Specific Challenges Related to the Physical, Mental and Sexual Health of LGBTQ+ Women

Brief submitted to the House of Commons Standing Committee on Health as part of its study on LGBTQ2 health in Canada

By the Quebec Lesbian Network (QLN)

April 2019

About the organization

The Réseau des lesbiennes du Québec - Quebec Lesbian Network (RLQ - QLN) is the only non-profit advocacy group for lesbians and sexually diverse women in Quebec. It represents LGBTQ+ women (women who identify as lesbian, queer, bisexual, trans, pansexual, gender fluid, radical, political and feminist lesbians, etc.) from all regions across Quebec, regardless of age, social class, cultural and linguistic community, and so on. The QLN plays an advocacy role in dealing with government and social agencies regarding the quality of life of sexually diverse women.

The QLN was founded in 1996, during the Quebec gay and lesbian general conference, to give Quebec lesbians an independent voice in the public forum. During the conference, thirty women decided to form an ad hoc committee. In the decade that followed, the QLN proved to be a relevant organization raising important issues. The fact is that sexually diverse women tend to be made invisible, both outside and within the LGBTQ+ community.

Current situation and specific challenges

With this invisibility comes a number of challenges currently affecting sexually diverse women. These challenges, which are complex due to double discrimination based on gender and sexual orientation, include a number of issues related to the physical and psychological health of LGBTQ+ women. Studies show that most women who identify as lesbians seek therapy for mental health issues not only related to being excluded from their peers, but also from their various immediate environments (Ruble & Forstein, 2007). In fact, 66% of lesbians seek support for various mental health issues stemming from many situations of discrimination and violence to which they have been exposed – and/or have fallen victim to – both directly and indirectly (Benton & Haller, 2010). The mental health issues are especially related to (external and internal) lesbophobia experienced by those women, which leads to a considerable increase in self-destructive behaviours such as alcohol and psychoactive drug use (Benton & Haller, 2010). Isolation almost always leads to depression for these women. The fact that they live "in the closet," keeping their sexual orientation a secret, considerably increases their risk of developing an array of psychological issues, including experiencing one or more major depressive episodes (Benton & Haller, 2010). Lesbians have a five-fold greater risk of suicide (Lhomond & Saurel-Cubizolles, 2009) and, according to the 2007 Ruble & Forstein study, they are much more likely to develop anxiety than males in the LGBTQ+ community. Lesbians are also often targeted by various forms of violence and intimidation due to their sexual orientation and gender, not to mention the hidden violence experienced by women who have recently identified with the LGBTQ+ community. Take, for instance, domestic violence in female couples. The fact that little is known about this taboo issue renders their problems invisible. Few services are provided to these women, which results in lesbians showing greater symptoms of post-traumatic stress disorder (Zellinger, 2004 and Drabble, Eliason & Reyes, 2010). Because these women live in hiding, the specific

challenges they face are often eclipsed in the shadow of gay and trans advocacy. Just because we hear little to nothing about these issues does not mean that they do not exist. According to Ruble & Forstein (2007), 66% of women who ask various organizations for help identify as lesbians. In order to take control of their health, women need services, political representation and positive role models who are open with their own sexual orientation. Invariably, women who hide their sexual orientation for fear of being judged will not discuss issues with health care professionals. They will not speak out when subjected to psychological, physical, sexual and other types of violence.

There are numerous cases of sexual discrimination and sexual violence in universities. Various studies show that lesbians are twice as likely as heterosexual women to experience assault (15.5% versus 7.5%) (Dibble, 2010). Those who are openly lesbian are three times more likely to experience sexual assault on campus (Rothman, 2011). One European study, *Violence Against Lesbians*, specifically looked at the forms of violence experienced by lesbians (an exceptionally rare study subject). The researchers found that 98% of these women experienced verbal abuse, 24% experienced physical violence and 44% experienced sexual violence because of their sexual orientation (Ohms, Müller, 2001). While the study was conducted over a decade ago, more recent research confirms that the situation is relatively unchanged. According to the *Enquête Sexualité, Sécurité et Interactions en Milieu Universitaire* (ESSIMU) [survey of university community interactions, safety and sexuality] (2016), 42% of university students and staff members have experienced at least one form of sexual violence. Sexually diverse women are more likely to experience some form of sexual violence (39.2% of respondents) than heterosexual women; they also experience more harassment (ESSIMU, 2016). This violence is committed mostly by men: 90.9% versus 27.4% for women (ESSIMU, 2016). However, this new data does present the full picture, given that victims of sexual assault tend to stay silent and isolated: 61% of them do not report the individuals who assaulted them (ESSIMU, 2016). It should also be pointed out that there is a glaring lack of exhaustive studies specifically on sexually diverse women in both Quebec and Canada.

In a (rare) study, recently published in *The Journal of Adolescent Health and Medicine* (2018), Quebec university researchers found that sexual and gender minorities have a higher risk than heterosexual and cisgender students of experiencing sexual violence on university campuses (Edwards KM & coll., 2015). Though the specific rates of sexual violence vary depending on the definition used, sexual assault research shows that cisgender men report the lowest rates of sexual assault, followed by cisgender women. Transgender and non-binary individuals, on the other hand, report rates two to three times higher than cisgender women (Edwards KM & coll., 2015). In addition, gay, lesbian, bisexual and questioning students report higher rates of sexual assault than heterosexual students (Coulter RW, 2017). However, those statistics only reflect those individuals who have the courage to report their assaults, because women have long been silenced. By its inaction, society implicitly tolerates such assaults against women. This makes it difficult to break the silence. Given that variations exist within sexual minorities, some studies

(Coulter RW 2017, Ford J, 2016, Blosnich J, 2012), but not all (Coulter RW & Rankin, 2017), found that individuals who identify as bisexual experience higher rates of sexual violence than those who identify as gay or lesbian. Furthermore, young adults are increasingly adopting sexual identities that fall outside "traditional" categories. Examples include queer identity (associated with attraction patterns that reject the gender binary) and pansexuality (Mereish EH, 2017). We still do not know whether students with these identities have a higher risk of experiencing sexual violence. The study provides specific strategies to prevent sexual violence, such as encouraging universities to work with at-risk groups to develop prevention strategies, create safe spaces and change transphobic, lesbophobic and homophobic attitudes among university staff members. These frontline employees, much like health workers (on and off campus), should have to the tools needed to develop strategies to change those attitudes. These tools should be created by consulting with LGBTQ+ community groups that work with those target groups on a daily basis, without however making the target groups, especially women, invisible within the community.

Working with community groups provides insight into the challenges faced by sexually diverse women, which are far too often hidden in our society. Just because someone's lived experience cannot be seen or heard does not mean it does not exist. Take, for instance, domestic violence in female couples. The fact that little is known about this taboo issue renders their problems invisible; this leads to a lack of services tailored to their needs. LGBTQ+ couples have the same rights and social protections as heterosexual couples when it comes to domestic violence (Institut national de santé publique du Québec, 2016) but more work is required to provide LGBT individuals with better access to services tailored to their needs (Institut national de santé publique du Québec, 2016). In Quebec, there is little to no awareness about domestic violence in LGBTQ+ women couples and there are very few support services, apart from the Centre de solidarité lesbienne (CSL). Yet domestic violence is also present in same-sex couples and has the same types of repercussions as for heterosexual couples. According to the most recent (2016) Statistics Canada general social survey, 8% of gay Canadians report being victims of domestic violence – twice as much as heterosexual Canadians, where the self-reported rate of domestic violence can be as high as 4%. Assuming that gender is a social construct, women are conditioned by their upbringing to be deferential. Society conditions them to be soft, gentle, seductive and often submissive. Our social constructs tend to trivialize sexual violence committed against women and to ignore domestic violence in female couples. The silence around sexual violence perpetrated against women stems from their social conditioning. For example, they will refrain from reporting their assaults to the police for fear of being judged or ignored. This situation occurs at different levels, especially in the legal system. If these women cannot use the legal system, how can we claim to have representative statistics? In that sense, we must not reproduce heteronormative and heterosexist prejudice when providing health services to sexually diverse women, or else victims will keep quiet about their condition and their health problems. There needs to be a change in attitudes, so as not to trivialize the violence perpetrated against women,

regardless of the context in which it occurred, be it committed by a man or another woman, in public or in private. To this day, women are still considered inferior, vulnerable, weak and submissive, and most of the violence against women is committed by men. To advocate for LGBTQ+ health, and more specifically (for the purposes of this brief) for LGBTQ+ women's health, is to first and foremost advocate for gender equality. Equal rights, equal opportunities and equality among individuals are concepts that are fundamental to the physical and mental health of sexually diverse women. Women have the right to not be discriminated against based on gender and sexual orientation. They have the right to be women and to love women. Many sexually diverse women experience double discrimination (potentially triple, quadruple, etc., for women who are racialized, trans, and so on) on a daily basis when they see a general practitioner or a specialist, as well as when they go to hospitals, schools, and public and private long-term care facilities. Regardless of their situation or age, these women still face invisible challenges and systemic discrimination stemming from phallocratic and heteronormative social constructs. It is important to highlight the challenges faced by sexually diverse women with campaigns geared toward raising public awareness and changing attitudes. Empowerment campaigns for LGBTQ+ women are important if we are to understand their vulnerable situation and give them the opportunity to take control over their lives, making them masters of their own physical and psychological well-being. It is in this context, and for the reasons mentioned in this brief, that the government should draft legislation banning conversion therapy in Canada.

The QLN wishes to make the following recommendations:

Recommendations

- Recognize sexually diverse women as an at-risk group and make them a priority in the next action plan on sexual violence. Ensure that their specific issues are taken into account and that initiatives to combat sexual violence are inclusive of their realities.

- Mount prevention and awareness campaigns aimed at LGBTQ+ women with a focus on empowerment to make them less vulnerable to physical and psychological abuse.

- Ensure that compulsory classes on sexuality are introduced in schools and given time and prominence equal with other subjects. As well, give special consideration to having them taught by sexuality experts and provide them with the necessary resources to teach these classes in all primary and secondary schools across the country.

- Take steps to address mental health problems, in particular by funding grassroots organizations working to break the isolation experienced by sexually diverse women through efforts to change attitudes and deliver services tailored to their unique needs.

- Educate, inform and train mental, physical and sexual health professionals on the specific issues pertaining to sexually diverse women, no matter where they access services (hospitals, schools, long-term care facilities, women's centres, etc.)

- Develop prevention strategies to create safe spaces and address transphobic, lesbophobic and biphobic attitudes in front-line health workers. These workers, like those working on university campuses, should have the necessary tools for strategies to change attitudes and be able to help protect groups of women who are more vulnerable to sexual violence.

- Ban and legislate against conversion therapies in Canada.

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