



British Columbia
Centre of Excellence
for Women's Health

Vancouver, BC
CANADA

Out in the Cold

The Context of Lesbian Health
in Northern British Columbia

By Lynda Anderson
Theresa Healy
Barbara Herringer
Barbara Isaac
and Ty Perry

Report available
in alternate formats



Out in the Cold

The Context of Lesbian Health
in Northern British Columbia

By Lynda Anderson
Theresa Healy
Barbara Herringer
Barbara Isaac
and Ty Perry





**British Columbia
Centre of Excellence
for Women's Health**

**Centre d'excellence de la
Columbie-Britannique
pour la santé des femmes**

Main Office

E311 - 4500 Oak Street
Vancouver, British Columbia
V6H 3N1 Canada

Tel 604.875.2633

Fax 604.875.3716

Email bccewh@cw.bc.ca

Web www.bccewh.bc.ca

Women's Health Reports

Copyright © 2001 by British
Columbia Centre of Excellence
for Women's Health

All rights reserved. No part of
this report may be reproduced
by any means without the written
permission of the publisher,
except by a reviewer, who may
use brief excerpts in a review.

ISSN 1481-7268
ISBN 1-894356-18-7

Executive Editor Lorraine Greaves
Senior Editor Leslie Timmins
Copy Editor Robyn Fadden
**Graphic Design
& Illustration** Michelle Sotto

**Canadian Cataloguing
in Publication Data**

Out in the cold

Includes bibliographical references.
ISBN 1-894356-18-7

1. Lesbians—Medical care—British Columbia,
Northern.
2. Lesbians—Health and hygiene—
British Columbia, Northern.
- I. Herring, Barbara M.
- II. BC Centre of Excellence for Women's Health.
- III. Series: Women's health reports (Vancouver, B.C.).

RA564.87.O97 2001
362.1'086'643097118
2001-911024-3

Contents

Acknowledgements

I. Executive Summary	2
II. Introduction	3
The North	4
III. Background	5
A. The Legacy of Homophobia in Health Care	5
B. Qualitative Research on Lesbian Health Care	6
C. Exclusion of Lesbians: Biases in Contemporary Medical Research	7
D. British Columbia: Related Literature	8
IV. How We Did the Research	9
A. Project Goals	9
B. Community Participation	9
C. The Research Team	9
D. Finding Participants	10
E. Data Collection	10
F. Confidentiality	11
G. Data Analysis	11
V. Research Findings	12
A. Major Findings	12
B. Lesbians' Strategies for Health Care: Benefits and Risks	17
VI. Conclusion	19
VII. Policy Recommendations	20
Authors and Research Team	22
References and Bibliography	23

Acknowledgements

To Maria Hudspith, University of British Columbia MA candidate and lesbian activist, for her encouragement, energy and enthusiasm on the initial draft of the successful proposal, and her scholarship and expertise on the literature review.

To the northern lesbians who participated in the research project, our sincere thanks. Your commitment to our healthy community will be a legacy for future lesbians.

To Kristiann Allen, Research Associate, British Columbia Centre of Excellence for Women's Health Northern Secretariat, for editing assistance.

And finally, to the British Columbia Centre of Excellence for Women's Health for funding this research project, and especially to Theresa Healy, PhD, former Coordinator of the Northern Secretariat of the BCCEWH.

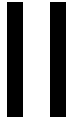


Executive Summary

Three primary research questions guided our investigation into lesbians' experiences of the formal health care system in northern British Columbia. First, how do lesbians describe their experiences of formal (allopathic) health care services? Second, what barriers do they experience? Third, how do lesbians negotiate these barriers and address their health and wellness needs inside and outside of the formal health care system?

This qualitative study illuminates the impact of the anti-lesbian/anti-gay social climate of the north and its permeation into health care services. For lesbians living in this context, considerations of personal safety and personal freedom are intricately intertwined with health. Significant changes are needed in services and in the community at large to bring down the barriers that obstruct lesbians' access to health care.

This report documents a uniquely collaborative participatory action research process that blurred conventional boundaries between researcher and researched and has led to social action initiated by participants.



Health as a state of “physical, emotional and social well-being” may be difficult to achieve for lesbians who live in northern communities where homosexuality is reviled and personal safety may be at risk as a result.

Introduction

Since the late 1970s, the field of health promotion has reconceptualized health as a state of physical, emotional and social well-being, rather than as merely the absence of disease. It is now widely recognized that community, culture, identity, family and self-esteem have implications for human development and overall health and for health service provision and utilization.

Recent qualitative studies have demonstrated that lesbians continue to face persistent barriers in the formal health care system (Denenberg, 1995; Stevens, 1995; Rosser, 1993; Rankow, 1995). The history of medicine itself is replete with examples of biases against and maltreatment of lesbians. In northern B.C., health services are also influenced by the pervasive anti-lesbian/anti-gay biases of the communities in which they are located. Health as a state of “physical, emotional and social well-being” may be difficult to achieve for lesbians who live in northern communities where homosexuality is reviled and personal safety may be at risk as a result.

Out in the Cold reveals that this reality is more complex and contradictory than it would initially seem. Although many participants in this study expressed anger against the oppressiveness of their communities, those who lived in rural or isolated settings also described the positive impact of proximity to the northern wilderness and the privacy it afforded them. Although biases and barriers within the health care system had driven most participants away from it, many stressed the benefits of their autonomous health care strategies. Independence and ingenuity are consistent with the pioneering spirit of northern people, yet this autonomy is not without a cost: social isolation and undetected illness are two of the possible detriments to health.

Our research adds to the growing body of literature on lesbian health and enhances it with an examination of the complex and contradictory influence of place and with a uniquely collaborative research design. This project has also been a catalyst for action strategies initiated by lesbian participants. A monthly potluck event where food, conversation

and health ideas are shared has started in one community, an important and necessary strategy to help bridge the gap left by inadequate and inaccessible services.

The North

The communities that we visited vary in terms of cultural and religious values and economic infrastructure, but “share common features such as long, cold winters, low population base, geographic isolation and limited accessibility to the resources of the larger urban centers” (Isaac & Stokes, 1999). The area covered by the research spans the upper two-thirds of B.C., with only about 300,000 inhabitants. Due to prohibitive travel costs and time constraints, this study concentrates on lesbians in communities reachable by main highways.

The resource-based industries that dominate northern B.C.’s economy have a masculine and transient nature, which is disadvantageous for women in general because the focal point of such communities is men’s work, hence men’s experience. Geographic isolation often means that people are even more strongly influenced by male dominance, religion and traditional sex-based roles. These gender disparities co-exist with fierce independence, self-reliance, and pervasive conservatism. The

experiences of women, and more particularly of lesbians, are marginalized. Right-wing, Christian fundamentalist, anti-homosexual rhetoric is expressed in everyday encounters and through local media. With their small populations, northern communities are an environment where everyone knows everyone else’s business. Women who are known to be lesbian may be reviled and ridiculed, which signifies considerable threat and personal risk.

Geographic isolation often means that people are even more strongly influenced by male dominance, religion and traditional sex-based roles.



Background

A. The Legacy of Homophobia in Health Care

Homosexuality was defined throughout the early twentieth century as a disease: a “congenital constitutional weakness,” an “inborn predisposition to perversion,” or “hereditary taint” (Stevens & Hall, 1991, p. 295). This perversity was thought to be dangerous and contagious, and many lesbians and gay men were confined in insane asylums to protect the virtuous from contamination. Freud’s theories, which described same-sex attraction and behaviour as pre-Oedipal (a stage that would be outgrown by healthy individuals in favour of the “moral imperative” of heterosexuality (Carlson, 1992, p. 46)), dominated medical thinking. Behaviours that could be considered unconventional or gender-inappropriate (e.g., involvement in skilled labour, dedication to career, involvement with social movements) were also considered part of the diagnostic criteria for lesbianism (Stevens & Hall, 1991). These so-called unbiased, scientific definitions of lesbianism worked in concert with social stereotyping and prejudice to create “the lesbian” in the medical imagination. This construction has shaped the policies and practices of health care and continues to influence lesbians’ experiences with the health care system today.

In the 1960s, in much of the western world, the emerging lesbian and gay rights movement began to promote lesbians and gays as normal, respectable members of society. Lesbian and gay activists turned their attention to the medical stigmatization of homosexuality, lobbying to remove homosexuality from the American Psychiatric Association’s (APA) Diagnostic and Statistical Manual of Mental Disorders II (DSM II), the publication that defines and categorizes mental illnesses. Homosexuality had been listed as a pathology, placed alongside psychiatric disorders and psychoses. In 1973, after several years of lobbying, the APA removed homosexuality from the DSM II (Stevens & Hall, 1991), but lesbianism has continued to be seen as an illness by many health care professionals as recently as 1992 (Gentry, 1992; Eliason, Donelan & Randall, 1992; Mathews et al., 1986).

B. Qualitative Research on Lesbian Health Care

Health care providers have demonstrated the unique struggles that lesbians continue to face (Denenberg, 1995; Stevens, 1995; Rosser, 1993). A study of nurse educators in the United States found that 25 per cent of participants saw lesbianism as immoral and wrong and 52 per cent believed that lesbians should undergo treatment to become heterosexual (Rankow, 1995). A recent survey of the American Association of Physicians for Human Rights found that 67 per cent reported knowing of instances where lesbian, bisexual or gay patients had been refused care or had received substandard care because of their sexual orientation (Rankow, 1995).

For lesbians, the assumption of heterosexuality determines the experience of dealing with the health care system, as it does in society in general. To ensure that adequate care is provided, lesbians must often make a declaration of their sexual identity or sexual practices. This disclosure is often met with disgust, fear, hostility or misunderstanding, and the anticipation of such a reaction may discourage a woman from being out (Rosser, 1993). The fear of identifying as a lesbian means that some lesbians must

pass as heterosexual in health care settings, providing incomplete or inaccurate information about themselves in an effort to camouflage their lesbianism and ensure appropriate treatment. This often results in misdiagnosis and improper treatment, as well as discomfort and anxiety for the patient (Rankow, 1995; Denenberg, 1992; Stevens, 1992). Lesbians are also silenced by the systemic preoccupation with women's reproductive issues, which remains the most highly funded area of women's health research and practice.

Ambiguity concerning lesbian sexual practices could mean that some physicians may not inform lesbian clients about specific preventative steps to ensure safe sex. Though lesbians have low rates of sexually transmitted diseases, susceptibility to STDs differs from heterosexual behavioural risks in that the spread of STDs in the lesbian population has more to do with modes of transmission than number of partners (Shaw, 1989).

The relevance of wellness to the quality of the physician-client relationship is considered in much of the literature on lesbian health care experiences (Trippet & Bain, 1992; Adams, 1989; Edelman, 1986; Smith, Johnson & Guenther, 1985). Trippet and Bain (1993 & 1992), Gentry

While lesbians may confront many of the same issues as heterosexual women, they also face unique barriers due to societal homophobia and heterosexism.

(1992), Eliason (1991), Adams (1989) and Stevens and Hall (1988) emphasize the responsibility of health care providers to familiarize themselves with the social context of lesbian lives in order to provide sensitive care.

C. Exclusion of Lesbians: Biases in Contemporary Medical Research

Where much research has focused on white, heterosexual men, the particular health needs and experiences of women and minority groups have been marginalized or ignored altogether. Although the contemporary women's health movement has drawn attention to the unique needs of women, the diversity of women's experiences is only beginning 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. While lesbians may confront many of the same issues as heterosexual women, they also face unique barriers due to societal homophobia and heterosexism. These institutionalized power relations compound others, such as classism, sexism

and racism, all of which are entrenched in society generally and the health care system in particular.

In many studies, lesbians are either subsumed under the category of women or grouped together with gay men. Few studies that focus on women make a distinction between lesbians and heterosexual women. Indeed, in many studies, researchers make an assumption of universal heterosexuality.

Perceived as similar to gay men, lesbians are further removed from traditional realms of inquiry, which obscures the interrelationship between heterosexism, homophobia and sexism. Indeed, "thought of as homosexuals, and thus defined in opposition to their heterosexual counterparts, lesbians naturally become excluded from obstetrics/gynecology, the medical specialty devoted to women's health" (Rosser, 1993, p. 187).

Gay men and lesbians are hardly a homogenous homosexual group who share identical barriers to care. Most research on homosexuals has emphasized the gay male subject to the neglect of research that might specifically benefit lesbians (Eliason, Donelan & Randall, 1992; Trippet & Bain, 1992; Simkin, 1991; Reagan, 1981).

The unique issues faced by lesbians

are rarely examined. This gap in both the medical and social science research has many repercussions. For instance, there is a lack of understanding of epidemiological trends among lesbians, and very little knowledge about lesbians' conceptions of health and illness.

D. British Columbia: Related Literature

There are some limited data about the situation for both gays and lesbians in central B.C. in a quality-of-life study by the Healthy Communities Committee (1997). Findings revealed that gay and lesbian respondents felt that the city of Prince George has a negative atmosphere, including discrimination by doctors, few women physicians and few available services for lesbians and gays. In addition, a report on lesbians who live in northern B.C. provided some insight into little-explored experiences of lesbians in small and isolated communities, including some data about formal health care (Sorrell & Watson, 1997). However, this research did not specifically explore barriers to health care.

IV

How We Did the Research

A. Project Goals

The goal of this project was to identify barriers to health care for lesbians in northern B.C. and make recommendations for health policy and practice. At the same time we wanted to build community capacity and empowerment (Gaventa, 1988), to take social action and inspire it. To this end we designed a highly collaborative participatory action research model that would give participants equal voice in the research process, foster connections between lesbians and develop resources and supports that could be used afterwards.

Three primary research questions informed our investigation:

1. How do lesbians in northern British Columbia describe their experiences of health care services?
2. What barriers do they experience?
3. How do lesbians negotiate these barriers and address their health and wellness needs inside and outside the formal health care system?

Within each question we compared the experiences of lesbians living in urban areas with those in rural and remote settings.

B. Community Participation

We designed this study so that participants had equality of voice in every stage of the process, from commenting on research methods, vetting data and analyses, to giving feedback on reports. We wrote and disseminated a broadsheet designed in newsletter format and plain language to summarize the research highlights and invite comment. Newcomers who had not participated in the pilot stages also had access to the broadsheet.

C. The Research Team

The research team was made up of academic and community members of diverse backgrounds. All of us are lesbian and live in the north.

Our passionate participation in the research process was checked and vetted at every stage by the non-team participants.

Socializing time was built in to allow connections and bonds to be made and to allow mutual trust and confidence in the research process to grow.

Instead of trying to manufacture objectivity, we embraced our subjectivity as lesbian researchers and took an active part as participants in focus group discussions. Our unique position as researchers living within the research context reflects the circumstance of small northern communities in which researcher and researched are often known to each other and where researchers have “insider” knowledge and experience of the subject. Our position provided an advantage to understanding the meaning and significance of the experiences non-team participants shared with us. It is important to note that our passionate participation in the research process was checked and vetted at every stage by the non-team participants. They assessed, critiqued and changed the data and analyses to ensure that we captured what they intended.

D. Finding Participants

The project was advertised with an accompanying assurance of discretion in a lesbian/gay positive magazine, newsletter, listserves, and in brochures and posters at lesbian-gay positive venues and dances. An advertisement went into the Central Interior Buy and Sell. Sorrell and Watson’s (1997) project researchers contributed their contact lists. Because many

lesbians live in remote locations where it is not safe to post a call for participation, key participants were sought to contact other lesbians living in their area. Finally, community contacts and team members used their own social and professional networks to link participants with the project.

E. Data Collection

In consultation with participants, we decided that focus groups would form the foundation of the narrative data collection. In addition, 30 research participants (including two research team members) took part in interviews, including one-to-one interviews, interviews with one researcher and a couple, or one researcher and two acquaintances. After the pilot focus groups, a community meeting was held so that participants and other interested lesbians could comment and review.

Socializing time was built in to allow connections and bonds to be made and to allow mutual trust and confidence in the research process to grow. Questions were open-ended to encourage free association of ideas. Theatre skits of issues that lesbians face in the health care system were sometimes presented as a way to foster discussion. Each formal meeting or interview was audio taped (with informed consent) and notes were taken to record the

For those concerned with confidentiality and personal safety, private interviews were conducted at a site chosen by the participant. Given the danger surrounding disclosure for lesbians, no identifying information was recorded.

interviewer's thoughts, feelings and observations.

F. Confidentiality

The issue of confidentiality is very particular in the north due to the smallness of communities. For those concerned with confidentiality and personal safety, private interviews were conducted at a site chosen by the participant. Given the danger surrounding disclosure for lesbians, no identifying information was recorded. In vetting the research data and analyses, participants could check to see that their anonymity had been protected.

G. Data Analysis

The research team held five day-long sessions to compare and debate interpretations, identify broad themes and elucidate specific findings. A critical understanding emerged from our analysis of participants' narratives: many lesbians associate health and healthiness with their northern, rural lifestyle, which afforded them the opportunity to live in nature, be near animals, grow their own food and enjoy a sense of privacy. We acknowledge the value of these experiences as part of a broad strategy to health. To focus exclusively on interactions with formal health care would diminish the significance of this relationship

between health/wellness and the northern social context.

V

Research Findings

A total of 40 lesbian women participated in the focus groups and interviews. They ranged in age from eighteen to “too-old-to-want-to-talk-about-it”, women who had identified as lesbians for decades and “baby dykes” newly claiming their sexuality. We spoke to women in Smithers, Houston, Fort St. James, Burns Lake, Hixon, Fort St. John and Prince George. Six women had been born in the north; most had lived here from five to fifteen years. Some worked the land, some were health care professionals, some combined motherhood and paid work. Nine were members of the research team.

A. Major Findings

Three major groups of findings emerged from our analysis of participants’ descriptions of their experiences of health and health care in the north. These are:

- ☺ The northern context has a critical impact on the health and wellness of lesbians living here.
- ☺ Formal health care services are permeated by the homophobia and heterosexism of northern society. Homophobic responses from health care providers had discouraged most participants from all but the most minimal use of formal (allopathic) health services.
- ☺ Many participants perceived the biases and barriers they encountered in health services as unremarkable. Generally, participants emphasized their own strengths and coping abilities. Most participants believed that autonomy from the formal health care system had enhanced their health and wellness. Some participants were aware that this autonomy, self-affirming and health-enhancing in one sense, could contribute to ill health, including undiagnosed disease.

In the patterns of behavior that emerged in each finding, the decision to come out or not to come out – to reveal or conceal one’s sexual identity in the community and in health care – is an abiding dilemma. This study flags this dilemma as a determinant of lesbian health and wellness.

A sense of belonging and personal security – key components of health and wellness – are largely unavailable to lesbians who live in a social climate hostile to homosexuality.

Lesbian health within the context of place is a key understanding arising from this study. The interaction of these two factors, place and sexual identity, give rise to contradictions. Lesbians who embrace the northern ethos of self-reliance tend to assume responsibility for making up the shortfall in health services. Although ample evidence of barriers to lesbian health and health care were revealed, many participants' descriptions minimized the impact of these barriers. Many women, though acutely aware of the oppressive anti-gay biases in their communities, expressed a deep sense of belonging to the natural world of the north, a relationship from which they derived genuine inspiration, strength and power.

—☺ **The northern context has a critical impact on the health and wellness of lesbians living here.**

Social Belonging and Personal Safety

"There are certain people in this community and certain groups of people with whom I feel my safety is compromised."

A sense of belonging and personal security – key components of health and wellness – are largely unavailable to lesbians who live in a social climate hostile to homosexuality.

Right-wing, Christian fundamentalist, traditional family "values" carry messages of hatred and intolerance. "When they say 'gay lifestyle', it's funny," one woman commented. "I live next to my neighbour and my neighbour is heterosexual and I live the same lifestyle they do. I do the same Friday night thing. My sexual preference is different, that's all. The term 'lifestyle' is code – code for hate."

The lesbians we spoke with emphasized the day-to-day oppressiveness of their lives in northern cities and towns and the sanctioned power of anti-gay groups or individuals to potentially cause them physical or emotional harm. Accepted hatred of lesbians and gays, pervasively demonstrated in newspaper editorials and public anti-lesbian/gay forums, impacts negatively on lesbians. Criticism and hatred allowed in the media, homophobia within the educational system and publicly distributed religious propaganda that condemns homosexuality inflicted an overwhelming fear in some women. Although not every participant experienced this level of fear, most shared an awareness of the health stresses resulting from these circumstances.

In small communities, most people's lives and relationships are put under a microscope of curiosity and rumour. But for lesbians in the north,

“The most detrimental thing to my overall well-being is the isolation, the feeling of not belonging, of not being included. Overcoming that is a horrendous challenge.”

such interest carries a threat to personal and family safety. The decision to be “out” or not, to negotiate work settings, leisure settings and everyday interactions with this risk in mind is stressful. “Because I have had to really hide who I am for such a long time, I’m finding I’m a lot more stressed,” one participant said. “There’s the fear of, the risk of, losing my job if I’m out. My boss has made one comment about that. So, [I’m] hiding again.”

“It is tiring, being lesbian,” a member of the research team said. “It’s work. Either you’re out and being held up as representing the entire Lesbian Nation and feeling obligated to speak out for rights and dignity, or else hiding it and trying to survive and just be ordinary.”

This “work” of just being lesbian includes creating and sustaining alternative families and relationships in the face of a traditional heterosexual “family values” discourse. It entails seeking out other lesbians where there are few, or deciding to avoid other lesbians and face isolation as a result. Unlike cities in southern Canada, in the north there are few on-going lesbian-positive organizations to turn to. “I realized I hadn’t built a support system,” one woman recounted. “We do have dances, but [nothing] other than that. The most detrimental thing to my

overall well-being is the isolation, the feeling of not belonging, of not being included. Overcoming that is a horrendous challenge.”

Rural respondents who were not out assumed that neighbors, co-workers and health care providers knew they were lesbians. One woman expressed it this way: “I don’t believe in being a hero. Your own safety, your own health and your own life is worth more than making a statement, sometimes.” These women relied on people’s good will to just “not say the words” that might result in rejection or lack of care. “Privacy” is a right in the hands of others, not one we exercise ourselves.

Health Care in the North

Health care in the north is underfunded, treatment options in small and remote communities scarce. Participants who lived in rural and remote areas had to choose between doing without health care services or travelling long distances. In winter, road conditions can be hazardous. Those who farmed and raised livestock did not have the extra income to travel. Usually, however, these women expressed a sense of acceptance regarding limited access. Consistent with a pioneering attitude, they expected to make do. Lesbians living in cities placed a greater emphasis on

problems of limited access. They cited a scarcity of female doctors and specialists. “My experience with doctors in the north is that women generally get short shrift and for lesbians it’s [even] harder.” Another woman told us, “The current doctor I have would say, ‘You do exactly as I say or I will fire you as a patient.’” Changing doctors is discouraged; an implicit agreement between doctors in Prince George ensures a lack of mobility for patients. This creates an additional disadvantage for lesbians: consider the situation of one participant who saw her doctor attending an anti-lesbian/anti-gay public forum.

The North as Home

Some participants felt accepted as members of their communities. Others cited the benefits of living outside of cities and of proximity to wilderness. Some expressed this value in spiritual terms; others emphasized the satisfactions of self-reliance, self-determination and privacy. “I’m free to grow a lot of what I eat. I can get exercise. Just being able to stand out in my backyard and watch a beaver, breathe in fresh air that doesn’t have pollution in it. I like to sit in my yard and hold my partner’s hand if I want to. And I don’t think you can do those things in a city.”

—☺ **Formal health care services are permeated by the homophobia and heterosexism of northern society. Homophobic responses from health care providers had discouraged most participants from all but the most minimal use of formal (allopathic) health services.**

Homophobia in the Northern Health Care System

From the intake form at a doctor’s office to hospital emergency rooms, heterosexist and homophobic attitudes permeate northern health care services. “A heterosexual woman doesn’t go in afraid to say, ‘This is my partner.’ She will not have to think about whether or not this doctor in an emergency will hate her if she discloses that she is in this relationship, or if he will treat her differently.” Another participant laughed ruefully as she recounted how a receptionist yelled across a full waiting room, “Your medical card says your husband’s name is Sally.... How can that be?”

Some participants described positive encounters with health care professionals. Others, who stated they had not experienced biases and barriers, later revealed that they had not told their physician or public health nurse that they were lesbian. Most participants used formal health care services minimally. Sometimes

Most often rejection of health care services was related to explicit, demeaning experiences of homophobic responses by health care providers.

this withdrawal was described in terms of a rejection of a western medical model that focussed on disease rather than wellness. “[Health] involves a spiritual component and emotional component and sexual and physical and intellectual and sensual,” a participant told us, “and I had to start taking a holistic approach to health, and I had to separate myself from the medical system.”

Most often, however, rejection of health care services was related to explicit, demeaning experiences of homophobic responses by health care providers. “[The doctor] was very attentive and real talkative before I told him that I was a lesbian,” one woman said, “and then the room became silent. His whole attitude changed, you could tell. And he stared at me. Like stared at me, you know.” “Almost every doctor that I have had has been heterosexual,” another woman told us. “They don’t even know anything about lesbian health. ‘No, I don’t need the pill, this is the fifth time you’ve asked me.’” Lesbian women are caught in a potential catch-22 situation: claim our sexual identity and risk the possibility of censure and poor health care, or conceal it and deal with medical ignorance. Not surprisingly, a few participants revealed that they had simply

rejected the system in anticipation of its rejection of them.

Lack of Confidentiality

When the size of communities is factored in, the risks associated with disclosure of sexual identity intensify. In the small towns and cities of the north, the physician who did your pap test may be the person sitting next to you at a restaurant. Participants who lived in rural and remote areas expressed the most concern about being out to health care providers. Some avoided going to their doctor altogether, others who could afford to travelled to another community. These women tended to cite geographical isolation and the extreme winter climate as significant barriers to health care, but lack of confidentiality was highest on their list. Even lesbians who lived in Prince George expressed reluctance to use the lesbian-positive health services that exist there because they did not want to blur the boundaries of social and professional relationships.

Participants who worked in health services validated this concern: they reported that the systems in which they worked have lax protocols for keeping medical files confidential. Nurses, social workers and psychologists who participated in this study also recounted how lesbians are routinely

negatively labeled in their workplaces. They observed that health professionals in the north appeared to lack any understanding and any resources to help them understand the impact that these biases have on lesbians and their families.

For lesbian women who took their children to health services, the dilemma of disclosure was exacerbated by fear of reprisal against their children from other institutions such as school or the courts in the case of child custody disputes.

History's Legacy

Participants were very aware of the history in medicine of pathologizing homosexuality, of labeling it according to a heterosexist value system.

"To be labeled is a fear. Labeled as sick because you are a lesbian, labeled as depressed because you are a lesbian, labeled as anxious because you are a lesbian." Another participant recounted this experience: "When I went to that doctor I was in the midst of a breakup. He wanted to put me on Prozac. Maybe it's paranoid on my part [but I wondered if] it was because I'm a lesbian."

—☺ **Many participants perceived the biases and barriers they encountered in health services as unremarkable. Generally, participants empha-**

sized their own strengths and coping abilities. Most participants believed that autonomy from the formal health care system had enhanced their health and wellness. Some participants were aware that this autonomy, self-affirming and health-enhancing in one sense, could contribute to ill health, including undiagnosed disease.

Many participants expressed anger over the lack of lesbian-positive, accessible services and gratitude and relief that this research study would address these problems. At the same time, few used the word "barrier" to define their negative experiences. They emphasized the increased health, wellness and self-esteem that had resulted from withdrawal from, or minimal use of, formal health care. Self-reliant and self-determined, many women felt that taking on responsibility for their own health was empowering, and that homophobia and heterosexism was simply "to be expected" of life in the north. Although several participants considered their disengagement to be involuntary, they shared the belief that their health had been enhanced by doing so.

B. Lesbians' Strategies for Health Care: Benefits and Risks

Strategies such as self-education about alternative, non-western health

care practices, exercising, eating well and contact with nature were seen as beneficial and superior to traditional western health care approaches. Some women used information they had learned from lesbian-friendly nurses and physicians, usually from other parts of the province, from physiotherapists, personal networks and research to create self-care routines.

Many women did not access formal health care except in the case of a critical incident. As researchers, we had to ask if these health- and self-enhancing strategies might also be symptoms of denial. Participants from both urban and rural areas told us that they too questioned whether or not their “holistic” approach was chosen entirely out of a belief in its efficacy, or because of dissatisfaction with and mistrust of the health care system. Some women remarked on the painful irony that while they were “proactive” and doing “all the right things” they might also be risking stress-related and undiagnosed illnesses by disengaging from health care services. If illness did occur, these women would not have the option of turning to medical professionals with whom they had established long-standing relationships.

Strategies such as self-censorship or avoiding other known lesbians,

which participants used to protect their lives (and lovers’ and families’ lives) and sense of personal security – health in its most essential form – may also result in social isolation and alienation.

VI

Conclusion

Lesbians living in Canadian cities in the south may feel alienated from health care services, but in contrast to lesbians who live in the north they have more choice with regard to services and more access to lesbian communities for support. In the north, in cities, towns or rural settings, lesbians live in a pervasive climate of homophobia and heterosexism. Considerations of personal freedom, safety and health are complexly and uniquely intertwined, suggesting new understandings about the determinants of lesbian health and wellness in the context of place.

More research is needed with groups who were not reached by this research and who suffer from extreme isolation (psychological and geographical). In particular, respectful and supportive research methodologies to aid women living “double lives” need to be developed. In addition, further research is required to assess the needs of older lesbians living in northern and remote regions in particular. The researchers are aware of many who have lived their lives “in the closet” and who are faced with death of partners and life-threatening illnesses, but whose lifelong silence is a barrier to connection and support.

VII

Policy Recommendations

Increase capacity for lesbian-positive care within the system

Policy at institutional levels should call for broad-based change to the following areas:

Reception practices: Physical surroundings need to reflect an acceptance of a woman regardless of her sexual orientation. Posters that depict a variety of women, rather than only the white heterosexual middle-class mother, for example, would signal that all women are welcome.

Treatment room procedures: Common practices of treatment rooms (both private practice and emergency wards) must excise the standard assumption that women are heterosexual.

Medical personnel: All admitting room and ambulance personnel, family physicians and specialists who have any initial contact with women need to be informed and proactive about the potential for harm arising from heterosexist assumptions and homophobia.

Increase the capacity of the health information system to provide safe, anonymous care

Technology as access: 1-800 numbers, websites and other technological sources of information and referral should be developed and advertised to the public.

Innovative print materials: Patterned on the AIDS and Fetal Alcohol Syndrome informational strategies, develop and promote print materials on lesbian health care needs and resources. These can be posted or left in safe and accessible places.

Educational and informative sessions: Lesbian health consumers develop the curriculum for awareness-training of health information system personnel.

Increase the capacity of the lesbian community

Peer support: Training, workshops and logistical support on health care

issues and the health care system should be developed for and by lesbians.

Preventative strategies: Preventive and educational sessions on health, nutrition, stress, etc. must be developed with a specific focus on the lesbian audience.

Community awareness: Implement broad-ranging public educational and promotional campaigns to increase understanding of lesbian realities and rights and community responsibilities.

Community safety: Commitment to a broad range of community development strategies to ensure safer communities for all.

Diversity awareness: Lesbians come in all ages, classes, ethnic and cultural groupings, employment and education categories. Diversity awareness of differences and similarities must be stressed both within communities and in formal and informal health care systems.

Increase the capacity of the professional training system

Develop policy recommendations to local health authorities: Present recommendations on policy review and revision of training supplements to regional health authorities.

Curriculum development for health care providers: Support the develop-

ment of curricula and training programs for health care providers, especially frontline staff, to enhance their ability to serve diverse clients and patients of the health care system.

Training institutions: Provide recommendations and suggest curricula to health care training institutions – especially medical schools – on the particular requirements of lesbian patients. Expand the current average of three hours of training hours devoted to lesbian health and gay health in medical school training (for review of this see Robinson & Cohen, 1996).

Utilization of local expertise: Local organizations supporting lesbian and gay rights are eager to assist in the development and provision of policy and curricula recommendations and in the provision of training. Give them the incentive to do so by providing adequate resources to develop materials and assuring that their efforts will bring results.

Authors and Research Team

Authors

Lynda Anderson, PHN
Coordinator
Women's Wellness Programs
Northern Interior Health Region,
Prince George

Theresa Healy, PhD
Coordinator
Northern Secretariat
B.C. Centre of Excellence
for Women's Health

Barbara Herringer, PhD
Chair
Social Work
Associate Professor
Women's/Gender Studies,
University of Northern British
Columbia

Barbara Isaac, PhD (cand)
Principal Investigator
Assistant Professor
Social Work and Women's/
Gender Studies, University of
Northern British Columbia

Ty Perry, MA (cand)
Gender Studies
University of Northern British
Columbia

Research Team

Ida Alleman, MA
Counsellor
Intersect Child and Family Services,
Prince George

Lynda Anderson, PHN
Coordinator
Women's Wellness Programs
Northern Interior Health Region,
Prince George

Marlene Cust, PhD
Psychologist
Prince George

Theresa Healy, PhD
Executive Director
Community Planning Council of
Prince George

Barbara Herringer, PhD
Chair
Social Work
Associate Professor
Women's/Gender Studies, UNBC

Maria Hudspith, MA (cand)
Educational Studies
University of British Columbia

Barbara Isaac, PhD (cand)
Principal Investigator
Assistant Professor
Social Work and Women's/Gender
Studies, UNBC

Laurie McKinnon, PhD
Psychologist
Private Practic, Prince George

Ty Perry, MA (cand)
Gender Studies
UNBC

References and Bibliography

Inclusive Research

Canadian Research Institute for the Advancement of Women (1996). Feminist research ethics: A process. Second Edition.

Canadian Research Institute for the Advancement of Women (1996). Research partnerships: A feminist approach to communities and universities working together.

Kirby, S., & McKenna, K. (1989). Experience, research, social change: Methods from the margins. Toronto: Garamond Press.

Lather, P. (1991). Getting smart: Feminist research and pedagogy with/in the postmodern. New York, London: Routledge.

Bibliography

Adams, M.L. (1989). "You're all right so long as you act nice." Lesbians' experience of the North American health care system. Fireweed, 53-67.

Andrews, S. (1997). Gynecologic and obstetric care of lesbian and bisexual women. In H. Varney (Ed.), Varney's midwifery. Third Edition. London: Jones and Bartlett.

B.C. Centre for Disease Control. (1996). Annual report.

Bell, D., & Valentine, G. (1995). Queer country: Rural lesbian and gay lives. Journal of Rural Studies, 11 (2), 113-122.

Bradford, J., & Ryan C. (1987). The national lesbian health care survey. Washington, DC: National Lesbian and Gay Health Foundation.

Buenting, J.A. (1992). Health life-styles of lesbian and heterosexual women. Health Care for Women International, 13, 165-171.

Carlson, D. L. (1992). Ideological conflict and change in the sexuality curriculum. In J.T. Sears (Ed.), Sexuality and the curriculum: The politics and practices of sexuality education. New York: Teachers College Press.

- Cassidy, R., & Hughes, T. (1995). Lesbian health: Barriers to care. In B. McElmurry & P.R. Spreen (Eds.), The Annual Review of Women's Health, Vol. 3. New York: National League for Nursing Press.
- Cole, R., & Cooper, S. (1991). Lesbian exclusion from HIV/AIDS education: Ten years of low-risk identity and high risk behaviour. SIECUS Report.
- Collier, H. (1982). Counselling women: A guide for therapists. New York: Free Press.
- Coates, K., & Morrison, W. (1992). The forgotten north: A history of Canada's provincial norths. Toronto: James Lorimer & Company.
- Denenberg, R. (1995). Report on lesbian health. Women's Health International, 5 (2), 81-91.
- DeVault, M. (1999). Liberating method: Feminism and social research. Philadelphia: Temple University Press.
- Douglas, C.J., Kalman, C.M., & Kalman, T.P. (1985). Homophobia among physicians and nurses: An empirical study. Hospital and Community Psychiatry, 36 (12), 1309-1311.
- Edelman, D. (1986). University health services sponsoring lesbian health workshops: Implications and accessibility. Journal of American College Health, 35, 44-45.
- Eliason, M.J., Donelan, C., & Randall, C. (1992). Lesbian stereotypes. Health Care for Women International, 13, 131-144.
- Eliason, M.J., & Randall, C.E. (1991). Lesbian phobia in nursing students. Western Journal of Health Research, 13 (3), 363-374.
- Findlay, D. (1993). The good, the normal and the healthy: The social construction of medical knowledge about women. Canadian Journal of Sociology, 18 (2), 115-135.
- Fisher, S. Lesbian health issues: A guide for gynaecologists.
- Freedman, E. (1982). Resources for lesbian history. In M. Cruikshank (Ed.), Lesbian studies: Present and future. New York: The Feminist Press.
- Gaventa, J. (1988). Participatory research in North America. Convergence, 21 (2/3), 19-28.
- Gentry, S.E. (1992). Caring for lesbians in a homophobic society. Health Care for Women International, 13, 173-180.
- Glassman, C. (1995). Lesbians and HIV disease. Journal of Gay and Lesbian Social Services, 2 (3/4), 61-74.

- Hall, J. (1992). An exploration of lesbians' images of recovery from alcohol problems. Health Care for Women International, 13, 181-198.
- Hamelin, L.E. (1989). Images of the north. In C.S. Coates & W.R. Morrison (Eds.), Interpreting Canada's north: Selected readings (pp. 7-17). Mississauga, Ontario: Copp Clark Pitman.
- Healthy Communities Committee. (1997). Lesbians, gays and bisexuals. In Quality of life: Report on the quality of life in Prince George. City of Prince George, B.C.
- Hugman, R. (1991). Power in caring professions. London: MacMillan.
- Isaac, B., & Stokes, J. (1999). Northern communities – southern bureaucracies: Power imbalances within hinterland services to children. In R. Delaney, K. Brownlee & K. Zapf (Eds.), Strategies for northern social work practice. Thunder Bay, Ontario: Centre for Northern Studies, Lakehead University.
- Jones, R. (1988). With respect to lesbians. Nursing Times, 84 (20), 48-49.
- Lucas, V.A. (1992). An investigation of the health care preferences of the lesbian population. Health Care for Women International, 13, 221-228.
- Mathews, C.W.M., Booth, M.W., Turner, J.D., & Kessler, L. (1986). Physicians' attitudes toward homosexuality – survey of a California county medical society. The Western Journal of Medicine, 144 (86), 106-110.
- Maguire, P. (1987). Doing participatory research: A feminist approach. Amherst, Massachusetts: The Center for International Education, University of Massachusetts.
- Martinez-Brawley, E. (1990). Perspectives on the small community. Washington: NASW Press.
- Narayan, U. (1988). Working together across difference: Some considerations on emotions and political practice. Hypatia, 3.2, 31 - 47.
- Nechas, E., & Foley, D. (1994). Unequal treatment: What you don't know about how women are mistreated by the medical community. New York: Simon & Schuster.
- Park, P. (1992). The discovery of participatory research as a new scientific paradigm: Personal and intellectual accounts. The American Sociologist, 23 (4), 29-31.
- Potts, K. (2000). Personal Communication, UNBC, February, 2000.
- Randall, C.E. (1989). Lesbian phobia among BSN educators: A survey. Journal of Education, 28 (7), 302-306.
- Rankow, E. (1995). Lesbian issues

for the primary care provider. Journal of Family Practice, 40 (5), 486-491.

Reagan, P. (1981). The interaction of health professionals and their lesbian clients. Patient Counselling and Health Education, 3, 21-25.

Reinharz, S. (1992). Feminist methods in social research. New York, Oxford: Oxford University Press.

Renzetti, C.M. (1993). Violence in lesbian relationships. In M. Hansen & M. Naraway (Eds.), Battering and family therapy: A feminist perspective. Newbury Park: Sage.

Robertson, A., & Minkler, M. (1994). New health promotion movement: A critical examination. Health Education Quarterly, 21 (3), 295-312.

Robertson, M. (1992). Lesbians as an invisible minority in the health services area. Health Care for Women International, 13, 155-163.

Robinson, G., & Cohen, M. (1996). Gay, lesbian and bisexual health care issues and medical curricula. Canadian Medical Association Journal, 155, 709-711.

Rosser, S. (1993). Ignored, overlooked or subsumed: Research on lesbian health and health care. National Women's Studies Association Journal, 5 (2), 183-203.

Rothblum, E.D. (1994). Introduction

to the special section: Mental health of lesbians and gay men. Journal of Consulting and Clinical Psychology, 62 (2), 211-212.

--. (1994). "I only read about myself on bathroom walls": The need for research on the mental health of lesbians and gay men. Journal of Consulting and Clinical Psychology, 62 (2), 213-220.

--. (1990). Depression among lesbians: An invisible and unresearched phenomenon. Journal of Gay and Lesbian Psychotherapy, 1 (3), 67-87.

Sears, J. (1992). Dilemmas and possibilities of sexuality education: Reproducing the body politic. In J.T. Sears (Ed.), Sexuality and the curriculum: The politics and practices of sexuality education. New York: Teachers College Press.

Shaw, N.S. (1989). New research issues in lesbian health. Women's Studies, 17, 125-137.

Simkin, R.J. (1991). Lesbians face unique health care problems. Canadian Medical Association, 145 (12), 1620-1623.

Simms, G. (1996). Aspects of women's health from a minority/diversity perspective. Paper given at the Canada-USA Women's Health Forum.

Skinner, W.F. (1994). The prevalence and demographic predictors of illicit and licit drug use among lesbians and gay men. American Journal of Public Health, *84* (4), 1307-1310.

Smith, D. (1987). Women's perspective as a radical critique of sociology. In S. Harding (Ed.), Feminism and methodology: Social science issues. Bloomington, Indiana: Indiana University Press.

Smith, E.M., Johnson, S.R., & Guenther, S.M. (1985). Health care attitudes and experiences during gynecological care among lesbians and bisexuals. American Journal of Public Health, *75* (9), 1085-1087.

Sorrel, S., & Watson, J. (1997). And they lived happily ever after. Report on the LABIA project, Prince George, UNBC.

Stevens, P.E. (1996). Lesbians and doctors: Experiences of solidarity and domination in health care settings. Gender and Society, *10* (1), 24-41.

--. (1995). Structural and interpersonal impact of heterosexual assumptions on lesbian health care clients. Nursing Research, *44* (1), 25-30.

--. (1994). HIV prevention education for lesbians and bisexual women: A cultural analysis of a community intervention. Social Science and

Medicine, *39* (11), 1565-578.

--. (1994). Lesbians' health-related experiences of care and non-care. Western Journal of Nursing Research, *16* (6), 639-659.

--. (1994). Protective strategies of lesbian clients in health care environments. Research in Nursing & Health, *17* (3), 217-229.

--. (1993). Marginalized women's access to health care: A feminist narrative analysis. Advances in Nursing Science, *16* (2), 39-56.

--. (1992). Care experiences of a radically and economically diverse group of lesbians: A narrative study. Ann Arbor, Michigan: UMI.

Stevens, P.E., & Hall, J.M. (1991). A critical historical analysis of the medical construction of lesbianism. International Journal of Health Services, *21* (2), 291-307.

--. (1990). Abusive health care interactions experienced by lesbians: A case of institutional violence in the treatment of women. Response, *13* (3), 23-27.

--. (1988). Stigma, health beliefs and experiences with health care in lesbian women. Image: Journal of Nursing Scholarship, *20* (2), 69-73.

Todd, A.D. (1989). Intimate adversaries: Cultural conflict between doctors and patients. Philadelphia: University

of Pennsylvania Press.

Trippet, S.E., & Bain, J. (1993). Physical health problems and concerns of lesbians. Women & Health, 20 (2), 59-70.

- -. (1992). Reasons American lesbians fail to seek traditional health care. Health Care for Women International, 13, 145-153.

Vancouver-Richmond Health Board Gay, Lesbian, Bisexual, Transgender Population Health Advisory Working Group. (1997). Proceedings from the GLBT Health Conference.

Vasquez, C. (1994). The myth of invulnerability: Lesbians and HIV disease. Focus: A Guide to AIDS Research and Counselling, 8 (9), 1-6.

White, T.A. (1979). Attitudes of psychiatric nurses toward same sex orientations. Nursing Research, 28 (5), 276-281.

Winnow, J. (1992). Lesbians evolving health care: Cancer and AIDS. Feminist Review, 41 (Summer), 68 - 76.

Young, E.W. (1988). Nurses' attitudes toward homosexuality: Analysis of change in AIDS workshops. The Journal of Continuing Education in Nursing, 19 (1), 9-12.