifying information. The interview transcripts are being kept for thesis defense purposes, and later, for preparing a publication. All identifying information, such as the list of participants, has been destroyed. The interview tapes have been offered to the participants and I have destroyed the tapes of those participants who did not want them.

Due to my position of “insider” in the lesbian community, participants were informed before the interview began, that I would not acknowledge them in another setting (social or otherwise) unless they acknowledged me first.

▽ Risk to Participants

There is a tension between the moral duty to conduct research with vulnerable groups in order to improve services and the inevitable lack of resources that can be committed to such a venture. When conducting this research with women who identify as lesbian it is important to recognize that many of the women are vulnerable because of their many and enduring experiences of loss, hardship and discrimination. In many cases disclosure of their sexual orientation has cost lesbians a great price.

During the interview, participants were asked to share issues with which they have struggled, such as concerns related to their sexual orientation, coming out, depression and suicide. Compounding this is a lack of accessible and comprehensive health and social services for lesbians. In order to alleviate this tension, a written commitment for provision of follow-up counselling support was obtained from the Western Ottawa Community Resource Centre, formerly the Community Resource Centre of Goulbourn, Kanata and West Carleton (Appendix F). Participants were told that they could access this service free of cost.

▽ Deception

There was no deception used at any time during this study. Participants were advised in full of the purpose of this study and the manner in which the information would be collected and used.

DATA ANALYSIS

The data gathered in the semi-structured interviews were analyzed qualitatively. To begin the analysis process, eighteen audio taped interviews were transcribed into printed text. To ensure accuracy, the raw data (printed text) were compared with what was heard on the audio tape.

Next, an inductive content analysis of the verbatim transcripts of interviews was conducted (Barnsley & Ellis, 1992; Patton, 1990). The interview guide formed the descriptive analytical framework for a cross-interview analysis (Patton, 1990). To obtain an overall picture, each interview transcript was read in its entirety. I read the transcripts a second time and coding notes were used to capture themes and categories. Coding refers to an unrestricted mode in which the researcher identifies categories depicted by the data itself (Patton, 1990). Each interview transcript was then analyzed carefully and repeatedly for themes, creating as many categories as needed in order to organize and explain.

Each code was then entered into an Excel database allowing me to easily manipulate the data. Ten Excel worksheets were created capturing thirty-eight themes and four categories (see example worksheet, Appendix G). The Excel worksheets allowed me to easily total the number of participant responses for each theme and category providing me with the raw numbers and percentages required to complete the tables in Chapter V. Next, I reviewed the interview transcripts to locate quotes that would illustrate each theme.

The general themes and categories generated, were then compared with the research question, literature review and theory base (Patton, 1990).

DATA QUALITY

To ensure data quality, the themes and categories that emerged from the transcripts and field notes were compared with the research questions, literature review and theory base. I confirmed and verified findings by linking three levels of understanding: The meanings and interpretations of the participants, my own interpretations of those meanings, and the confirmatory, theory-connected operations. General themes and categories generated, were then compared with the research question, literature review and theory base.

Miles and Huberman (1994) describe tactics for “confirming” and “verifying” our findings which include: checking for representativeness; checking for researcher effects; triangulating; weighting the evidence; checking the meaning of outliers; following up surprises; making if-then tests; and replicating a finding.

I checked for **representativeness** by ensuring that participant recruitment was diverse.

Various points of entry into the lesbian community were utilized with the hopes of attaining a

broad sample of women who identify as lesbian. Flyers were distributed in a board range of formal and informal settings.

In addressing **researcher effects**, I acknowledged my position as “insider” in both the lesbian and the health and social service communities. In an attempt to reduce biases, three pre-test interviews were conducted. At this time, I asked myself if I had influenced the interview through my actions, body language or line of questioning. Each time the interview guide revised to ensure that it was able to capture differing points of view from the participants. As well, as part of a reflective process the field notes that were kept to keep track of any analytical insights that occurred during the data collection process were reviewed by me. Again, I repeatedly asked myself if I had influenced the interview through my actions, body language or line of questioning.

Findings of this study were supported using the technique of **triangulating**. Pattern matching was completed using different data measures. Qualitative text (participants words) were compared with quantitative data (Excel worksheets), findings from other studies (literature review) and the theory base.

Stronger data can be given more weight in the conclusion (Miles and Huberman, 1994). In **weighting the evidence**, stronger data is obtained when the field worker is trusted, data is collected in an informal setting, and the respondent is alone with the field worker. This

researcher's position of "lesbian" and "social worker" allowed for trust between researcher and participant. As well, conducting face-to-face interviews in a setting of the participants' choice increased comfort of the participant thereby increasing the strength of the data.

"A good look at the exceptions, or the ends of a distribution, can test and strengthen the basic finding." (Miles and Huberman, 1994:269). I checked the meaning of outliers and followed up surprises throughout the research process. A good illustration, from this research, of a surprise and outlier is as follows: During the interview, one participant stated that her sexual orientation was never a barrier when accessing health and social services. As the interview continued it became clearer that this participant's sexual orientation was not a barrier for her because she did not feel it was relevant to attaining comprehensive service, and therefore did not feel a need to disclose it.

If-then tests, a very important technique in qualitative data analysis, were utilized for this research. Miles and Huberman (1994) note the classic formal statement: "if p , then q ." Assuming p to be true, then the researcher looks to see whether q is true. An example from this research: *If* - lesbians are fearful of disclosing their sexual orientation to service providers *then* - they are hesitant to access service for fear of heterosexism.

Quality is enhanced when they are confirmed by more than one “instrument” measuring the same thing. I replicated findings by analysing data using different methods; that is qualitative and quantitative methods to confirm my findings.

In summary, I utilized a variety of techniques as outlined in the literature by Miles and Huberman (1994) to ensure data quality. Utilizing these techniques helped me to have more confidence in my findings.

LIMITATIONS OF THIS STUDY

This study offers preliminary findings on the health and social service needs of lesbians in Ottawa. There are limitations to conducting research with an “invisible” population. Discrimination may ensure that only the most “out” lesbians come forward to participate in research that is targeted at lesbians. Those women who are struggling with their sexual orientation and the profound isolation that can accompany this struggle may choose not to “out” themselves by participating in such a study. Therefore, the sample may have been intrinsically biased because participants were volunteers, each willing to share with me their health and social service needs. Their agreement to participate makes these participants different from those who chose not to participate. It is conceivable that some of those who did not volunteer to participate may have been less comfortable with the topic and have different opinions and experiences.

A second limitation centers on confidentiality and anonymity. While it is important for Community Health and Resources Centres to address the issues of race, culture, class and ability when developing accessible and comprehensive services to lesbians, I did not ask participants to identify as such. This decision was based on the risk to confidentiality and anonymity that is inherent when conducting research in a small community, such as the lesbian community in Ottawa. However, it can be stated that a number of women with difference in race, culture, class and ability were interviewed for this study.

Interviews were conducted in English, eliminating potential participants who do not speak English.

And finally, as someone who is both a social worker and an “insider” in the lesbian community, I may have elicited responses that the participants thought the researcher wanted to hear. However, this limitation may be balanced as both of these roles, social worker and lesbian, may offer participants the safety they need with which to express their concerns and needs.

CHAPTER V

FINDINGS

PRESENTATION OF FINDINGS

The goal of this study was to facilitate an understanding of the specific issues with which lesbians struggle, to develop some clarity about lesbian health and social service needs, and to encourage the development of safe, accessible and comprehensive health and social services within local Community Health and Resource Centres.

The results include a description of the participants and a presentation of the most salient themes emerging from the data. There are thirty-eight themes that fall into four main categories:

- Lesbian Mental Health Concerns
- Lesbian Access to Health & Social Services
- Barriers to Accessible and Comprehensive Service
- Potential Areas for Improving Services

First, tables and composite descriptions of the participants are provided, including the service area they reside in, a description of their neighbourhood, their year of birth, total income, and in

From Margin to Mainstream: Lesbian Health and Social Service Needs
Kia Rainbow

what language they prefer to receive services. Second, each category is presented with tables, narrative descriptions and direct quotes of participants to illustrate each theme. Finally, each category or theme is compared to the research question, theory base and literature review.

In many instances, the findings of this study are compared to the results of the Pink Triangle Services (2001) GLBT survey carried out in the Ottawa area. The PTS Community Needs Survey reached 826 GLBT respondents and 47 service provider respondents. This survey was available in English and French in hard copy and online. Although the methodologies used in the PTS (2001) study are not the same as in this study, the comparisons lend further weight to some of the results, and are worth considering.

DESCRIPTIONS OF THE PARTICIPANTS

The information collected on the Fact Sheet describes the participants' ages, the service areas they reside in, how they would describe their neighbourhood, what their total personal and household income is, and what language they prefer to receive services in.

TABLE 1 Self-identity		
Lesbian	17	94%
Bisexual	1	6%
Total number	18	

Participants were eighteen women from the Ottawa area. How participants identified themselves during the interviews is shown in *Table 1*.

B Age of Participants

TABLE 2 Age of participants		
< age 25	1	5%
25 - 39	10	56%
40 - 59	7	39%
Age 60+	0	0%
Total number	18	

Participants ranged from age thirteen to forty-four. *Table 2* gives the age breakdown of all participants. The table shows that most participants (95%) were between the ages of 26 and 59.

According to the 1996 Census data (Statistics Canada, 1996) 70% of the Ottawa general population is between the ages of 26 and 59. In this study, youth and lesbians over age 60 are

underrepresented; youth, 5% compared to 13%, and age 60 or older, 0% compared to 17% in the general population of Ottawa (Statistics Canada, 1996).

B Service Area Participants Reside In

TABLE 3		
No. of participants by service area		
Centretown Ottawa	4	22%
Nepean	3	17%
Pinecrest-Queensway	3	17%
Somerset West	3	17%
Sandy Hill	2	11%
Western Ottawa	1	6%
Vanier	1	6%
Gloucester	1	6%
Carlington	0	0%
South-East Ottawa	0	0%
Lowertown	0	0%
Overbrook Forbes	0	0%
Cumberland	0	0%
Total number	18	

Participants came from all parts of the Ottawa area. The areas were identified using the service areas of the thirteen Ottawa area Community Health and Resource Centres. *Table 3* shows the highest number of participants (22%) residing in the service area of the Centretown Community Health Centre. The next highest were the Somerset West Community Health Centre, the Pinecrest-Queensway Health and Community Services and the Nepean Community Resource Centre, each with 17% of participants residing in their service area. None of the participants resided in the service areas of Carlington Community and Health Services, South-East Ottawa

Centre for a Healthy Community, Lowertown Resource Centre, Overbrook-Forbes Community Resource Centre, or Cumberland Community Resource Centre.

B Type of Neighbourhood Participants Reside In

TABLE 4		
No. of participants by neighbourhood		
Urban / downtown	9	50%
Suburban/ residential	7	39%
Rural	2	11%
Total number	18	

The type of neighbourhood that participants live in is shown in *Table 4*. Half, (50%) of the participants reported that they live in an urban or downtown setting. A fairly large percentage (39%) indicated that they consider their neighbourhood to be suburban or residential. A small percentage (11%) indicated that they live in a rural neighbourhood. These numbers are consistent with the PTS (2001) study that found most GLBT respondents resided in an urban/downtown setting (51%) and few in a rural setting (4%).

B Participants Income

TABLE 5 Total personal income		
< \$20,000	5	28%
\$20,000-\$39,999	4	22%
\$40,000-\$59,999	6	33%
\$60,000-\$79,999	3	17%
\$80,000 +	0	0%
Total Number	18	

Table 5 shows the participants' total personal income (gross before deductions) from all sources in the past twelve months. Many participants (28%) have a personal income of less than \$20,000.

The average income of persons aged 25 or older in Ottawa is \$30,000 (Statistics Canada, 1996).

Low income can be a barrier to lesbians accessing mental health services.

TABLE 6 Total household income		
< \$20,000	0	0%
\$20,000-\$39,999	0	0%
\$40,000-\$59,999	0	0%
\$60,000-\$79,999	0	0%
\$80,000 +	6	34%
Total Number	6	

Participants were asked to provide a total household income if they were living in a common-law relationship with someone. Twelve participants (66%) did not give the income for their household as they identified as single. *Table 6* illustrates that six participants (34%) indicate household incomes of greater than \$80,000. Given this statistic, one could conclude that the free services that Community Health and Resource Centres provide may not be required by the persons living in these households. However, the dynamics within a relationship are not revealed with the above statistic, therefore, we cannot assume that both persons have equal access to the household income.

▣ Preferred Language of Service

TABLE 7 Preferred language of service			
English	17	94%	
Either French or English	1	6%	
French	0	0%	
Other	0	0%	
Total Number	18		

Participants were asked in what language they would prefer to receive services. *Table 7* indicates that seventeen participants (94%) identified that they would prefer to receive services in English. Only one participant (6%) indicated that she would prefer either French or English. However, it is difficult to assess the accuracy of the question as the one participant that chose the category, either French or English, noted in her interview that she finds a great cultural difference between

French Canadian and Anglophone people and that she preferred to access services that are Francophone.

In summary, my research sample was primarily white (14 out of 18), English speaking women, who identify as lesbian, between the ages of thirteen and forty-four. Most participants resided in the urban/downtown service area of Centretown Community Health and Resource Centre.

LESBIAN MENTAL HEALTH CONCERNS

There are many issues, such as concerns related to stress, depression and suicide that can affect a person's mental health. This section provides a summary of the mental health issues of concern to the participants in this study.

Participants were presented with a list of nineteen possible mental health related issues and asked to check which one are or have been a concern for them. Participants could check as many as apply.

Table 8
Issues/struggles identified

Stress	18	100%
Sexual Orientation	16	89%
Coming out to family	16	89%
Relationship issues with intimate partner	16	89%
Anxiety	15	83%
Coming out to co-workers	14	78%
Loneliness	14	78%
Depression	14	78%
Feeling suicidal	13	72%
Coming out to friends	12	67%
Isolation	9	50%
Historical abuse	9	50%
Death of a loved one	9	50%
Job loss	8	44%
Substance abuse	7	39%
Partner abuse	6	33%
Parenting and child rearing	4	22%
Caring for an ill loved one	3	17%
Blending families/step parenting	2	11%

As *Table 8* indicates, over half (67% to 100%) of the eighteen participants identified concerns with stress, sexual orientation, coming out to family, anxiety, coming out to co-workers, depression, loneliness, feeling suicidal and coming out to friends.

H STRESS is an issue of concern for all participants

All participants (100%) identified stress as an issue of concern. As one participant expressed it

...

I started to realize that I was really coming out and also about telling my parents and friends...all these fears: What are they going to do? How are they going to handle it? How am I going to handle it? And, can I handle being in a relationship? I was so stressed out...I would have panic attacks sometimes at night. I was feeling isolated. I felt vulnerable, stressed, and nervous... all that kind of stuff...that sense of being alone.

This result is somewhat higher than the PTS (2001) study that shows that stress is a part of daily life for 81% of GLBT respondents. Anderson, et al. (2001) and Hughes, et al, (2000) found that due to societal homophobia and heterosexism, being lesbian is believed to expose persons to high rates of both external and internal stress.

In a study comparing lesbians' and heterosexual women's mental health, Hughes, et al. (2000) notes that both lesbians and heterosexual women reported moderate levels of stress. The differences came in the **sources** of stress, with heterosexual women rating children, and lesbians rating sexual identity as their highest source of stress.

■ Most participants identified their SEXUAL ORIENTATION as an issue of concern

Studies have shown that lesbians and heterosexual women share many of the same mental health concerns (Anderson, et al, 2001; Collett, 1982; Hughes, et al, 2000; Jay, 1995; Neisen & Sandall, 1990; Rothblum, 1990; Trippet, 1994; Woodman, 1989).

In this study, sixteen of the eighteen participants (89%) identified their sexual orientation as an issue of concern. Two participants express their struggles with their sexual orientation:

So I just told myself that it's not an issue [being lesbian] and you'll just never have to deal with it. You'll never, never tell anybody and that's the way it's going to be. And then I met somebody who I really cared for... but just fought it continually. I just would not admit that...you know... [I was lesbian] and I basically ended up, being rude to her...because I hated myself for having those feelings toward her.

I resigned from a Protestant church where I was a full time minister. My life had been the Church, my identity was the Church, my family was the Church. I met a woman and I ended up being very attracted to her. I tried and tried to stop my feelings for her but in the end I stayed true to myself and left the comfort of the Church. I was lost, afraid and alone. I felt that by giving in to being lesbian, I would be doomed for hell... I was tormented inside.

This finding is supported in research by Jay (1995) and Jordan & Deluty (1998) which states that lesbians have the added pressure of being lesbian in a heterosexist society. Sixteen participants (89%) identified their sexual orientation as an issue of concern. The experience of growing up “different” in a society that demands or expects that everyone be exclusively heterosexual can be devastating. Because of antigay stereotypes, along with negative beliefs and attitudes in mainstream culture, lesbians are faced with the additional burden of knowing that this identity is condemned by society at large. According to the Jordan & Deluty study (1998), internalized beliefs about lesbianism complicate the process of lesbian self-acceptance, and often have profound effects on a woman’s self-esteem.

B Most participants identified **COMING OUT** as an issue

Table 8 shows that participants indicated that the coming out process was more or less of an issue depending on whom they were coming out to. Participants struggled most with coming out to family (89%), secondly, coming out to co-workers (78%) and lastly, coming out to friends (67%). The following is a sample of comments that illustrate participants' struggles with coming out:

It's big, very mind boggling [being lesbian], when you get it all wrapped up inside and you can't let all this out. It's like festering inside and you want to let it all out and you don't know who to let it out to.

I struggled [with coming out] since I was in my early twenties. I just felt like I was in an enclosed room with no windows or doors...everyday...I was just getting smaller and smaller.

I am coming out and my mother isn't taking it too well, I am thirteen...the only problem I have right now is my mom.

I was a woman of the cloth and living a gay life was so wrong in the Protestant church. If anyone found out, I would have been forced to resign immediately.

The PTS (2001) study found that 71% of respondents reported being out to their fathers compared with 87% being out to close friends. Hughes et al. (2000) and Jay (1995) found that

issues around being “closeted” and “coming out” cause increased feelings of isolation and stress for women who identify as lesbian.

R DEPRESSION and FEELING SUICIDAL are concerns for most participants

Fourteen of the eighteen participants (78%) identified depression as a concern. This finding is consistent with the PTS (2001) study where depression was reported most often as an issue of concern by GLBT respondents.

It is critical to highlight that thirteen participants (72%) identified that feeling suicidal was a concern for them. One participant expressed her struggle with depression and feeling suicidal...

I've struggled with depression pretty much most of my life. Certainly as a teenager I was extremely depressed and I think I sort of alternated between anxiety and depression today. I've also felt suicidal at times, not in recent years, but in my twenties and certainly as a teenager.

This high incidence of depression and suicidal feelings among lesbians has been acknowledged in other studies. For example, the PTS (2001) study states that: “a number of studies have suggested that mental health problems in general, and depression and suicide in particular, may be more of an issue for the GLBT population compared to the general population. Young lesbian and gay people are two to three times more likely to kill themselves than heterosexual youth and account for 30% of all youth suicides.”

Half (50%) of the eighteen participants identified the death of a loved one, historical abuse, which includes physical, emotional and/or sexual abuse, and isolation as issues of concern.

The PTS (2001) study found that isolation was one of the issues checked most often by GLBT respondents (33%). Less than half of the participants in my study indicated having issues or concerns with job loss (44%), substance abuse (39%), partner abuse (33%), parenting and child rearing (22%), caring for an ill loved one (17%) and blending families and/or step parenting (11%).

E OTHER ISSUES of concern to lesbians

Table 9 Other issues identified		
Struggle with faith/church	2	11%
homophobia	1	6%
Myth of a lesbian utopia	1	6%
Gender identity, butch identity	1	6%
Bi-sexual not part of lesbian community	1	6%
Physical disabilities	1	6%
Finding my calling	1	6%

Table 9 indicates the other issues of concern for participants, including faith/church (11%), homophobia, gender/butch identity, discrimination against bisexual people in the lesbian community, and physical disabilities (6% each).

In summary, an exploration of the specific issues with which lesbians' struggle indicates that all participants (100%) identified stress as an issue of concern for them. Over half of the participants identified concerns with sexual orientation, coming out to family, anxiety, coming out to co-workers, depression, loneliness, feeling suicidal and coming out to friends.

Research reveals that while lesbians share many of the same mental health concerns as heterosexual women, the differences between them came in the sources of stress, with lesbians rating sexual orientation as their highest source of stress. These findings underline the need for Community Health and Resource Centres to ensure accessible and comprehensive services for lesbians.

LESBIANS' ACCESS TO HEALTH & SOCIAL SERVICES

This section examines lesbians' access to and experience with health and social services. During the interview, participants were asked if they had ever sought support for the issues they identified on the checklist. If they had accessed service, they were asked to share their experience. If they had not accessed service, they were asked to share why not. Participants were also asked if they had ever sought support at their local Community Health and Resource Centre.

E EVERYONE HAD SOUGHT SUPPORT for at least one issue they identified as a concern

All participants (100%) had sought some type of support for at least one of the issues they identified.

The Hughes, et al. study found that 78% of lesbians reported that they had received counseling for an emotional or mental health problem. The PTS (2001) study shows that only 40% of GLBT respondents had used counselling/therapy services within the past five years. Studies by Hughes et.al. (2001) and Bradford, et al, (1994) show that higher rates of therapy/counselling were found among lesbians (78%) than heterosexual women (56%).

Participants identified this support as either positive or negative.

B Most participants had a **POSITIVE EXPERIENCE** when seeking support

Table 10 Positive experience with seeking support		
Female counsellor	6	33%
GLBT service	5	28%
Support group	5	28%
Psychologist	4	22%
Lesbian counsellor	4	22%
General physician	3	17%
University	3	17%
Addiction centre	2	11%
Employee assistance program	1	6%
Women's resource centre	1	6%
Secondary school	1	6%
Friends	1	6%

Sixteen participants (89%) identified as having had a positive experience from twelve different sources. *Table 10* indicates that participants received the most positive experience of support from a female counsellor (33%), support group (28%), or a GLBT service (28%).

Participants described their experience as positive when they felt that the service provider was gay positive.

The experience of two participants' with a gay-positive service provider are reflected in the comments below:

She [the psychologist] was superb. She's the only one that I give a lot of credit to for the fact that I am where I am today. Because she really made me see...and I don't know what she did or said or anything...but somehow she made me realize that it's okay to be gay. I'll never forget walking out of her office after that first visit. I felt like so much weight had been lifted off my shoulders. I felt like I could fly. She was not lesbian but gay-positive.

She was a great counsellor, she was a good mix for me, being in my headspace, being able to speak to me about things [sexual orientation]...we could really relate. She was feminist and straight.

The finding of this study is consistent with research completed by Roth (2002) which indicates that the quality of mental health services for lesbian clients is dependent upon the degree of sensitivity of the staff to diverse sexual orientations.

Participants also described their experience as a positive one when the service provider explicitly identified as lesbian. This is reflected in the comments below:

My counsellor was a woman and she was a lesbian...and you know it was great.

While I was talking to her about my girlfriend she told me that she was a lesbian. I felt a lot more comfortable after that.

Participants also noted that an experience was positive when the isolation they were feeling was relieved. As one participant expressed it ...

She was very good [the psychologist]...she connected me to another client of hers who was a lesbian, and she connected me with other resources.

R Some participants had **NEGATIVE EXPERIENCES with seeking support**

Ten participants (56%), identified having a negative experience with accessing support from six different sources. This contrasts with the PTS (2001) study where 12% of GLBT respondents felt that they had received poor or negative treatment because they were gay, lesbian, bisexual and/or transgender.

Table 11 Negative experience with seeking support		
Counsellor	5	28%
Psychiatrist	4	22%
Psychologist	3	17%
General Physician	3	17%
EAP Counsellor	1	6%
Grade School Counsellor	1	6%

Table 11 indicates that participants received the most negative experience of support from a counsellor (28%), psychiatrist (22%), general physician (17%) and psychologist (17%). Participants identified a negative experience when there was an assumption of heterosexuality

among services providers or a lack of awareness about lesbians and lesbian issues. One participant states...

He [a psychiatrist] started using me as a research subject...he was really focusing on that... that one of the reasons for my sexual orientation was childhood abuse.

The PTS (2001) study also identified lack of awareness, on the part of the health care provider, as a key reason for dissatisfaction with service.

II NOT EVERYONE IS RECEIVING THE SUPPORT they need

Two thirds (67%) of participants had, at some point in their lives, wanted service for an issue of concern and yet did not receive it. When asked why not, all responded that they were not aware that services existed, as can be seen below:

I didn't access support because I didn't know where to go.

I have been looking for a group for survivors of partner abuse...I haven't found one yet.

The PTS (2001) study reported that over half (51%) of GLBT respondents are not getting the help and support they need. Respondents of this study identified areas of concern where the needs are unmet as: violence in a relationship (75%), finding a partner (69%), finding friends (62%), child custody (59%), loneliness/isolation (57%), job search/job loss (52%), homophobia

(50%), involvement with the criminal system (50%), pregnancy/adoption (50%), substance use (48%), family relationships (45%), parenting/child rearing (43%), feeling suicidal (43%), caring for an ill loved one (39%), the end of a relationship (38%), coming out (33%), depression (30%) and the death of a loved one (26%).

E Participants accessed support at their LOCAL COMMUNITY HEALTH & RESOURCE CENTRE

Participants were asked if they ever sought support at their local Community Health and Resource Centre.

Table 12 Participants accessing service at their local CHRC		
Sought support	8	44%
Did not seek support	10	56%
Total Number	18	

Table 12 indicates that eight participants (44%) have sought service at their local Community Health and Resource Centre. The participants accessed medical, counselling and group services at their local CHRC.

Ten participants (56%) have never sought support at their local Community Health and Resource Centre.

I was suicidal at that time. I did not seek support. I had no way of labeling it [butch identity] as something about which you could seek support. I just thought I was strange, different from everyone else. If you're different and it has a label [like 'homosexual'], then there must be other people like you...or they wouldn't have created the label. But if you're different, and it does not have a label [like butch identity] then you think that you're just a freak...what support could there be? Right?

In summary, all participants (100%) had sought some type of support for issues they identified. Sixteen participants (89%) identified as having a positive experience. Ten participants (56%) identified having a negative experience with accessing support from six different sources. Over half (67%) of participants had, at some point in their lives, wanted service for an issue they were concerned with and yet did not receive it. Of significance to Community Health and Resource Centres is the fact that eight participants (44%) received service at their local CHRC, however, not necessarily disclosing their lesbian identity. These findings underlie the importance of ensuring accessible programs and services, providing GLBT training to all staff, advertising services to lesbians, and eliminating heterosexist bias at first point of contact – information and referral.

BARRIERS TO SERVICE

This section examines potential barriers to accessible and comprehensive health and social services for lesbians. Participants were asked to identify any barriers that might cause them difficulty when accessing service at their local Community Health & Resource Centre.

Table 13 No. of participants who identified barriers to service		
Barriers	16	89%
No Barriers	2	11%
Total Number	18	

Table 13 indicates that most participants (89%) identified barriers to accessing service. This suggests that services are not easily accessible.

Table 14
Barriers to service

Lack of awareness among service providers	8	44%
Assumption of heterosexuality	6	33%
Fear of a negative reaction / homophobia	6	33%
Confidentiality	6	33%
Fear of disclosing	5	28%
Not aware of services offered at CHRCs	6	28%
Aware of possibility of inappropriate service at CHRC	3	17%
Lack of advertising in GLBT community	3	17%
Experience with being seen as "ill" or to be "fixed"	2	11%
Lack of symbols such as the rainbow flag	2	11%
Lack of lesbian services being offered at CHRC	2	11%
Fear of being forced to come out	1	6%

Table 14 indicates that participants identified eleven barriers to accessing service.

E Service providers have a LACK OF AWARENESS around lesbian issues

The greatest barrier for participants (44%) to accessing service was concern that service providers lack awareness about lesbians and lesbian issues. The following comments illustrate participants experience with service providers who lack awareness of lesbian issues:

The reason I went to counselling was to sort out my issues so we could have a healthy relationship. I had a straight counsellor. She just didn't have that understanding of the dynamics that are specific to same gender relationships...I could talk to her about other things but not specifically lesbian stuff. At that point I just gave up... I didn't get the help I needed when I needed it.

I am coming to seek a service and I have to tell them [the service provider] about the [lesbian] community and what is going on in the community. They should already be set up with what local resources are available for lesbians... not me teaching them.

The finding of this study is consistent with the findings of several researchers (Gartrell, 1987; Gentry, 1992; Gillow & Davis, 1987; Liljestrand, Gerling, & Saliba, 1978; McDermott, Tyndall & Lichtenberg, 1989; Roth, 2002) who note the importance of mental health providers being knowledgeable and sensitive to the uniqueness of lesbian experiences.

⌘ The ASSUMPTION OF HETEROSEXUALITY is a barrier to accessing service.

Six participants (33%) identified the assumption of heterosexuality as a barrier to accessing service. In a study by Anderson, et al. (2001), it was found that for lesbians, the assumption of heterosexuality prevalent within organizations will determine if they will access the health and social services system. As noted in the literature review, this assumption of heterosexuality greatly influences whether a woman will choose to be “out” or to pass as heterosexual. Fears that a disclosure of sexual orientation will be met with disgust, fear, hostility or misunderstanding can cause lesbians to avoid accessing much needed services.

⌘ Most participants feel the need to PASS

Participants were asked what their experience is with “passing” (not letting people know they are lesbian).

Table 15		
Participants experience with passing		
Pass/closeted	10	56%
Open/out	8	44%

Table 15 indicates that eight participants (44%) are open about their sexual orientation.

As one participant expresses...

I'm not out at work and I don't know that I will ever be. There was a time when I used to try to go to the extreme to cover it up. I used to joke about guys and stuff like that. For the longest time if people shot down gay people I would stick up for them...but at the same time being cautious not to be too pro gay...because I figured they might figure it out. And I always had a huge fear that somebody would ask me...come straight out and ask me if I was gay. And I would have froze if somebody would have asked me that question. Thank God nobody did. I still have a couple of family members that I have to come out to.

The PTS (2001) study reported that 54% of lesbians are quite open about their sexual identity.

However, it remains that in this study it was found that ten participants (56%) feel a need to keep their sexual orientation a secret.

Two issues appear out of "passing" for lesbians. One is they spend much needed energy on trying to hide a very important and relevant part of themselves. The second is that if they do pass, they feel like they are lying, compounding their issue/struggle. As one participant expressed it...

What would she think of me when she finds out I've been lying.

II FEAR OF COMING OUT OF THE CLOSET in order to obtain appropriate service was identified as a barrier.

Participants identified fear of a negative reaction from service providers (33%), the assumption of heterosexuality (33%) and consequently, a fear of disclosing their sexual orientation (28%) as barriers to service. Participants' fears of a negative reaction from service providers are expressed:

She [my physician] doesn't know, and it makes me feel uncomfortable sometimes. I feel like I want to tell her and then I am a little concerned about my image, in her eyes. I don't know why, but I do. I feel she would feel different toward me.

Honest to God... the thought crossed my mind... I will not tell my surgeon I'm a lesbian because what if she slips the knife... by accident...what if she doesn't do what she's supposed to do while I'm under the knife. It was awful.

No, I've never told her... it just never came up... I just didn't feel... there was no time. How am I going to bring it up...what was I going to say, while I was in the stirrups... 'oh, by the way.... It is still unspoken.

A study by Herek & Berrill (1996) notes that the threat of secondary victimization often acts as a barrier to seeking medical, psychological, or mental health services. The anticipation of negative reaction may discourage lesbians from being out.

Anderson, et al. (2001) states that the fear of identifying as a lesbian means that some lesbians feel they must pass as heterosexual women in health care settings, providing incomplete or inaccurate information about themselves in an effort to camouflage their lesbianism and ensure treatment. "Passing" can result in improper service, as well as discomfort and anxiety for the client (Anderson, et al, 2001).

Participants in this study share their concerns with coming out in order to access service:

If I call I would have a problem saying that I am a lesbian...it would probably stop me from accessing services....

I would have to say...okay...I'm a lesbian...you have to basically define yourself to get the services you want.

I hate that [looking for services]... I find the whole process awkward. Because who wants to be on the phone with a straight person and saying I'm a bisexual woman looking for...

■ CONFIDENTIALITY was identified as a barrier

Thirty-three percent (33%) of participants identified confidentiality and specifically being "insiders" (CHRC staff or volunteers) as a barrier to accessing service. As one participant expresses...

I volunteered there [at a local CHRC]. I didn't access services because I knew too many people there and confidentiality would have been an issue for me.

Other concerns around confidentiality centered around the intimate size of the lesbian community. The following comments reflect some participants' concerns:

Confidentiality would be an issue. In the Ottawa [lesbian] community everybody knows everybody and it is very incestuous sometimes.

They [service providers] are under the oath of confidentiality... but people do talk... and our [lesbian] community is small.

¶ LACK OF SERVICES available was identified as a barrier

Lack of services being offered to lesbians was a barrier that two participants (11%) identified.

As one woman expresses it:

You [CHRCs] don't have all these groups like you do for other people...that's a problem I find today. They don't have enough support groups out there for the lesbians, and they should. We're just as good as they are [heterosexual people]... you know what I mean?

The finding of this study is considerably lower than the PTS (2001) study which indicates that half (51%) of the GLBT respondents are not getting the support they need. The PTS study shows

that respondents with issues reported at least one unmet need, 32% had one or two unmet needs, and 19% reported three or more unmet needs.

B NOT BEING AWARE OF SERVICES was identified as a barrier

Two other barriers that participants identified was that they were not aware of services offered at local CHRCs (28%) and some participants (17%) felt this was due to a lack of advertising in the GLBT community. The following comments illustrate these barriers to accessing service:

I just didn't know who to contact. I knew in the phone book there was a phone number for the gay line. That's pretty much all I knew.

I really don't know what services are available. I didn't know who to talk to...how do you know? The phone book? I didn't know where to go.

I knew then that I would have to search for some sort of counselling...you have to search...it is not easily found. Not too many people advertise. I find it more aggravating to an already stressful situation.

Table 16
Other barriers to service

Stigma (using a community service)	2	11%
Culture	1	6%
Money	1	6%
Shyness	1	6%

As *Table 16* indicates other barriers that participants experienced were culture, shyness, lack of money and the stigma attached to utilizing a counselling service. The following comment illustrates culture as a barrier to accessing service:

I think my [...] culture has impacted a lot more, even now, on my homosexuality. In my [ethnic] community it is still very closeted.

In summary, most participants (89%) identified barriers to accessing service. Coming out of the closet in order to obtain appropriate service was identified as a large barrier. Participants identified concern that service provider would lack awareness around lesbians and lesbian issues (44%), fear of a negative reaction from service provider (33%), the assumption of heterosexuality (33%) and consequently, a fear of disclosing their sexual orientation (28%) as barriers to service. Ten participants (56%) felt a need to keep their sexual orientation a secret.

Two issues come out of “passing” for the lesbians interviewed. The first issue is that they spend much needed energy on trying to decide whether to hide or disclose a very important and relevant part of themselves. Second, when a woman who identifies as lesbian “passes” they feel like they are not being genuine. When they pass they feel as if they are lying, compounding their presenting problem and increasing their level of stress.

Two other barriers that participants identified were not being aware of services offered at local CHRCs (28%) and some participants (17%) felt this was due to a lack of advertising of services

in the GLBT community. These findings highlight the need for decision-makers within Community Health and Resource Centres to address systemic barriers to service.

POTENTIAL AREAS FOR IMPROVING SERVICES

This section examines the services that lesbians identify as necessary for good mental health. Participants were asked what kinds of support services would best meet their needs as lesbians. The results can be categorized in five main sections. They are:

- ▣ Providing Specialized Services for Lesbians
- ▣ Preferred Characteristics of a Service Provider
- ▣ Support Services that Would Best Meet Lesbian Clients Needs
- ▣ Increased Visibility of Lesbian Services
- ▣ Preferred Location of Services

▽ Providing Specialized Services for Lesbians

Participants were asked if they felt there was a need for specialized services for lesbians.

Table 17 Specialized Services			
Yes	16	89%	
No	1	5%	
Not available	1	6%	

Table 17 indicates that 89% of participants feel there is a need for specialized support services for lesbians. Participants noted that they need specialized services because of the unique issues that they face as lesbians. The following comments illustrate two participants' reasons for wanting specialized services:

There are different issues and different dynamics because we deal with societal pressures and homophobia and all that...

There are issues that queer women face, as a couple, that are unique to them. Like...how do you deal with your in-laws?

Research shows that while lesbians and heterosexual women share many of the same mental health concerns (Anderson, et al, 2001; Collett, 1982; Hughes, et al, 2000; Jay, 1995; Neisen & Sandall, 1990; Rothblum, 1990; Trippet, 1994; Woodman, 1989) and hence may need access to many of the same support services, lesbian issues are compounded by heterosexism. In a study by Jay (1995), she notes that mental health services have long been associated with heterosexist bias. Historically, the discipline of psychology has maligned and pathologized lesbian persons in theory and practice. Today there remains a large portion of those in the helping professions who continue to regard lesbianism as abnormal and sick. Consequently, lesbian-positive services are necessary.

■ LESBIAN ONLY services were seen as a must

Sixteen participants (89%) also noted that they wanted services, especially support groups, that are for lesbians only. Many felt that lesbian-only services are necessary because of society's homophobic attitudes toward lesbians. This need for lesbian/bisexual women-only services is expressed in the following comments:

When you're dealing with an abusive relationship you don't want to go into a group and also have to deal with people's homophobia or discomfort. And even if you establish guidelines that you don't tolerate any sort of discrimination or prejudice, whether it's verbal or non-verbal, you still can't take away people's attitudes.

At some points I had a need to be in a group specific to the lesbian community. The same way that sometimes I need to be in a francophone group...because I need to speak French...I can express myself more.

This is consistent with a study by Cabaj & Stein (1996) that shows that services may be evaluated in terms of climate of safety, or the degree to which lesbians feel safe to disclose their identity. Cabaj & Stein (1996) note that if clients do not feel safe enough to be open about their sexual orientation, they may become further burdened or inhibited by the need to constantly self-monitor their language and behaviour and therefore limit service participation.

▽ Preferred Characteristics in a Service Provider

When participants were asked what kinds of support services would best meet their needs, they described the characteristics they felt were necessary in a service provider.

Table 18
Preferred Characteristics
in a Service Provider

Female	16	89%
GLBT positive	13	72%
Lesbian	10	56%
Feminist	3	17%
“Out”	2	11%

As *Table 18* indicates, participants identified five characteristics that would make them more comfortable with a service provider. Over half of the participants identified being more comfortable accessing service from someone who is female and GLBT-positive and/or lesbian.

⌘ Most participants want a **FEMALE** service provider

Sixteen participants (89%) wanted a female service provider. This is consistent with a study by Hughes, et al. (2000) where almost all lesbians (94%) indicated that having a counselor of the same gender was important to them.

□ Participants want their service provider to be GLBT-POSITIVE

Thirteen participants (72%) would be most comfortable with a female service provider who is GLBT-positive. The following comments illustrate how participants feel about a GLBT-positive service provider:

I don't care about the sexual orientation [of the service provider] as long as the person is obviously understanding, supportive and treats you totally equal with no difference, whether you are homosexual or heterosexual.

A lesbian counsellor is not that important, as long as the heterosexual one is well informed and knows what they are talking about.

Several researchers (Gartrell, 1987; Gentry, 1992; Gillow & Davis, 1987; Liljestrand, Gerling, & Saliba, 1978; McDermott, Tyndall & Lichtenberg, 1989) have noted the importance of mental health service providers being knowledgeable and sensitive to the uniqueness of lesbian experiences (Roth & Murphy, 1986), especially in validating the consequences of living a life of secrecy.

E TRAINED staff were seen as necessary

Thirteen participants (72%) noted the importance of staff training to ensure that service providers are GLBT-positive. The following comment expresses one participants' need for well-trained staff:

Educate the people that provide services, front line services, and the people who provide the background service.

This is consistent with the PTS (2001) study where 65% of GLBT respondents stated that they would like to be able to use the variety of wellness services available to all Ottawa residents without having to hide their sexual or gender preference and without having to explain and educate them on how to work appropriately with GLBT people.

F Over half of the participants would prefer a LESBIAN service provider

Ten participants (56%) stated that they would be most comfortable with a lesbian service provider. Participants expressed their need for a lesbian service provider:

I've had gay-positive [service providers] and where that's helpful is knowing that I'm not being judged. But where it's not helpful...there are dynamics in lesbian relationships and lesbian partner abuse and just the family dynamic for lesbians. Things are different if you're a lesbian. As open-minded as you may be ... I'm

really sensitive to Somalian women – but I'm not Somalian... I don't have a full understanding of their experiences.

When lesbian counsellors are not available gay-positive is the next alternative. But I certainly don't find the same empathy or level of understanding from someone who is gay-positive as I do from a lesbian.

For couple counselling I would prefer that she be lesbian. Because that's where there will be specific interactions where our relationships as a same sex couple will come up.

I think when you have a team of counsellors in any setting... when you're claiming that you service everybody, then I think that you need to have one person on the team representing the [lesbian] community.

In the study by Hughes, et al, (2002), 79% of lesbians preferred a counsellor who is of the same sexual orientation.

Participants noted the importance of having a lesbian facilitator in a group setting. A sample of comments that illustrate the need for a lesbian group facilitator are:

I wouldn't want them [the facilitators] to be straight, because if they were straight they wouldn't understand how I'm feeling inside, as a lesbian.

A straight [facilitator]...I don't think they would understand...the facilitator would have to be gay.

To have a lesbian facilitator would be a must.

R Some participants would like a FEMINIST service provider

Three participants (17%) expressed the desire for a feminist service provider. One participant expresses her desire for a feminist service provider:

Feminist first and foremost... and feminist in the true sense of the word, and to me a feminist would be lesbian-positive.

The finding of this study is considerably lower than the findings of the Hughes, et al. (2002) study where 87% of lesbians preferred a therapist who was feminist.

R Some participants want "OUT" service providers

Two participants (11%) stated the importance of an "out" lesbian facilitator in a group setting.

Two participants express their need for an "out" lesbian service provider (group facilitator):

The group facilitators weren't lesbian...they [the group facilitators] made a huge effort to be lesbian-friendly but it is not the same. I was the only "out" lesbian there... so sometimes I would feel left out and it would feel heterosexist. A few lesbians came out to me after the group was over, they didn't come out in the group.

If one of the facilitators would say it [I'm lesbian] then I would feel more comfortable.

Studies by Cabaj & Stein (1996), Herek & Green (1996) and Hughes et al. (2000) relating to staffing patterns identify the importance of “out” lesbian staff. These studies note that contact with openly lesbian individuals is strongly associated with more favorable attitudes toward lesbians, which affects both staff and clients.

▽ Support Services that Meet Lesbian Clients Needs

Participants were asked what types of support services would meet their needs. They identified five major types: Support group, information and referral services, individual counselling, couples counselling and public education.

Table 19 Types of Support Services		
Support group	13	72%
Information and referral	7	39%
Individual counselling	7	39%
Couples counselling	4	22%
Public Education	2	11%

As shown in *Table 19*, over two thirds (72%) of participants would utilize a support group. Participants also identified information and referral to lesbian services, individual counselling, couples counselling and public education as required services.

H Most participants would utilize **SUPPORT GROUPS**

Thirteen participants (72%) stated that they would utilize a support group. A support group can be an effective means of breaking isolation. This is what one participant expressed:

It would be best to have a group setting because I would have support from other lesbian mothers...how they do things, how they feel, how their life is with their children.

When surveying service providers, the PTS (2001) study found that 79% of respondents identified isolation of GLBT persons as a high priority issue that needs addressing in Ottawa. The study also indicates that 57% of GLBT persons who reported isolation as an issue weren't getting the help they need to deal with it.

Table 20		
Types of support groups		
Coming "out"	7	39%
Social/drop-in	5	28%
Youth	4	22%
Partner abuse	3	17%
Sexual abuse	2	11%
Parenting	2	11%
Relationships	2	11%

Table 20 indicates that participants identified seven types of support groups that would be beneficial to them. These include a coming out group, a social drop-in group, a group for youth, a group to explore and understand partner abuse, a sexual abuse group, a group for parenting

issues, and a group that explores healthy relationships. A sample of comments that illustrate the need for different types of support groups are:

I think that would be very helpful to have a drop-in group on a weekly basis, so that more people would come out of the closet. That would be really helpful because I know there are a lot of lesbian women out there and they are not coming out of the closet...and basically I'm in the same boat right now...hiding in their selves...and we don't want that...we want to come out.

I would like to see a group that we could chat or meet people, something like a drop-in group for lesbians.

I think that relationship issues are a big deal and I think it would be really helpful to have groups like that...for better communication and to deal with anger and stress management.

■ INFORMATION AND REFERRAL was seen as very important

Seven participants (39%), identified the need for information and referral to lesbian services and the lesbian community. One participant expresses her isolation and the need for information and referral:

My thing was isolation...like I am the only dyke who lives here. I needed to know what is going on, information and referral...a lot of it [my struggle] was to try to find where the social network was, and a group as well...a lesbian group...a social group.

A study by Collett (1982) shows the importance of linking lesbians to the lesbian community. The lesbian community provides space where lesbians can be accepted and affirmed, rather than being tolerated, feared or treated as invisible in mainstream society.

Participants noted that it would be helpful if service providers asked and explored the “right” questions at the beginning of service. Here is one participant’s surprise and delight with being asked an explicit question by a service provider during the intake process:

She actually asked me! She asked if I had a partner and when I said yes, she said, male or female!

Research completed by Roth (2002) indicates that services need to be sensitive to how their staff welcomes and greets clients. According to Roth (2002) should a lesbian not feel safe to come out, silence about her sexual orientation can negatively impact all aspects of service.

E Participants want INDIVIDUAL and COUPLES COUNSELLING

Seven participants (39%) expressed a need for individual counselling services and 22% wanted couples counselling. This finding is lower than the PTS (2001) study which indicates that 51% of the GLBT respondents are not getting the counselling support they need.

E PUBLIC EDUCATION was seen as important

Participants also discussed the importance of educating the public on issues of heterosexism, homophobia and to address myths and stereotypes concerning lesbians. A youth participant commented on how she felt:

A counsellor came to the school for a presentation, to talk about gay and lesbian stuff...that was really cool. I thought it was a good idea and that it would help because people would be more aware.

▽ Increased Visibility of Services to Lesbians

Over half (56%) of participants identify advertising of lesbian services as a key element to increasing access. They identified four means of advertising:

- E Advertising services to lesbians in local CHRC literature
- E Advertising services to lesbians in the GLBT community
- E Displaying a lesbian-positive symbol at the waiting areas of CHRCs
- E Advertising services to lesbians in mainstream newspapers

Table 21 Increased visibility of lesbian services		
CHRC literature	6	33%
GLBT community	4	22%
GLBT positive symbol	4	22%
Mainstream newspapers	3	17%

Ⓔ Participants want services to lesbians stated in CHRC LITERATURE

As *Table 21* indicates, 33% of participants felt that services to lesbians should be advertised/stated in general literature such as pamphlets, flyers and resource lists. Two participants share how important it is to be explicit:

I saw an advertisement recently for a couples workshop in the United Church. They explicitly said same-sex couples are welcome. It was not enough just to say couple counselling because in this world people still would not think to assume that it would include same-sex couples...so you have to state it explicitly.

I saw pamphlets on what services were offered with regards to grief, etc. at the hospitals. Pamphlets from the schools... pamphlets on what is available for the homeless...all kinds of stuff as to what was available for resources in the area. But I saw nothing on social services with regards to lesbians and gays.

Ⓔ Advertising services to lesbians in the GLBT COMMUNITY would increase visibility and access

Four participants (22%) stated that it is important for Community Health and Resource Centres to advertise services to lesbians in the GLBT community. Participants suggest advertising in Capital Xtra, Ottawa's lesbian and gay biweekly newspaper:

If you [CHRCs] advertise in an appropriate place, like Capital Xtra, it makes it known that you are comfortable in dealing with these [lesbian] issues.

I will be looking in Capital Xtra and seeing what is advertised and calling those services. They [the CHRCs] should advertise in places that I would be looking like any newspaper, a women's bookstore, or somewhere in the gay community. Then I would go 'oh that is neat...I would call. I would know that the service was there and that it was important enough for them to advertise it.

E Participants want GLBT PRIDE SYMBOLS in the waiting areas

Four participants (22%) expressed the importance of displaying GLBT pride symbols in the CHRC waiting areas. Two participants' comments are stated below:

If I was going to [access a CHRC] I would ask myself...which one has a flag in the window?

I think seeing a rainbow is a welcoming sign right off the bat.

A study by Cabaj & Stein (1996) states the importance of providing a lesbian-positive environment, noting that as with all new environments, lesbians may be faced with a sense of not knowing how their sexual-minority status will be received. Physical aspects, such as facades and waiting rooms must display pride symbols welcoming to lesbians such as the rainbow flag, posters and reading material.

R GLBT AWARENESS TRAINING is a must for all staff

One participant identified the need for all CHRC staff to have GLBT awareness training before displaying a GLBT-friendly symbol in the waiting area. As she expresses...

I don't think you should put a sticker [rainbow flag] on the door until you're sure your staff is supportive...because putting a sticker on the door tells a gay person that this is a safe place...if it is not a safe place...that is really detrimental.

This concern is expressed in the study by Cabaj & Stein (1996) where it states that those agencies that do explicitly welcome lesbian clients must consider whether a gay pride symbol, such as the rainbow flag, represents the level of care that a client may expect to receive.

R Services to lesbians should be advertised in MAINSTREAM NEWSPAPERS

Three participants (17%) felt that it was important to advertise services to lesbians in mainstream newspapers. This is reflected in the comments below:

I think it is hard to see what resources are out there. As a lesbian I would like that the resource Centres give their GLBT information in the local newspapers. This would allow the community to see and know about lesbian lives.

I think they should have some more advertising towards that [serving lesbians]. There's the Penny Saver, the [a west-end local paper], there's the Sun Newspaper...lot's of papers out there. You can go [advertise] on the net.

▽ Preferred Location of Services

Participants were asked if they would most likely access services at their local Community Health and Resource Centre and/or at a GLBT Community Centre located in Ottawa centre.

Table 22 Ideal location of services		
Local CHRC only	6	34%
GLBT CRC	4	22%
Either	6	33%
Not available	2	11%

⌘ Most Participants would like all **LOCAL COMMUNITY HEALTH AND RESOURCE CENTRES** to have the ability to service lesbians

A majority of participants (67%) said that they would like to see all thirteen local Community Health and Resource Centres provide services to lesbians. The following comments illustrate participant's needs for local services:

People think that all the queers are downtown but as you know there's some in Kanata.

I would access some place that is around my area, just because it's more convenient.

In my case there is an ex-partner out there...I would probably use a local one [CHRC]...it is a different neighbourhood.

Six participants (34%) expressed that they would **ONLY** access service at their local CHRC, saying that they would not be comfortable accessing service at an exclusively GLBT community centre. The following comments illustrate participants' fears of being seen accessing an exclusively GLBT Centre:

I wouldn't go to a GLBT centre because clearly that is what it is...and I would be identified as lesbian...and I don't want that. It made it easier to go to my local centre because you don't identify. Same as Pink Triangle Services...because going there identifies you as lesbian...it stops me from going.

I still struggle a bit myself...I'm still concerned with being somewhere where people from work might see me.

I know there's big talk of starting a GLBT centre downtown. But I don't think doing that hits the people that need service so desperately... like people in the suburbs and rural areas. Also, if you're not out and not sure of your orientation, you're not going to walk into a center that's identified widely as a gay place.

This highlights the importance of all CHRCs providing services to lesbians. Participants who said that they are fearful of being "found out" are less likely to access services at a site that works exclusively with GLBT persons since entering the building would be tantamount to publicly "coming out".

E Some participants would access a GLBT COMMUNITY CENTRE

Ten participants (56%) stated that they would use the services of a centralized GLBT Community Resource Centre. This is consistent with the PTS (2001) study where 55% of GLBT respondents supported of a GLBT Community Centre.

Four participants (22%) stated that they would be **most comfortable** accessing services at a GLBT Community Centre. The comments below illustrate participants' desires for a GLBT Community Centre.

You know that if you are going to a GLBT Centre that they are going to be [lesbian] positive. I am not saying that CHRCs will not be positive...but you cannot guarantee it.

If I know it was set up for GLBT people, then yes I would access it, because I would know that all resources in the Centre were for the gay community. I would probably even volunteer there.

One participant suggested that it would be beneficial to have staff from a GLBT Community Centre seconded to work at the thirteen local Community Health and Resource Centres.

What I would like to see in the long run is have one GLBT centre, but have staff seconded [to CHRCs] for groups or to offer other resources.

CHAPTER SUMMARY

Findings of this study reveal that lesbians are not receiving accessible and comprehensive mental health services from their local Community Health and Resource Centres. All participants identified stress as an issue of concern for them; rating sexual orientation as their highest source of stress. It is critical to highlight that thirteen participants (72%) identified that feeling suicidal was a concern for them. This high incidence of depression and suicidal feelings among lesbians has been acknowledged in other studies.

All participants sought some type of support for an issue of concern to them. Most identified having a negative experience when accessing support, identifying eleven barriers to service. The largest barrier identified was the assumption of heterosexuality among service providers. Due to this assumption, and the fear of a negative reaction from service providers, most women did not identify as lesbian when accessing service thereby limiting safe and comprehensive services. All participants would like to see services offered to lesbians at their local CHRC. It is vital to highlight that six participants (34%) expressed that they would ONLY access service at their local CHRC, stating that they would not be comfortable accessing service at an exclusively gay, lesbian, bisexual and transgender community centre for fear of being “found out”. These findings are consistent with findings of other studies, as seen in the literature review. They highlight the need for: specialized support services for lesbians; a commitment to employing “out” lesbian

front-line service providers; accessible and comprehensive information and referral services; and an increase in the visibility of services to lesbians.

CHAPTER VI

CONCLUSIONS & RECOMMENDATIONS

This study documents the mental health concerns of women who identify as lesbian, their health and social service needs, the barriers to accessible and comprehensive service and the potential areas for improving services. Although more detailed research is required in many areas, it is clear that local Community Health and Resources Centres must provide or increase mental health services to lesbians.

CONCLUSIONS

A social constructionist framework allows for an understanding of sexual orientation across time and place. The existence and value of lesbians has been, and continues to be, greatly influenced by the historical, social and political construction of lesbianism. For example, before Hitler's rise to power, **The Institute of Sexual Science** in Vienna was producing lesbian and gay-friendly research and the streets of Berlin were considered safe for "out" lesbians and gay men.

With the rise of Nazis power in 1933, came the looting of the institute, the burning of any historical research that valued homosexuality, and the incarceration of lesbians and gay men in German concentration camps.

This legacy of oppression against lesbians is carried with us into this century, however, today it is not so visible. Through our some of our laws, we state acceptance of lesbianism, however, as social constructionist theory tells us, there is a deep-rooted, systemic oppression underneath this tolerance. This deep-rooted oppression leaves lesbians with an inheritance of mistrust and fear causing them enormous amounts of stress and feelings of suicide.

The systemic oppression of lesbians has forced them to be invisible and allowed for their exclusion in the development of mental health services. What we see today in health and social services is part of the continuation of centuries of oppression.

▽ Lesbian Mental Health Concerns

Lesbians share many of the same mental health concerns as heterosexual women, including stress, depression and feeling suicidal. All participants (100%) in this study identified stress as an issue of concern. In other studies, the differences between heterosexual women and lesbians came in the sources of stress, with lesbians rating sexual orientation as their highest source of stress. It is critical to highlight that thirteen participants (72%) identified that feeling suicidal was a concern for them. A high incidence of depression and suicidal feelings among lesbians has

been acknowledged in other studies. These findings have serious implications for providers of mental health service and it is essential that Community Health and Resource Centres provide comprehensive service to lesbians.

▽ Lesbian Access to Health and Social Services

Decision-makers at Community Health and Resource Centres must ensure that programs and services are accessible to lesbians. Research reveals that lesbians access service at a higher rate than heterosexual women. Findings of this study indicate that all of the participants (100%) had sought some type of support for the issues they identified.

Ten participants (56%) identified having a negative experience with accessing support. They identified the service providers' lack of awareness about lesbians and lesbian issues as the key reason for their dissatisfaction with service. This finding highlights the importance of providing GLBT training to all staff.

Findings of this study highlight the importance of CHRCs increasing and advertising services to lesbians. Twelve participants (67%) had, at some point in their lives, wanted service for an issue they were concerned with and yet did not seek support. Participants indicated that they did not seek service because they were not aware that any lesbian specific services existed.

Of significance to this study, is the fact that eight participants (44%) sought support at their local Community Health and Resource Centres for medical, counselling and group services. Due to heterosexist bias, not all of these women identified as lesbians, thereby limiting their access to safe and comprehensive service. This finding highlights the importance of eliminating heterosexist bias at first point of contact - information and referral.

▽ Barriers to Accessible and Comprehensive Service

Findings of this study highlight the need for decision-makers within Community Health and Resource Centres to address systemic barriers to service. Sixteen participants (89%) identified eleven barriers to accessing service.

The most significant barriers to service included:

- Lack of awareness among service providers about lesbians and lesbian issues
- An assumption of heterosexuality
- Fear of a negative reaction from service providers
- Fear of disclosing their sexual orientation
- Not being aware of services offered at CHRC or lack thereof.

Ten participants (56%) felt a need to keep their sexual orientation a secret when accessing services due to fear of a negative reaction from the service provider. It is important for CHRCs to

recognize that when lesbians feel a need to "pass" it is because they do not feel safe to disclose their sexual orientation, consequently, their access to comprehensive service is compromised.

▽ Potential Areas for Improving Services

The program and service needs of lesbians cannot be overlooked. From this research, it is evident that specialized support services for lesbians are needed. Sixteen participants (89%) felt there is a need for such specialized support services for lesbians because of the unique issues that they face as lesbians.

A commitment to employing "out" lesbian front-line service providers is a must for CHRCs. Findings of this study reveal that ten participants (56%) would be most comfortable with a lesbian service provider. Findings also reveal the need for CHRCs to ensure that all front-line service providers are trained to work with lesbian clients as thirteen participants (72%) stated they would be comfortable with a female service provider who is GLBT positive.

Accessible and comprehensive programs and services must be ensured. Findings of this study reveal that participants require information and referral services, individual counselling, couples counselling and support groups. Findings reveal that thirteen participants (72%) would utilize a support group. CHRCs must consider providing lesbian-only support groups for a variety of issues such as coming-out, partner abuse and healthy relationships. Lesbian-only support groups offer lesbians a safe environment to explore issues.

CHRCs must consider increasing the visibility of services to lesbians. Findings indicate that over half (56%) of participants identify advertising of lesbian services as a key element to increasing their access to service, they included:

- ☐ Advertising services to lesbians in local CHRC literature such as pamphlets and flyers
- ☐ Advertising services to lesbians in the GLBT community
- ☐ Displaying a lesbian-positive symbol at the waiting areas of CHRCs
- ☐ Advertising services to lesbians in mainstream newspapers

It is essential that all local CHRCs offer programs and services to lesbians. Findings of this study indicate that most participants (67%) expressed that they would like to see all thirteen local Community Health and Resource Centres provide services to lesbians. It is important to highlight that six participants (34%) expressed that they would **ONLY** access service at their local CHRC, saying that they would not be comfortable accessing service at an exclusively GLBT Community Centre for fear of being "found out".

In summary, this study has been successful in bringing together some of the voices of women who identify as lesbian. The findings of this research may allow Community Health and Resource Centres to understand more clearly the specific issues with which lesbians struggle, their health and social service needs and concrete ways in which to improve service to lesbians.

RECOMMENDATIONS FOR PRACTICE

The researcher makes the following recommendations based on the findings of this study.

1. Establish a COMMITTEE, under the direction of the Coalition of Community Health and Resource Centres

The Coalition consists of the thirteen Community Health and Resource Centres that service the Ottawa area. The committee should bring together CHRC staff that are responsible for developing and implementing programs and services.

The aim of the committee would be to:

- ☒ Address the mental health needs of lesbians.
- ☒ Address barriers to service.
- ☒ Increase accessible and comprehensive programs and services.
- ☒ Monitor and evaluate services to lesbians.
- ☒ Ensure that ALL local CHRCs are providing service to lesbians.

2. Develop and Implement a Lesbian-friendly HUMAN RESOURCE STRATEGY

- ▽ Provide GLBT sensitivity training for all Community Health and Resource Centre staff. GLBT sensitivity training should be provided to all CHRC staff.

This training should be a part of the core training requirements of the centre, ensuring that all new staff members, students and volunteers are trained.

- ▽ Provide lesbian sensitivity training and resources to front-line service providers. Lesbian sensitivity training should be implemented so that those who provide direct service will work effectively with clients who are lesbian.

- ▽ Provide staff the opportunity to monitor their work with lesbian clients.

Supervision by someone experienced and knowledgeable with issues related to lesbians should be available to staff. Provide periodic education about the concerns of lesbians and opportunities for staff members to discuss and process their own heterosexism.

- ▽ Hire qualified, "out" lesbian, front-line service providers.

3. Develop and implement accessible and comprehensive PROGRAMS AND SERVICES

▽ **Provide accessible and comprehensive information and referral services.**

Ensure that all intake forms are inclusive. Provide opportunities for lesbians to identify themselves as such. Offer the choice of lesbian specific services to all women.

▽ **Increase the amount and types of support groups for lesbians.** Support groups are an effective means of breaking isolation. Provide lesbian and bisexual women-only support groups. Provide different types of support groups such as coming out and healthy relationships groups.

▽ **Increase lesbian-friendly counselling services.** Provide both individual and couples counselling to lesbians ensuring that staff are either “out” lesbians or GLBT positive.

▽ **Provide public education activities** to address myths and stereotypes concerning lesbians.

▽ **Evaluate program and services** in terms of a climate of safety, or the degree to which lesbians feel safe to disclose their sexual orientation.

4. Increase the VISIBILITY of service to lesbians

▽ State in general CHRC literature such as pamphlets, flyers and resource lists that services are provided to lesbians.

▽ Advertise services to lesbians in the GLBT community. Places to advertise include: Capital Xtra, Ottawa's lesbian and gay biweekly community publication and the internet site, www.ottawagirl.com

▽ Advertise services to lesbians in mainstream newspapers.

NEED FOR FURTHER RESEARCH

There is a clear need for further research in the area of lesbian health. As stated in Chapter III: Gaps in Research, most of the studies relating to lesbian mental health and social service needs are being conducted in the United States, few have been completed in Canada. Due to the differences in context between the United States and Canada, we are at risk of creating a skewed view of lesbian mental health. For instance, Canada's somewhat progressive laws on lesbian and

gay rights may help to promote better mental health. If we are to adequately meet the needs of lesbian clients, building knowledge around the Canadian context of health care is essential.

Suicidal ideation among lesbians is an area that must be explored in more depth. The results of the study were alarming with 13 of 18 participants identifying feeling suicidal as an issue of concern. This statistic clearly indicates that there is a serious problem within the lesbian community. Given the difficulty of reaching such a hidden population one might begin with a national, on-line survey to explore the degree to which this finding can be generalized in a larger population. If the high incidence of suicidal feelings were found to be true in the larger lesbian population the implications for mental health services and further research would be enormous.

As well, further research, again perhaps through a national, on-line survey, is required to identify the mental health and social service needs of young lesbians, particularly teens. As stated earlier studies such as PTS (2001) noted that depression and suicide is higher among youth than adults.

DISSEMINATION

The final report and/or an executive summary of the final report will be made available to all research participants at their request (included in Appendix E), Pink Triangle Services, the Coalition of Community Health & Resource Centres and any other interested parties (Barnsley & Ellis, 1992, Kirby & McKenna, 1989; Maguire, 1987).

A presentation will be made at the Ontario Association of Community Health & Resource Centres conference in June of 2003. The Ontario Association consists of sixty-five Community Health and Resource Centres that serve the province of Ontario. The goal of the presentation will be to: 1) facilitate an understanding of the specific issues that lesbians struggle with; 2) present recommendations outlining lesbian's social health and social service needs; and 3) encourage the Community Health and Resource Centres to develop accessible and comprehensive health and social services.